

# Connecticut

## UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022  
(generated on 08/03/2020 8.39.06 AM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

and

Center for Mental Health Services  
Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2021

End Year 2022

#### State SAPT DUNS Number

Number 103626086

Expiration Date

#### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

#### II. Contact Person for the SAPT Grantee of the Block Grant

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

Mailing Address P.O. Box 341431 410 Capitol Avenue

City Hartford

Zip Code 06134

Telephone 860-418-6676

Fax 860-418-6691

Email Address Miriam.Delphin-Rittmon@ct.gov

#### State CMHS DUNS Number

Number 103626086

Expiration Date

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

#### II. Contact Person for the CMHS Grantee of the Block Grant

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

Mailing Address 410 Capitol Ave

City Hartford

Zip Code 06134

Telephone (860) 418-8650

Fax

Email Address Miriam.Delphin-Rittmon@ct.gov

### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

### IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

### V. Date Submitted

Submission Date

Revision Date 7/29/2020 2:11:38 PM

### VI. Contact Person Responsible for Application Submission

First Name Susan

Last Name Bouffard

Telephone 860-418-6993

Fax

Email Address susan.bouffard@ct.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

#### Footnotes:

# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

### Fiscal Year 2021

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"



generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR 975.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"



generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.


The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: CONNECTICUT

Name of Chief Executive Officer (CEO) or Designee: Ned Lamont

Signature of CEO or Designee: 

Title: GOVERNOR

Date Signed: 7/31/2020  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

#### Fiscal Year 2021

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
<b>Title XIX, Part B, Subpart III of the Public Health Service Act</b>		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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  1. The dangers of drug abuse in the workplace;
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- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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  1. Abide by the terms of the statement; and
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- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.



The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2021

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
<b>Title XIX, Part B, Subpart III of the Public Health Service Act</b>		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §5794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.


The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.



I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Ned Lamont

Signature of CEO or Designee<sup>1</sup>: 

Title: GOVERNOR

Date Signed: 7/31/2020

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

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Name

Title

Organization

---

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## Planning Tables

**Table 2 State Agency Planned Expenditures [MH]**

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 1/1/2021 Planning Period End Date: 1/1/2022

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$1,471,323	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$590,759,353	\$0	\$0
7. Other 24 Hour Care		\$1,877,976	\$0	\$39,440,138	\$154,672,479	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$10,472,522	\$0	\$20,819,178	\$839,422,199	\$0	\$9,975,629
9. Administration (Excluding Program and Provider Level)***		\$15,000	\$0	\$0	\$87,370,619	\$0	\$0
<b>10. Total</b>	<b>\$0</b>	<b>\$13,836,821</b>	<b>\$0</b>	<b>\$60,259,316</b>	<b>\$1,672,224,650</b>	<b>\$0</b>	<b>\$9,975,629</b>

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

\*\* Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

\*\*\* Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2020      Planning Period End Date: 9/30/2022

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$13,719,986	\$13,763,902
2 . Primary Substance Abuse Prevention	\$4,493,223	\$4,446,346
3 . Early Intervention Services for HIV**	\$0	
4 . Tuberculosis Services	\$0	
5 . Administration (SSA Level Only)	\$0	
<b>6. Total</b>	<b>\$18,213,209</b>	<b>\$18,210,248</b>

\* Prevention other than Primary Prevention

\*\* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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**Footnotes:**

NOT FINAL

# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2020      Planning Period End Date: 9/30/2022

Strategy	A	B	C
	IOM Target	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1. Information Dissemination	Universal	\$343,164	\$495,484
	Selective	\$13,163	\$10,431
	Indicated	\$14,461	\$15,647
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$370,788</b>	<b>\$521,562</b>
2. Education	Universal	\$1,078,691	\$1,073,548
	Selective	\$41,376	\$22,601
	Indicated	\$45,455	\$33,901
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$1,165,522</b>	<b>\$1,130,050</b>
3. Alternatives	Universal	\$43,099	\$41,290
	Selective	\$1,653	\$869
	Indicated	\$1,816	\$1,304
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$46,568</b>	<b>\$43,463</b>
4. Problem Identification and Referral	Universal	\$28,868	\$41,290
	Selective	\$1,108	\$869
	Indicated	\$1,216	\$1,304
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$31,192</b>	<b>\$43,463</b>
	Universal	\$2,154,129	\$1,486,450

5. Community-Based Process	Selective	\$82,627	\$31,294
	Indicated	\$90,774	\$46,941
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$2,327,530</b>	<b>\$1,564,685</b>
6. Environmental	Universal	\$417,977	\$247,742
	Selective	\$16,033	\$5,216
	Indicated	\$17,613	\$7,823
	Unspecified	\$0	\$0
	<b>Total</b>	<b>\$451,623</b>	<b>\$260,781</b>
7. Section 1926 Tobacco	Universal	\$100,000	\$100,000
	Selective		
	Indicated		
	Unspecified		
	<b>Total</b>	<b>\$100,000</b>	<b>\$100,000</b>
8. Other	Universal		\$743,225
	Selective		\$15,647
	Indicated		\$23,470
	Unspecified		\$0
	<b>Total</b>	<b>\$0</b>	<b>\$782,342</b>
<b>Total Prevention Expenditures</b>		<b>\$4,493,223</b>	<b>\$4,446,346</b>
<b>Total SABG Award*</b>		<b>\$18,213,209</b>	<b>\$18,210,248</b>
<b>Planned Primary Prevention Percentage</b>		<b>24.67 %</b>	<b>24.42 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**



## Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2020      Planning Period End Date: 9/30/2022

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
Universal Direct	\$3,154,692	\$2,979,052
Universal Indirect	\$1,003,786	\$1,244,977
Selective	\$159,509	\$88,927
Indicated	\$175,236	\$133,390
<b>Column Total</b>	<b>\$4,493,223</b>	<b>\$4,446,346</b>
<b>Total SABG Award*</b>	<b>\$18,213,209</b>	<b>\$18,210,248</b>
<b>Planned Primary Prevention Percentage</b>	<b>24.67 %</b>	<b>24.42 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**

NOT FINAL

## Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2020      Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input checked="" type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

**Footnotes:**

NOT FINAL

# Planning Tables

**Table 6 Non-Direct-Services/System Development [SA]**

Planning Period Start Date: 10/1/2020      Planning Period End Date: 9/30/2022

Activity	FFY 2020			FFY 2021		
	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$0	\$0	\$0	\$0	\$0	\$0
2. Infrastructure Support	\$0	\$0	\$0	\$0	\$0	\$0
3. Partnerships, community outreach, and needs assessment	\$0	\$0	\$0	\$0	\$0	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$0	\$0	\$0	\$0	\$0	\$0
5. Quality Assurance and Improvement	\$0	\$0	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$0	\$0	\$0	\$0	\$0	\$0
7. Training and Education	\$0	\$0	\$0	\$0	\$0	\$0
<b>8. Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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**Footnotes:**

NOT FINAL

## Planning Tables

**Table 6 Non-Direct-Services/System Development [MH]**

MHBG Planning Period Start Date: 10/01/2020      MHBG Planning Period End Date: 09/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems	\$200,000	\$50,000
2. Infrastructure Support	\$450,000	\$450,000
3. Partnerships, community outreach, and needs assessment	\$100,000	\$100,000
4. Planning Council Activities (MHBG required, SABG optional)	\$15,000	\$15,000
5. Quality Assurance and Improvement	\$80,000	\$65,000
6. Research and Evaluation	\$0	\$0
7. Training and Education	\$75,000	\$65,000
<b>8. Total</b>	<b>\$920,000</b>	<b>\$745,000</b>

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**Footnotes:**



## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>69</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>69</sup> <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

#### Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

DMHAS (Department of Mental Health and Addiction Services) has been a single integrated department since 1995, servicing all behavioral health needs of adults. In 2012, the Mental Health Planning Council expanded its purview and membership to include substance use concerns and became the Behavioral Health Planning Council. Connecticut has been submitting combined mental health/substance abuse block grant applications since 2014/15. In 2018, Connecticut restructured its advocacy/evaluation/planning entities from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) into integrated Regional Behavioral Health Action Organizations (RBHAOs). The 5 RBHAOs cover the state via the 5 DMHAS regions for all behavioral health issues, including naloxone education and distribution. The RBHAOs are tasked with the annual review of the behavioral health service system and the priority setting process. Presentations for the Council are a mix of behavioral health concerns inclusive of substance use related topics.

The Children's Behavioral Health Advisory Council and the Adult Behavioral Health Planning Council were presented the 20/21 Block Grant Application at meetings in June and July and invited to comment and make recommendations. That information is included in the block grant application.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Joint Behavioral Health Planning Council in Connecticut is comprised of the Adult Behavioral Health Planning Council coordinated by DMHAS and the Children's Behavioral Health Advisory Council, coordinated by DCF. Meetings are held separately for the adult and children's council and also jointly.

Duties of the Behavioral Health Planning Council include:

- to review the combined SABG/MHBG application/plan provided by DMHAS and to submit any recommendations for modifications of those plans

- to serve as advocates for adults with DMI and children with SED and their families, as well as others with behavioral health problems

- to monitor, review, and evaluate, at least annually, the allocation and adequacy of behavioral health services in Connecticut  
Council membership includes representation from the RBHAOs, state agencies, other public and private entities concerned with

the need, planning, operation, funding, and use of behavioral health services; family members of adults with SMI and children with SED; persons in recovery from behavioral health conditions; representatives of organizations of individuals with mental health and/or substance use disorders and their families and community groups advocating on their behalf. Stakeholders from communities across Connecticut will find their interests represented by the RBHAO council members attending the meetings. Because the RBHAOs conduct an annual review of the service system in order to establish priorities to inform the block grant and other activities, they utilize community stakeholder connections to hold focus groups and community conversations with those regional stakeholders and other interested parties to collect information on the service system, including strengths, needs/gaps and barriers, and make recommendations. They construct regional reports based on their findings which are integrated into a statewide report.

Children's Behavioral Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) ) to "promote and enhance the provision of behavioral health services for all children" in Connecticut. The CBHAC serves as the state's Children's Mental Health Planning Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state's System of Care for children and families. CBHAC is comprised of the Commissioners of Children and Families, Social Services, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, five members appointed by the leadership of the General Assembly, as well as fifteen members appointed by the commissioner of DCF. The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. "At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." In addition, a parent is to serve as co-chair of the CBHAC/CMHPC. CBHAC meetings held throughout the year include time for review of the MHBG. Meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan in January, March and June of 2020..

*Please indicate areas of technical assistance needed related to this section.*

N/A

*Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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**Footnotes:**

In 2020, due to the COVID-19 pandemic, the schedule of Planning Council meetings was disrupted in the following ways: the Joint Behavioral Health Planning Council meeting scheduled for March 12, 2020 was canceled and all subsequent meetings of the Adult and Joint Planning Councils have been held via teleconference call.

NOT FINAL



**Adult State Behavioral Health Planning Council  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Wednesday, July 15, 2020 - 12:30 PM – 2:30 PM	
<b>Location:</b>	conference call	
<b>Attendance:</b>		
<b>Members Present:</b>	Marcia DuFore, Pam Mautte, Margaret Watt, Allison Fulton, Angela Duhaime, Lisa Jameson, MuiMui Hin-McCormick, Ingrid Gillespie and Donna Maselli	
<b>Staff Present:</b>	Susan Bouffard, Michael Giralmo, Karin Haberlin	
<b>AGENDA ITEM</b>	<b>DISCUSSION</b>	<b>ACTION</b>
<b>Introductions</b>		
<b>Review of Minutes</b>	Minutes from the April 15, 2020 meeting were approved without changes.	
<p><b>Presentation on DMHAS Responses to 2019 Priority Report Recommendations</b></p> <p>Susan Bouffard</p>	<p>Susan prefaced the presentation by saying that she reviewed the recommendations from the 2019 Regional Priority Setting Reports and then followed up with the various DMHAS managers/directors to collect information on actions taken in response to the recommendations. She chose only to include the items for which some action had been taken. She went through her power point presentation (see attached). Following the presentation there were comments and questions as follows:</p> <ul style="list-style-type: none"> <li>• What could be done in response to AU and CCAR choosing not to include problem gambling training as part of their Peer Support Specialist or Recovery Coach training when they receive DMHAS funding?</li> <li>• Susan was thanked for following up with this presentation when it was requested at the previous meeting.</li> <li>• The access line that was recommended to need improvement was not the 211 line, but the 1-800 access line; however, there had not been complaints about this line recently</li> <li>• Data requested by the RBHAOs that was still desired was not just on suicide, but also on self-injury. Susan asked Michael whether the Critical Incident data could be the source of this information and he agreed. Someone also suggested the UCONN health center may be able to help.</li> <li>• The recommendation that hadn't been acted on by DMHAS should not be left out, but perhaps a slide should be inserted listing what hasn't been addressed. Along this same vein, how can Council members advocate more effectively for larger system change, e.g., additional FEP or peer respite program? Susan suggested the State Board meeting might be a good venue and then suggested that, as had previously been done, DMHAS leadership be invited to a presentation by</li> </ul>	<p>Power point presentation attached.</p>

	<p>the regions on their regional report recommendations, perhaps as a group. It was also pointed out that there are a number of online options that might be useful.</p> <ul style="list-style-type: none"> <li>• Telehealth, while it has expanded in a big way due to the virus, still has issues: <ul style="list-style-type: none"> <li>○ Free minutes given by phone companies early in the virus ended June 30; if people qualify for state phones they should also receive unlimited minutes</li> <li>○ The focus has been on the provider end and reimbursement; not what patients need to access</li> <li>○ Barriers for patients to access telehealth need to be addressed and will be a special session focus. This includes training patients on how to use the technology</li> <li>○ Staff/agencies need training on what they can communicate without violating HIPAA as some agencies refused to email resource information because they thought it was a violation. DMHAS practices and policies need to be reviewed to make sure they aren't barriers to services and client information.</li> <li>○ DMHAS staff aren't allowed to use zoom and some other platforms for group discussions, but seem to be limited to using Microsoft Teams. As a result, staff have missed webinars and meetings that might have been helpful. The policy on this should be reconsidered.</li> </ul> </li> </ul>	
<p><b>Block Grant Update</b></p> <p>Susan Bouffard</p>	<p>The first draft of the allocation plans to OPM were submitted yesterday. OPM will review and will respond to DMHAS with questions, edits, etc. Once OPM has finished reviewing all the allocation plans on all the block grants received by state agencies, a public hearing will be scheduled. All allocation plans will be considered that day by the committees of the state legislature, but that date has not been set. The public is invited to participate and may testify.</p> <p>Susan created the 2021 mini-application in webbgas which is due Sept 1. This is a much shorter document than the full block grant application completed last year. It includes:</p> <ul style="list-style-type: none"> <li>• fiscal tables</li> <li>• council membership list, including contact information, role, etc.</li> <li>• information on Specialized Syringe Programs (overseen in Connecticut by DPH)</li> <li>• state information</li> <li>• forms for the Governor to sign</li> <li>• public comment and planning council comment</li> </ul>	

	<p>As the fiscal tables aren't yet done, the mini-application will be sent for review to the Planning Council via email in August. It will also be posted on the internet.</p> <p>The schedule of meetings for the Adult and Joint Council meetings for 2021 have been established but Susan was unable to reserve rooms in Page Hall because of the virus. Even is holding meetings in Page hall will be allowed in 2021, the plan is to continue with the remote meeting option as well.</p> <p>Susan will be orienting Michael to her responsibilities related to the block grant as she is retiring Sept 1. DMHAS will probably not post her position for a replacement until Sept 2 at the earliest. Susan received many well wishes from the council.</p>	
<p><b>DMHAS Update</b></p> <p>Michael Giralmo</p>	<ul style="list-style-type: none"> <li>• Michael is hoping to hire a replacement for Susan ASAP</li> <li>• The Mental Health Bed Website has a soft launch 8/3 and full launch 8/17. Julienne Giard is the project lead</li> <li>• COVID19 grant from SAMHSA: Every state was given an opportunity to apply for 2 million dollars for persons needing services related to COVID19. <ul style="list-style-type: none"> <li>○ Funding will go to United Way to be a resource for those in need.</li> <li>○ Mobile crisis structure will be enhanced</li> <li>○ DMHAS will work with DCF on the Family Based Recovery Program</li> <li>○ Will respond to an increase in Intimate Partner Violence/Domestic Violence</li> </ul> </li> <li>• Crisis Counseling Program (CCP) grant is also related to COVID19 as all states, in response to the virus, were declared disaster areas. Michael Giralmo is the project lead. Funding, unlike most other grants, is from FEMA which is partnering with SAMHSA. DMHAS only administers this grant, the funding goes to DEMHS. This is a two phase grant: <ul style="list-style-type: none"> <li>• Phase 1: 45-90 days</li> <li>• Phase 2: 9 months</li> </ul> </li> </ul> <p>The grant went live April 30, so DMHAS must continue requesting 30 day extensions until their Phase 2 plan, which has been submitted but takes up to 12 weeks to review, has been approved. This grant will last approximately one year and is based on the life cycle of a disaster. In order to be eligible for the grant, the state has to demonstrate that existing resources are insufficient to meet demand, for example for homeless persons and senior citizens. The O'Donnell group received a contract for a media campaign. Mental Health First Aid is being provided as part of outreach. Data is being compiled, but it does not include PHI or PPI. DBHRN has not been activated and exactly what demand there will be is unknown.</p>	

	<ul style="list-style-type: none"> <li>• DMHAS continues to work with state-operated and PNPs to provide them PPE which they acquire through the Governor’s unified command and then distribute. Residential programs had to reduce capacity to accomplish social distancing, but this was based on each programs’ unique circumstances in concert with DMHAS leadership. At this point, some programs are beginning to increase their capacity again. During this same period, utilization of outpatient services has increased due to reduced no-shows and use of phone sessions. However, it isn’t known whether this is true primarily for patients already in established therapeutic relationships versus new clients.</li> <li>• The Adult Crisis Call Line, the “ACTION” line is being implemented by United Way in 4 phases to be fully in place by December 2020. They are connecting with all mobile crisis around the state. United Way will provide after-hours coverage. At this point, both 211 and the local mobile crisis number remain active. Consideration is being given to having a 1-800 number that would be easy for people to remember, unfortunately, no numbers with the word “ACTION” in them are available. Someone asked whether data will be collected on how many crisis calls involved law enforcement. Michael said there was great interest in collecting this data.</li> </ul>	
<p><b>Other Business</b></p>	<ul style="list-style-type: none"> <li>• Ingrid reported that she and others would be participating in the first gaming disorders certification program in the state</li> <li>• Margaret reported that this is her last Council meeting as she is leaving The Hub (Region 1 RBHAO) and going to Positive Directions. The person who would normally be her back up is out on maternity leave, so all inquiries should be directed to Janice Anderson at The Hub.</li> </ul>	

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Wednesday, April 15, 2020 - 12:30 PM – 2:30 PM	
<b>Location:</b>	conference call	
<b>Attendance:</b>		
<b>Members Present:</b>	Marcia DuFore, Pam Mautte, Margaret Watt, Allison Fulton, Michele Devine, Ellen Econs and Donna Maselli	
<b>Staff Present:</b>	Susan Bouffard, Michael Giralmo, Karolina Wytrykowska	
<b>AGENDA ITEM</b>	<b>DISCUSSION</b>	<b>ACTION</b>
<b>Introductions</b>		Add review of the January 15, 2020 minutes to the next meeting's agenda.
<b>Review of Minutes</b>	Minutes from the January 15, 2020 meeting were not available at this time.	
<b>2019 OCME Data Presentation</b> Susan Bouffard	<p>CT had 1200 accidental drug-related deaths in 2019, an increase from 1018 the previous year. Three-quarters of the decedents were male, 72% were non-Hispanic Caucasian, and most were between the ages of 30 and 59. Fatal overdoses overwhelming involved opioids (95%) and the most frequently used opioid by far was fentanyl/analogues (82%). While alcohol and benzodiazepines were present in about one-quarter of all fatal overdoses, cocaine involvement rose from 32% in 2018 to 39% in 2019. The top ten lists of both town of residence and town of death for overdose victims was presented as well as the setting of the overdose, which was most commonly a residence (79%). The 49 people who came from out of state, but died in CT from a drug overdose, were primarily from neighboring states.</p> <p>17% of the decedents were using what would be considered a behavioral health medication (antidepressant and/or antipsychotic) at the time of their death, but it is not known whether these were prescribed to the victim, taken by the victim but prescribed for someone else or used for the purpose of getting high. In terms of concurrent illicit substance use, only 31 of the 206 persons using a behavioral health medication did not also have an illegal substance in their system at the time of their death. Of interest was the fact that those with a behavioral health medication involved were primarily older Caucasian females.</p> <p>Only 8% of the decedents had no illicit substances involved and these were also older and Caucasian, but as likely to be male as female. The most common substances resulting in the overdose deaths of these individuals were benzodiazepines (53%), alcohol (38%), oxycodone (38%), and antidepressants (34%).</p> <p>Changes from 2018 to 2019 overdose deaths in CT included an increase in cocaine-involvement and</p>	Susan was asked to email the town data to members and to provide additional information on xylazine. Pam Mautte volunteered to send additional information on xylazine which she had discovered.

	<p>small shifts from non-Hispanic Caucasian persons to non-Hispanic African American and Hispanic persons. A statistical analysis conducted revealed that significantly more non-Hispanic African Americans and Hispanics used cocaine compared to non-Hispanic Caucasians. A review of national data found evidence of greater cocaine use as well as nonfatal and fatal overdoses among non-Hispanic African Americans which is consistent with the data found in CT in 2019. It is posited that the expansion of fentanyl/analogues beyond heroin into cocaine, methamphetamine and counterfeit prescription pills has expanded the population of substance users now at elevated risk of overdose.</p>	
<p><b>Block Grant Update</b> Susan Bouffard</p>	<p>In response to the coronavirus, concerns were expressed about the ability of providers to expend funds and for the state to meet spending requirements within existing deadlines given social distancing expectations. Susan had sent these concerns to the SAMHSA project officers for a response. SAMHSA’s response was that while they are not able to change statutory requirements such as deadlines, they plan to be flexible and supportive of states and will accept re-budgeting and revising plans as long as they don’t exceed spending amounts already established. SAMHSA has a list of resources available on their website at <a href="http://www.samhsa.gov/coronavirus">www.samhsa.gov/coronavirus</a>.</p> <p>The next requirement of the block grant schedule is typically the request from OPM to DMHAS for allocation plans. This is generally received in June and expected to be submitted in July. It is not known at this time whether this will be delayed in light of the coronavirus or not.</p> <p>For several years since the Affordable Care Act and Medicaid expansion resulted in re-budgeting funds from DMHAS to DSS, CT has received notice for failure to meet its Maintenance of Effort (MOE) threshold regarding substance use expenditures in the state. The MOE is based on the average of spending for the previous two fiscal years. The state has been submitting requests for material compliance each year and realized that at some point, based on the formula for determining MOE, that eventually the MOE would be re-calibrated and, consequently, achieved. That point was reached with the most recent submission of the SABG annual report last December 2019. Unfortunately, the MHBG annual report that was submitted at that same time resulted in a notice of failure to meet the mental health MOE. Upon closer inspection, it was realized that this apparent MOE issue was in fact the result of an error in reporting such that \$30 million dollars in funding for substance use services to children had erroneously been included in mental health services expenditures for children in FY 2017. As a result, the calculation raised the baseline threshold which DMHAS subsequently failed to achieve in the past fiscal year. A letter explaining this has been drafted for SAMHSA and is currently being reviewed by the fiscal</p>	

	<p>unit. We expect SAMHSA will accept this explanation and will then ask us to make the necessary revisions to correct the errors.</p>	
<p><b>DMHAS Update</b> Michael Giralmo</p>	<ul style="list-style-type: none"> <li>• Over the last 4 weeks, DMHAS has been working to respond to COVID-19 <ul style="list-style-type: none"> <li>○ Working with mental health and substance use providers to maintain services, implement health services, assist residential providers to establish operational continuity plans (including temporarily decreasing capacity to create isolation spaces) and maintain system flow</li> <li>○ DMHAS is working closely with DOH and CCEH on the Shelter Decompression effort whereby approximately 1200 homeless persons have been relocated to hotels across the state to accomplish the social distancing required by the virus response. EQMI has been identifying current and former DMHAS clients from among the homeless persons to enable contacts to reach out to them and offer services/support</li> <li>○ PNP CEOs have been contacted to encourage outreach and service provision to homeless persons</li> <li>○ Surveys were sent to all residential providers to ask them about Personal Protective Equipment (PPE) availability and needs. DMHAS is working with other agencies to locate any excess PPE items so they can be distributed to those in need.</li> </ul> </li> <li>• SAMHSA grants <ul style="list-style-type: none"> <li>○ DMHAS is applying for a grant for Pregnant and Parenting Women (PPW) with substance use disorders. DMHAS previously applied for this grant in 2017.</li> <li>○ The 3<sup>rd</sup> year of the Statewide Opioid Response (SOR) grant is coming due and will be applied for.</li> <li>○ All 50 states were offered up to \$2 million per state to expand behavioral health services during the COVID-19 pandemic. There were only 8 days between grant notice and application deadline, but DMHAS senior managers completed and submitted the application.</li> </ul> </li> <li>• A new adult crisis care center is expected to go live as of July 1, 2020 through a contract with United Way which was the vendor selected through the RFP process.</li> </ul> <p>Feedback and questions to the update included:</p> <ul style="list-style-type: none"> <li>• Concerning services for the homeless relocated to hotels, DMHAS' response was perceived as prompt and impressive, but concern was expressed about overdoses occurring at some hotels and whether Narcan training was needed. Training not only could be provided, but actually is being</li> </ul>	<p>Michael will get answers to questions posed and will ensure the council is informed; and will have PPE surveys re-sent to providers.</p>

	<p>provided by some RBHAOs to shelter staff.</p> <ul style="list-style-type: none"> <li>• PPE Survey was apparently not received by all providers and will be re-sent</li> <li>• Regarding the SAMHSA grant to expand services during the pandemic, what is the plan for these funds if granted? Will grant funds be used to support and increase capacity of current warm lines (i.e., CHR?)</li> <li>• Concerning the new adult crisis center, will it replace the existing LMHA-based mobile crisis system? What will the hours of operation be? What is the status of the learning collaborative planned for the mobile crisis teams? What will the messaging be regarding this new crisis center? It is thought that the new adult crisis center will not replace, but will be in addition to the existing mobile crisis system and will function as the initial site called for triage 24/7 before being passed on to local services.</li> </ul>	
<p><b>Suggestions for future presentations</b> Susan Bouffard</p>	<p>Susan informed the council that she is actively scheduling presentations based on previous suggestions, but would like to know if Council members had generated any additional ideas that they would like her to pursue. One suggestion was to have DMHAS provide an update on recommendations made by the RBHAOs to DMHAS in their regional reports.</p>	
<p><b>Other business</b></p>	<ul style="list-style-type: none"> <li>• Region 4 had a meeting of ministerial leaders and legislators to discuss health disparities highlighted by the COVID-19 virus</li> <li>• An appeal was made to continue to offer Planning Council meetings remotely, even when social distancing ends</li> </ul>	
<p><b>Adjournment</b></p>	<p>The meeting was adjourned following a reminder that the next Joint Council meeting is scheduled for June 11, 2020 at 2 pm and the next Adult Council meeting is scheduled for July 15, 2020 at 12:30 pm.</p>	



NOT FINAL

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Wednesday, October 16, 2019 - 12:30 PM – 2:30 PM	
<b>Location:</b>	CVH, Page Hall, Room 212	
<b>Attendance:</b>		
<b>Members Present:</b>	Marcia DuFore, Pam Mautte, Margaret Watt, Allison Fulton, Lisa Jameson, Michele Devine and Donna Maselli	
<b>Staff Present:</b>	Susan Bouffard and Erin Leavitt-Smith	
<b>AGENDA ITEM</b>	<b>DISCUSSION</b>	<b>ACTION</b>
<b>Introductions</b>		
<b>Review of Minutes</b>	Minutes from the July 17 <sup>th</sup> meeting were approved with no changes.	
<b>Older Adults and Behavioral Health Presentation</b> Erin Leavitt-Smith	<p>Erin Leavitt-Smith reviewed a handout on Older Adults and Mental Health issues. DMHAS defines older adults as anyone 55 years of age or older. CT is the 5<sup>th</sup> “oldest” state in terms of its numbers of seniors. Differentiation was made between signs of normal aging (e.g., loss of vision or hearing acuity) and conditions not considered part of normal aging (e.g., dementia, depression). The “three D’s” that are common psychiatric disorders in older adults are dementia, depression, and delirium. It can be challenging to determine which of the three conditions are present and possible for more than one to be present concurrently. Additionally, substance use, especially alcohol, can complicate the clinical picture in addition to misuse of prescription drugs, particularly opioids and benzodiazepines. In general, the longer an older adult can remain off medications, the better.</p> <p>Urinary Tract Infections (UTIs) are a common cause of delirium or behaviors that appear psychotic in older adults. If the person is delirious, they would present with a fluctuating level of consciousness. Delirium suggests a change in medical status and may be resolved with intervention.</p> <p>The course of dementia is a progressive loss of functioning. There is no cure for dementia at present. Aricept, a medication prescribed to assist with memory function, slows, but does not stop the progression of dementia. There are multiple types of dementia: frontotemporal, Alzheimer’s, Parkinson’s, etc.</p>	<p>Susan will forward information on the annual conference on working with Older Adults to the Planning Council when she receives it from Erin.</p>

	<p>Depression can be a side effect of medications. Antidepressants shouldn't be the only treatment option. Other options include exercise, being outside in nature, and staying connected, active, and involved. Senior centers are an excellent resource and many provide multiple programs.</p> <p>Problem Gambling should also be considered in older adults. Signs of possible gambling problems were reviewed.</p> <p>There are a number of issues related to providing services for older adults. DMHAS' goal is to keep people out of nursing homes if they don't need that level of care, but costs for paying for services in the home are also problematic. Persons who provide services in the home are not paid well, and if they are family members, they are not being paid at all; however, in CT, family members can be certified for elder care through DSS, but the person they are caring for has to be on Medicaid and all resources must be expended. Caregivers often need assistance to take on responsibilities for those they care for (e.g., finances) as well as emotional support as functioning as a caregiver can prove very demanding and isolating.</p> <p>Another concern in working with older adults is the risk of abuse. For persons over 60, Protective Services should be contacted and are required to conduct an assessment in response to allegations. DMHAS also conducts investigations and can terminate staff found culpable.</p> <p>The first annual conference on working with older adults was held in 2019 and was a huge success. Registration filled up so quickly that many people who wanted to go were unable to attend. The next annual conference is scheduled for April 24, 2020, again free at Masonicare, and they will allow more attendees. Erin will email Susan the registration information when it becomes available and Susan will share it with the Planning Council.</p>	
<p><b>Block Grant Update</b> Susan Bouffard</p>	<ul style="list-style-type: none"> <li>• The Allocation Plans presented at the Public Hearing in September were approved by the legislative committees and required lengthy testimony on the part of the Commissioner.</li> <li>• DMHAS finally received the Draft Compliance Monitoring Report from SAMHSA based on the visit in April 2018. A response is due back to SAMHSA by November 17<sup>th</sup>. Each manager responsible has been asked to review their respective sections to identify any inaccuracies and to report any progress/improvements made since the compliance monitoring visit.</li> </ul>	<p>Susan will follow up with the request for TA expenditures last year and statewide priorities for the regional reports completed this year.</p>

	<ul style="list-style-type: none"> <li>• DMHAS is working on the Annual Reports due to SAMHSA in December: mental health, substance use, and Synar.</li> <li>• DMHAS has agreed to accept new Technical Assistance (TA) funds for the remaining fiscal year, but it is unknown at this point the amount or restrictions on expending these funds. The Planning Council asked to know what the TA funds were expended on for the most recent year and asked for statewide priorities based on the regional reports submitted by the RBHAOs to inform a discussion of how TA funds should be spent for the current year.</li> </ul>	
<p><b>DMHAS Update</b> Susan Bouffard</p>	<ul style="list-style-type: none"> <li>• DMHAS hosted a “sold out” Harm Reduction conference</li> <li>• The Live Loud campaign has won 2 media awards and it’s reach has been extended through multi-state agencies and private partners (e.g., DCF, CT Realtors)</li> <li>• DLA-20 training is being conducted three days this week. The DLA-20 is the selected assessment tool to replace the Global Assessment of Functioning (GAF) measure previously required as part of diagnosing with the Diagnostic and Statistical Manual (DSM), but now defunct. Morning sessions are for staff to learn how to administer the tool. Afternoon sessions are limited to those who will train others. It is anticipated that this effort will go live in January 2020.</li> <li>• DMHAS has scheduled the fourth annual Integrative Medicine Conference for December 6, 2019 from 9 – 4 at the Red Lion Hotel in Cromwell. Susan sent an email to the Planning Council members in the morning to “save the date” for this upcoming conference.</li> <li>• Mobile Crisis Re-design : phase one implementation will be rolled out following an RFP for a Statewide call center (following documented input from multiple stakeholders – state operated and PNP LMHAs, providers, consumers, etc.) The Planning Council asked to see the survey results and pointed out that they have made this request more than once. They are concerned: 1. that the call center seems to be the only focus, 2. that it is a separate operation from DCF’s efforts, and 3. other recommendations made by stakeholders do not appear to be priorities. They requested that someone from DMHAS present the findings of the survey to the Planning Council.</li> <li>• CT was awarded (through DSS) a 2.8 million substance use disorder planning grant and will be working with OPM, DSS, DCF, etc.</li> </ul>	<p>Susan will follow up on the request for a presentation on the survey findings to the planning council.</p>
<p><b>Other Business</b></p>	<ul style="list-style-type: none"> <li>• There was no other business and the meeting was adjourned.</li> </ul>	

<b>Minutes submitted by</b>	Susan Bouffard, PhD.	
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NOT FINAL

**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Thursday, June 11, 2020, 2:00 – 4:00 PM	
<b>Location:</b>	Teleconference	
<b>Attendance:</b>		
<b>Members Present: (via telephone)</b>	Doriana Vicedomini, Marcia DuFore, Donna Maselli, Tom Burr, Pamela Mautte, Margaret Watt, Lisa Jameson, Michael Giralmo, Ellen Econs, Laura Watson, and Nan Arnstein	
<b>State Staff &amp; Guests</b>	Jason Lang, Gabrielle Hall, Tim Marshall, Mary Cummins, Susan Bouffard, Michael Giralmo and Karolina Wytrykowska.	
<b>AGENDA ITEM</b>		<b>ACTION</b>
	The minutes of 11/14/20 were accepted without correction.	
Agency Updates (DMHAS) Michael Giralmo	<ul style="list-style-type: none"> <li>In response to COVID19, DMHAS is working with Providers across the state regarding residential program accommodations. DMHAS is also working to expand and ensure reimbursement for tele-health options. Outpatient Utilization appears to have increased during the virus. Connecticut was issued two declarations: 1) Disaster Services and 2) Individual Assistance. A crisis counseling program grant was applied for, but this FEMA grant is different than the usual SAMHSA grants. The grant will be administered by DMHAS. Crisis Counseling is not a mental health service. The application was submitted and approved. DMHAS asked for grant funds for seniors in congregate care nursing homes where COVID-19 cases are high, as well as for senior services in the community. Persons experiencing homelessness moved into hotels across the state in order to accomplish social distancing. There are not enough shelter staff to manage the homeless population in both shelters and hotels. Crisis Counseling services will be accessed by calling 211. The last component of the DMHAS grant is outreach to disaster survivors. ACTION Adult Crisis Telephone Intervention Outreach Network is set to begin on July 1, 2020. There will be a substance abuse website for folks in need of a bed nearby. DMHAS is also working on a mental health bed website for those in need of services in their area. This should go live by the end of August 2020. No name or website names have been decided on, but CT Mental Health Services.com is being considered.</li> </ul>	
Jason Lang, Ph.D. CHDI	<ul style="list-style-type: none"> <li>Jason Lang from the Child and Health Development Institute (CHDI) presented on “Evidence-Based Treatments for Children &amp; Trauma Screening: Lessons Learned in CT.” CHDI is an independent non-profit program to improve health and mental health services for people throughout the state. Evidence-based treatments are</li> </ul>	

- expensive to implement. There are 10.7 to 13.4 million youth with mental illness in USA. Most children who need mental health treatment in Connecticut do not get it.
- DCF is responsible for child protection, children’s behavioral health, substance use and prevention. DCF funds a range of children’s BH services across levels of care. DCF has been focused on Quality Assurance and Quality Improvement with a trauma-informed approach.
  - Evidence-Based Treatment (EBT) is based on scientific evidence to show effectiveness. Treatment procedures are developed and implemented consistently. Standardized assessment measures are used to screen for eligibility and to evaluate treatment progress. Each EBT has one or more targeted focus areas. Settings can include the home, school, clinic and others. First outpatient EBT occurred in 2007 and was called Trauma-Focused CBT.
  - TF-CBT: For children 3-18 years old in clinics. It addresses single, multiple, and/or complex trauma and has a strong parent/caregiver component.  
MATCH: For children 6-15 years old. This addresses Anxiety, Depression, Trauma and Conduct Problems.  
ARC: For children 3-18 years old. This is a clinic-based, flexible, components-based intervention to address complex trauma. It focuses on supporting families to build safe, healthy relationships, and to help children build skills to regulate moods and energy states. This can be used to treat a variety of trauma types and caregivers are very involved.  
CBITS: For children in all grade levels K-12. This is a group intervention for children suffering from trauma. It is school-based with 10 group sessions (and some individual/caregiver/teacher sessions)  
CFTSI: For children 7-18 years old. This focuses on early intervention after trauma or disclosure. The goal is to prevent development of PTSD.
  - Trauma Screening: For child experiencing trauma, everyone is talking about being better trauma-informed and aware than 10-15 years ago. There are some gaps in the system for children experiencing trauma. Children experiencing trauma are not always identified or recognized. The idea of Trauma screening is to screen early and connect the young person with services. Sometimes doctors, teachers and caregivers are unaware that children are experiencing trauma. Trauma screening can identify those children who need clinical assessment or treatment, but in order to do this, they need parent/caregiver support and sometimes caregivers are unaware of the impact of trauma and don’t know how to support their child. There is a big difference between trauma screening and ACES screening. ACES was originally

	<p>developed as part of a research study and proved helpful for looking at population indicators of trauma. If the purpose of screening is to identify children who are suffering from trauma, it's necessary to look beyond just events they've been exposed to and more about how they are doing.</p> <ul style="list-style-type: none"> <li>• In Connecticut, there have been some examples of trauma screening that have scaled up. In child welfare, DCF is screening all children placed in care for trauma using a standardized tool, the Child Trauma Screen, part of the Multidisciplinary Evaluation. Juvenile Justice is also using the Trauma Screen at intake. The pandemic may have changed the process over the last several months. Schools and Early Childhood settings have the potential to identify trauma early because those are the places children are the most, although there is not a lot of screening there except those schools that have been trained in CBITS. Pediatric Primary Care has an interest in trauma, but use of standardized screening is limited because physicians don't get reimbursed in the same way they do for developmental or behavioral health screening. Child welfare involved children's' trauma rates were the highest.</li> <li>• Some concerns about screening were re-traumatizing children by asking about trauma, some workers already knew about the case from their case plan because they've known the family for years, or screening didn't provide any new information. CHDI did some work with Child Welfare and Juvenile Probation officers to get feedback about what they learned about screening. They said it was easy to administer, improved their understanding, and for 1 out of every 4 children screened, their treatment plan was changed. High levels of stress were rare.</li> <li>• The National Child Traumatic Stress Network is a great resource for anything trauma related. Website is: <a href="http://www.ntcsn.org">www.ntcsn.org</a></li> </ul>	
<p>Agency Updates (DCF) Tim Marshall</p>	<ul style="list-style-type: none"> <li>• DCF employees are tele-working and also continue to provide care in direct care settings where we have 24-hour bed capacity. There are four workgroups discussing what a safe return to work would look like. Recommendations are being developed. Providers were asked for suggestions. Virtual treatment will bring enhancements to treatment. DCF leadership continues to make racial justice a priority and sponsored an event: "The Color of COVID-19". There is continued work going on in direct service and systems developments and grant activities. DCF is working with schools on a potential surge in the number of kids with mental health needs. Provider system will connect more directly with schools.</li> </ul>	
<p>Block Grant Tim Marshall, DCF</p>	<ul style="list-style-type: none"> <li>• DCF with Mary Cummins did a lot of work to prepare the mental health block grant allocation plan. DCF added a new review to finalize draft allocations. Mary and Tim presented to Executive Team. DCF is waiting on consultation with the Fiscal</li> </ul>	



	division. Protective Services referrals are down since COVID-19 and we are in the slow reporting summer season.	
Block Grant Susan Bouffard, DMHAS	<ul style="list-style-type: none"> <li>DMHAS is working on the allocation plan with DCF. The allocation plan is due back to OPM on July 10, 2020. There will be a public hearing which everyone is welcome to attend on the allocation plans. Date will be sent to council members once it is known. All allocation plans are processed on the same date. SAMHSA is unable to change deadlines due to federal law, but is attempting to be flexible with states that have chosen to re-budget. SAMHSA is encouraging remote/virtual events as they cannot extend deadlines.</li> <li>The Planning Council will be getting a new representative from OPM as Bailey Mulqueen has departed.</li> </ul>	
Other Business	None	
Next Joint Meeting:	September 2020 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm unless held remotely.	

NOT FINAL

**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Thursday, September 12, 2019, 2:00 – 4:00 PM	
<b>Location:</b>	Connecticut Valley Hospital, Page Hall – Room 217	
<b>Attendance:</b>		
<b>Members Present:</b>	Jo Hawke, Marcia DuFore, Donna Maselli, Nikki Richer, Thomas Burr, Bailey Mulqueen, Laura Watson, Alison Fulton (by phone) and Margaret Watt	
<b>Staff Present:</b>	Tim Marshall, Michael Giralmo, Mary Cummins, Susan Bouffard, Maguena Deslandes, Carolyn Westerholm and Chrishaun Jackson	
<b>AGENDA ITEM</b>		
	The minutes of 6/13/19 were accepted without correction.	<b>ACTION</b>
<b>DMHAS Update</b> Michael Giralmo	<ul style="list-style-type: none"> <li>• The Block Grant application was submitted.</li> <li>• DMHAS was awarded a second year of the SOR grant and will continue activities begun in year one.</li> <li>• Mobile crisis will be re-designed utilizing a call center and based on the DCF model. The Council would like to learn more specifics about this topic and want to know the results of a survey conducted on mobile crisis.</li> <li>• Michael has been selected as the new Director of EQMI.</li> </ul>	Michael will see if survey results are available for a presentation on the topic of mobile crisis to be scheduled.
<b>FAVOR Presentation</b> Carolyn Westerholm Maguena Deslandes	<p>FAVOR is an organization founded in 2002 serving families with children and youth that have behavioral health needs.</p> <p>The <b>Family Peer Support Program</b> provides to the Intensive Care Coordination program two Family Peer Support Specialists at Beacon. Family Peer Support Specialists are family members with children with behavioral health needs themselves or other lived experience. The goal of this program is to prepare, engage and empower families in the decision making process using a strengths-based approach, meeting people where they are, working with all family members, educating them on their rights, and supporting them at meetings regardless of the venue (with providers, schools, etc.) Referrals are from Care Coordination with services provided for 6 months and from the community or families for Brief Intervention with services provided for up to 3 months. Last year they received 800 referrals, 85% of which were for brief intervention, so they have a wait list. While waiting for services, a triage coordinator gives the family action steps and the Peer Support Specialist contacts them within 48 hours to provide assistance. Data is collected on a variety of measures.</p> <p>The <b>Family System Manager Program</b> was established in 2012 in six regions. The focus is on</p>	

	<p>youth and family engagement and services include education, development, and support for families, youth, and partners to develop a family integrated system. They help families learn to understand what it's like to sit at the table. Much of what they do is coalition building; helping to create systematic change. Training, community conversations and technical assistance (especially CLAS) are provided.</p>	
<p><b>DCF Presentation</b> Tim Marshall</p>	<ul style="list-style-type: none"> <li>• Block Grant application completed by Susan and Mary was submitted.</li> <li>• Allocation Plans were created and the public hearing on them is next Monday. Susan had emailed the Adult Behavioral Health Planning Council information about the hearing day and location. Another option for those interested may be to watch the proceedings on CTN rather than attend in person.</li> <li>• DCF just completed a 4-year System of Care “The Connect” grant, including a no cost extension. All activities were completed in August. DCF was invited to apply for a sustainability grant (4 million over 4 years) which they have been awarded. FAVOR will be a partner in helping to continue to build upon the system of care over the next 4 years. While the prior 4-year grant focused on decreasing congregate care for children, the new 4-year grant will focus on reducing the number of children going to EDs and Psychiatric Residential Treatment Facilities (PRTF). Data reveals a lack of communication between primary care providers (PCPs), schools, and behavioral health providers. CONNECT III will focus on creating mini-hubs to improve communication. An initial activity, created tear-away pads to be filled out by PCPs and used to refer children for behavioral health services. Parents take the form to the behavioral health provider and it is faxed back to the PCP.</li> <li>• Related to FEP, DCF is working with Yale at their clinical high risk program and STEP in an effort to increase capacity.</li> <li>• Suicide prevention activities – the plan is to establish 5 regional suicide advisory boards and one manager per region. CONNECT III will add 3 network of care managers which will bring the total to 6 network of care managers from Beacon</li> </ul>	
<p><b>Block Grant Update</b> Susan Bouffard</p>	<ul style="list-style-type: none"> <li>• 20/21 Block Grant Application was submitted. It was posted on the DMHAS and DCF websites as required and will remain posted as SAMHSA directs.</li> <li>• The annual mental health, substance use, and Synar reports have been created and are due in December. We are actively working on completing these documents.</li> <li>• We have yet to receive the written report from the compliance monitoring visit in April 2018. Marcia asked whether any work was being done to improve areas identified in the verbal feedback received at the time of the visit. Susan said efforts are underway to address areas identified as needing improvement.</li> </ul>	<p>Susan will locate the list of topics previously suggested for TA.</p>

	<ul style="list-style-type: none"> <li>• We don't yet know SAMHSA's plan for technical assistance (TA) funds going forward. It is clear that SAMHSA leadership wants to use the decentralized strategy used last year mid-cycle to provide states with funds strictly designated for TA only, but the new fiscal year is underway and so far we have not received any information on how TA funds will be managed. Marcia suggested that we re-vive the list constructed at a previous meeting on suggested topics for TA in the hopes that we can be prepared to allocate TA funds if we receive word that they are available and must be spent by the end of the fiscal year.</li> <li>• CT has a new mental health project manager at SAMHSA: Michelle Gleason</li> <li>• The public hearing for the allocation plans will be Monday, September 16<sup>th</sup> beginning at 10 am in the LOB room 2E.</li> </ul>	
<b>Other Business</b>	<ul style="list-style-type: none"> <li>• It was suggested that the council again try conducting a meeting with remote conferencing.</li> </ul>	Susan and Mary will try to arrange a remote meeting at an upcoming Joint Council meeting
<b>Adjournment</b>	<ul style="list-style-type: none"> <li>• The meeting was adjourned at 3:15 pm.</li> </ul>	

NOT FINAL

**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Thursday, November 14, 2019, 2:00 – 4:00 PM	
<b>Location:</b>	Connecticut Valley Hospital, Page Hall – Room 217	
<b>Attendance:</b>		
<b>Members Present:</b>	Doriana Vicedomini, Marcia DuFore, Susan Bouffard, Tim Marshall, Donna Maselli, Tom Burr, Pamela Jones-Mautte, Allison Fulton, Michele Devine, Nicki Richer, Margaret Watts, Jennifer Abbatemarco	
<b>Members Present: (via telephone)</b>	Laura Watson, Lisa Jameson	
<b>AGENDA ITEM</b>		
	The minutes of 9/12/19 were accepted without correction.	<b>ACTION</b>
Presentation on Teen Pregnancy	<ul style="list-style-type: none"> <li>• Donna Maselli from the Department of Public Health presented on a DPH grant funded by the Administration of Children and Families, Department of Health and Human Services. DPH has held the Personal Responsibility Education Program (PREP) grant beginning in 2010. The funding announcement stated that DPH could pick certain target populations to work with including youth in foster care, runaway and homeless youth, and youth in areas of high teen birth. DPH contacted DCF to partner with them since the state plan was first developed in 2010. The grant is refunded with a 5-year grant and they give us another year. Halfway through the grant, the age of kids served was increased to up to 25 youth who are pregnant and parenting which brought in DMHAS. They also started working in public schools to have all youth receive the education.</li> <li>• DMHAS facilitators trained Solnit North, Solnit South and the school, as well as training the Health Teachers to deliver the program. They developed the curriculum and held a two-day training. Early this year, the Department of Education added career counselling as one of the classes. DMHAS did a training with the staff on the importance of youth and high risk. DMHAS facilitators are trained to look for youth who feel uncomfortable with training and allow youth to step out of the training. DCF goes by the AAP recommendations for youth regarding health screenings, but there are also ACOG best practice standards that has recommendations on health exams for girls.</li> <li>• Some of the issues encountered when working with the DMHAS YAS program was obtaining referrals from DCF. An observation was that the majority of the youth being served were Caucasian. There was concern that Black and Hispanic youth were not being referred to the program.</li> </ul>	

<p>Agency Updates (DMHAS) Susan Bouffard</p>	<ul style="list-style-type: none"> <li>• Technical assistance dollars have come through from the Block Grant. Working with the Commissioner on priorities which may include recovery citizenship and co-occurring disorders and treatment. Starting a workgroup to look at these and open to ideas.</li> <li>• Mental health services: DMHAS received \$94,150; DCF received \$40,350 totaling \$134,500. Substance Use services received \$328,827. DMHAS' ASO for CT Beacon HealthOptions has taken in a data match for Governor's Office project called "Familiar Faces," top 500 utilizers across all state agencies.</li> <li>• The ASO is taking on administrative functions related to our work with DSS OPM and DOH and housing agencies related to homeless individuals with a Medicaid span of 40,000+. Model includes vouchers and supportive housing services. DSS is working with DMHAS, DCF and other Connecticut state agencies to look at using the 115 waiver to expand Substance Use services in Connecticut.</li> <li>• Connecticut is continuing projects from SOR1 to SOR2 federal grant dollars for Opioid response. An RFP for an Adult Recovery Center for crisis was released on November 1<sup>st</sup> and is on the DMHAS website.</li> </ul>	
<p>Agency Updates (DCF) Tim Marshall</p>	<ul style="list-style-type: none"> <li>• Commissioner Dorantes and her staff will be attending the December 6<sup>th</sup> CBHAC meeting at Beacon HealthOptions. Beacon is managing some DCF cases that are not necessarily abuse and neglect cases. Some programs throughout the country can offer services if there is concern about risk levels, after a DCF investigation occurs and when there is not a legal standard to open a case. Connecticut falls into one of those states. The population that has been offered services without a full substantiation of abuse and neglect increased to approximately a third of DCF's caseload. That population which is consistent with the new federal legislation, Federal Family Protection Services Act, will try to get interventions before they come to detention in DCF. Since these families don't fall into abuse and neglect, DCF with the Governor's approval and OPM, has turned the case management function over to the administrative service organization.</li> <li>• Voluntary Services which families have been lobbying for many years not to have, so that families who need support to get behavioral health services don't come to DCF, soon can go to Beacon. Voluntary Services is 250-300 families annually. These are families who have been going through the Careline to get financial support from DCF to meet the behavioral health needs that are outside of the resources they have. The Voluntary Services contract has not been executed and discussion continues with meetings for stakeholder input. There isn't a plan for how long Beacon will work with families for Voluntary Services, but the average length of stay is 6 months, but many families can stay from months to years. DCF is trying to mirror the amount of time and labor the DCF staff are putting into the families and mirroring that in the communities.</li> <li>• The number of families that DCF has worked with on a child welfare basis has been approximately 1,000-1,200 families annually that are unsubstantiated. This group is</li> </ul>	

	<p>receiving case management and linkages. For the families that are unsubstantiated, DCF completes a 33/45 day evaluation of the investigation and at the conclusion, there is no substantiation of abuse/neglect. They are offered support to be maintained and transferred to ongoing. Families can say yes or no. In a child welfare investigation, workers have some standard tools they have to use for families who may be at risk for abuse and neglect. They may come out high on those, but there was no abuse/neglect found. There are statutory requirement to open a DCF case.</p>	
<p>Block Grant Update Susan Bouffard</p>	<ul style="list-style-type: none"> <li>DMHAS received draft report from the compliance monitoring visit from April 2018. Report has been delayed. They have 30 days to review for inaccuracies. There was not anything in the draft report that DMHAS felt was overlooked. The annual reports for the block grant are due December 2nd and are in the process of being completed. The annual report is due the end of December and requires the Governor's signature.</li> </ul>	
<p>Other Business</p>	<ul style="list-style-type: none"> <li>From the Connecticut Prevention Network, there are upcoming regional workshops on Diazepam, Opioid and Stimulants. Region 2 workshop is on December 13<sup>th</sup>, from 9:00-12:30 at the Connecticut Medical Society. Region 5 workshop is at Danbury Hospital on November 22<sup>nd</sup>, 9:00-12:30. Region 4 workshop occurred on November 1<sup>st</sup>. Flyers to be forwarded to meeting members.</li> <li>DCF has done work on the children's side for universal screenings. After a year of analysis, the Children's Behavioral Health Implementation Advisory Board put out a one-page document of the different screening tools in Connecticut. They listed the different screening tools and made recommendations for folks considering using screening tools primarily for children. Schools have been asking for the best approach to screening, how to screen, what to screen for, primarily to best meet student mental health needs. Will try to get one of tri-chairs from Children's Advisory Board to do a presentation.</li> </ul>	
<p>Next Joint Meeting:</p>	<p>March 12, 2020 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.</p>	

### 2020 Adult and Joint Behavioral Health Planning Council Meetings

Council Meeting	Date	Time	Location
Adult	January 15, 2020	12:30 – 2:30 pm	Page Hall CONF. ROOM 212
Joint (DMHAS chairs)	March 12, 2020	2 – 4 pm	Page Hall CONF. ROOM 217
Adult	April 15, 2020	12:30 – 2:30 pm	Page Hall CONF. ROOM 212
Joint (DCF chairs)	June 11, 2020	2 – 4 pm	Page Hall CONF. ROOM 217
Adult	July 15, 2020	12:30 – 2:30 pm	Page Hall CONF. ROOM 212
Joint (DMHAS chairs)	September 10, 2020	2 – 4 pm	Page Hall CONF. ROOM 217
Adult	October 21, 2020	12:30 – 2:30 pm	Page Hall CONF. ROOM 212
Joint (DCF chairs)	November 12, 2020	2 – 4 pm	Page Hall CONF. ROOM 217

Adult Council meetings are always the third Wednesday of January, April, July, and October.

Joint Council meetings are always the second Thursday of March, June, September, and November.



## September Minutes

# Children's Behavioral Health Advisory Committee (CBHAC) Friday, Sept. 6, 2019 Minutes

### Introductions

**Approval of Minutes:** Minutes were not approved due to lack of quorum

### 1. State Agency Updates

- a. DCF
  - i. Vanessa Dorantes, DCF Commissioner, is still working on reorganization of the department and making changes. She will be attending the December CBHAC meeting with members of her leadership team.
  - ii. Kristina Stevens left position at DCF and there are still a few other vacant positions.
- b. DMHAS
  - i. No report
- c. SDE
  - i. New Commissioner Appointed: Miguel Cardona, worked as assistant superintendent for Meriden. Former 4<sup>th</sup> grade teacher, bilingual, and had a focus on serving youth and families.

### 2. Presentation: Tammy Sneed, HART Director, State Department of Children and Families

- a. HART Human Trafficking Response Teams (17 Teams throughout the state). HART Multidisciplinary teams respond to every case of sexual abuse, trafficking and any case of death. One interview, with goals of linking to services and ensuring arrest/conviction.
- b. NestFoundation.org Playground video about Child Trafficking in U.S.
- c. Two categories of child trafficking: Sex Trafficking and Work Trafficking
- d. Majority of children being trafficked are U.S. children, not children trafficked in from other countries.
- e. Trafficking Victims Protection ACT (TVPA) important legislation. Protects victims, expands definition to include trade of any valued commodity, not just money,
- f. Domestic Minor Sex Trafficking (DMST) Legislation in CT protects victim from prosecution, victims receive affirmative defense, victims classified as "uncared for" under DCF provisions allowing Department to provide services.
- g. Risk Factors and pattern of Tactics discussed.
- h. CT has been a leader in gather data
- i. Questions and Discussion
  - i. Slide deck will be distributed
  - ii. [Tammy.sneed@ct.gov](mailto:Tammy.sneed@ct.gov) or [DCFHart@ct.gov](mailto:DCFHart@ct.gov)

### 3. Discussion of SCCC Meeting

- i. Statewide Community Collaborative leaders met 8/29/19 and reviewed the community collaborative survey results and made recommendations. The survey:

1. Gathered information on how to improve Network of Care and Systems of Care
2. Survey was released on July 1, 2019;
3. Co-chairs of the collaborative completed the survey
4. New questions were added

ii. Recommendations presented and reviewed at CBHAC. No additional feedback given regarding language or content.

#### 4. **Announcements**

- a. Update Agenda with the following dates:  
Next CBHAC Meeting Oct. 4<sup>th</sup>  
Next Joint Council meeting Sept 12<sup>th</sup> 2-4, CVH Paige Hall, Room 217
- b. I Can Conference, Sept. 26<sup>th</sup>
- c. Hartford/ West Hartford System of Care Meeting Sept. 16<sup>th</sup> 10-12 at the Village for Children and Families.
- d. Hartford Drill Drum and Dance, loss of one of their members.

#### October Minutes

### **Statewide Council of Community Collaboratives and Children's Behavioral Health Advisory Committee (CBHAC) Friday, October 4, 2019 Minutes**

#### **Welcome**

- A moment of silence was observed in recognition of the passing of our colleague, friend, and CBHAC member, Evelyn Melendez.

#### **State Agency Updates**

DSS--Bill Halsey

- The state received a planning grant of \$2.8 million over 18 months to assess unmet needs of kids and families in the Medicaid system. The work will help with future expansion efforts; the goal is the expansion of the 1116 waiver to increase revenue to the state. DSS will solicit feedback from CBHAC on grant activities.

SDE--Scott Newgass

- The new commissioner, Miguel Cardona, has been appointed.
- Project Aware has quarterly meetings and is expanding existing services. Staff are preparing for a federal site visit.
- A trauma symposium is planned.
- Attendance and truancy efforts are focusing on expanding mental health services.

DMHAS--Stephanie Rivera

- The statewide substance abuse committee has developed a 5-session curriculum that will soon be piloted in West Haven and Bridgeport.

DCF--Tim Marshall

- JoShondra Guerrier from Florida will be taking over the position vacated by Kristina Stevens. With this all most appointments at DCF have been filled.
- The state received a sustainability grant (CONNECT) that will focus on reducing residential treatment and emergency room visits, as well as creating better linkages between mental health providers, schools, and physicians.
- The block grant report has been submitted and approved. There is very little change. However, \$300,000 has been given to enhance mobile crisis and the national suicide hotline.

**Membership Update -- Jo Hawke**

- There are several vacancies on CBHAC. Attendees are encouraged to apply. Applicants must attend 2 CBHAC meetings, be active in their local collaboratives, and complete an orientation.

**Planning Activity --Jo Hawke and Doriana Vicedomini**

- CBHAC attendees reviewed the 3 foci for the previous year and voted to keep them for FY20.

**Presentation on Mobile Crisis--Amy Evinson and Arnold Trasante**

- Arnie and Amy presented an overview of the mobile crisis program (formerly EMPS) and answered questions. Copies of the materials are attached.
- Public Act 13-178 requires Mobile Crisis to establish MOAs with each school district, charter and technical school to respond to students in crisis, provide onsite interventions, and mediate police involvement as appropriate.
- Mobile Criss has a Performance Improvement Center at CHDI.

**Planning for next meeting**

- Next joint SCCC/CBHAC meeting will be on November 1

**November Minutes**

**Statewide Council of Community Collaboratives and Children’s Behavioral Health Advisory Committee (CBHAC)**

**Friday, November 1, 2019**

**Minutes**

Welcome and Introductions --Jo Hawke and Gabrielle Hall

- Minutes were voted and approved.

State Agency Updates:

- DSS—Rodrick Winstead requested that members participate in a focus group after the next CBHAC meeting. The topic of the focus group will be unmet needs of children and families on Medicaid.
- DMHAS – They will roll out a training on motivational interviewing and trauma for young adult service providers in the coming months.
- DCF – The new Commissioner and her executive team will present at CBHAC in December. DCF will organize several listening sessions and workgroups Family First Legislation. Tim also announced the new award which will focus on decreasing psychiatric residential treatment and emergency room visits. This work will seek to improve communication between behavioral health service providers, schools, and primary care providers. There will be initiatives to recruit, train, and support involvement of families and youth and to expand the local, regional, and statewide NOC infrastructure.

#### SCCC Survey Results –Lisa Pallazo

- 96% of co-chairs completed the survey in July. The majority of collaboratives have less than 15 members attending. Most have at least one parent/caregiver member attending, but less than 13% have youths attending. Many have initiatives to combine with other groups e.g., LISTS, Regional NOCs. There has been a significant increase in collaboratives having organized infrastructure and practice standards.

#### SCCC Recommendations –Gabrielle Hall

- Recommendations were reviewed. They had previously been presented at CBHAC and approved by the membership.

#### Collaborative Opportunities –Tim Marshall

- DCF will have \$1800 in funding from the Mental Health Block grant for Community Collaboratives to help with meeting expenses and support building infrastructure guided by the practice standards.

## December Minutes

### **Children’s Behavioral Health Advisory Council (CBHAC)**

**Minutes – Friday December 5, 2019**

#### **Welcome, Introductions, Minutes Assignment**

1. Change in agenda order: Discussions with DCF Commissioner and Her Executive Team will precede DSS Grant Update.
2. Nan Arnstein has agreed to take minutes of the meeting on a regular basis.

#### **Approval of Minutes**

1. A quorum was confirmed.

2. There are no revisions to the previous month's minutes.
3. A motion to accept the minutes was made, seconded and approved.

### **Agency Updates**

1. Department of Justice
  - a. Representative has no answers regarding co-operative living.
  - b. The department is trying to right-size services.
  - c. FFT services are being provided statewide.
  - d. The department is collaborating with DCF on vocational services.
  - e. A MOU was established with DCF to provide MST services.
  - f. Services for suspended prosecution for Motor Vehicle theft have been instituted.
2. DMHAS
  - a. Piloting substance abuse training with the adult services team has begun.
  - b. Two opportunities for young people service training exist – Advocacy Unlimited.
    - i. Youth led retreat for 18 – 28-year-olds in January 2020.
3. Department of Education
  - a. Commissioner is in the process of organizing the department – emphasis on Culture – Climate – Safety and Equity.
  - b. Looking to collaborate with DCF on evidence-based practices.
  - c. Academic achievement is still important.
  - d. Working with the new Head of Partnerships from the Governor's office.
4. DSS
  - a. New Medicaid supportive housing initiative is starting soon.
  - b. Planning grant will be discussed later in the meeting.
  - c. Substance Use Focus Group will be discussed later in the meeting.

### **DCF Commissioner and her Executive Team**

1. Commissioner Vanessa Dorantes comments:
  - a. Next week marks her 27<sup>th</sup> year with DCF. She has spent most of her time in Region 5.

- b. She is pleased with how DCF has evolved over the years and to see so many family members and youth at the table this morning.
  - c. DCF is an agency that is everchanging and therefore the department is still restructuring to match the goal established last spring.
  - d. Culture: importance of social workers and the relationships with other agencies, providers, children and families.
    - i. Emphasized the importance of lived experience and data to look at spending and racial disparities.
  - e. DCF mission is the same but has a new value statement: children assisted by the department will not be defined by their experiences. The ultimate goal is success for the families.
  - f. Child and Family Services Plan
    - i. A 5-year plan.
    - ii. Reaching out to other agencies working with children and families – 12 agencies have signed on.
    - iii. Weaving this plan into the Family First Prevention Initiative Plan that will go into effect in CT in October 2020.
  - g. Plan to visit all the department offices and the 3200 employees.
2. Administrator of Community Consultation and Support: JoShonda Guerrier
- a. Completing her 2<sup>nd</sup> month on the job after relocating from Florida's DCF arena.
  - b. Acknowledges this is a transitional time for CT DCF and is looking forward to working through the changes.
  - c. Family First Prevention Initiative
    - i. Federal legislation passed in February 2018.
    - ii. CT DCF website: [CTFamilyFirst.ct.gov](http://CTFamilyFirst.ct.gov).
    - iii. The week of December 2<sup>nd</sup> was the kickoff for the five committees established to construct CT's plan. It is important to have parent and youth leadership at the table. CT's FFI is a tool in DCF's arsenal.
      - 1. Candidacy: who should be the target for use of the prevention services.
      - 2. Kinship Care and Foster Care: kinship navigator program; how will the use of kinship care change in CT, and review of the standards of a national model.
      - 3. Community and Family Engagement: plan is to build integrated systems.

4. Program and Services Array: CT is resource rich; evaluation of how families are currently served and how they will be serviced in the future. The plan is to work across the child welfare system to provide support.
5. Fiscal: review of what is being spent, what needs to be spent and which departments will share the expense.

### 3. Questions

- a. CT has many resources but lacks liaison between agencies at the parent level – is there a plan to create this position?
  - i. There are infrastructure concerns, and this is the time to determine what CT needs and to determine the next step and is a Parent Advocate the next step.
  - ii. Ken Cabral (former DCF employee) is now working at DSS and provides an excellent opportunity for liaison with other agencies.
- b. Kinship Care – what is going to happen?
  - i. 43% of children under DCF care are placed in kinship care.
  - ii. This is an opportunity to create opportunities to step forward and determine a waiver process that is now available.
  - iii. Looking to reestablish the BIO and Foster Care family collaborative relationship that is for the benefit of the child.

Goal is for timely permanency

### January Minutes

## **Children’s Behavioral Health Advisory Council (CBHAC) Minutes – Friday January 3, 2020**

### **Welcome and Introductions**

1. The membership discussion was postponed until February.

### **Approval of Minutes**

4. A quorum was confirmed.
5. There are no revisions to the previous month’s minutes.
6. A motion to accept the minutes was made, seconded and approved.

### **Agency Updates**

5. Department of Justice
  - a. No report.
6. DMHAS
  - a. Statewide training for young adults is in progress.
  - b. The department is looking to strengthen the integration of mental health and substance abuse treatments.

- c. January 25, 2020: Young Adult (18-26-year-olds) Training Institute will be held at the Chrysalis Center in Hartford.
- 7. Department of Education
  - a. Commissioner is in the process of organizing the department – emphasis on Culture – Climate – Safety and Equity.
  - b. Money is going out to the districts.
  - c. Focusing on accountability.
  - d. Bureau of Special Education is now housed under Student Support Services.
- 8. DSS
  - a. No report.
- 9. DCF
  - a. New year resulting in a new focus of work.
  - b. Family First legislation and its implementation is the priority right now. This work will transform services across the state.
- 10. Favor
  - a. There were no material findings from the state and federal audits.
  - b. Five workgroups have been formed to address the Family First legislation requirements.
    - i. Encourage family involvement - especially youth and young adults.
    - ii. Happy to see the large number of parents and youth at the meeting today.
  - c. There have been some new hires recently.
  - d. The focus is responding to family requests and needs.
  - e. Taylor Ford: Newsletter will be out on January 6, 2020.
    - i. January is human trafficking month.
    - ii. The focus for 2020 is diversity and equity.
    - iii. Newsletter will be available through e-mail. Facebook and will be distributed to the CBHAC contact list.

**First Episode Psychosis - Institute of Living  
Patricia Graham, Dr. Zajak, Dr. Zalzal and Debbie Wong (parent)**

*Patricia Graham:*

1. led the group in an activity from Mental Health First Aid that resulted in a list of definitions of the word psychosis (crazy, breakdown, crisis, trauma, mental illness, problem, mental, fear, psycho, disturbed, lack of emotion, criminal, hearing voices, homeless, insecurity, dangerous, sick, no follow-up, hard to engage and lost).
2. First Episode is applied to 16 - 26-year-olds and sometimes to 13 - 18-year-olds.
3. Psychosis definition: cluster of symptoms that interfere with daily activities.
4. The First Episode Psychosis program at the IOL is a smaller track program within the adolescent program:
5. In-patient program at first.
6. The program was started in 2013 and the staff was expanded in 2019.
7. The program is a clinical program and therefore is not grant funded.

*Dr. Zajak: Psychiatrist*

1. Population of 13 - 18-year-olds still in school.



2. Puberty has a big effect on the psychological health of a child.
3. The first procedure completed is a full medical workup (thyroid, epilepsy, endocrine system, autoimmune system issues can all look like psychosis).
4. The family and the child are involved to establish a sense of the trajectory of the child's life.
5. A cognitive workup is done and then a diagnosis is reached.
6. Length of the program: partial hospitalization: 6-8 weeks / intensive outpatient: 3-4 months.

*Dr. Zalzal: Psychologist*

1. During partial hospitalization the child is involved in skill building groups, activity groups and process groups.
2. The following treatment modalities are utilized: individual therapy, family therapy, group therapy and medication management.
3. How to support the families when the child is discharged is given great consideration.
4. Testing components to determine what is really going on with the child:
  - a. Psychological, cognitive, verbal comprehension and speed of processing.
5. Compensatory group work that includes social situations and relationship interactions.
6. A family support group of current and former patient families is offered.
7. The parents and families usually have limited knowledge and education about psychosis which increases the associated stigma. Emphasis is placed on the beliefs that recovery is possible and that success is a reality.

*Debbie Wong: Parent*

1. Story of her son's journey from attempted suicide, depressive and psychotic events.
2. Horrified by the gaps and the needless barriers in the system:
  - a. Initial hospital situation was 75 minutes from home.
  - b. Barriers to getting information directly because her son was 16 years old.
3. IOL program has no geographic catchment area, the staff is very caring and listened well, the family was not excluded from treatment discussions.
4. Her son was ultimately diagnosed with schizophrenia, is currently 18 years old.
5. The parent is concerned about the transition from the children to the adult mental health system.

*Questions:*

1. What are the criteria for admittance into the program and what is the capacity?
  - a. The capacity is 18 children. There is currently no waiting list. In the past the waiting list has been up to 2 weeks. The IOL assists in getting help in the meantime. The child is evaluated for other treatment tracks at the IOL.
  - b. The criteria for admittance are that there may be a psychosis going on. There is no geographical catchment area and the child must have transportation to the program and the family must be available once a week for inclusion in the treatment.
  - c. Other tracks include a partial hospitalization program, and LGBTQ+ day and a 7 Challenges substance abuse program.
2. Is the program only available for children up to the age of 18 years old?
  - a. Yes.

- b. The IOL has a Young Adult program for individuals between the ages of 18 and 26 and an Adult Program for individuals over the age of 26. These programs are grant funded and research based. One of the criteria is that admittance to the program needs to occur within the first 2 years following the first episode.
- 3. Is the Mobile Crisis team part of the program?
  - a. No.
- 4. Is there a forum for teachers to recognize symptoms of early psychosis?
  - a. No. The IOL is limited in what it can offer.
- 5. What happens to the child's school schedule?
  - a. There is some flexibility in the schedule and the IOL works with the school to schedule the child's classes to support the child missing time. In some cases, there is a tutor in place to assist the child.
  - b. This is a big concern for the IOL. It is the school's responsibility to obtain mental health treatment for its students if needed. The IOL works with students on their homework and in many cases attends PPTs.
- 6. What can a parent do if their child is experiences symptoms of psychosis prior to age 13?
  - a. The Village for Children and Families has a program but is it doing enough?
  - b. It is rare for a child to experience schizophrenia prior to the onset of puberty.
  - c. Trauma in early childhood resulting in PTSD, depression and anxiety can result in dysregulation. There is a thorough evaluation with a psychiatrist using medical and mental health testing to determine a diagnosis.
- 7. Are referrals needed for 21 - 23-year-old individuals?
  - a. No. Self-referrals can be made through the Assessment Center at the IOL. There is an Adult Program designed to assist individuals with returning to work.
- 8. What is the time frame for treatment?
  - a. 4 - 6 months generally; sometimes as long as 9 months.
- 9. What are the qualifications to enter and what about substance abuse issues?
  - a. The initial 3-week period involves attendance 5 days per week. This will provide the staff with a clear understanding of what is going on.
  - b. Logistics of admittance:
    - i. Assessment Center screens calls to make sure the individual is directed to the correct department.
    - ii. The Program Manager reviews the case and schedules an Intake Interview.
    - iii. If the Intake Interview results in acceptance into the program and admission date is established.
  - c. All insurances are accepted.
- 10. Is there a socialization - job training component to the program and who are the partners involved?
  - a. This is being considered in the expansion planned being formulated.
  - b. There are 2 programs in the state: IOL and Yale. These two programs are leading the country in terms of treatment.
  - c. As part of the Mental Health Block Grant award States must allocate 10% (~\$150,000 in CT) to the following:
    - i. Identification of need and
    - ii. Expansion of the capacity around CT.

- d. There is a lot of work still to be done to plug the gaps in the system. The benefits of early intervention include better outcomes and lower costs.
  - e. Yale is doing some work on Clinical High Risk for Early (younger than 13 years old) Psychosis.
11. Race and language are also barriers to treatment. What can CBHAC do to help increase capacity?
- a. Barriers are driven by culture and funding and are financially tied to limitations on outreach across the state.
  - b. Patients are predominantly of color.
  - c. CBHAC is welcome to assist by getting information out to the community.
  - d. A family support group consisting of current and former patients exists. It meets twice each month.
  - e. The IOL Family Resource Center has a number of free programs available.

### **Subgroup Committees**

1. Time does not permit breaking out into the two groups. The group will meet as a whole to discuss the Community Collaborative.
2. 2020 focus:
  - a. Update the practice standards.
  - b. Issue the annual survey in July.
  - c. Complete the annual report by the October 1<sup>st</sup> deadline.
  - d. Share the System of Care PowerPoint presentation as part of the community presentations.
  - e. The Community Collaborative PowerPoint presentation will be available on the WRAPCT.org website by the end of January.
3. Tim Marshall indicated there is money from the Block Grant to fund the Community Collaboratives - ~\$1,800 each. These funds can be used to fund governance, bylaw development and training. It is important to remember the importance of the Community Collaboratives as they have the local knowledge of what is needed locally.
4. If there is no co-chair or chair who is responsible to maintain the collaborative?
  - a. Look to the Practice Standards for guidance.

### **General Updates / Announcements**

1. January is National Mentoring Month. There is information available on the Governor's Prevention website. There is a great need to provide kids with services.
2. Census will be starting in March. It is very important to be counted as the results determine the amount of money allocated to the State of CT. The Hartford Public Library will have resources to assist in being counted. The census may be completed on-line, on the telephone and in person.
3. V for FC will meet the 3<sup>rd</sup> Monday of the month at the Village for Children and Families from 10:00am - 12:00 noon.
4. Tim Marshall spoke of the differences between Rural and Urban service availability. One of the barriers is language.
  - a. There is a need to recruit people into the service professions that are bilingual and represent the diversity within the community.
  - b. Competency standards start with the Boards and there needs to be equal representation of the community.
  - c. Mentoring kids to come back into the community is an opportunity.

5. The DSS Focus Groups will be meeting in the New Haven and Litchfield rooms at 12:15 pm today.

## **February Minutes**

### **Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, February 7, 2020**

#### **Minutes**

### **Welcome and Introductions**

### **Approval of Minutes**

1. A quorum was confirmed.
2. There are no revisions to the previous month's minutes.
3. A motion to accept the minutes was made, seconded and approved.

### **Agency Updates**

1. DMHAS
  - a. Opportunities for youth involvement exist.
  - b. The department is looking to strengthen the integration of mental health and substance abuse treatments.
2. State Department of Education
  - a. A coordinator is being hired to expand the emphasis on Culture – Climate – Safety and Equity.
  - b. Four new members have been appointed to the State Board of Education.
3. DSS
  - a. Received a 7-year Federal grant (Integrated Care for Kids). The activity is focused in New Haven and will be administrated by Clifford Beers Clinic.
4. DCF
  - a. Moving forward with the CONNECT System of Care continuing grant. There has been some delay due to contract negotiations and implementations.
  - b. Voluntary Services transition from DCF to Beacon Health Options is pending contract negotiation. Mary Cummings (DCF) and Gabriel Hall (Beacon) will be coordinating the transition.

### **Membership Update**

1. Presentations by potential members will be given at the March meeting. After completion of a confidential vote the elected candidates' names will be presented to the DCF Commissioner for approval.

## Prescriptions for Medicaid Eligible Children - Psychotropic and Psychoactive

**Dr. Sandra Carbonari - Pediatrician and Dr. Alex Geertsma - Pediatrician**

*Dr. Carbonari:*

1. Training in behavior health is not extensive in medical schools.
2. There need to be realistic expectations of pediatricians - time constraints.
3. Pediatricians need to know what the parents want them to know.
4. There is a capacity issue involved: not enough people and care coordination capabilities.

*Dr. Geertsma:*

1. There is a long history of need for behavioral health education among pediatricians.
2. The biggest problem is manpower: fewer doctors in pediatric primary care. The nurse practitioners are trying to pick up some of the slack.
3. FREDLA issued *A Report on Family Experiences with the Use and Monitoring of Antipsychotic Medications for the Children* in the Spring of 2018 that addresses the issues involved.
4. The real question is how to expand capacity for behavioral health issues because the "in and out fee for service" model does not work.

*Questions:*

1. Medical Home Initiative
  - a. This is an embedded model that addresses prevention and family education. It is being replaced by PCMH+ (Patient Centered Medical Home).
2. Prescription and Monitoring of Drugs
  - a. Beware of "pill pushers".
  - b. There needs to be a level of trust between the parents and the MD and the MD and the parents.
    - i. There is concern surrounding the child's welfare visit that includes a parent's concern that something is not right with the child and the issue is not being addressed.
  - c. There are no guidelines for prescribing behavioral health medications on the doctor's side.
  - d. Access Mental Health system is a program that provides information for physicians and care coordination.
3. School system referrals for treatment
  - a. Who is and how is accountability established when school refers child to pediatrician who refers child to a specialist?
  - b. Parents need to communicate between physicians / providers.
4. HIPPA considerations:
  - a. A Green Form release exists and is widely used.

## General Updates / Announcements

1. Doriana is facing serious medical issues and will not be attending meetings for the foreseeable future.
2. The West Hartford System of Care Meeting is being held on the 4<sup>th</sup> Monday of February at the Village for Children and Families from 10:00AM - 12:00PM.

**Next Meeting: Friday March 6, 2020.**

### March Minutes

## **Children's Behavioral Health Advisory Council (CBHAC) Minutes – Friday March 06, 2020**

### **Welcome and Introductions**

1. Jo Hawke is stepping back as co-chair. Dorianna Vicedomini is recovering nicely from her surgery. Gabrielle Hall from Beacon Health Options will step in to chair the meetings during this period of transition.

### **Approval of Minutes**

4. There was no quorum, therefore the February minutes will be voted on in April.

### **Agency Updates**

5. Department of Justice
  - a. No report.
6. DMHAS
  - a. An application for an early intervention grant from SAMHSA has been submitted.
  - b. Outcome research is being conducted on Apartment - Young Adults.
  - c. Specialized substance use trainings with a focus on young people are being conducted.
7. Department of Education
  - a. No report.
8. Department of Corrections
  - a. No report.
9. DSS
  - a. Substance Use Implementation grant is in progress.
  - b. There are 7 focus groups consisting of 68 participants.
  - c. Providers are being interviewed; 37 interviews completed out of 148 total providers.
  - d. An overview of the responses obtained from the focus groups was provided.
10. DCF
  - a. IFCS (Integrated Family Care and Support) program is being rolled out. This is a diversion program for unsubstantiated cases run by Beacon Health Options.
  - b. Voluntary Services transition from DCF to Beacon Health Options is occurring. It is anticipated that 300 families per year will utilize these services.
  - c. These transitions will allow DCF to focus on substantiated cases and child welfare issues.
  - d. DCF will provide a 1-page overview of the IFCS and Voluntary Services programs at the April CBHAC meeting.

11. Favor
  - a. No report.
12. Marcia Dufore from NCRBH Action Organization presented information regarding a survey designed to collect information about anxiety among youth around school attendance. Flyers were distributed and participation was encouraged.

### **Membership Update**

2. Presentations by potential members were given by Lindsey Kyle, Kenneth Benefield, Sabra Mayo, Donald Vale and Dr. Alex Gertsma.
3. The vote was tabled until March due to the lack of a quorum.

### **Subcommittee Breakout Meetings**

1. The Community Collaborative and the Community Mental Health Block Grant committees met separately.
2. Community Mental Health Block Grant:
  - a. Overview of the 2021 block grant: This money is used for data collection, evidence-based programming, suicide prevention trainings, workforce development and includes first episode psychosis outreach.
  - b. DCF priorities were discussed. They will include family engagement and providing a comprehensive array of services.
  - c. URS table of CT data are available on the DCF website.
  - d. There is a need for a separate Education Subcommittee to discuss and to improve policies for school interactions.
3. Community Collaboratives
  - a. Three items were discussed:
    - i. Funding: each collaborative is eligible to apply for \$1,800. The co-chairs of each collaborative have received the application. The money must be spent by September 30, 2020.
    - ii. Annual Survey: The survey is to be completed by the co-chairs of each collaborative. Yale will assist in data collection and the results will be presented to CBHAC.
    - iii. CBHAC Highlights: parent involvement and engagement has increased during the year; and families have raised issues and then a presentation on those issues have occurred.

### **General Updates / Announcements**

3. It is important to have full participation in the 2020 census.
4. March 11, 2020: A Suicide Prevention seminar in Spanish will be given in East Hartford.
5. The West Hartford System of Care Meeting is being held on the 4<sup>th</sup> Monday of February at Pope Park from 10:00AM - 12:00PM.
6. The North Central Network of Care meeting will be held at the East Hartford Public Library on March 11, 2020 from 9:30 AM - 11:30 AM. The topic will be Anxiety and School Attendance.

**Next Meeting: Friday April 3, 2020.**

## April Minutes

Cancelled due to Covid 19

## May Minutes

### **Children's Behavioral Health Advisory Committee (CBHAC) Friday, May 1, 2020 Minutes**

**Approval of Minutes:** Minutes were not approved due to lack of quorum

#### **5. State Agency Updates**

- a. DMHAS - Jenn Abbatemarco
  - i. DMHAS activated an incident command structure, which coordinates DMHAS's response to the COVID 19 crisis. COVID-19 memos and responses are available on the DMHAS website under COVID 19, which includes all of the memos the commissioner has published to date & relevant agency information
  - ii. DMHAS Staff—are currently teleworking in accordance with Social Distancing recommendations and guidelines; DMHAS has a core group of clinical staff at each site. DMHAS Residential programs remain fully staffed and operating on a 24 hr. basis
  - iii. Focus on helping clients/young adults who have difficulties with the stay-at-home guidelines. Currently doing some activities to help them remain connected to family members (doing a lot of online activities while remaining active with Advocacy Unlimited and Street Smart Center, which provides children with opportunities to engage in virtual programming)
- b. SDE- Scott Newgass
  - i. Discussed the challenges of youth remaining home and following social distancing guidelines
  - ii. SDE's first priority was to ensure meals were available to students, particularly those students on free, reduced priced lunches. Many cities with high poverty rates; anyone under 18y/o qualifies for the meals. Turnaround time was within 24 hours to create a plan to redistribute foods to students and families
  - iii. A number of students are not connected and will not benefit from the online instruction that currently exists/taking place. Additionally, SDE also aware of the number of students that have not logged on to access the online academics and supports being offered. The group is mostly comprised of high school students. SDE continues to put out information to parents to



- deal with issues their facing; Commissioner Cardona expressed interests in having staff develop videos to address some of the needs
- iv. Parents raised concerns about Planning and Placement Team (PPT) meetings being cancelled. Clarified that PPT's are not being cancelled, but instead postponed. School districts are still required to hold PPT's but also understand the practical limitations to holding PPT's as it relates to maintaining privacy/confidentiality and meaningful participation of parties involved
  - v. Concerns raised around young adults couch surfing, identifying vulnerable youth and making sure school staff are trained on how to identify sex trafficking. With nowhere to stay and financial strain, some youth and young adults might engage in acts of prostitution to support themselves. Housing insecurity and the current COVID-19 situation leaves some more vulnerable and prone to exploitation. Many school staff have participated in sex trafficking training to be aware of the signs. Lack of face to face contact poses a barrier to help
  - vi. Scott will provide legal aid & legal advocacy program information along with Special Education document
  - vii. Anyone experiencing difficulties with getting their students' special needs met or aware of someone with special education needs, they can contact the Bureau of Special Education; staff available by phones to assist
  - viii. Parents can also contact CPAC (Ct Parent Advocacy Center)
- c. CSSD - John Torello
- i. Currently doing virtual meetings unless an emergency exists; MST and other providers are seeing families by FaceTime and virtual meetings. Doing a good job on the juvenile side to develop creative ways to meet the needs. Able to provide some assistance around basic needs
  - ii. Courts are currently open and operating on limited basis, not shut down; closed Tuesdays & Thursdays but open on Monday, Wednesday, Friday
  - iii. Juvenile Detention reviews and arraignments are being heard only by Hartford and Bridgeport courts at this time; remaining court Probation Officers working at courts are operating on a "skeleton crew" to address the youths who arrive at court
  - iv. With respect to detention centers, the courts are trying not to bring kids in as much as possible. As of May 1<sup>st</sup>, the Bridgeport detention facility has 31 youths and Hartford 16. Detention centers have seen a 45% reduction since March 1<sup>st</sup>. Juvenile Detention currently at 45% capacity due to COVID; Attorneys working with all the detention cases, trying to identify who can be released early and safely without any significant risk to the client(s) and/or public safety
  - v. Detention reviews are happening via video conferencing and utilizing strict screening methods before admission
  - vi. Bridgeport Detention only taking youths diagnosed with COVID; 7 adolescents tested positive for COVID at Bridgeport Detention so far
  - vii. Young, healthy Adult Probation Officer recently passed away in the Stamford area. Court is trying to mitigate as much as possible while

providing services. Groups were suspended initially but engagement has been going well; youth are utilizing technology to engage with services. Programs facilitate Zoom groups

d. DSS- Rod Winstead

- i. CT DSS still continue to operate all programs; most staff working remotely on a regular or rotating basis through the office to ensure physical distance guidelines continue
- ii. DSS added 25,000 new Medicaid members- due to economic factors associated with COVID epidemic; DSS #1 priority is trying to remain committed to help all providers with over 900,000+ Medicaid members during this public health emergency
- iii. DSS has issued 29 provider bulletins; provider bulletins are documents that're sent to all providers statewide that explains changes to programs, how DSS services are offered, relaxing things so that people get access to services on medical and behavioral health side
- iv. To know what changes have been made to SNAP food stamp or any other programs; changes in eligibility requirements; go to [DSS.ct.gov](http://DSS.ct.gov) for additional information; Visit [Ct.gov/coronavirus](http://Ct.gov/coronavirus)- to look at all changes with agencies statewide

e. DCF – Tim Marshall

- i. DCF is operating on the Incident command structure; majority of staff are teleworking using virtual telecommunications platform & other virtual communications in accordance with HIPPA compliance; DCF is still operating in their facilities, 24-hour beds and hospitals as necessary, with all safety precautions and needed COVID protections.
- ii. Careline taking referrals, staff going out in the communities with PPE (Personal Protective Equipment) to complete intakes and assess referrals that come into DCF
- iii. DCF launched Talk It Out line; [Talkitoutct.com](http://Talkitoutct.com)- an opportunity for families feeling stressed, working from home, families helping children with online learning; Talk it Out support line- launched to help families who are stressed and struggling; offers a compassionate presence and listening ear; Call 1-833-258-5011, completely confidential, not associated with DCF Careline or any protective services; Number of successful calls and hits on the website since launch
- iv. All the activities related to the Family First plan are currently on pause; original plan was to be implemented by October 1st; All of the workgroups and planning committees paused due to COVID; stay tuned on details on how it will proceed
- v. Successfully transitioning Voluntary Services from DCF to BHO; May 1st live date; Calls still go through the Careline, but BHO will take calls directly; CBHAC has been advocating for this change for a long time
- vi. Provider community (behavior health professionals) and Protective Service have been doing a good job from early COVID isolation phase; incredible amount of work that went into working with families and kids virtually

- vii. Total volume of child and families served is down due to the limitations of virtual treatment. Some families do not have hardware or connectivity.
- viii. Recently, it appears that some in the provider community and some families have experienced virtual meeting fatigue in both school & treatment sector; Providers mentioned that families need downtime due to long virtual meetings/sessions; Families feel overwhelmed by virtual face to face time
- ix. DCF commended all the work CBHAC and other leaders have done

**6. Presentation: Tim Marshall, State Department of Children and Families, CONNECT grant**

- i. Discussed System of Care grant- March kickoff event; Awarded Connect III Sustainability grant- builds off of the previous 6-year grant; Gives us a 10-year period to focus on systems development activities; Mostly to develop system work and improve service system as a whole
- ii. Focused on Serious Emotionally Disturbed (SED); Federal definition defined by children without an intervention will potentially need to be removed from home/community and diagnosed within past 6 months with a DSM condition
- iii. Strong focus on reducing inpatient hospitalization, use of ER's and PRTFs; trying to identify serious needs/high risk kids in line with early episode psychosis
- iv. Partners are DCF, Beacon Health Options, CHDI, YALE, FAVOR, all care coordination agencies throughout the state; care coordination is the primary service category used for the CONNECT III grant
- v. Goals: Increase access for kids and families in service system through education and awareness; Heavy emphasis placed on workforce development & training- training both the provider community and families using WrapCT training modules and the grant curriculums; will continue with the current modules and develop additional ones as needed
- vi. Goals: Recruit and sustain family/youth involvement at all levels of care; remain data driven; develop Carehubs, building one relationship at a time between, schools, local behavioral health providers and Pediatricians/PCP
- vii. Emphasize the need for schools and behavioral health providers and primary care and behavioral health need to partner together
- viii. Continue CLAS work, racial injustices, health equity planning, highlight discrepancies and identify barriers that get in the way and develop a more equalized treatment arena.
- ix. Continue to expand and examine the reduction of the high need services like ED's, PRTFs; Evaluation activities - will continue to use the community conversation structure and look at the service data and track family outcomes
- x. Will continue with 6 workgroups, paired down from 10; visit Plan 4 children or Connecting to Children websites; activities will be posted to these locations
- xi. Carehubs will continue to establish linkages and develop better relationships in an effort to improve and work on infrastructure at the grass roots level

- xii. Activities to help Primary Care Physicians be aware of patients with Behavior health needs and connect to provider; Developed the green form, but ongoing work will continue; Pediatricians get notified when behavioral health referral is made when children and families are connected
- xiii. Connecting to care site has animated videos that provides historical overview of where CT has been, how far we've come and where were going; Healthy Lives CT site shows how to maintain good healthy connections for children and families
- xiv. Encouraged people to support and join connecting to care mission; Slowly phasing out the WrapCT domain name; but will still connect individuals to ConnectingtocareCT website.

#### **7. Announcements**

- a. Stay tuned for statewide Steering team; preparing for 1st virtual meeting to help guide the work
- b. CBHAC will continue to bring updates to this group
- c. Workgroups open to public; Steering team by voting members, small group of 10-12 w/youth and family voice
- d. Gabrielle announced Mental Health Awareness Month (MHAM); will send it out to the CBHAC group; encouraged folks to share MHAM calendar with network and personal connections; noted website and additional resources on backside of MHAM calendar along with TalkItOut support line; Activities include: virtual Scavenger hunt; Youth Bingo; Teen Bingo; word searches
- e. Gabrielle provided regional contact information for FSM/NOC's

#### **June Minutes**

### **Children's Behavioral Health Advisory Council (CBHAC) Minutes – Friday June 5, 2020**

#### **Welcome and Introductions**

- 2. Gabrielle Hall facilitated the meeting via Zoom. The meeting will consist of the following Agency updates: DMHAS, Dept. of Education, Juvenile Justice Services, DSS and DCF.

#### **Approval of Minutes**

- 5. There was no quorum, therefor the February, March and May minutes will be voted on in September.

#### **Agency Updates**

- 13. DMHAS - Jenn Abbatemarco
  - a. All are saddened by the events of the last week (George Floyd and protests). DMHAS opposes discrimination in any form.
  - b. Tele-work continues with core teams of clinical staff rotating through the offices.

- c. DMHAS is working on a plan to safely bring employees back to onsite work. The plan probably will mirror the state government and other agencies.
14. Department of Education - Scott Newgass
- a. The department acknowledges this is a difficult time and a crisis of consciousness, in addition to the COVID-19 pandemic.
  - b. The current school year will not reconvene in person. The department will maintain summer school guidance.
  - c. There is great concern for the students who are not logging on to interact with teachers.
  - d. Plans are being considered for reopening schools in the fall. There may be a mixture of in-person learning and distance learning.
  - e. There is not additional information as to whether the students will be able to keep the donated laptops and Chromebooks.
15. Department of Juvenile Justice Services - No Report
16. Department of Social Services - Ron Winstead
- a. The Department of Social Services opposes racism at every level and believes everyone should be treated the same.
  - b. The staff is continuing to work virtually and on a rotating basis throughout the office.
  - c. The Commissioner is also working as the Interim Commissioner of the Department of Public Health. The team is working to increase testing for COVID across the state.
  - d. The CMS Substance Use Disorder Planning Grant work is continuing.
  - e. The Clifford Beers Clinic is managing the Integrated Care for Kids grant.
  - f. COVID-19: The Department is working with its providers and members as changes to provide continued access to services. Telehealth and Telemedicine protocols continue to evolve and are being addressed by a work group.
17. Department of Children and Families - Tim Marshall
- a. The Department is committed to racial justice activities and to assure cultural and ethnic equities exist. The Department developed presentation "The Color of COVID" to assist in the on-going dialogue of disparities in health outcomes. DCF is working on developing a framework that moves people from conversation to action.
  - b. Staff continues to work virtually with some first line workers rotating through the regional offices. Meetings with families have been occurring virtually.
  - c. The Department has established five workgroups to address reopening policies and procedures. Guidelines for providers are being developed.
  - d. Behavioral health community consultations are being held to improve collaboration between the department and the school systems in Naugatuck, Waterbury and Middletown. Lessons learned will be brought to other districts.

**Voluntary Care Management Program - Beacon Health Options**

1. The coordination of voluntary services transferred from DCF to Beacon Health Options on May 1, 2020.
2. A presentation was given that describes the process to obtain these services, the eligibility criteria, the exclusionary criteria, the referral process, the role of voluntary care managers and the key outcome measurements.
3. The implementation plan was explained.

4. Beacon Health Options is looking forward to this opportunity.
5. Questions about the program can be directed to Network of Care Managers and Family System Managers.

Next meeting: September 4, 2020.

NOT FINAL

## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
 State Vocational Rehabilitation Agency  
 State Criminal Justice Agency  
 State Housing Agency  
 State Social Services Agency  
 State Health (MH) Agency.

Start Year: 2021 End Year: 2022

Name	Type of Membership*	Agency or Organization Represented	Address, Phone, and Fax	Email(if available)
Jennifer Abbatemarco	Youth/adolescent representative (or member from an organization serving young people)	DMHAS - YAS	1800 Silver Ave Middletown CT, 06457 PH: 860-262-6962 FX: 860-262-6962	jennifer.abbatemarco@ct.gov
Tiffanie Allain	Providers	PATH	277 South St. Brooklyn CT, 06234 PH: 860-412-0041	tallain@pathct.org
Nan Arnstein	Providers	Creative Arts for Developing Minds	141 Weston St. Hartford CT, 06142 PH: 860-834-3359	narnstein@creativeartsdm.org
Craig Burns	State Employees	Dept of Correction (DOC)	24 Wolcott Hill Rd Wethersfield CT, 06109 PH: 860-692-6262 FX: 860-730-8287	craig.burns@ct.gov
Erica Charles-Davey	Parents of children with SED/SUD		247 Collins St. Hartford CT, 06105 PH: 860-951-1830 FX: 860-310-2260	ericadevy@gmail.com
Joan Cretella	Family Members of Individuals in Recovery (to include family members of adults with SMI)		225 Beach St. West Haven CT, 06516 PH: 203-933-4272	
Michele Devine	Persons in recovery from or providing treatment for or advocating for SUD services	SERAC	228 West Town St. Norwich CT, 06360 PH: 860-848-2800 FX: 860-848-2801	serac.ed@sbcglobal.net
Marcia DuFore	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Amplify	151 New Park Ave. Hartford CT, 06106 PH: 860-667-6388	mdufore@amplify.org
Ellen Econs	State Employees	Bureau of Rehabilitation Services	410 Capitol Ave. Hartford CT, 06134 PH: 860-308-4523 FX: 860-262-5852	ellen.econs@ct.gov
Antonia Edwards	Parents of children with SED/SUD			antonia.edwards@yahoo.com
			846 Wethersfield	

Maria Feliciano	Providers	Disability Rights CT	Avenue 06114 Hartford CT, 06114 PH: 860-297-4300	Maria.Feliciano@DisRightsCT.org
Michaela Fissel	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Advocacy Unlimited	300 Russell Rd. Wethersfield CT, 06019 PH: 860-667-0460 FX: 860-666-2240	mfissel@advocacyunlimited.org
Kathy Flaherty	Others (Advocates who are not State employees or providers)	CT Legal Rights Project	CLRP, PO Box 351 Middletown CT, 06457 PH: 860-262-5033 FX: 860-262-5035	kflaherty@clrp.org
Allison Fulton	Persons in recovery from or providing treatment for or advocating for SUD services	Western CT Coalition	7 Old Sherman Turnpike Danbury CT, 06810 PH: 203-743-7741	afulton@wctcoalition.org
Ingrid Gillespie	Persons in recovery from or providing treatment for or advocating for SUD services	Liberation Programs	Liberation Programs Norwalk CT, 06850 PH: 855-542-7764	ingrid.gillespie@liberationprograms.org
Gabrielle Hall	Providers	Beacon Health Options	500 Enterprise Dr. Rocky Hill CT, 06067 PH: 860-707-1016	gabrielle.hall@beaconhealthoptions.com
William (Bill) Halsey	State Employees	Department of Social Services	25 Sigourney St. Hartford CT, 06106 PH: 860-424-5077 FX: 860-424-4812	william.halsey@ct.gov
Josephine Hawke	Parents of children with SED/SUD		65 Woodmere Rd. West Hartford CT, 06067 PH: 860-231-9856 FX: 860-563-3961	johawke@sbcglobal.net
Brenetta Henry	Parents of children with SED/SUD		73 Governor St. East Hartford CT, 06108	brenetta.henry@yahoo.com
Irene Herden	Others (Advocates who are not State employees or providers)		49 Bogue Ln East Haddam CT, 06423 PH: 860-873-1999 FX: 860-873-1999	evherd@comcast.net
MuiMui Hin-McCormick	Persons in recovery from or providing treatment for or advocating for SUD services	Rushford	1250 Silver St. Middletown CT, 06457 PH: 860-852-1021 FX: 860-343-1732	muihui.hin-mccormick@hhchealth.org
Lisa Jameson	Parents of children with SED/SUD		112 Bell-Aire Cir. Windsor CT, 06096 PH: 860-623-5790	lisajameson22@gmail.com
Tim Marshall	State Employees	Department of Children and Families	505 Hudson St. Hartford CT, 06105 PH: 860-550-6531 FX: 860-556-8022	tim.marshall@ct.gov
Mary Martinez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7 Mary Shepherd Pl. Hartford CT, 06120 PH: 860-719-5080	mryadvcomm35@gmail.com
Donna Maselli	State Employees	Department of Public Health	410 Capitol Ave. Hartford CT, 06134	donna.maselli@ct.gov



			PH: 860-509-7505	
Pamela Mautte	Others (Advocates who are not State employees or providers)	Alliance for Prevention and Wellness	127 Washington Ave. North Haven CT, 06473 PH: 203-892-6418	pmautte@bhcare.org
Debbie McCusker	Parents of children with SED/SUD		35 Maywood St. Waterbury CT, 06704 PH: 203-757-7569	jamesmccusker@sbcglobal.net
George McDonald	Parents of children with SED/SUD		PO Box 2617 Hartford CT, 06146 PH: 860-794-6283	
Carol Meredith	State Employees	DMHAS - Prevention Division	410 Capitol Ave. Hartford CT, 06134 PH: 860-418-6826 FX: 860-418-6792	carol.meredith@ct.gov
Scott Newgass	State Employees	CT State Department of Education	450 Columbus Ave Hartford CT, 06106 PH: 860-807-2044 FX: 860-807-2127	scott.newgass@ct.gov
Daisy Olivo	Providers	FAVOR, Inc.	185 Silas Dean Hwy. Wethersfield CT, 06109 PH: 860-837-1436	dolivo@favor-ct.org
Maureen O'Neill-Davis	Parents of children with SED/SUD		Torrington CT, 06790 PH: 561-762-4747	maureenod65@gmail.com
Edwin Renaud	State Employees	CVH	PO Box 351 Middletown CT, 06457 PH: 860-262-5496 FX: 860-262-5895	edwin.renaud@ct.gov
Barbara Roberts	Family Members of Individuals in Recovery (to include family members of adults with SMI)		42 School St. Woodbury CT, 06798 PH: 203-263-3250	barbararoberts882@gmail.com
Heather Tartaglia	Providers	CREC	111 Charter oak Hartford CT, 06106 PH: 860-509-3732	heathertaglia@crec.org
Peter Tolisano	State Employees	DDS	460 Capitol Ave. Hartford CT, 06106 PH: 860-418-6086	peter.tolisano@ct.gov
John Torello	State Employees	Court Support Services Division (CSSD)	936 Silas Deane Highway Wethersfield CT, 06109 PH: 860-721-2157	john.torello@jud.ct.gov
Benita Toussaint	Parents of children with SED/SUD		45 Niles St. Hartford CT, 06105 PH: 860-249-4806	toussaintbenita@yahoo.com
Ofelia Velazquez	Parents of children with SED/SUD		55 Taylor Street Hartford CT, 06010 PH: 860-313-9130	ovy4252@yahoo.com

Doriana Vicedomini	Parents of children with SED/SUD		9 Kingfisher Ln. Suffield CT, 06078 PH: 504-259-4327	dmv35@aol.com
Laura Watson	State Employees	DOH	505 Hudson St. Hartford CT, 06106 PH: 860-270-8169 FX: 860-706-5741	laura.watson@ct.gov
Margaret Watt	Parents of children with SED/SUD	The Hub	1 Park St. Norwalk CT, 06851 PH: 203-840-1187	mwatt@thehubct.org

\*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2021 End Year: 2022

Type of Membership	Number	Percentage of Total Membership
<b>Total Membership</b>	<b>43</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	12	
Vacancies (Individuals and Family Members)	2	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	4	
Representatives from Federally Recognized Tribes	0	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>26</b>	<b>60.47%</b>
State Employees	11	
Providers	6	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>17</b>	<b>39.53%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	10	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>16</b>	
Youth/adolescent representative (or member from an organization serving young people)	1	

\* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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#### Footnotes:

## Environmental Factors and Plan

### 22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA. The state should provide the permanent URL allowing SAMHSA and the public to view the state's Block Grant plan during plan development and after submission to SAMHSA.

#### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
  - a) Public meetings or hearings?  Yes  No
  - b) Posting of the plan on the web for public comment?  Yes  No  
If yes, provide URL:
  - c) Other (e.g. public service announcements, print media)  Yes  No

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**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### 23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction<sup>1,2</sup> on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018<sup>3</sup>.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers<sup>4</sup>. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs<sup>5</sup>: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. **Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

<sup>1</sup> Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

<sup>2</sup> Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

<sup>3</sup> Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

<sup>4</sup> Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

<sup>5</sup> ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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**Footnotes:**

As of 2019 in Connecticut, there are 13 Specialized Syringe Programs (SSPs) in urban areas across the state. These SSPs are either funded (10) or supported with supplies (3) provided by the Connecticut Department of Public Health (DPH). In 2019, 1,137,746 syringes were distributed and 753,292 syringes were collected. A total of 4,428 persons were served by SSPs, half of whom (50.7%) were new clients. New HIV cases in Connecticut continue to decline.

Given these circumstances, DMHAS is not proposing to use SABG funds for elements of SSPs.

NOT FINAL

## 2020-2021 Combined Block Grant Behavioral Health Needs Assessment

The behavioral health needs assessment for Connecticut is based on a variety of quantitative and qualitative data sources including the National Survey on Drug Use and Health (NSDUH) 2017 as well as the Connecticut State Report based on the 2016 and 2017 NSDUH Reports; the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Report for FY 2018; the 2015 Connecticut Behavioral Health Barometer; The DMHAS Statewide Priority Setting Report conducted in 2019; DMHAS Enterprise Data Warehouse (EDW) data; data from the Connecticut Office of the Chief Medical Examiner (OCME); and US Census Data.

DMHAS also funds and collaborates with Connecticut's **State Epidemiological Outcomes Workgroup (SEOW)**. The SEOW is administered by the Center for Prevention Evaluation and Statistics (CPES) and operates through a contract with the University of Connecticut's Health Centers' Department of Community Medicine. The following agencies comprise the SEOW: Department of Mental Health and Addiction Services (DMHAS), Department of Public Health (DPH), Department of Consumer Protection (DCP), Department of Children and Families (DCF), Department of Correction (DOC), Office of Policy and Management (OPM), Department of Emergency Services and Public Protection (DESPP), State Department of Education (SDE), Office of Early Childhood, Regional Behavioral Health Action Organizations (RBHAOs), Connecticut Hospital Association (CHA), Board of Pardons and Parole, Connecticut Data Collaborative, University of Connecticut (UConn) Health, Office of the Child Advocate, (UConn) Center for Public Health and Health Policy, CT Youth Services Association, and AIDS-CT. Specific tasks of the SEOW include:

- Identify, collect and analyze data related to behavioral health problems
- Assess data quality and utility
- Support a statewide needs assessment that measures the prevalence and distribution of substance use and mental health-related problems
- Identify indicators of risk and protective factors for substance use and related problems
- Identify populations experiencing health disparities
- Disseminate data to increase access to a greater number of stakeholders

### Prevalence and Treated Prevalence

#### Mental Health

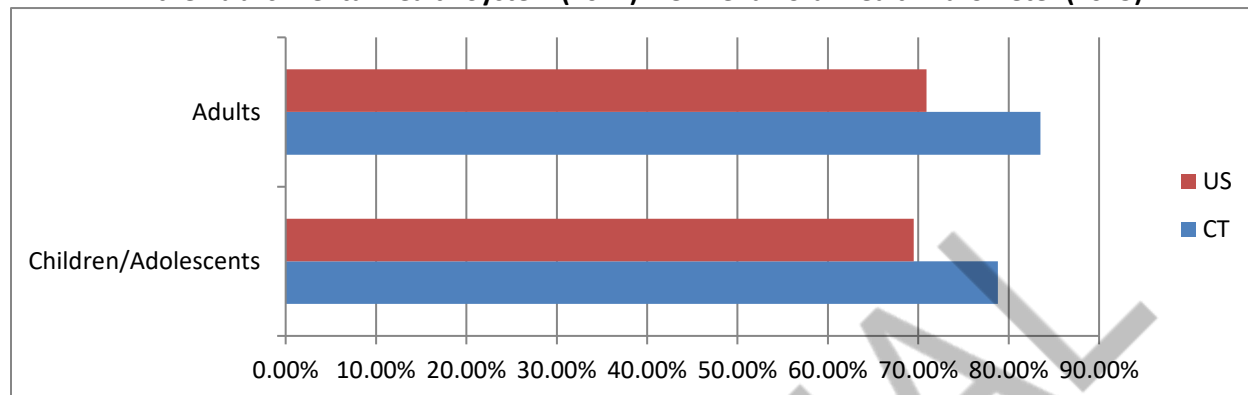
##### **Any Mental Illness (AMI)**

In SFY 2018, the DMHAS Annual Statistical Report, which reflects services provided by DMHAS funded and operated programs, reported more than 54,000 persons served in mental health programs only. Seventy-two percent of clients had a single mental health program admission. Nearly equal percentages of males and females received DMHAS mental health services. Most clients served were White/Caucasian (61%), followed by Black/African American (18%) and "Other" (14%). Twenty-one percent of clients served in DMHAS mental health programs were of Hispanic/Latino origin. Comparing percentages receiving mental health services to state population percentages, White/Caucasian clients were underrepresented (comprising 68% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 16% of the state population, respectively). The average age of clients receiving mental health services was 45.8 years ( $\pm 15.4$ ).



Of special interest to DMHAS, mental health consumers served in the public mental health system in Connecticut in 2014 reported improved functioning at rates greater than the national average.

**Mental Health Consumers in CT and the US Reporting Improved Functioning from Treatment in the Public Mental Health System (2014) – CT Behavioral Health Barometer (2015)**



**Any Mental Illness in the Past Year (NSDUH 2016 – 2017)**

	Age 18+	Ages 18 - 25	Age 26+
<b>U.S.</b>	18.6%	23.9%	17.7%
<b>Northeast</b>	18.0%	24.1%	17.0%
<b>Connecticut</b>	18.2%	25.6%	17.0%

Connecticut residents had similar percentages for any mental illness for all ages except young adults (18 – 25) where it slightly higher than both the U.S. and Northeast percentages. On a positive note, higher percentages across age groups in Connecticut were recipients of mental health services in the past year compared to northeast and US figures.

**Received Mental Health Service in the Past Year (NSDUH 2016 – 2017)**

	Age 18+	Ages 18 - 25	Age 26+
<b>U.S.</b>	14.6%	13.9%	14.7%
<b>Northeast</b>	15.7%	15.2%	15.7%
<b>Connecticut</b>	16.6%	18.4%	16.3%

According to the Connecticut Behavioral Health Barometer (2015), about 214,000 adults with AMI each year from 2010 to 2014 (47.5%), received mental health treatment/counseling which was similar to but greater than the national average of 42.7%.

**Serious Mental Illness (SMI)**

Data from the Annual Statistical Report SFY 2018 reveals that more than half of the clients served (62%) in the DMHAS system met criteria for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, major depression, and PTSD.

**Serious Mental Illness in the Past Year (NSDUH 2016 – 2017)**

	<b>Age 18+</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	4.4%	6.7%	4.0%
<b>Northeast</b>	4.2%	6.6%	3.8%
<b>Connecticut</b>	4.2%	7.4%	3.6%

Connecticut residents had lower percentages of serious mental illness for all ages except young adults (18 – 25) where it was slightly above both the U.S. and Northeast percentages.

**Depression**

Connecticut percentages for depression were similar to the national and regional estimates for all age categories except those ages 18 – 25 where it was slightly higher.

**Major Depressive Episode in the Past Year (NSDUH 2016 – 2017)**

	<b>Age 18+</b>	<b>Ages 12 - 17</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	6.9%	13.0%	12.0%	6.1%
<b>Northeast</b>	6.8%	12.1%	11.8%	6.0%
<b>Connecticut</b>	7.0%	13.2%	13.1%	6.0%

Data from the Annual Statistical Report indicated 17% of clients had depressive disorders and 12% had bipolar and related disorders, together accounting for nearly a third of all diagnoses treated. The Behavioral Health Barometer – 2015 for Connecticut reported past year treatment for Major Depressive Episode (MDE) in adolescents based on annual averages from 2007-14 was 52.3% which was higher than the national average of 38.1%. This reflects MDE treatment for Connecticut adolescents at about 11,000 annually.

**Suicide/Suicidal Thoughts**

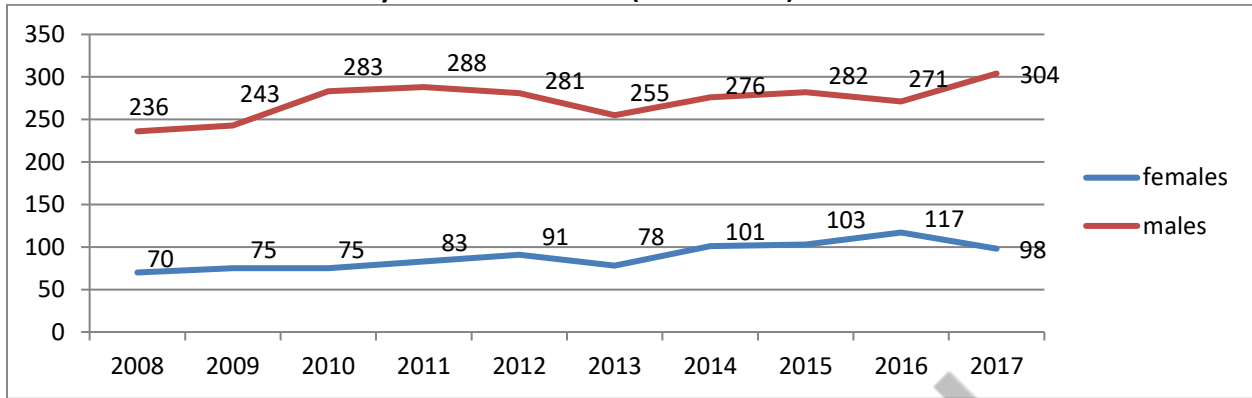
Connecticut rates for serious suicidal thoughts for all age categories are similar to national and regional estimates.

**Serious Thoughts of Suicide in the Past Year (NSDUH 2016 – 2017)**

	<b>Age 18+</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	4.2%	9.6%	3.3%
<b>Northeast</b>	4.0%	9.5%	3.1%
<b>Connecticut</b>	4.1%	10.0%	3.1%

Examining suicides over the past decade (as seen in the graph above) reflects a gradual rising trend for both sexes until the paths diverge in 2017 with a decrease for females and an increase for males. Males continue to outpace females at a rate of about 3:1.

**Suicides by Sex in Connecticut (2008 – 2017) from OCME data**



**Substance Use**

Over 57,000 persons were treated in substance use programs only by DMHAS based on the Annual Statistical Report for FY 2018. Seventy percent of clients had a single substance use program admission. More than twice as many males (68%) as females (31%) received DMHAS substance use services. Most clients served were White/Caucasian (63%), followed by “Other” (16%), and Black/African American (14%). Twenty-two percent of clients served in DMHAS substance use programs were of Hispanic/Latino origin. Comparing percentages receiving substance use services to state population percentages, White/Caucasian clients were underrepresented (comprising 68% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 16% of the state population, respectively). The average age of clients receiving substance use services was 38.9 years (+ 12.8).

**Alcohol**

Connecticut residents of all ages continue to consume alcohol and to binge use alcohol at higher percentages than national and regional estimates.

**Alcohol Use in the Past Month (NSDUH 2016 – 2017)**

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	51.2%	9.5%	56.7%	55.2%
<b>Northeast</b>	56.4%	10.6%	63.2%	60.3%
<b>Connecticut</b>	60.2%	11.4%	67.0%	64.7%

**Binge Alcohol Use in the Past Month (NSDUH 2016 – 2017)**

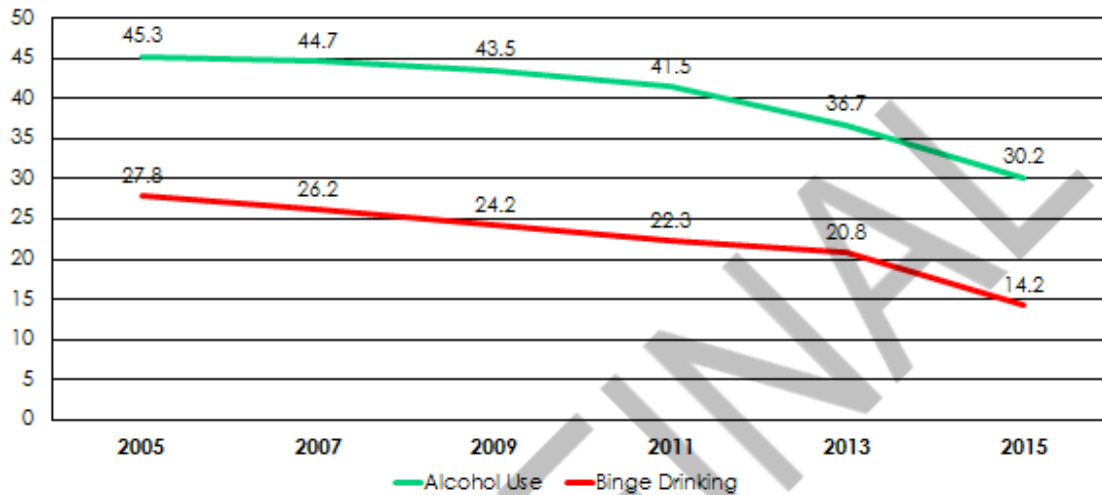
	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	24.4%	5.1%	37.6%	24.5%
<b>Northeast</b>	26.5%	5.8%	43.7%	25.9%
<b>Connecticut</b>	28.3%	6.4%	47.0%	27.8%

**Underage (12 - 20) Alcohol Use and Binge Use in the Past Month**

	Alcohol Use in the Past Month	Binge Alcohol Use in Past Month
<b>U.S.</b>	19.5%	12.0%
<b>Northeast</b>	22.9%	14.9%
<b>Connecticut</b>	23.9%	15.8%

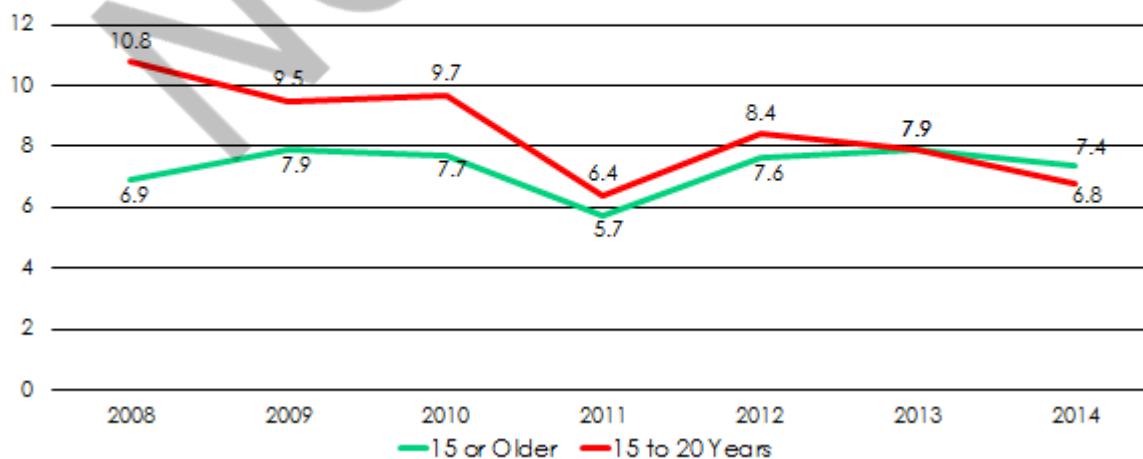
However, as the chart below indicates, overall trends of underage alcohol use and binge alcohol use have been declining in the state for over a decade.

### PERCENT OF HIGH SCHOOL STUDENTS REPORTING PAST 30-DAY ALCOHOL USE AND BINGE DRINKING: YRBS, CONNECTICUT, 2005-2015



Alcohol-related motor vehicle accidents have likewise declined in recent years.

### ALCOHOL-RELATED MOTOR VEHICLE ACCIDENTS PER 10,000 POPULATION AGED 15 TO 20 YEARS OLD VS. POPULATION AGED 15 OR OLDER: CT, 2008-2014

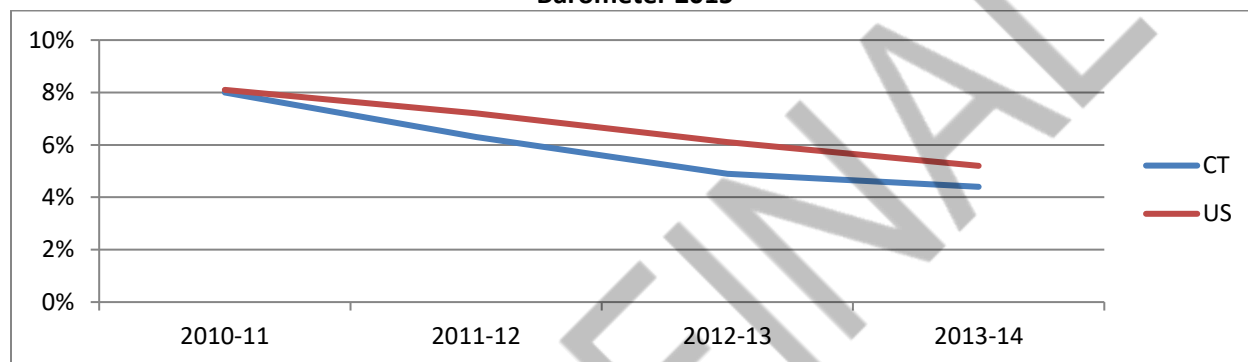


For those admitted to DMHAS substance use programs in 2018, alcohol was identified as the drug of choice in 37% of cases. Small numbers of persons received treatment for alcohol abuse/dependence in Connecticut (7.1%) based on 2010-14 Behavioral Health Barometer data from 2015, but this is similar to the national average of 7.3%. This reflects about 16,000 persons receiving treatment for alcohol abuse/dependence in Connecticut annually.

### Cigarettes

With the exception of 18 – 25 year olds, Connecticut residents smoke cigarettes less than the regional or national estimates; and the numbers have been declining for some time.

**Past Month Cigarette Use among Adolescents - (2010-11 to 2013-14) – CT Behavioral Health Barometer 2015**



**Cigarette Use in the Past Month (NSDUH 2016 – 2017)**

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	18.5%	3.3%	22.9%	19.5%
<b>Northeast</b>	17.5%	2.9%	22.4%	18.3%
<b>Connecticut</b>	16.8%	2.5%	23.7%	17.4%

### E-Cigarettes/Electronic Nicotine Delivery Systems (ENDS)

In recent years, Connecticut has passed laws related to the use of e-cigarettes/electronic nicotine delivery systems (ENDS) for minors, including:

- Prohibiting minors from buying or possessing e-cigarettes/ENDS in public
- Prohibiting anyone from selling, giving, or delivering e-cigarettes/ENDS to minors
- Restricting use of e-cigarettes/ENDS in public places, like restaurants, universities, health care facilities, airports, hotels, etc.
- Requiring dealers and manufacturers of e-cigarettes/ENDS to register with the Department of Consumer Protection

These legislative steps were taken in response to the dramatic rise in use of e-cigarettes/ENDS. According to the CDC, recent increases in the use of e-cigarettes/ENDS are what is driving the increase in tobacco product use among youth. They report that 5% of middle school students and 21% of high school students have used e-cigarettes/ENDS in the last 30 days. The Connecticut Department of Public Health Youth Tobacco Survey results, collected during the spring of 2017, found 10% of 9<sup>th</sup> graders and

20% of 12<sup>th</sup> graders reported current use of e-cigarettes/ENDS. Unfortunately, most of the students surveyed believed there was no or little risk associated with use of these devices.

### Illicit Substances

Illicit substances include marijuana, misuse of prescription medications, heroin, cocaine, etc.

**Illicit Drug Use in the Past Month (NSDUH 2016 – 2017)**

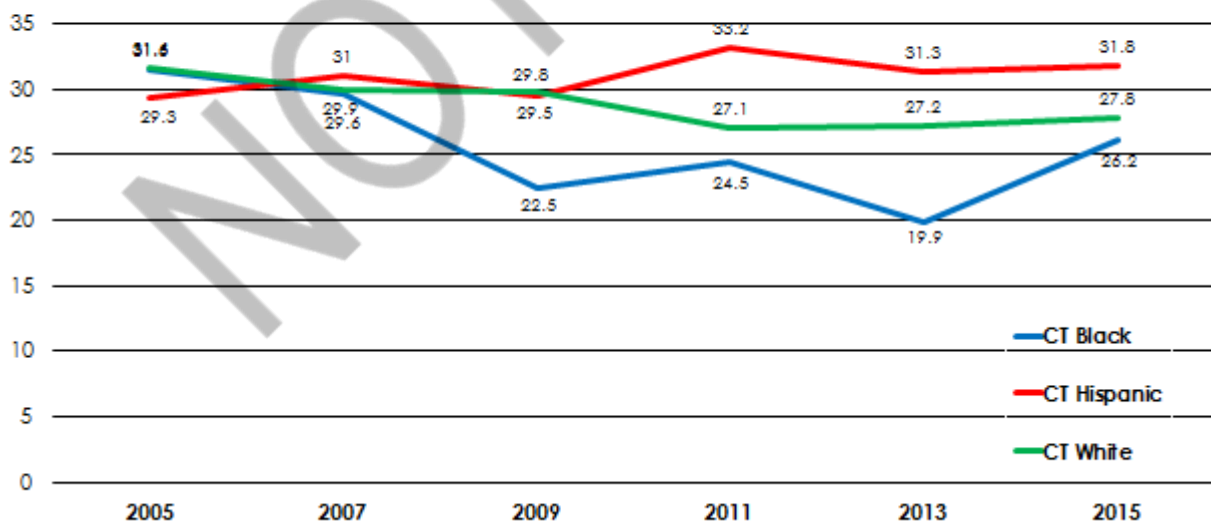
	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	10.9%	7.9%	23.7%	9.2%
<b>Northeast</b>	11.6%	8.1%	27.1%	9.5%
<b>Connecticut</b>	12.3%	9.6%	32.7%	9.3%

Illicit drug use percentages for Connecticut exceed both the national and regional estimates. Subtracting out marijuana use is informative as it reveals that most of the illicit drug use is accounted for by marijuana. The remainder of the illicit drug use is generally within the national and regional range with the exception of young adults 18 – 25.

**Illicit Drug Use Other than Marijuana in the Past Month (NSDUH 2016 – 2017)**

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	3.4%	2.4%	7.1%	2.9%
<b>Northeast</b>	3.4%	2.1%	7.7%	2.9%
<b>Connecticut</b>	3.7%	2.3%	9.3%	3.0%

### PERCENT OF CONNECTICUT HIGH SCHOOL STUDENTS OFFERED/SOLD/GIVEN AN ILLEGAL DRUG ON SCHOOL PROPERTY: YRBS, 2005-2015



Past year illicit drug abuse/dependence among persons 12+ has been remarkably stable in recent years, according to data from the Connecticut Behavioral Health Barometer -2015, varying only within 0.4% for both Connecticut and the nation (from 2.5% to 2.9%).

Past year treatment for illicit drug abuse/dependence among persons 12+ in Connecticut based on annual averages from 2007-14 revealed that 20.1% received treatment which is much greater than the national average of 13.9%. This means that about 18,000 persons each year in Connecticut receive treatment for illicit drug abuse/dependence.

### **Marijuana**

As noted above, marijuana continues to be the primary illicit drug used in the state. With neighboring states legalizing recreational marijuana use, perceptions of risk associated with smoking marijuana monthly continue to decline and use continues to rise.

**Marijuana Use in the Past Month (NSDUH 2016 – 2017)**

	<b>Age 12+</b>	<b>Ages 12 - 17</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	9.2%	6.5%	21.5%	7.6%
<b>Northeast</b>	9.8%	6.8%	24.9%	7.8%
<b>Connecticut</b>	10.6%	7.9%	30.4%	7.7%

Percentages for Connecticut and the northeast for monthly marijuana use exceed the national average for all age categories except adults 26+. In concert with greater use is less perceived risk from smoking marijuana which is less than the national and regional percentages across the board. Eleven percent of persons admitted to substance use services in FY 2018 identified marijuana/hashish/THC as their drug of choice.

**Perception of Great Risk from Smoking Marijuana Once a Month (NSDUH 2016 – 2017)**

	<b>Age 12+</b>	<b>Ages 12 - 17</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	26.9%	25.8%	12.9%	29.4%
<b>Northeast</b>	25.3%	25.3%	11.8%	27.5%
<b>Connecticut</b>	22.0%	22.4%	10.4%	23.9%

### **Heroin**

The opioid crisis, which has taken a heavy toll on the northeast, appears at this point to have peaked. The 2016-2017 data presented below, however, reflects the prior rise in heroin use, but does not reflect the illicitly manufactured fentanyl which overtook heroin as the primary opioid involved in overdose deaths in the state.

**Heroin Use in the Past Year (NSDUH 2016 – 2017)**

	<b>Age 12+</b>	<b>Ages 12 - 17</b>	<b>Ages 18 - 25</b>	<b>Age 26+</b>
<b>U.S.</b>	0.3%	.05%	0.6%	0.3%
<b>Northeast</b>	0.5%	.05%	0.8%	0.4%
<b>Connecticut</b>	0.7%	.06%	1.3%	0.7%

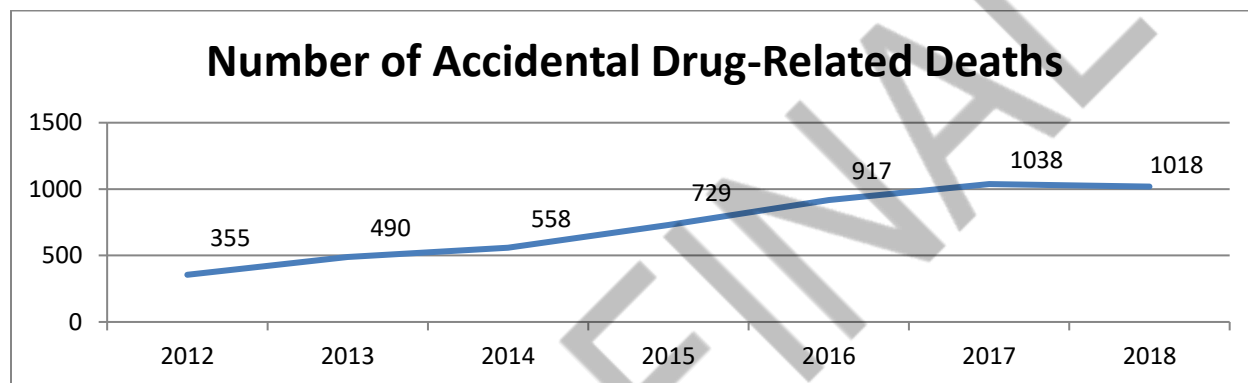
For persons admitted to substance use programs in FY 2018, the Annual Statistical Report noted that 36% identified heroin as the primary drug of choice.

In calendar year 2018, Connecticut's Office of the Chief Medical Examiner (OCME) reported a total of 1018 accidental drug-related deaths, 93% of which involved opioids. Nationally, per the CDC, about 66% of fatal overdoses involve opioids. This means that nearly every death in Connecticut involves an opioid

and for the majority of cases, that means the involvement of illicitly manufactured fentanyl. In fact, 74% of fatal overdoses involved fentanyl/fentanyl analogues, 38% involved heroin, and 14% involved prescription opioids. In addition, most fatal overdoses involved other substances in addition to opioids, primarily cocaine (32%), benzodiazepines (27%) and/or alcohol (26%).

The typical fatal overdose victim in Connecticut in 2018 was a non-Hispanic white male between the ages of 30 and 59 who was using fentanyl and other substances and on the day he overdosed, so did two other people in our state.

Despite these disturbing statistics, for the first time since 2012, the total number of accidental drug-related deaths in Connecticut decreased from calendar year 2017 to 2018, suggesting perhaps, that the epidemic may have peaked.



#### Pain Reliever Misuse

Percentages related to misuse of prescription opioids are similar to the national percentages, but greater than for the northeast region. Only 4% of persons admitted for substance use services in FY 2018 reported “other opiates” as their primary drug of choice.

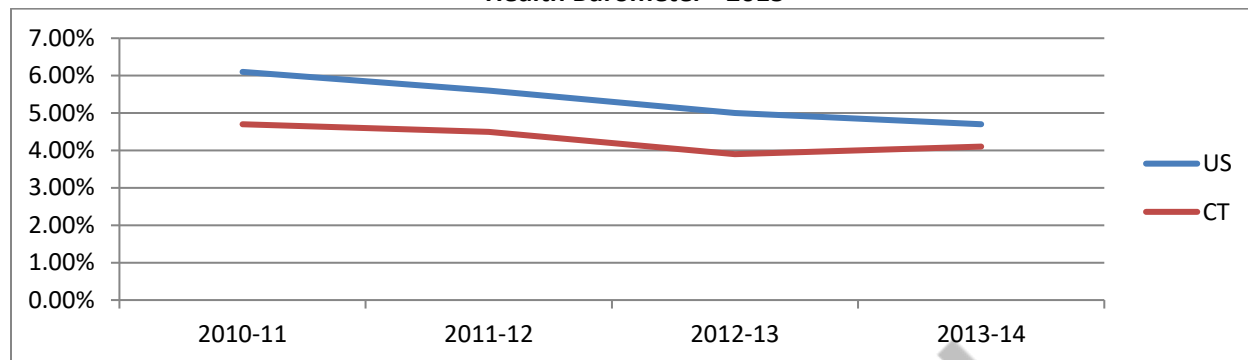
#### Pain Reliever Misuse in the Past Year (NSDUH 2016 – 2017)

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	4.2%	3.3%	7.1%	3.8%
<b>Northeast</b>	3.8%	2.6%	6.6%	3.4%
<b>Connecticut</b>	4.2%	3.2%	7.5%	3.8%

Examining the trend over time of nonmedical use of pain relievers among adolescents from 2010-11 to 2013-14 finds percentages declining for both Connecticut and the nation.



**Past Year Nonmedical Use of Pain Relievers among Adolescents (2010-11 to 2013-14) – CT Behavioral Health Barometer - 2015**



**Stimulants**

In Connecticut, use of stimulants, especially cocaine, has been increasing since 2012, and in 2018 there were 21 cases of methamphetamine found in fatal overdose data. In response to this finding, DMHAS has modified its CQI plan to include monitoring of stimulant use as an adjunct to the primary opioid crisis. The increase in cocaine use is reflected in the table below.

**Cocaine Use in the Past Year (NSDUH 2016 – 2017)**

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	2.0%	0.5%	5.9%	1.6%
<b>Northeast</b>	2.3%	0.5%	6.7%	1.9%
<b>Connecticut</b>	2.7%	0.6%	8.4%	2.1%

Based on the Annual Statistical Report FY 2018, 7% of admissions to substance use services were for a primary cocaine problem.

However, the rise in methamphetamine use as detected in accidental drug-related deaths in the state is not reflected in the following table, perhaps as the increase is too recent.

**Methamphetamine Use in the Past Year (NSDUH 2016 – 2017)**

	Age 12+	Ages 12 - 17	Ages 18 - 25	Age 26+
<b>U.S.</b>	0.6%	0.2%	0.9%	0.6%
<b>Northeast</b>	0.3%	0.1%	0.5%	0.3%
<b>Connecticut</b>	0.3%	0.1%	0.5%	0.3%

**Co-Occurring Mental Health and Substance Use**

Nearly one-third (32%) of the persons treated by DMHAS in FY 2018 had both a mental health (SMI) and substance use diagnosis. Nearly 7,000 persons (6,947) received services from both mental health and substance use programs during the same fiscal year. These clients were more male (60.5%) than female (39.5%). Sixty-two percent were white/Caucasian, 19% were black/African American and 14% were “other”. Twenty percent were Hispanic/Latino. Compared to the U.S. Census Bureau data, white/Caucasian persons were underrepresented (comprising 68% of the population), while Black/African American and Hispanic/Latino were overrepresented (comprising 12% and 16% of the

state population, respectively) in treatment. The average age of persons receiving both mental health and substance use services was 41.9 years ( $\pm$  12.2).

### Persons Served in DMHAS Programs

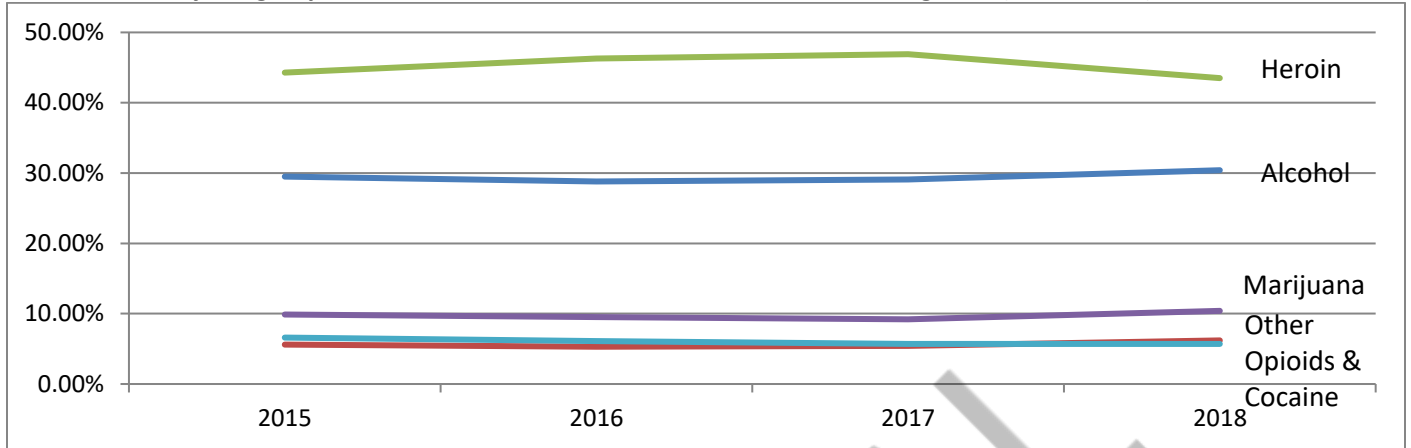
The following data is from the FY 18 Annual Statistical Report available at:

<https://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreport2018.pdf>. During SFY 18 (July 1, 2017 – June 30, 2018), DMHAS served a total of 105,540 people; 57,501 were treated in substance use programs and 54,986 were treated in mental health programs. These totals include 6,947 co-occurring clients who received services from both mental health and substance use treatment services, but are included as a separate category in the demographic table below. An almost equal number of males and females received mental health services, while more than twice as many males than females participated in substance use services. Most clients were White/Caucasian (62%), followed by Black/African American (16%), and Other Race (15%). Twenty-one percent of DMHAS clients were of Hispanic/Latino ethnicity, primarily of Puerto Rican origin (12%). Younger clients were more likely to receive substance use services (average age 38.9 years) while older clients were more likely to receive mental health services (average age 45.8 years). The most utilized level of care was Outpatient with 99% of mental health clients and 91% of substance use clients received these services. For mental health clients, Outpatient services include standard outpatient (64%), Case Management (15%), Crisis Services (12%), and Social Rehabilitation (11%). For substance use clients, Outpatient services include Pre-Trial Intervention (34%), standard Outpatient (36%), and Medication Assisted Treatment (27%). Residential services were the next most utilized, with 4% of mental health clients and 17% of substance use clients receiving these services. Inpatient levels of care were received by 2% of mental health clients and 5% of substance use clients. Some clients participated in more than one level of care during the fiscal year. Young Adult Services (YAS) serve clients 18 – 25 with a history of involvement in the Department of Children and Families (DCF) and major mental health problems. Of the DMHAS population 18 – 25 treated during the fiscal year, 8.6% or 1,194 received specialized YAS services.

Substance-related and addictive disorders were the most frequently diagnosed condition among those receiving services from DMHAS at 44%. The largest mental health category diagnosed outside of substances was Depressive Disorders (17%), followed by Schizophrenia Spectrum and Other Psychotic Disorders (12%) and Bipolar and Related Disorders (10%). Over 60% of the clients met criteria for SMI (serious mental illness) with a diagnosis that included one or more of the following: schizophrenia (and related disorders), bipolar (and related disorders), major depression, and PTSD. Two out of three clients (69%) meet criteria for a substance use disorder. One-third of clients (33%) meet criteria for a co-occurring disorder (both SMI and a substance use diagnosis).

Among admissions to substance use programs, heroin (44%) was the most frequently reported primary drug. Combining Heroin with other opioid drugs accounted for the primary drug in 49% of all substance use admissions. Alcohol was reported as the primary drug in 30% of admissions; Marijuana/Hashish/THC in 10% of admissions; and Cocaine in 6% of the admissions.

**Primary Drug Reported at Admission to DMHAS Substance Use Programs (2015 -2018)**



**Demographics of Clients Served**

	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
<b>Gender</b>								
Female	15,791	31.2%	24,102	50.2%	2,744	39.5%	42,637	40.4%
Male	34,309	67.9%	23,883	49.7%	4,201	60.5%	62,393	59.1%
Transgender	2	0.0%	20	0.0%	-	-	22	0.0%
Unknown	452	0.9%	34	0.1%	2	0.0%	488	0.5%
<b>Total</b>	<b>50,554</b>	<b>100.0%</b>	<b>48,039</b>	<b>100.0%</b>	<b>6,947</b>	<b>100.0%</b>	<b>105,540</b>	<b>100.0%</b>
	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
<b>Race</b>								
American Indian/Alaska Native	222	0.4%	272	0.6%	46	0.7%	540	0.5%
Asian	349	0.7%	575	1.2%	25	0.4%	949	0.9%
Black/African American	6,925	13.7%	8,703	18.1%	1,310	18.9%	16,938	16.0%
Native Hawaiian/Pacific Islander	123	0.2%	116	0.2%	11	0.2%	250	0.2%
White/Caucasian	31,965	63.2%	29,324	61.0%	4,328	62.3%	65,617	62.2%
More than one race	433	0.9%	242	0.5%	41	0.6%	716	0.7%
Unknown	2,575	5.1%	2,171	4.5%	183	2.6%	4,929	4.7%
Other	7,962	15.7%	6,636	13.8%	1,003	14.4%	15,601	14.8%
<b>Total</b>	<b>50,554</b>	<b>100.0%</b>	<b>48,039</b>	<b>100.0%</b>	<b>6,947</b>	<b>100.0%</b>	<b>105,540</b>	<b>100.0%</b>
	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
<b>Ethnicity</b>								
Hispanic-Cuban	108	0.2%	78	0.2%	17	0.2%	203	0.2%

Hispanic – Mexican	402	0.8%	212	0.4%	32	0.5%	646	0.6%
Hispanic-Other	4,281	8.5%	4,004	8.3%	476	6.9%	8,761	8.3%
Hispanic – Puerto Rican	6,196	12.3%	5,578	11.6%	876	12.6%	12,650	12.0%
All Hispanics	10,987	21.8%	9,872	20.5%	1,401	20.2%	22,260	21.1%
Non-Hispanics	35,048	69.3%	35,175	73.2%	5,179	74.6%	75,402	71.4%
Unknown	4,519	8.9%	2,992	6.2%	367	5.3%	7,878	7.5%
Total	50,554	100.0%	48,039	100.0%	6,947	100.0%	105,540	100.0%
	<b>Substance Use</b>		<b>Mental Health</b>		<b>Both</b>		<b>Total</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>
<b>Age</b>								
18 – 25	7,368	14.6%	5,544	11.5%	594	8.6%	13,506	12.8%
26 – 34	14,775	29.2%	7,988	16.6%	1,731	24.9%	24,494	23.2%
35 – 44	11,236	22.2%	7,880	16.4%	1,627	23.4%	20,743	19.7%
45 – 54	9,001	17.8%	10,339	21.5%	1,700	24.5%	21,040	19.9%
55 – 64	5,773	11.4%	10,820	22.5%	1,141	16.4%	17,734	16.8%
65+	1,410	2.8%	4,945	10.3%	154	2.2%	6,509	6.2%
Unknown	991	2.0%	523	1.1%	-	0.0%	1,514	1.4%
Total	50,554	100.0%	48,039	100.0%	6,947	100.0%	105,540	100.0%

### Workforce Development and Shortages

According to the HRSA Fact Sheet 2018 for Connecticut, the state is short 43 Primary Care Providers and 34 Mental Health Professionals. HRSA designated Medically Underserved Areas (MUA) and Populations (MUP) data follows.

<b>Medically Underserved Areas in Connecticut (HRSA 2018)</b>		
<b>from highest to lowest need</b>		
<b>Location</b>	<b>Score</b>	<b>Rural/Non-Rural</b>
New Haven (Governor Service Area)	0.0	Non-rural
Windham (Governor Service Area)	0.0	Rural
Hartford Service Area	39.1	Non-rural
Hartford Service Area	46.8	Non-rural
New London Service Area	47.7	Non-rural
New Haven Service Area	52.2	Non-rural
Middlesex Service Area	52.5	Non-rural
New London Service Area	54.4	Non-rural
Fairfield Service Area	54.6	Non-rural
Central Bristol Service Area	56.8	Non-rural
South end Stamford Service Area	58.3	Non-rural
Fairfield Service Area	59.6	Non-rural
New Haven Service Area	59.6	Non-rural
New Haven Service Area	59.8	Non-rural

New Haven Service Area	59.8	Non-rural
New Haven Service Area	59.8	Non-rural
Central Waterbury Service Area	59.8	Non-rural
Hartford Service Area	60.2	Non-rural
Hartford Service Area	60.9	Non-rural
<b>Medically Underserved Populations – Low Income (HRSA 2018)</b>		
<b>From highest to lowest need</b>		
Central Torrington Service Area	41.1	Rural
Northcentral New Britain Service Area	41.6	Non-rural
South Norwalk Service Area	46.8	Non-rural
West Haven Service Area	47.1	Non-rural
Rockville Service Area	47.8	Non-rural
East Hartford Service Area	47.9	Non-rural
Norwich Service Area	50.9	Non-rural
Danbury Service Area	52.9	Non-rural
Southeast Windham Service Area	56.1	Non-rural
Central Waterbury Service Area	59.8	Non-rural
West Stratford Service Area	62.5	Non-rural
<b>Low Income Population with Health Professional Shortage – Primary Care (HRSA 2018)</b>		
<b>From highest to lowest need</b>		
<b>Location</b>	<b>Health Professional Shortage Area Score</b>	<b>Health Professional Shortage Area FTE</b>
Bridgeport	18	0
Hartford	16	0
Bristol Service Area	15	0
Central Meriden	15	0
New Haven/West Haven	15	0
New London	15	0.35
Town of Windham	15	0
Ansonia	14	0
East Hartford	14	0
Norwich	14	0
Torrington	14	0
Central Norwalk	13	0
Mansfield	13	0
Middletown Service Area	13	0
Waterbury	13	0
Danbury	12	0
Groton	12	0
Northwest Enfield	12	0
Putnam Service Area	12	0
South end Stamford	12	0
Stratford	10	0
<b>Geographic or Low Income Area with Health Professional Shortage – Mental Health (HRSA 2018)</b>		
<b>From highest to lowest need</b>		
<b>Location</b>	<b>Health Professional</b>	<b>Health Professional Shortage</b>

	<b>Shortage Area Score</b>	<b>Area FTE</b>
Low Income Hartford	19	0
Low Income Bridgeport	17	0
Low Income New Haven/West Haven	17	0
Region 3 (Eastern Connecticut)	16	6.77
Middlesex County	16	1.88
Litchfield County	13	1.76
Low Income Danbury	11	0
Low Income South end Stamford	10	0

### **2018/19 Statewide Priority Setting Process**

DMHAS is committed to supporting a comprehensive, unified planning process across its state-operated and funded mental health and substance use services at local, regional, and state levels. The purpose of this planning process is to develop an integrated and ongoing method to: 1) determine unmet mental health and substance use treatment and prevention needs; 2) gain broad stakeholder (persons with lived experience, advocates, family members, providers, and others) input on service priorities and needs; and 3) monitor ongoing efforts that result in better decision-making, service delivery, and policy-making. A description of the entire priority setting process for 2018/19 follows.

#### **Background:**

This was the first year implementing a revised priority setting process. Transitioning from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) to integrated Regional Behavioral Health Action Organizations (RBHAs) meant changes were also indicated for the Priority Setting Process. Formerly separate survey processes were reorganized into a unified activity comprehensively assessing the entire DMHAS behavioral health service system. The final agreed upon process involved months of planning with representatives from the RBHAs, the DMHAS Prevention Division, the DMHAS Block Grant State Planner, the State Epidemiological Outcomes Workgroup (SEOW) and University of Connecticut Health Center's (UCHC) Center for Prevention Evaluation and Statistics (CPES). The basic steps in the process are:

- **Quantitative Data Collection** based on a wide array of local, state, and national surveys and assessments
- **Qualitative Data Collection** from multiple stakeholders (consumers, families, town officials, law enforcement, providers, etc.) in community conversations, focus groups, routine meetings, community events, etc.
- **Workgroup ranking** of the list of behavioral health conditions based on the dimensions of magnitude, impact and burden
- **Completion of regional reports** inclusive of all the elements above into a structured format along with strengths, identified needs/gaps/barriers, and recommendations

#### **Priorities:**

Based on the 5 regional reports, the top 3 priorities were:

1. Mental health conditions
2. Alcohol use
3. Non-medical use of prescription drugs

1. **Mental Health Conditions:** A broad ranging topic, but the focus of concern expressed by the regions was the increase in anxiety and depression in young people

2. **Alcohol Use:** Prior to the opioid epidemic, alcohol was the substance of greatest concern and the primary reason for most substance use treatment admissions to DMHAS. With so much attention focused on the opioid crisis and its associated consequences, attention was diverted from the most commonly used and abused substance – alcohol. A number of regional reports remarked on the need to return focus to substances and issues other than opioids.

3. **Non-medical Use of Prescription Drugs (NMUPD):** Because of the known association between prescription opioid misuse and heroin/fentanyl use which has fueled our current opioid epidemic, much scrutiny has been given to prescription opioids. However, the regions expressed concern over the lack of attention to threats posed by benzodiazepines and stimulants which are also frequently prescribed and abused, but largely ignored.

#### **Emerging Issues:**

The most notable emerging issue was vaping. The percentage of high school students that have tried vaping and concerns about the addictiveness of both nicotine and marijuana are raising alarm. Advertising that promotes vaping as a cessation strategy is questioned. The dramatic rise in vaping has afforded little opportunity for data collection.

**Strengths:** Many strengths, assets and resources were identified in the regional reports. They have been grouped together by topic in this section.

*The Continuum of Care* – DMHAS has a broad treatment continuum with many behavioral health providers representing all levels of care along with several system of care collaboratives. Specific improvement in the quality of the mobile crisis team response was noted.

*Recovery Supports* – DMHAS has committed to developing and maintaining recovery supports which are widely available. There are dozens of free support groups, trained peers in recovery, recovery coaches in emergency departments and outpatient centers, family support groups, warm lines staffed by people in recovery, along with specific recovery support groups too numerous to name. In addition, the Connecticut Community for Addiction Recovery (CCAR) offers telephone recovery support, support groups and recovery coach training. Advocacy Unlimited (AU) offers Toivo, peer bridgers, recovery university, and hearing voices network. Finally, there are 12-step meetings specific for Spanish speakers, teens, medical professionals, etc.

*Access* – Greater access to services has been made possible by expansion of satellite offices, open access appointments, more MAT and IOP groups, the CT Addictions.com bed availability site, the 1-800 access line, Beacon Health Options' MAT locator map, and some hospitals providing better access at their Emergency Departments (EDs). The Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) model is being utilized. Also, some vans are providing mobile outreach and Medication Assisted Treatment (MAT).

*Integration* – Integration of behavioral health with overall health and wellness focused activities has become more common. Some LMHAS have established medical clinics on site or have close collaborative relationships with nearby primary care providers. Some providers have become certified FQHCs themselves. Some providers are starting to screen for conditions beyond their usual range using SBIRT.

More LMHAs now offer MAT. Usual naloxone training has been combined with QPR suicide prevention training.

*Wellness* – Similar to integration efforts mentioned in the above paragraph, a number of providers are expanding their focus toward health and wellness, in particular clubhouses, the Chrysalis Center, and LPCs were noted. Some schools are now addressing mental health wellness and mindfulness.

*Schools* – Enhancements promoting mental health have been added at a number of individual schools. These include designating “Zen Dens” or rooms meant to provide an opportunity for students to de-stress; school-based health services; schools contracting for in-school support; inclusion of social-emotional programming into the curriculum; receipt of suicide-prevention funds; and use of EMPS through 211 for students in need. AmeriCorps, VISTA Corps and Prevention Corps service members are working with some school districts to provide faculty education, identify and deliver curriculum enhancements and provide resources and support information to students and others at health and wellness events. Some regions have Therapeutic Alternative Schools as options.

*Grassroots/Community efforts* – There are a number of task forces, coalitions and grassroots organizations actively working to forward behavioral health issues. There’s been greater involvement on the part of communities and providers, some of which have chosen to apply for, and been awarded, grants, including grants for communities to address underage drinking and/or non-medical use of prescription drugs. Communities have supported medication drop boxes and take-back days. Community health improvement projects of local hospitals include behavioral health goals and a number of hospitals participate or host Community Care Teams (CCTs) or navigators working to improve outcomes for persons with behavioral health issues who are homeless or frequent visitors to EDs. There have been community collaborations for youth and juvenile justice. The 211 info line is an asset as are stakeholder partners including LPCs and CACs.

*Law Enforcement* – Improved communication and interactions between first responders and behavioral health providers was noted along with the perception that first responders are more accepting of trainings such as Mental Health First Aid (MHFA) and Crisis Intervention Team (CIT). In addition, there is the sense that because of these efforts, there is reduced stigma/shame and greater willingness to respond to behavioral health crises. More municipalities are initiating diversion strategies from arrest to treatment with HOPE or HOPE-like models.

*Suicide* – The Connecticut Suicide Advisory Board (CTSAB) is the coordinating body for most suicide prevention activities statewide. Other strengths of the system include the Statewide Suicide Network of Care, *Gizmo’s Pawesome Guide to Mental Health Curriculum* educational campaign, and the One Word, One Voice, One Life campaign. Suicide prevention and awareness have been implemented in a number of school districts. There are QPR and CONNECT trainers available to provide suicide prevention training regionally.

*Opioid Epidemic* – The focus on the opioid epidemic has also brought increased attention to mental health issues and suicide. There are a multiplicity of medication drop boxes and promotion of take back events. Many naloxone training sessions and distribution have occurred across the state. The Change the Script and the Live Loud campaigns to raise awareness have been well received. The state has a number of stationery and mobile specialized syringe services (SSPs) funded by DPH. Connecticut has been the recipient of millions in federal grants to fund interventions to respond to the opioid crisis. At this point, many first responders, pharmacies, libraries, schools, hospital EDs, and others are armed with



naloxone. There is a Narcan NOW app and DPH's NORA (Naloxone and Opioid Response App) which handily cover all the critical information needed and can be downloaded to a mobile phone. Other strengths related to this topic include the involvement of New England HIDTA (High Intensity Drug Trafficking Area), mandatory use of the state's prescription drug monitoring program; and expansion of MAT to LMHAs, hospitals, substance use programs, health centers and other locations.

*Children/Youth/Adolescents* – Specialized services for younger persons in need of behavioral health services include The Center for Child and Adolescent Treatment Services, which is an IOP helping adolescents, teenagers and their families; the Connecticut Institute for Communities offers a comprehensive array of primary care and behavioral health services for all ages; Multi-Dimensional Family Therapy (MDFT) is offered at Wheeler for at risk youth; summer camps for special needs youth are available; there are 2 specialized first episode psychosis (FEP) programs in the state; and more wrap around and in-home service options for children are available.

*Problem Gambling* – There are Bettor Choice providers to treat problem gambling along with gambling awareness teams, gambling awareness events, youth led gambling awareness conferences, and the ambassador pilot program designed to address problem gambling concerns specific to the Asian American/Pacific Islander community.

**Needs:** The identified needs/gaps/barriers are also organized by topic.

*The Continuum of Care* – There is a lack of “one stop shopping” such that the entire family, regardless of their ages or behavioral health needs, could be provided treatment and support services at one location. Ideally, if behavioral health interventions are provided early, before situations escalate and become emergencies, the outcomes would be better. Calls made to mobile crisis, however, can result in long delays, including children waiting at EDs without other options. There are two FEP programs in Connecticut, meaning not all regions have a local FEP program. More of the following were identified as needed: respite, long term addiction treatment, and inpatient rehabilitation beds; outpatient and intensive outpatient services; and specialized services for adolescents, adults with autism, persons with co-occurring conditions, and LGBTQI persons.

*Recovery Supports* – The sentiment was expressed that more support services were needed, rather than treatment per se. Recovery supports needed included case management, community support services, and the following specialized support groups: SMART Recovery groups for those 25 and older, women with postpartum depression, persons with co-occurring conditions, those with suicidal ideation, and those facilitating groups. Akin to recovery coaches in the ED for substance use issues was the proposal to have peer support specialists in the ED to assist patients with mental health issues. Job opportunities for Peer Support Specialists were noted as lacking. Young adults were described as needing more life skills training.

*Access* - It remains a challenge to navigate the behavioral health system for those who are unfamiliar with it and there is a lack of services on demand. In rural areas, and for those who are disabled/home bound, there are fewer service options combined with limited transportation and the need for more satellite offices, telehealth and mobile options to address the shortage. Warm hand offs are needed when persons are transitioning between levels of care.

Access is also limited by the shortage of behavioral health providers, especially prescribers, and insurance barriers, such as high copays and deductibles, Medicare obstacles for accessing services by older adults, and high staff turnover.

*Integration* – greater communication and coordination are needed and better collaboration among state agencies, namely DPH, DMHAS, DCF and law enforcement. Further integration of behavioral health and primary care was advocated for along with police initiatives in behavioral health and increased involvement of local officials, especially with regard to the opioid crisis. It was noted that MHFA and YMHA still haven't happened in some schools and communities while stigma still persists. More early screening using SBIRT and ASBIRT are needed.

*Schools* – There is a lack of current and evidence-based curricula related to behavioral health education in the schools as well as a lack of inclusion of problem gambling prevention and education on brain health and the media.

*Opioid epidemic* – One region noted it has only one methadone clinic for the entire area. Some of the private and private nonprofit programs that offer methadone only accept cash and don't provide the necessary adjunct services. Some MAT clinics can't seem to hire qualified staff and some staff members aren't well informed or supportive of MAT.

*Other substance use issues* – LGBTQI persons and their use of methamphetamine need specialized services. Vaping needs to have primary prevention services focused on it for both nicotine and marijuana use and it needs to be designated as a substance use disorder. There is a sense that some persons aren't fully detoxified from alcohol before being discharged. There are no specific adolescent detox beds.

*Safe affordable housing* – There continues to be a lack of safe affordable housing options, especially for persons with behavioral health conditions. Not all sober homes are credentialed and the quality of sober homes and halfway houses varies considerably.

## **Recommendations:**

Prevention of substance use –

- Provide training and supports for youth compliance inspections, including point of sale identification checks to prevent under 21 purchases of tobacco and alcohol
- Raise awareness and provide education to decrease access to and availability of alcohol, heroin and prescription drugs, especially for 14 – 25 year olds, 65+ year olds and LGBTQI
- Compare perceived risk and use rates for vaping in 2019 and identify effective strategies for outreach and education about the dangers for youth
- Continue efforts to decrease opioid overdose deaths through promotion of prevention/treatment/recovery activities for opioid use disorder with a focus on high risk communities
- Provide stable and adequate funding to support education, training and capacity building
- Increase parental perception of risk of alcohol and ENDS (electronic nicotine delivery systems) use through education
- Schools need to adopt firm policies and procedures in response to ENDS use
- Raise awareness about benzodiazepine and cocaine use and misuse

- Support legislation to require blister packaging of medications to prevent diversion
- Develop a comprehensive plan to address the potential legalization of marijuana
- Address the pro-social community beliefs and behaviors regarding marijuana

#### Treatment of Substance use –

- Increase available resources: long term programs, detox beds, drug/alcohol counselors, DMHAS-funded MAT providers, individual therapy services, inpatient/residential rehab, transitional levels of care, and outpatient/intensive outpatient
- Ensure substance use providers are co-occurring disorder treatment capable
- Continue to develop and advertise other effective approaches for providing treatment on an outpatient basis (in-home, sober housing, mobile, MAT induction in hospitals and correctional settings) so people don't overdose while waiting for treatment
- Explore options for mobile and telehealth for those in rural areas with limited transportation
- Address the stigma associated with EAP and professional consequences
- More ENDS cessation programs are needed and ENDS promoted as a cessation tool should be challenged
- N-O-T youth cessation doesn't include vaping so under 18 cessation options are limited
- Marijuana use ignored or overlooked when persons are in treatment for other substances
- MAT not available at all programs in the region
- Lack of alternative pain management options
- Police departments need more clinical support

#### Recovery from Substance Use –

- Support efforts to ensure safe and affordable sober homes and study access to qualified sober housing
- Review the function of access line and recommend improvements
- Expand recovery coaches to community-based settings and police/fire departments
- Increase recovery supports, especially services for youth and young adults and options other than faith-based AA
- Support establishing recovery-friendly communities using SOR mini-grant funding to LPCs and coalitions
- Decrease stigma
- Lack of options for step down services

#### Prevention/Promotion of mental health issues –

- Assist in compiling local data about suicide and self-injury
- Support legislation to ensure social-emotional curriculum and positive school climate for k-12
- Local workforce training/education to build capacity; target awareness/education for 14 – 25 and LGBTQI populations
- Region 4 school surveys don't include a measure for anxiety – adjust the 2019 survey
- Provide stable and adequate funding to support education, training and capacity building
- Stigma and lack of awareness continues
- Increased screen time for youth and adults leads to disconnection and poor relationship skills

#### Treatment of Mental health issues –

- Ensure mental health services providers are co-occurring disorder treatment capable

- Support recommendations of psychiatric workforce taskforce to address shortages of providers; there is a shortage of pediatric psychiatrists as well as Spanish – and Portuguese-speaking providers
- In region 1: Develop an FEP and consider converting a CSP to an ACT
- Increase co-occurring disorder treatment capacity; increase early screening
- Explore offering mobile and telehealth options for rural areas/transportation barriers
- Address gap of supported, supportive and residential housing. DMHAS will have to look for revenues in its state allocation for housing supports/services that aren't subject to federal requirements targeting a narrow definition of homelessness.
- More early identification services and access to placement especially for youth; increase parity
- Suicide-bed availability and psychiatric care for children/adolescents
- Access to care before it becomes acute (people must decompensate to the point of being unable to care for themselves before they receive care or only receive treatment once incarcerated)
- Increase workforce to match treatment demand
- Early identification and intervention services and crisis services not available equally across the region
- Current commitment criteria make it nearly impossible to be admitted involuntarily to a hospital for inpatient care
- Need more trauma-informed care
- Adults not aware of EMPS

#### Recovery from mental health issues –

- Develop peer respite programs throughout the state to decrease hospitalization
- Increase mental health recovery support groups
- Provide SPF training to region 4 CAC members to plan and implement strategies to address lack of affordable housing
- Support a continued role for CACs due to their necessity for vital consumer engagement and critical community monitoring role. DMHAS contracts are unclear about funding for CACs
- Recovery coaches in EDs for mental health
- Lack of access in rural areas – need telehealth
- Those who are less acute don't have enough treatment options
- Increasing community level housing supports for SMI would improve treatment/outcomes
- Advanced suicide prevention strategies such as community level saturation of evidence-based education (QPR or MHFA) would decrease risk and improve outcomes

#### Prevention of Problem Gambling –

- Keep offering training for community prevention specialists
- Provide education/awareness of problem gambling for older adults and targeted campaign for enlisted military/families (at the submarine base)
- Review the school survey questions on perceived risk and use rates for problem gambling to address the overlap between computer gaming, sports betting and gambling
- Continue conversations with key community informants about prevalence and strategies being used to address anxiety, vaping and problem gambling among youth and young adults
- Include computer gaming as a topic in all problem gambling training
- Raise awareness of risks

- Online gaming and sport betting are accessible and easily hidden

#### Treatment of Problem Gambling –

- Continue research to measure prevalence change and better understand impact of problem gambling on communities
- Lack of problem gambling treatment services in northeastern part of state
- Expand Disordered Gambling Integration Project (DigIn) in areas where gambling is expanding and increase promotion of the HelpLine in those same areas (East Windsor, Enfield and Windsor Locks)
- Increase awareness of problem gambling services
- Problem gambling associated with increased smoking and drinking

#### Recovery from Problem Gambling –

- Ensure problem gambling supports are available in multiple languages
- Increase access to gambling recovery support groups
- Engage leaders of Gamblers Anonymous to expand GA meetings in those areas where gambling is expanding (East Windsor, Enfield and Windsor Locks)
- Promote inclusion of problem gambling in Recovery Coach and Recovery Support Specialist training
- Lack of awareness of local recovery supports
- People with gambling disorders are at increased risk of suicide

#### Prevention of integrated behavioral health concerns –

- Integrate messaging about MH/SU/PG to fight stigma, raise awareness of how interrelated they are and promote wellness
- Develop videos, webinars, and digital toolkits to be disseminated statewide
- Invest in social media buys to reach a bigger audience
- Revisit SBIRT screening programs to integrate other conditions – consider using Region 1 tool
- Expand certified prevention specialist staffing at RBHAOs to enhance primary prevention of all behavioral health issues and the ability to provide local training
- Develop universal trauma screening for k-12 to address trauma at trauma-informed schools
- Integrate mental health/prevention/Strategic Prevention Framework (SPF) model
- Elicit feedback from Hartford Foundation Community Fund Advisory Committee

#### Treatment of Integrated behavioral health concerns –

- Remove eligibility barriers for co-occurring disorders clients to get treatment and expand capacity to treat behavioral health and physical co-morbidities
- Increase the number of bilingual/multilingual providers and staff cultural competence
- Conduct a statewide campaign to increase awareness of available treatment resources and physician understanding of MAT
- Improve Veyo or find another transportation service
- Incentivize providers to accept private insurance and Medicaid
- Remove siloes and integrate programs and structures
- First responders should have clinicians available to respond with them to triage and avoid ED revolving door
- Increase collaboration to address adult behavioral health issues (currently limited to opioid treatment or overdose prevention)

#### Recovery of integrated behavioral health concerns –

- Increase supportive housing services for the behavioral health population
- Increase case management resources across programs, ease restrictions so more people have access
- Revisit benefits policies and job programs to decrease employment barriers
- Conduct external evaluation of AU, CCAR and MH-America peer training programs to cross walk and develop best practices
- Support legislation to make peer support reimbursable
- Increase support for culturally competent recovery models

#### Other General Recommendations -

- Expand ADPC to include and address MH/PG
- Merge children and adult mobile crisis services
- Provide comprehensive treatment and “one stop shopping” to address entire family
- Ensure all relevant state agencies are represented on the BHPC
- Work creatively with housing providers to address need for affordable, supportive housing
- Coordinate suicide and opioid response across DMHAS/DCF/DPH
- Use DPH training materials for NORA and CPMRS (CT Prescription Monitoring and Reporting System) rather than separate materials
- Work with DOC and DMV to develop a legitimate alternative form of identification to better care for the undocumented
- Explore creating slots for case management from the General Fund (as done in Maryland) for high need individuals regardless of ability to pay
- Ensure information and websites are available in multiple languages
- Make use of video conferencing technology/webinars to decrease travel time
- Regionalize conferences/trainings to maximize participation
- Have a better coordinated system of all behavioral health issues in elementary/middle/high school

### **Consumer Satisfaction Survey Measures**

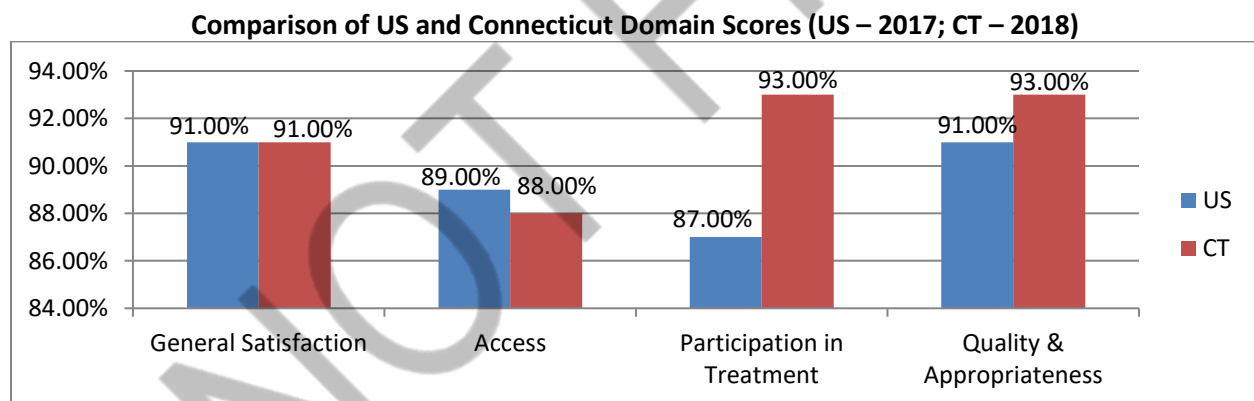
DMHAS conducts an annual consumer satisfaction survey in order to better understand consumers’ experiences with the public state-operated and community-funded service delivery system, as well as to use these data for quality improvement. The Consumer Survey has been administered annually since 2000, using a version of the Mental Health Statistics Improvement Program’s (MHSIP) *Consumer-Oriented Mental Health Report Card*.

The survey is offered to consumers/individuals in recovery within the context of their treatment for behavioral health issues. Most levels of care are required to participate in the survey. State-operated and private nonprofit providers are required to collect and report results to the Office of the Commissioner, where the data is collated, analyzed and synthesized into an annual report. For FY 2018, over 23,000 surveys from 100 providers within the DMHAS behavioral health system were received. The FY 18 full report is at: <https://www.ct.gov/dmhas/lib/dmhas/consumersurvey/cs2018.pdf>.

Since 2005, DMHAS has been utilizing a *Recovery Domain* that was added to the survey. The Recovery domain is comprised of five questions which assess perception of “recovery oriented services”. The

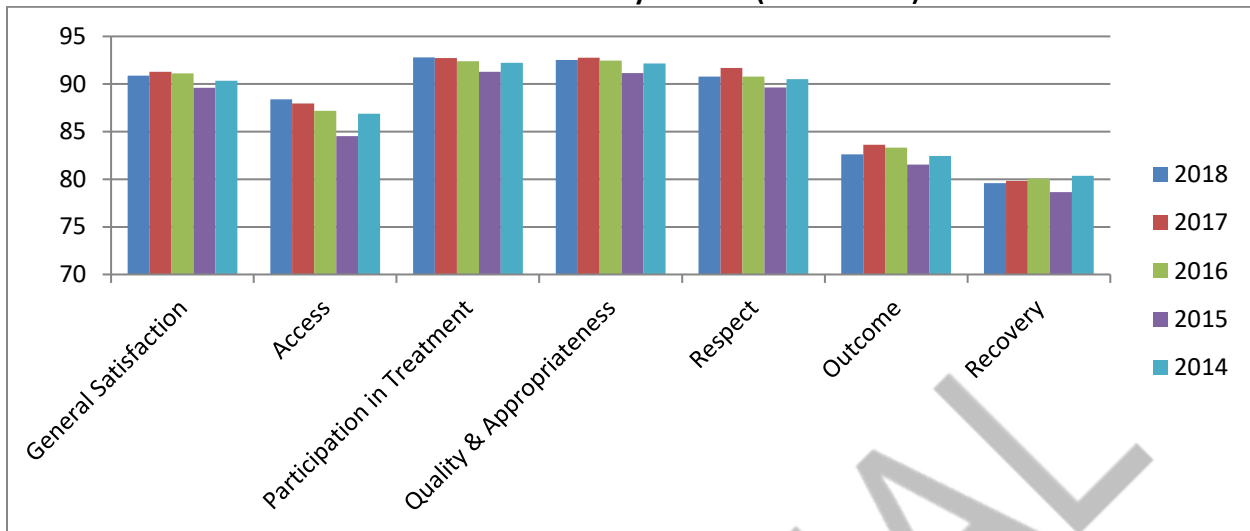
recovery questions were developed in collaboration with the Yale Program for Recovery and Community Health. This addition provides DMHAS with valuable information regarding its success in implementing a recovery-oriented service system. DMHAS also uses an additional *Respect* Domain to collect information about perceived respect towards people in recovery. Two other instruments are included in the survey. The first is the WHOQOL-BREF Quality of Life instrument which is a widely used, standardized quality of life tool developed by the World Health Organization. This 26-item tool measures consumer satisfaction with the quality of the person’s life in physical, psychological, social and environmental domains. DMHAS received 1,800 QOL responses. The other tool added is the 8-question Health Outcomes Survey which includes items from the CDC’s Behavioral Risk Factor Surveillance System (BRFSS). These questions ask about body mass index (BMI), chronic health conditions, overall health from a physical and psychological perspective, and drinking habits. A total of 1,933 surveys were received on these Health Outcome Measures. The national emphasis on the integration of behavioral health and primary health care underscores the importance of these optional tools.

Of the 23,628 surveys returned, 25% were from outpatient programs, 6% from intensive outpatient, 14% from Medication Assisted Treatment programs, 8% from Case Management, 10% from residential programs, 9% from employment or social rehabilitation programs, and 28% from either other levels of care or from respondents who didn’t identify the program type. A comparison of consumer survey findings (2018) and national results (2017 CMHS Uniform Reporting System Output Tables) reveal that Connecticut respondents reported higher levels of satisfaction in all consumer satisfaction domains than the national averages with the exception of the Access domain where there was a 1% difference.



The following figure shows satisfaction rates over the past five years indicating the stability of the percentages over time.

**CT Satisfaction Trends by Domain (2014 – 2018)**



DMHAS has historically compared satisfaction scores across its subpopulations, even though the MHSIP was standardized only on consumers of mental health treatment. The Connecticut survey includes not just mental health clients, but substance use and co-occurring clients as well. Highlights of these comparisons include:

- More clients in mental health programs reported satisfaction in the Access, Appropriateness, General Satisfaction and Respect domains while more clients in substance use programs reported satisfaction in the Outcome and Recovery domains.
- Across all programs, more women reported satisfaction with services in the Access, Appropriateness, General Satisfaction, Participation in Treatment and Respect domains while more men reported satisfaction in the Outcome and Recovery domains.
- Across all programs, white respondents were more satisfied than those in the Other Race category in the Appropriateness and Respect domains; Black respondents were more satisfied in the Outcome domain than other races and more satisfied in the Recovery domain than White respondents; and both Black and White respondents were more satisfied than those in the Other Race category in the Participation in Treatment domain.
- Across all programs, Non-Hispanic clients were more satisfied than Hispanics in the Participation in Treatment and Respect domains.
- In the General Satisfaction domain, older clients were more satisfied than younger clients.

Individual questions on the QOL are scored from 1 to 5 with 1 being the lowest score and 5 being the highest. Domain scores are transformed to a 1 – 100 scale with higher scores indicating more satisfaction with quality of life. Responding to these questions is optional so consumers who did respond are a subset of those who responded to the Consumer Survey.

Results on the QOL survey found that clients served in substance use programs reported a significantly better quality of life with respect to physical health, psychological factors, and social factors. Mental health clients reported a significantly better quality of life with respect to environmental factors. There was no significant difference found for General QOL, although the score for substance use clients was slightly higher.



**Quality of Life Scores across DMHAS Subpopulations**

	Physical Health	Psychological	Social	Environmental	General QOL
<b>All Programs</b>	64.7	66.4	62.8	64.1	68.8
<b>Substance Use</b>	67.1	68.6	66.0	62.7	69.3
<b>Mental Health</b>	62.5	64.4	59.7	65.5	68.1

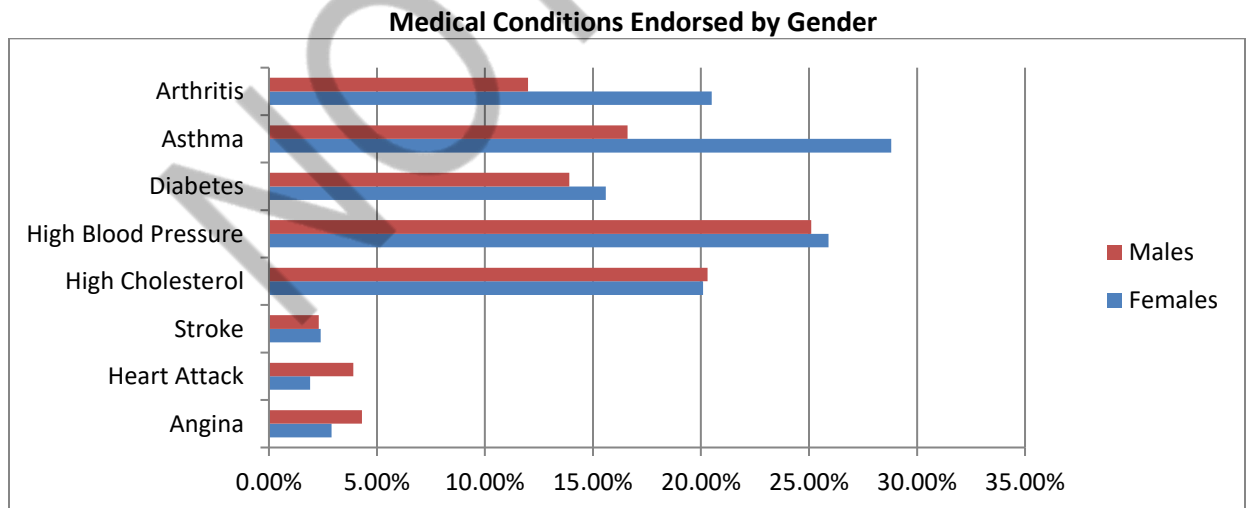
The QOL results also revealed that across all programs:

- Men reported better QOL than women in Physical Health, Psychological Factors, and General QOL
- Black respondents reported better QOL in Psychological Factors than White respondents
- White respondents reported better QOL in Environmental Factors than Other Races
- Non-Hispanic respondents reported better QOL in Environmental Factors than Hispanic respondents

As part of the FY 18 Consumer Satisfaction Survey process, DMHAS providers had the option to administer an 8-question Health Outcome Survey. The survey is available in English and Spanish. Body Mass Index (BMI), cardiovascular/respiratory/diabetes disease, overall health from physical and psychological perspectives, and smoking and drinking habits are all items. A total of 1,933 surveys were completed. Fifty-three percent of the responses were from clients in mental health programs and 45% were from clients in substance use programs. BMI could be calculated for 66.5% (1,286) of the respondents. The average BMI for clients was 32.2 ( $\pm 8.7$ ) with the women’s average at 32.4 ( $\pm 8.0$ ) and the men’s average at 32.1 ( $\pm 8.6$ ). According to the CDC, BMI categories for adults (ages 20 and older) indicate that all these averages reported fall into the Obese BMI category:

<b>Underweight BMI</b>	<b>Normal BMI</b>	<b>Overweight BMI</b>	<b>Obese BMI</b>
< 18.5%	18.5 – 24.9%	25.0 – 29.9%	30.0% +

Respondents endorsed the following list of medical conditions:



Despite the medical conditions reported, clients rated their overall health as excellent/very good/good 69.2% and 30.8% reported their overall health as fair/poor.

## Environmental Factors and Plan

### Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	# Of Locations (include mobile if any)	Narcan Provided
No Data Available					

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#### Footnotes:

As of 2019 in Connecticut, there are 13 Specialized Syringe Programs (SSPs) in urban areas across the state. These SSPs are either funded (10) or supported with supplies (3) provided by the Connecticut Department of Public Health (DPH). In 2019, 1,137,746 syringes were distributed and 753,292 syringes were collected. A total of 4,428 persons were served by SSPs, half of whom (50.7%) were new clients. New HIV cases in Connecticut continue to decline.

Given these circumstances, DMHAS is not proposing to use SABG funds for elements of SSPs.

NOT FINAL