Connecticut

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/17/2018 12.38.31 PM)

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 2019

End Year 2020

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

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	

VI. Contact Person Responsible for Application Submission

First Name	Susan
Last Name	Bouffard
Telephone	860-418-6993
Fax	860-418-6896
Email Address	susan.bouffard@ct.gov

Footnotes:
CT does not have an MCO.

State Information

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

Fiscal Year 2019

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
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. §§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.
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[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

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

Fiscal Year 2019

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
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and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
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**
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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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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)

Name

Title

Organization

Signature: Date:

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 1/1/2019 Planning Period End Date: 1/1/2020

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. Syringe Services Program							
c. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$0	$0	$233,032,017	$0	$2,664,929
6. Other 24 Hour Care		$573,303	$0	$24,457,196	$262,963,662	$0	$1,095,763
7. Ambulatory/Community Non-24 Hour Care		$4,592,525	$0	$1,709,111	$363,253,176	$0	$7,072,191
8. Mental Health Primary*		$0	$0	$2,574,285	$7,810,134	$0	$159,056
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$755,193	$0	$0	$90,631	$0	$0
10. Administration (Excluding Program and Provider Level)***		$20,000	$0	$0	$37,845,579	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	**$0**	**$5,941,021**	**$0**	**$28,740,592**	**$904,995,199**	**$0**	**$10,991,939**

* 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 9B should include Early Serious Mental Illness programs funded through MHBG set aside

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

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2018 Planning Period End Date: 9/30/2020

Expenditure Category	FY 2018 SA Block Grant Award	FY 2019 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$14,545,440	$12,949,637
2 . Primary Substance Abuse Prevention	$3,668,703	$5,179,032
3 . Tuberculosis Services		
4 . Early Intervention Services for HIV*		
5 . Administration (SSA Level Only)		
6. Total	**$18,214,143**	**$18,128,669**

* 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 are 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.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2018 Planning Period End Date: 9/30/2020

Strategy	IOM Target	FY 2018	FY 2019
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$1,126,544	$1,806,793
	Selective	$2,891	$931
	Indicated	$26,825	$54,757
	Unspecified	$0	$0
	Total	**$1,156,260**	**$1,862,481**
Education	Universal	$107,091	$168,509
	Selective	$275	$87
	Indicated	$2,550	$5,107
	Unspecified	$0	$0
	Total	**$109,916**	**$173,703**
Alternatives	Universal	$90,054	$106,920
	Selective	$231	$55
	Indicated	$2,144	$3,240
	Unspecified	$0	$0
	Total	**$92,429**	**$110,215**
Problem Identification and Referral	Universal	$6,606	$13,796
	Selective	$17	$7
	Indicated	$157	$418
	Unspecified	$0	$0
	Total	**$6,780**	**$14,221**

Community-Based Process	Universal	$2,042,730	$2,692,205
	Selective	$5,242	$1,388
	Indicated	$48,641	$81,590
	Unspecified	$0	$0
	Total	**$2,096,613**	**$2,775,183**
Environmental	Universal	$103,962	$138,946
	Selective	$267	$72
	Indicated	$2,476	$4,211
	Unspecified	$0	$0
	Total	**$106,705**	**$143,229**
Section 1926 Tobacco	Universal	$97,430	$100,000
	Selective	$250	$0
	Indicated	$2,320	$0
	Unspecified	$0	$0
	Total	**$100,000**	**$100,000**
Other	Universal	$0	$0
	Selective	$0	$0
	Indicated	$0	$0
	Unspecified	$0	$0
	Total	**$0**	**$0**
Total Prevention Expenditures		**$3,668,703**	**$5,179,032**
Total SABG Award*		**$18,214,143**	**$18,128,669**
Planned Primary Prevention Percentage		**20.14 %**	**28.57 %**

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2018 Planning Period End Date: 9/30/2020

Activity	FY 2018 SA Block Grant Award	FY 2019 SA Block Grant Award
Universal Direct	$2,965,780	$938,548
Universal Indirect	$608,638	$4,088,620
Selective	$9,171	$2,540
Indicated	$85,114	$149,324
Column Total	**$3,668,703**	**$5,179,032**
Total SABG Award*	**$18,214,143**	**$18,128,669**
Planned Primary Prevention Percentage	**20.14 %**	**28.57 %**

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2018 Planning Period End Date: 9/30/2020

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

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

SABG Planning Period Start Date: 10/1/2018 SABG Planning Period End Date: 9/30/2020

MHBG Planning Period Start Date: 10/01/2018 MHBG Planning Period End Date: 09/30/2020

	FY 2018				FY 2019			
Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$60,000				$210,000		$0	
2. Infrastructure Support	$400,000				$450,000		$0	
3. Partnerships, community outreach, and needs assessment	$148,200				$100,000		$0	
4. Planning Council Activities (MHBG required, SABG optional)	$15,000				$20,000		$0	
5. Quality Assurance and Improvement	$92,500				$183,000		$0	
6. Research and Evaluation	$0				$0		$0	
7. Training and Education	$184,450				$75,000		$0	
8. Total	**$900,150**	**$0**	**$0**	**$0**	**$1,038,000**	**$0**	**$0**	**$0**

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

Footnotes:
Respite in included in Infrastructure support but in CT is considered a direct service but included due to examples.

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or 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 a Behavioral Health Advisory/Planning Council (BHPC). 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 BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

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 behavioral health 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.

[72] **http://beta.samhsa.gov/grants/block-grants/resources**

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

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

The Department of Mental Health and Addiction Services (DMHAS) has been a single integrated department since 1995, servicing all behavioral health needs of adults. Connecticut has been submitting combined Mental Health and Substance Use block grant applications since 2014/2015. The biannual priority setting process is likewise integrated to cover mental health, substance use, and co-occurring populations and services.
In October 2012, the State Mental Health Planning Council expanded to encompass substance use services and was renamed the State Behavioral Health Planning Council. Membership now includes the DMHAS Director of Prevention and Health Promotion, among others with who self-identify as advocates for substance use issues.
In March 2018, the former Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) were replaced through a bidding process with Regional Behavioral Health Action Organizations (RBHAOs) which cover each DMHAS service region state-wide and are integrated entities responsible for advocacy, evaluation and planning for both mental health and substance use issues.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — (●) Yes ( ) No

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

3. Please indicate 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 Behavioral Health Planning Council, which is required under the Federal Public Health Services Act and the Community Mental Health Services Block Grant, has the following duties:
- To review the Combined SABG and MHBG application and state plan provided to the Council by DMHAS and DCF and to submit any recommendations for modifications of those plans
- To serve as advocates for adults with SMI and children with SED and their families, as well as other individuals with mental illness or emotional problems
- To monitor, review, and evaluate, at least annually, the allocation and adequacy of mental health services in Connecticut

Council representation includes the Regional Behavioral Health Action Organizations (RBHAOs), state agencies, other public and private entities concerned with the need, planning, operation, funding and use of mental health and related 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 illness and/or substance use and their families, and community groups advocating on their behalf. Stakeholders from communities across Connecticut, including consumers, family members, and providers will find their interests represented by the RBHAO council members attending the meetings. Presentations to the Council members range from such topics as the role of poverty in mental health issues (scheduled for October 2018) to the role of Recovery Coaches in hospital EDs that connect persons with substance use issues to other services (April 18, 2018). DMHAS and DCF provide updates on activities and initiatives within their respective departments and Council members share the activities and plans that they are involved in.

The RBHAO members (formerly the Regional Mental Health Boards - RMHBs and Regional Action Councils - RACs) are members of the Council and have been instrumental in conducting the annual priority setting process. The RBHAOs use DMHAS-provided regional profiles as a starting point from which to conduct their focus groups and community conversations to gain qualitative feedback about the behavioral health service system. They combine this data with information gleaned from other sources such as local/state survey results, data from the SEOW, public forums, evaluations, meetings, and interviews, etc., to produce regional priority setting reports. Reports are presented to the Commissioner, other DMHAS leadership and the Planning Council. Regional reports are organized into a single statewide report by the State Planner which then inform other planning efforts. Through this approach, the Council plays a vital role in determining the direction of the block grant.

Does the state have any activities related to this section that you would like to highlight?

In 2018, the former Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) were replaced through a bidding process with Regional Behavioral Health Action Organizations (RBHAOs) which cover each of the five DMHAS service regions state-wide and are integrated entities responsible for advocacy, evaluation, and planning for both mental health and substance use issues. Each RBHAO is required to have two staff members, one with expertise in mental health and one with expertise in substance use. These new entities are currently meeting to finalize the priority setting process going forward utilizing their new infrastructure.

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

NA

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]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.

Footnotes:

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, July 19, 2017 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Ingrid Gillespie, Kati Mapa, Tom Steen, Magda Lekarczyk, Peggy Ayer, Ingrid Gillespie, Kristie Barber, Lisa Jameson, Ellen Econs, Nikki Richer, Mui Mui Hin McCormick and Irene Herden	
Staff Present:	Karin Haberlin, Chrishaun Jackson, Susan Wolfe	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes from the April meeting were tabled as one section was blank.	Minutes will be corrected and brought to the next meeting for approval.
Block Grant Update Susan Wolfe	• The 18/19 Block Grant Application is due September 1st, 2017, but we have to work back from that date to fit in posting it to the web for public comment, review by this body (Planning Council), and obtaining the Governor's signature on the assurances and certifications. • The mental health and the substance use Allocation Plans were due on Monday, July 17, 2017, but they are still being worked on. OPM directed us to use the President's proposed budget to complete the plans and this means a 0.2% reduction for SAPT and a 26.5% reduction for MHBG. • The DMHAS and DCF state planners met with the chairs of the Adult and the Children's Planning Council last week to further discuss the priorities for the 18/19 Block Grant Application. Some items are proposed to serve as both priorities and as presentations to the planning council. Proposed as presentation topics for the Adult Council: o New CSP programs/fidelity reviews/outcome measures o One Key Question to determine women's reproductive intentions o Results of outpatient wait time study by Regional Mental Health Board Directors • And presentations proposed for the Joint Council: o Transportation/Mobility Managers o Expansion of MAT/Learning Collaborative o Expansion of Recovery Coach Services/Manchester HOPE initiative	

	○ Zero Suicide model (scheduled for the September meeting) ○ STEP program/Beacon contract (ESMI) (scheduled for November meeting)	
18/19 Block Grant Application Presentation Susan Wolfe	A handout outlining the different sections of the block grant and changes from the 16/17 block grant application was distributed. The State Information section was reviewed and changes described. The Planning Steps section was presented and the ways in which DMHAS fulfills the requirements for assessing the service system strengths and needs (with the behavioral health needs assessment based on a variety of data sources); identifying unmet needs and critical gaps (the priority setting process and results); and the Quality and Data Collection Readiness (describing the DMHAS and DCF data collection systems). The Planning Tables generated much discussion. The DCF-generated priorities related to Childhood Trauma, Family Engagement, Workforce Development, and Prevention of Suicide/MI were unchanged from the previous block grant submission except that the numbers were updated. • It was noted that for the PWID (previously IVDU) priority to increase the number of LMHAs prescribing Buprenorphine, DMHAS had reached out to DCF to see if they had an indicator they would like to add since they are making similar efforts within their department to address the opioid crisis. • There was clarification about the priority related to enhancing transportation that indeed this was related to the DMHAS 1-800 number designed to provide treatment on demand for persons with opioid use disorder and that rides, while primarily delivering clients to detox, could transport clients to other locations. It was recommended that an indicator for this priority be the percent of people who call to get rides and are actually accepted into treatment. • Expanding Recovery Support Services by increasing the number of Hospitals with Recovery Coaches caused much discussion related to the "siloing" of mental health and substance use rather than the integration. The Peer Specialists/Peer Bridgers as compared to the Recovery Coaches, receive different training, work in different locations, and support only mental health or substance use concerns rather than both. This is a much larger system issue and the Council made and approved a motion to draft a letter to the Commissioner regarding merging of peer services. • For the required SMI priority, the plan is to examine the 23 new CSP programs supporting SMI clients in the community in two ways: fidelity reviews and outcome measures. Council members agreed that the 2 indicators was a good idea.	If DCF provides a second indicator for the PWID priority, it will be incorporated. Susan will check with Lauren Siembab/Michael Michaud to determine whether this data is available. Marcia will draft a letter to Commissioner to be reviewed by the Council.

	• The TB priority, which plans to educate staff in infection control on the new risk factors/guidelines related to TB, was accepted without question. • New with this block grant is a priority for ESMI (Early Serious Mental Illness) which is the new term replacing FEP (First Episode Psychosis). Since the Beacon/DCF contract is the new piece, the priority indicator will be the percent of young people identified as ESMI who agree to engage in treatment. • The primary prevention priority options were presented in a handout based on data from UConn showing the problem substances in order: Alcohol (1st), Marijuana (2nd) and Opioids (3rd). Susan had endorsed marijuana as the priority based on the fact that the previous two priority setting rounds had identified the need for education on the risks of marijuana. It was pointed out that the way the priority was written confused perception of risk with use and needed to be corrected. It was agreed that changing the indicator from use to perception of risk was a better choice because it was felt there would be more of an impact, especially if the state chose to legalize recreational marijuana use. Further discussion resulted in a decision to have two indicators: adolescent and adult perception of marijuana risk, based on the idea that parents' influence children's likelihood of marijuana use based on their own beliefs that marijuana was the same as they had used as adolescents and was relatively safe. It was reported that there was much survey data to be able to measure these two indicators. One member felt that the primary prevention priority should be on cigarette smoking, but Susan pointed out that the data revealed that the top 3 concerns in Connecticut did not include cigarette use and that, in fact, cigarette smoking has been on the decline nationally for years. • The final priority is the one required for PWWDC on implementing One Key Questions in DMHAS women's programs. This priority was described as "an invasion of privacy" by one council member and not related to the reason women enter DMHAS treatment. After further discussion however, it was resolved that One Key Question serves to screen women to ensure their reproductive needs are being met by providing an opportunity to discuss reproductive preferences and related options. • When asked whether there were other priorities that should be added to the list, there was a discussion about the challenges of engaging clients in treatment. It was suggested that there was much work to be done in engaging clients in order for treatment to be effective and that it was difficult to measure engagement. In fact it can be measured by determining how many clients	Susan will change the indicators and correct any confusion in the language. Further discussions on the topic of

	have only a first, and no second appointments. But the bigger issue is whether strategies are being applied or planned to be applied to actually improve the level of engagement. There is no point in having a priority if it is not attached to initiatives designed to effect improvement. While this topic may not be appropriate for inclusion as a priority in the block grant, it is still worthy of further discussion. • Finally, the topics of mobile crisis and warm lines were brought up as needing attention. A particular case in region 5 was presented as an example of how mobile crisis can work effectively for clients and those concerned about them. But it was also pointed out that the resources are stretched and that there are inconsistencies across mobile crisis units with different hours, for example. It was suggested that there should be consistency across these programs. The first step seems to be looking at what each unit currently offers. The Planned Expenditure tables for mental health, substance use and prevention have yet to be completed. Fiscal/Prevention will complete them once the Allocation Plans are submitted. The Environmental Factors/Plan section which contains what are commonly referred to as "narratives" has switched for the most part from open ended questions to check boxes which are good in that they are simpler, but bad in that there is no opportunity to explain an answer. Support of State Partners was described as those other state agencies which DMHAS/DCF work with which provide support letters that are electronically submitted as part of the block grant application. The Planning Council section includes the members and their contact information; who they represent in terms of persons in recovery, family, providers, advocates or state employees, as well as diversity; ratio of those involved for personal versus professional reasons; and their input on the block grant, which is the purpose of this meeting. Finally, the block grant application will be posted to the DMHAS and DCF websites for a period of public comment which will also be incorporated into the block grant application. Marcia commented that greater effort to involve the planning council in the development of priorities was obvious. Others stated that the opportunity to have the discussion was a good opportunity. A couple of members expressed that the preponderance of priorities seemed weighted toward substance use, although another member pointed out that historically priorities had always been weighted toward mental health.	engagement should be scheduled. Members to collect data on what the different mobile crisis units offer. Planning council feedback and recommendations as well as those of the general public will be included in the block grant application.
DMHAS Update	• Privatization – was put on hold until after the union vote was finalized. The concession package for state employees was just approved, so privatization will not go forward per the agreement	

Karin Haberlin	worked out between the Governor and the unions. This means privatization efforts that were in the budget including closing Torrington and Danbury are not expected to be moving forward. DMHAS "paused" the RFP process for Torrington and has not moved forward with releasing the RFP for Danbury. It is not known what may happen if the legislature does not accept the union concession package. • Budget – DMHAS is evaluating how to manage the cuts that are being passed along to DMHAS under the Governor's Executive Authority. DMHAS' grant accounts have been reduced. Given the uncertainty of the budget, DMHAS is releasing only one month's funding to providers. All of these one-month payments should have been processed by the time of the Adult Council meeting. The council continues to experience a lot of anxiety due to the uncertainly of the times. • Grants – DMHAS continues to try to maximize funding by applying for federal grants. DMHAS has applied for SAMHSA's **Promoting Integration of Primary and Behavioral Health Care Integration Grant (PIPBHC)**. The grant would provide **2 million per year for 5 years**. This grant is aimed at better integrating primary health care with behavioral health care and would build upon integration efforts that began with our Behavioral Health Home Initiative. The grant would focus on Hartford, Bridgeport, and Waterbury. DMHAS has also recently submitted an application for a SAMHSA grant for **Pregnant and Postpartum Women**. This grant would be for **1.1 million per year for 3 years**. The grant is intended to expand the use of family based recovery and health services for substance using women. The goal is to enhance treatment options for these women and their families in the New Britain/Bristol and the Hartford/East Hartford areas. These areas were selected because these communities have a high number of risk factors related to pregnancy. These may include the following: inadequate or no pre-natal care, high teen birth rates, and high number of individuals below the poverty level. • Expansion of transportation for substance abuse services – DMHAS has expanded transportation to substance abuse services across the state as part of its 1-800 number. Transportation will be available between substance use levels of care including residential, DMHAS-funded recovery houses, and Supported Recovery Housing Services. Transportation must be accessed through the Access Line, 1-800-563-4086. While the rides are primarily to detox, other transportation destinations are possible.	
Other Business Marcia DuFore	No other business was conducted.	
Meeting Adjourned		
Next Adult meeting:	October 18, 2017 from 12:30 PM – 2:30 PM, Room 212, Page Hall, CVH	
Respectfully submitted:	Susan Wolfe, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, October 18, 2017 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Kristie Barber, Lisa Jameson, Ellen Econs and Irene Herden	
Staff Present:	Karin Haberlin, Chrishaun Jackson, Susan Bouffard, Kim Karanda and guest Jordana Frost (March of Dimes)	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes from the July meeting were reviewed and approved without corrections.	
One Key Question Presentation Jordana Frost Kim Karanda	Kim Karanda introduced the new DMHAS initiative "Every Woman Connecticut," a joint effort with many other agencies across the state that started in Connecticut in May 2017. Part of that effort is "One Key Question" which is a simple screening tool that asks women "would you like to become pregnant in the next year?" It opens up the opportunity for a conversation about the women's reproductive preferences and plans so that she can receive assistance with such things as Medication Assisted Treatment, access to contraceptive devices, etc. It is a holistic approach which includes reproductive health as part of health, analogous to how behavioral health is part of health. A list of recommended support materials to use as a resource was distributed. Jordana presented the need for One Key Question screening with a power point presentation that included the following information: • Not only is there an opioid crisis in process, but also a crisis with rising numbers of babies born with neonatal abstinence syndrome (NAS) • Half of all US pregnancies are unintended (3.4 million), in Connecticut (2013), 28.5% of pregnancies were unplanned unless the mother was an opioid user in which case the percentage rose to 90% • Optimal birth spacing is 18 months which is associated with improved health outcomes In Connecticut, DMHAS supports 7 programs for pregnant and parenting women. The One Key	Jordana will make the power point presentation available to be shared with the planning council.

	Question initiative is being rolled out beginning with the most vulnerable women, including the 7 specialized programs and the LMHAs. Much interest has been expressed, including by the Methadone providers, WIC counselors, WSPIC and others. Three training sessions have also been held. Jordana's email is JFrost@MarchOfDimes.org	
Block Grant Update Susan Bouffard	• The 2018/2019 Combined Block Grant Application & Plan was submitted on time (due Sept. 1st) • The MH and the SA Annual Reports are due to SAMHSA Dec. 1st and are being worked on • The Annual Synar Report is due Dec. 31st • We continue to collect documents as part of the document request related to the scheduled SAMHSA site visit April 24-26, 2018. SAMHSA has started identifying provider sites to visit.	
DMHAS Update Karin Haberlin	Karin shared that DMHAS did not get awarded either the pregnant and post-partum women grant or the behavioral health care integration grant. She distributed a handout with a timeline for the RFP for regional behavioral health action organizations. There were some questions: • Will the questions be posted before the answers are released? • Will DMHAS publish the list of RFP applicants? • What is the time of the bidders' conference as only the date is listed?	Karin will follow up to obtain answers to these questions which will be emailed to the planning council
Other Business Marcia DuFore	There was a brief discussion of the next adult and joint planning council meetings including a reminder that Vinod Srihari has been rescheduled for the November 9th Joint meeting to present on the first episode psychosis program (STEP) at CMHC/Yale.	
Meeting Adjourned		
Next Adult meeting:	January 17, 2018 from 12:30 PM – 2:30 PM, Room 212, Page Hall, CVH	
Respectfully submitted:	Susan Bouffard, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, April 18, 2018 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Lisa Jameson, Ellen Econs, Irene Herden, Nikki Richer, Mui Mui Hin-McCormick, Deborah Walker, Peggy Ayer, Mary Lou Word, Connie Anderson, Ingrid Gillespie, and Michele Devine	
Staff Present:	Chrishaun Jackson, Susan Bouffard, Jim Siemianowski and Rebecca Allen, Michael Serrano and Katie Siekiera from CCAR	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	There were no minutes from the January 2018 meeting as the meeting was canceled due to weather. However, it was pointed out that the previous meeting minutes from October 2017 should be reviewed.	Susan will follow up with the previous meetings minutes.
Recovery Coaches in Hospital EDs Presentation Rebecca Allen Michael Serrano Katie Siekiera	Rebecca provided an overview of the program at which Recovery Coaches go to hospital EDs to work with patients who present with substance use issues. Michael Serrano and Katie Siekiera then provided a brief history of their own recovery and spoke as Recovery Coaches about their experiences in the hospitals. CCAR was established in CT in 1998. The Recovery Coach training program was established at CCAR in 2008 and requires a minimum of 5 days (30 hours) of training. Further training was added to better equip the Recovery Coaches to do the job on topics such as ethics. At present there are 8 Recovery Coaches and plans to hire a few more. Through DMHAS grant funding, Recovery Coaches are available at the following hospitals: Manchester, Windham, Backus, Lawrence & Memorial, Midstate, Danbury, St. Francis, and Day Kimball. Both Bridgeport Hospital and Charlotte Hungerford Hospital will be on board soon. Additionally, Hartford Hospital will become the first privately funded Recovery Coach program. For participating hospital EDs, Recovery Coach services are available 8am – 12 am every day of the year within 2 hours after being contacted by hospital ED staff. Data is being collected by CCAR and by Yale PRCH. For the period March 1, 2017 (when the program was initiated) until March 31, 2018, the program has been contacted for 1,143 ED patients and 1,114 (97%) have been engaged to participate in the next step toward recovery. While the target population in the ED was patients with opioid overdoses, they see all patients brought in for substance-related issues and it turns out that only 9% of patients seen by the Recovery Coaches have had an overdose. Seventy	

	percent of the time, patients have an alcohol or alcohol plus other substance-related issue. Twenty-three percent of the time, the patient has a heroin or heroin plus other substance-related issue. For clients who agreed to take the next step toward recovery, the breakdown is as follows: • Detox - 595 • Community Supports (12-step, CCAR, Health/Wellness, etc.) - 320 • inpatient - 82 • outpatient - 44 • intensive outpatient - 43 • MAT - 30 The Recovery Coaches talked about the changes in the culture of the EDs because of their presence. Attitudes of staff toward people with substance use issues have changed and many staff members have asked the Recovery Coaches for help for family members or themselves. Hospital staff benefit by the Recovery Coaches spending time that the staff can't spare working with the patient and getting them to agree to and to locate placement as necessary at the next level of care. As this effort presumably reduces recidivism rates at the hospital, this also is a savings. Hospital ED staff only see people with substance use issues "at their worst" so the Recovery Coaches, as they do their job, are also modeling what recovery looks like. Typically, the Recovery Coaches estimate that they spend about 3 – 4 hours with each patient, 60 – 90 minutes of which is talking with them and the rest of the time is sorting out arrangements for the next level of care. They are able to arrange for Detox typically on the same day or the following day at the latest, however, placing patients in inpatient settings is more of a challenge. There was much interest in collecting data on patients involved with the ED Recovery Coaches. Demographic data is available in DDaP. The idea of conducting a pre-and post-assessment with one of the hospitals planned to, but not yet started with the program, was raised.	
Block Grant Update Susan Bouffard	SAMHSA will be on-site next Tuesday – Thursday for the routine 5-year compliance monitoring visit. As part of the visit, they will meet with the Behavioral Health Planning Council on Wednesday April 25th from 10 am – 12 pm in CVH Page Hall room 212. Those present are invited to attend. Several members indicated that they planned to attend. This session will be followed by a session from 1 – 3 pm for consumers at the same location.	
DMHAS Update Jim Siemianowski	SAMHSA released grant notifications: ▪ **ACT Services**: This grant is for $650,000/year for 5 years. DMHAS is reviewing the grant.	

	▪ **Outreach and Engagement for Young Adults with serious Mental Illness**: This is a very complicated grant. The feds want the program to link with 1st Episode Psychosis, but not be a part of it. This grant is for $400,000 and requires the state to assume more costs of the program over the course of the grant; covering ¾ of cost and the feds covering ¼ of the cost. Sustainability is a factor. DMHAS's main focus has been on Whiting. Whiting facility will be separating from CVH effective May 1, 2018. It will remain a part of DMHAS, but will be a separate facility with its own leadership team. The CEO will report to the Commissioner. Jim has been a part of the team rewriting its policies and procedures.	
Other Business Marcia DuFore	• Jim clarified that for the meeting of the Planning Council with SAMHSA, state staff would not be present as this is the approach that SAMHSA is taking • Janine Sullivan-Wiley gave an honorable mention to Lisa Jameson for her concern and involvement with Sex Trafficking and how it affects DMHAS clients. A conference on Sex Trafficking: CT Women's Consortium is scheduled for April 24, 2018	
Meeting Adjourned		
Next Adult meeting:	July 18, 2018 from 12:30 PM – 2:30 PM, Room 212, Page Hall, CVH	
Respectfully submitted:	Susan Bouffard, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, July 18, 2018 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Lisa Jameson, Mary Lou Anderson-Word, Connie Anderson, Pam Mautte, Carol Meredith and Allison Fulton.	
Staff Present:	Chrishaun Jackson and Susan Bouffard	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes from October 17, 2017 and from April 18, 2018 were reviewed and accepted without changes. The October 17, 2017 minutes hadn't previously been reviewed because the subsequent meeting when they were scheduled for review was canceled due to weather.	
RBHAOs Priority setting process restructure Carol Meredith	Carol Meredith explained that she is working with a team to create a guidance document for the regional reports. The guidance document will provide the context for the report and will include how the report should be organized and the activities that will be required. The outcome from the RBHAOs will be regional reports, not regional plans as "plans" implies something beyond the scope of the intent of the reports. There is a meeting to present the guidance document for review and discussion on July 31st. Carol was asked if the guidance document included a timeline. She answered that it did, but that she would like to reserve that for the discussion on the 31st.	
Allocation Plans Susan Bouffard	Susan explained that the allocation plans are state of Connecticut requirements, not federal block grant requirements. Notices of the requirement to complete allocation plans were sent about one month ago and the allocation themselves were due back to OPM July 13, 2018. DMHAS submitted an SAPT allocation plan and worked with DCF to submit a CMHS allocation plan. OPM may require edits to the plans which DMHAS and DCF will work with them to address. Once approved by OPM, there will be a public hearing before the Appropriations, Public Health and Human Services Committees of the General Assembly. The Commissioners responsible for all the various block grants will provide testimony at the public hearing and answer questions. Susan will email the planning council once the date is set for the public hearing as everyone is welcome to attend. She pointed out that it could be last minute as only 48 hours' notice is required. The allocation plans only address block grant dollars which between the CMHS and SAPT block grants amount to approximately 22 million dollars annually out of a DMHAS budget of approximately 600	Susan will email the date of the public hearing on the allocation plans.

	million. So the allocation plans do not tell the whole story. Additionally, the amounts in the allocation plans are estimates starting with President Trump's proposed budget, so they are also subject to change and frequently have changed over the past several years. In general, the formula for determining how much funding a state will receive in a block grant is based on the number of people estimated to need services x the estimated cost of providing those services x the state's estimated ability to pay for those services. For SAPT, the President's budget calls for $18.1 million for FY 2019. This is $50,000 less than his FY 2018 budget and $85,000 less than the actual FY 2018 allotment. DMHAS also estimates that it has about $500,000 carry forward, as block grants can be spent over a two year period. Within the SAPT block grant, because Connecticut continues below threshold with respect to new HIV infections, as of October 1, 2018 DMHAS can no longer spend SAPT funds for HIV services. For CMHS, the President's budget calls for $5.2 million for FY 2019. This is $1 million more than his FY 2018 budget, but $2 million less than the actual FY 2018 allotment. The 26% reduction on which last year's allocation plan was based was restored.	
Use of Technology to reduce Travel Time Susan Bouffard	Susan reported that she had discussed this proposal with Jim and they had agreed to pilot it with the 4 meetings of the Adult Behavioral Health Planning Council since the Joint council also involved DCF and might make it more complicated. IT told Susan that some staff at the Commissioners' Office already have WebEx accounts and the Adult Behavioral Health Planning Council could use one of those accounts for their meetings as long as they aren't scheduled for use at the same time. Webex connections allow both phone conversation and screen sharing for documents. Webex costs 28 cents a minute per person participating in the call, rather than a flat rate. The council felt this cost was excessive and suggested that further investigation be made into other options which are sometimes free. Uber conference by dial pad and zoom or skype were also proposed. It was also pointed out the Beacon Health Options has a good system with individual speakers/microphones at each seat which makes it possible to hear everyone that is speaking, something that is often a problem with traditional conference call arrangements. A final point made on this topic was that there may be some security or confidentiality feature of the Webex used by the state that other software lacks. It is clear that DMHAS does not allow staff to load any software they want.	Susan will follow up with Jim to determine next steps.
Block Grant Update Susan Bouffard	The block grants operate on a two-year cycle. In 2017 the full application/plan was submitted. In 2018 only a "mini-application" is required and that is due September 4, 2018. The mini-app will require the Governor's signature, fiscal tables, council membership, and new this year, information on specialized	Susan will send the mini-application electronically.

	syringe programs (previously known as syringe exchange programs). In recent years SAMHSA provided notice that they would allow use of SAPT block grant funds for naloxone and related activities. In Connecticut, however, it is the Department of Public Health and provides SSP, so most likely this will be NA for our state. There isn't a council meeting scheduled prior to the due date for the mini-app, so Susan will send it electronically to the council members in order to get their feedback, comments, questions, and recommendations for change. Since the end of the federal fiscal year is fast approaching, Susan provided an update of the status of the priorities: • Rides to detox: goal was 600, there were 1,500 • LMHAs ability to prescribe buprenorphine: goal was 7, but all 13 now have that capacity • Recovery coaches in EDs: goal was 6 hospital, there are 8, and about to be 10, hospitals • New CSP programs fidelity review: goal to complete baseline reviews and all are completed • New CSP programs outcome measures: goal was for 3 of 4 measures to meet or exceed goal, at present: social support goal of 60% was surpassed at 82%, stable living goal of 80% was surpassed at 92%, improved functioning goal of 65% is at 64%, and employment goal of 20% is not met at 13% • Educate infectious disease program staff of high risk factors: goal was for 6 and this training is scheduled for mid-September • Train women & children's programs on One Key Question: goal was 50% and this has been met • Perceived risk of Marijuana: goal for adolescents was 21.9%, NSDUH 15/16 is 24.7% • Perceived risk of Marijuana: goals for 26+ year olds was 28.3%, NSDUH 15/16 is 25.7% The remainder of the priorities belong to DCF. There was much discussion about the primary prevention goal related to marijuana in terms of why something so challenging as increasing perceived risk of marijuana use would be taken on in the face of so much legalization of marijuana for medicinal and recreational use. Data is emerging from places like Colorado where they now have experience with years' worth of marijuana availability. Concerns like combining marijuana with alcohol, traffic issues, and daily long term use were discussed. More needs to be done in terms of prevention to make a dent in the marijuana use issue. It was also pointed out that there were other data sets like the BRFS which are local and may be a more accurate measure. Additionally, the reality of rates of cigarette smoking among the behavioral health population begs for attention and was suggested as a priority for the next round of the block grant. Carol thought that the	

	priority setting process should be permitted to go forward to determine what priorities should be selected for the block grant. The new CSP outcome measures data also raised comments about persons not meeting eligibility for CSP services. Individuals have to be committed to all aspects of the program, including skill building, for example, and some persons just want one piece and won't commit to the whole thing which makes them ineligible. Also, some persons wanting services have primary substance use rather than mental health issues so they are not eligible either. It was suggested that we discuss membership of the council as we periodically do around the time that the block grant is due. Susan reported that at present our council membership was in pretty good shape relative to the ratios required by the block grant. She clarified that it is the full Joint Council that must meet the block grant requirements. There is good representation by parents of children with behavioral health conditions and all required state agencies are represented. The council could always benefit from more persons in recovery and greater diversity, notably there is a lack of men on the council. It was suggested that the membership list be emailed out to council members for review, particularly to consider persons on the list who infrequently or never attend meetings.	Susan will email the current membership list to the council members for consideration.
DMHAS update Susan Bouffard	• MAT 8 hour waiver training to prescribe buprenorphine was offered July 13th • DMHAS is co-sponsoring an Opioid Use Disorder conference on 9/21/18 which will feature Bill Moyers (Hazelton/Betty Ford Foundation) and Bertha Madras (Harvard) and 10 breakout workshops • DMHAS is developing a new Opioid Use Disorder campaign using social marketing that is targeting young males 18 – 40 using street opioids along with their family and friends. MAT will be the focus and the effort is meant to coordinate with the Change the Script campaign. The marketing firm (O'Donnell) has been hired and they have started collecting qualitative and quantitative data. The goal is to begin messaging in September • Another successful Consumer Satisfaction survey year has been completed with over 22,000 surveys received. This year, an additional 1800 clients in BHH programs completed surveys. • There are TA opportunities at no cost to the state, including for Block Grant monitoring and Crisis Response • STR year 2 is in process and is supporting a number of efforts including recovery coaches in EDs, MAT expansion, prevention activities, naloxone distribution, etc. • State opioid Response grant application is due August 13th and starts October 1st. It is an 11	

	million/2 year grant which will overlap by several months with the STR grant and will fund many of the same activities. A forum was held last week to solicit stakeholder input on other funding suggestions for this grant • Several other grants have been submitted, all competitive, and we are waiting to hear whether or not they have been awarded to Connecticut	
Other Business	Susan shared that Annie Harper will be presenting on poverty and mental health issues at the October meeting and there are a number of possible presentations that she could schedule for September, including a presentation on psychiatric services in prison by Craig Burns or the Manchester HOPE initiative. The council, however, was most interested in hearing DCF present on their services, including specifically, how shifting of funds/services to CSSD from DCF is impacting clients and services. They suggested including a representative from CSSD to joint Tim Marshall of DCF in the presentation.	Susan will contact Tim Marshall to see about a presentation for the September meeting.
Meeting Adjourned	The meeting adjourned at 2:05 pm	
Next meeting	The next Joint Behavioral Health Planning Council (DMHAS) meeting is September 13, 2018 from 2 – 4 pm at CVH Page Hall room 217. The next Adult Behavioral Health Planning Council meeting is October 17, 2018 from 12:30 – 2:30 pm at CVH Page Hall room 212.	
Respectfully submitted by	Susan Bouffard, PhD	

DRAFT

Joint DMHAS/DCF Council Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, June 8, 2017, 2:00 – 4:00 PM	
Location:	Connecticut Valley Hospital, Page Hall – Room 217	
Attendance:		
Members Present:	Lisa Jameson, Eileen Bronko, Janice Bendall, Nicki Richer, Janine Sullivan-Wiley, Nannette Latremouille, Peggy Ayer, Kati Mapa, Magda Lekarczyk, Ellen Econs, Irene Herdon, Laura Watson, Marjorie Foster, Maureen O'Neil-Davis, Doriana Vicedomini, Marcia DuFore, Mary Martinez, Mary Cummins	
Staff Present:	Tim Marshall, Jim Siemianowski	
Guest	Nan Arnstein	
AGENDA ITEM		***ACTION***
Review of Minutes	The minutes were accepted without correction.	
Specialized Treatment Early Psychosis (STEP) Program Vinod Srihari, Director CT Mental Health Center	Specialized Treatment Early in Psychosis (STEP) Program is one of two programs that DMHAS has set aside funding for intervening with people experiencing first episode psychosis (FEP). On the children's side for first episode psychosis, DCF discontinued CBITS, a trauma informed school-based program, and initiated a contract with ABH to identify potential FEP clients using databases. Dr. Vinod Srihari from the CT Mental Health Center was scheduled to present a power point on this program but unfortunately had to cancel. The presentation with Dr. Srihari will be rescheduled.	
Block Grant Update Jim Siemianowski	• Each year DMHAS and DCF go through a process where they submit allocation plans to OPM and in turn the Commissioners of DMHAS and DCF present these plans to the legislature. • This year the full block grant application and plan is due September 1, 2017. • Highlights of the plan will be presented during the individual DMHAS and DCF meetings next month. • **DMHAS -** has a new Center for Substance Abuse Treatment officer. An informal visit was conducted last month. DMHAS has been informed that next year will be a formal week long site visit with the Center for Substance Abuse Treatment, Center for Mental Health Services, and Center for Substance Abuse Prevention in CT at the same time to look at how the money is spent, tracked and if the rules and regulations are being followed. • **Note – Schedule the joint meeting in 2018 to coincide with the site visit from the Center for Substance Abuse Treatment officer.** **DCF -** CBHAC annually selects priority areas they want to support. This year they chose Access to Comprehensive Array of Services to support family and youth engagement, health promotion, prevention and early identification. DCF's priority areas based on those	

	for the block grant were family and youth engagement, suicide prevention, workforce development and childhood trauma. These topics aligned with CBHAC priorities and are areas that DCF continues to fund with block grant dollars.	
DMHAS Update Jim Siemianowski	• Through a competitive procurement process, DMHAS is replacing a state operated community mental health center with a private not for profit in Torrington. This is a large RFP, just over 6 million dollars. A bidder's conference was held and the due date for submissions is June 23, 2017. They hope to begin contracting with the new replacement agency on August 1, 2017 and to be fully operational by October 1, 2017. • The provider that is awarded this contract is expected to provide a full continuum of services; mobile crisis, jail diversion, and outpatient. They will assume responsibility for young adult's residential program for two young adult assertive community treatment teams and a recovery and wellness program. DMHAS is requiring that in order to get the award the provider must have a substance abuse license and a mental health outpatient psychiatric license. • An application was just completed for additional funding for services that are comparable to what DMHAS does in their behavioral health homes (BHH). They are trying to better integrate physical health and behavioral health so the BHH's are doing care coordination. • DMHAS is also working on a grant from CSAT which deals with pregnant and post-partum women who are using substances. They are currently evaluating data and looking at some of the communities with the greatest need. Funding from this would help support multi-disciplinary care teams doing family treatment for substance use.	
DCF Update Tim Marshall	• The legislative session ended with no budget and now the agency is determining what the potential consequences in the short term are with or without cuts. • There are practical issues with contracts, fiscal departments and maintaining current contract funding levels, renewals and amendments. They are waiting for the process to play out to determine if there will be any changes or reductions. • Unrelated to the block grant, DCF also has a federal System of Care grant. A site visit on this grant was conducted and the results of the report issued were positive with good recommendations.	

Other Business **Doodle Poll – Meeting time of the Joint Council:** Mary Cummins	A doodle poll regarding the time of this meeting was sent to the DMHAS participants. They came up with several days and times that could potentially work during the week but unfortunately do not work for the CBHAC participants. This all stems from the current meeting time of 2:00 – 4:00 not being a good time for parents with children. A time more convenient for parents with children might also help with increasing participation on the child side. Mary Cummins will discuss this with Susan Wolfe to determine what makes sense to bring to leadership. In a previous meeting council members discussed their choice of meeting topics. The top three were: • Expand the use of peers for the child and adult systems. • Same day access across child and adult systems and its impact on waits for appointments. • Expand/support suicide prevention across the life span including bridge signs, etc.	
Next Joint Meeting:	September 14, 2017 at CVH Page Hall, Room 217 from 2 – 4 pm.	

Joint DMHAS/DCF Council Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, March 8, 2018, 2:00 – 4:00 PM	
Location:	Connecticut Valley Hospital, Page Hall – Room 217	
Attendance:		
Members Present:	Nan Arnstein, Lisa Jameson, Janice Bendall, Ellen Econs, Laura Watson, Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Angela Duhaime, Carol Meredith, Nikki Richer, Mary Cummins, Tim Marshall, Tony Cormello, Renee Serafino, Pam Mautte	
Staff Present:	Susan Bouffard	
AGENDA ITEM		***ACTION***
Review and Approval of Minutes	The minutes of November 9, 2017 were accepted without corrections.	
Regional Behavioral Health Action Organizations (RBHAOs)	The 5 Regional Mental Health Boards (RMHBs) and 13 Regional Action Councils (RACs) competed through an RFP process for 5 new integrated structures called Regional Behavioral Health Action Organizations or RBHAOs. The prior structure was discontinued as of February 28, 2018 and the new organizations came into existence on March 1, 2018 so while the new RBHAOs have been identified, the restructuring process has not been completed. Efforts are underway in each region to accomplish this. Each new RBHAO will need to determine who from their organizations will be attending the Behavioral Health Planning Council. Invitations were sent to the new Executive Directors, but obviously all those interested are welcome to attend. One requirement of the contract is that there must be a representative on the board appointed by both the DMHAS and DCF Commissioners.	
RBHAOs and the future of the Priority Setting Process	Determining how the Priority Setting Process will occur in 2018 is still undecided given the change from RMHBs and RACs to the new RBHAOs. The prior process for even numbered years was labor intensive involving regional data profiles from DMHAS, consensus on questions to ask stakeholder groups to gather information, conducting the stakeholder groups, sending a survey monkey questionnaire to providers, etc. Each region would produce a regional priority setting report. Susan Bouffard would then merge the regional reports into a statewide priority setting report. In odd numbered years it was simpler in that regions were asked to update the findings from the prior year. It is a requirement of states receiving block grant funds that they conduct an evaluation of the service system on an annual basis. There is a prescribed process on the prevention side. Carol Meredith suggested the need to streamline and merge both processes and will be meeting with RBHAO's to begin discussions about streamlining the process.	

	The block grant reports are due 9/1/18. The allocation plans are due 7/1/18 and they go to OPM and to a public hearing before committees of the State Legislature.	
Block Grant Update	DMHAS has been preparing for months for a SAMHSA compliance monitoring visit which occurs every five years. The process has been changed in that CSAT (Center for Substance Abuse Treatment), CSAP (Center for Substance Abuse Prevention), and CMHS (Community Mental Health Services) previously all came separately for their own visits. They are now conducting combined visits with a team of seven - mental health, substance abuse treatment, substance abuse prevention, and fiscal analysis on April 24-26, 2018. On the first day of the review there will be meetings with different staff at DMHAS and DCF to ensure compliance with block grant requirements. The treatment folks will be going out daily to visit three different opioid treatment programs – CASA in New Haven, a methadone clinic in Hartford-the Hartford Dispensary, and Coventry House for pregnant women. Mental health folks are visiting an FEP (First Episode Psychosis) program-STEP in New Haven. Fiscal folks will be visiting the DMHAS business office and contracts units, to review their work. They will also be meeting with a consumer group of DMHAS/DCF services. They also want to meet with the Behavioral Health Planning Council in a private meeting. The meeting will occur on 4/25/18, from 10:00-12:00 pm, at CVH in Middletown, Room 212. All members of the planning council are invited to attend.	
Agency Updates (DCF) Tim Marshall	Transition of the DCF side of Juvenile Justice to judicial was discussed. Funding will be transitioning as of 7/1/18. Some of the funding SIDS are intertwined with other funds. A transition team from DCF and judicial have been meeting several times a month to discuss transitional issues. Judicial has agreed that DCF should retain dollars (10-11 million) that would transition to judicial. There is also the slated closure of CJTS in Middletown for 7/1/18. CSSD is re-procuring for secure settings.	
Agency Updates (DMHAS) Susan Bouffard	• The new Opioid Awareness Campaign "Change the Script" has launched which is a joint effort by DMHAS, DPH and DCF. Information is available at drugfreect.org. • The fiscal '17 annual statistical report is on the DHMAS website. A report has been issued for the last three years and explains who is being treated by DHMAS. • There is a new addiction bed availability site on the DMHAS website that shows availability of beds for various levels of care for substance use. • ATR funding is ending 4/30/18. • Recovery coaches in hospital EDs have connected over 700 patients to different levels of addiction treatment and services. Recovery coaches from CCAR will be attending the next meeting on 4/18/18 – the adult meeting - at 12:30 in room 212 to present on their work. • DMHAS is applying for SAMHSA grants; one with UConn Health as an evaluator for SBIRT; the other, project MANOR, and is with UConn Research as an evaluator for the homelessness project. • Legislation 2017 had required the Alcohol and Drug Policy Council to submit a report to	

	the legislature looking at substance use treatment referral programs established by police departments to compare with other states and make recommendations. The report has been submitted and an executive summary is on the internet and will be emailed to group. • State operated LMHAs, in collaboration with Dr. Dike, have launched mobile MAT (Medication Assisted Treatment) through ACT teams. • One of the mandates for the Synar Report is to access and report on the rate at which vendors sell tobacco to minors. Scientific surveys must be completed annually that require sampling of cigarette vendors, using minors age sixteen and seventeen, male and female, with a diverse racial mixture. Inspections are conducted annually and results are tabulated and submitted to SAMHSA as part of a block grant report. The threshold cannot exceed 20% otherwise there is a penalty. The program was started about 1990 or 1991 and was around 60-70%, which was the percentage of merchants who sold tobacco products to minors. The last report in December 2017 was below 10%. This is the second time falling below 10% was reached in 3 years. Hopefully, this trend continues and the goal is to keep it below 10% (a high rate compared to other states). • ABC presented a resource booklet called CT Connect for Families and is available on the Clearinghouse website and also the DCF website under substance abuse.	
Other Business	An article in the CT Post was on the CEO of United Services speaking about inequities in funding to different regions. Data highlighted the amount that the different LMHAs spend in different parts of the state in the range of $3,000-20,000 per client with state-operated or private along with the inequity in the number of beds. For DCF, regarding Community Based Services, extensive amounts of sizing the system is based on population. For example, Intensive In-Home Services receives a small amount of money but is not enough to provide statewide coverage. The biggest need areas tend to be Hartford, New Haven and Bridgeport. Tim Marshall offered to do an overview of the entire system, having oversight over the community based system, and suggested his colleagues, Mary Painter, Substance Abuse Director, and Jennifer Avenia present as well. This can be arranged for an upcoming agenda. A Senate bill (# 366) is before the legislature tomorrow. There was recently a similar house bill doing a study to look at funding for mental health, yet this is a Senate bill that sounds identical. There is testimony due tomorrow and a public hearing. One bill focused on children inpatient beds. The house bill is for DMHAS to study the mental health need of bed capacity for DCF. The Senate bill is for DMHAS to do the most efficient and effective means to fund mental health services and DMHAS could consult with other state agencies.	
Next Joint Meeting:	June 14, 2018 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.	

Joint DMHAS/DCF Council Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, September 14, 2017, 2:00 – 4:00 PM	
Location:	Connecticut Valley Hospital, Page Hall – Room 217	
Attendance:		
Members Present:	Lisa Jameson, Janice Bendall, Nicki Richer, Ellen Econs, Irene Herdon, Laura Watson, Doriana Vicedomini, Marcia DuFore, Nancy Alisberg, Gail Reyes-Walton, T. Kemp, Ingrid Gillespie, MuiMui Hin McCormick, Abby Wood, Jill Coffin, Kristie Barber, Margaret Watt	
Staff Present:	Mary Cummins, Jim Siemianowski, Susan Bouffard, Chrishaun Jackson	
Guest	Nan Arnstein	
AGENDA ITEM		***ACTION***
	Note: Prior to the start of this meeting, Susan conducted an Orientation to the Planning Council for new and interested members. A power point was provided which will be emailed to members.	Email Orientation power point to Planning Council.
Review of Minutes	The minutes were accepted without correction.	
Suicide Prevention/ Zero Suicide Andrea Duarte DMHAS Prevention Unit	Andrea presented a power point that provided an overview of suicide prevention efforts in Connecticut, including the Suicide Advisory Board (SAB). The state has received 3 Garrett Lee Smith grants, the most recent of which runs through 2020. Young people ages 10 – 25 and residents of Manchester, an identified "suicide hotspot", are the focus of these grants. DCF, DPH and DMHAS coordinate and braid their federal block grant funds to support suicide prevention. In 2015, CT joined the national Zero Suicide effort. Data showed increases in suicides in the state since 2008 with the recession. For communities, the Strategic Prevention Framework (SPF) is the approach utilized. For health and behavioral health care systems, the Zero Suicide model is used. There has been an overwhelming interest across the state in the Zero Suicide effort. The final part of the presentation focused on Gizmo, the therapy dog, and a book featuring Gizmo designed to educate children about mental health and how to seek help. Andrea pointed out that usual training tells children who need help to seek out a "trusted adult" without explaining what is meant by "trusted adult". Gizmo's book explains these sorts of issues to children in language they can understand.	Email copies of Andrea's presentation to members of the Planning Council.
Inpatient Hospital Study Jim Siemianowski	This item was not on the agenda as it was a last minute request by the Council chair. Jim presented a power point entitled: Psychiatric Services Study Report and provided a handout of the slides. He explained the origin of the study (and 2015 legislation) came from hospital concerns regarding access to state inpatient beds. The adult psychiatric system was the focus of this analysis. DCF did a separate section examining children's services. Assumptions were reviewed, including	Email copies of Jim's presentation to members of the Planning Council.

	the current budget realities, which limit new resources and the uncertainty over the future of the Affordable Care Act and Medicaid given the new administration. National trends were reviewed, including previous efforts to de-institutionalize psychiatric patients (as evidenced by closure of 2 of the 3 state psychiatric hospitals in Connecticut) and move them into community systems. Examining inpatient beds does not provide a complete picture without reviewing the rest of the system. Private hospital data, which must be submitted to the Office of HealthCare Access, was included as it covers bed days, utilization and capacity. Adult Inpatient Findings were that CT ranked 6th in the nation in terms of highest bed capacity with 17 beds/100,000 people. The national average was 11.7 beds/100,000 people. The number of state-operated beds has been constant (550 beds) for the past 20 years. Despite appropriate utilization of these state psychiatric beds, the turnover/discharge rate has slowed and wait times have increased from 18 to 28 days in recent years. As less complex clients have been discharged, that leaves more complicated clients in the psychiatric hospitals. An increase in beds for forensic patients (from 219 in 2000 to 232 in 2017) has also had an impact on availability of beds. The most surprising discovery, however, was that private hospitals have about 1,000 available psychiatric beds and on any given day, there are approximately 100 of these private beds that go unfilled. Part of the problem is that there is no mechanism to track real time bed availability. It was suggested that more intermediate bed capacity could relieve some of the pressure on the state beds. Outpatient Findings revealed a comprehensive array of residential beds and diversionary services positioned strategically across the state. Some patients require special discharge funds to be able to reside in the community because of the complexity of their cases, for example, a patient who has a history of arson. While residential services are appropriately utilized, movement out is insufficient for demand. Potential resources might be found at the 60 West nursing facility jointly managed by DMHAS and DOC where Medicaid is now covering services. Recommendations: Most recommendations involved enhanced management of existing resources, such as use of Community Care Teams (CCTs), which attempt to coordinate care of frequent ED utilizers, or regionalizing respite beds. Creating standardized and centralized real time tracking of bed availability was suggested to improve utilization of existing beds. Increasing the availability of high intensity residential programs, developing specialized funds/resources for patient that don't meet medical necessity, creating more intermediate beds in private hospitals, and maintaining annual increases to Discretionary Discharge funds, should funding be available, were all recommended.	
Block Grant Update Susan Bouffard	• The combined CMHS/SAPT block grant was submitted on time to SAMHSA. Comments and recommendations from the Planning Council on the block grant application, some of which resulted in changes to the selected priorities, were included in the application. The Block Grant Application and plan was also posted on the DMHAS and DCF websites and despite inviting	Susan will email the Planning Council with the date of the Public Hearing on the Allocation Plans

	public comment, none was received. This was also noted in the Block Grant Application. The SAPT project officer had already made some revision requests which have been completed. • At the moment, DMHAS is waiting for a date for the Block Grant public hearing before committees of the state legislature. All state agencies with Block Grants must complete Allocation Plans for OPM which are then presented to the state legislature committees. The Commissioner/designee for DMHAS and for DCF will provide testimony, be asked questions, and then a vote will be taken by the committees on whether or not to accept the Allocation Plans. Susan will email the Planning Council with the date of the public hearing once it is known. • DMHAS and DCF are scheduled for a formal "compliance monitoring" visit April 24-26, 2018. A team of about 8 surveyors from CMHS, CSAT, CSAP and Fiscal will arrive to conduct the visit. SAMHSA has already sent an extensive document request which is due to them this December. Provider site visits will also be a part of this compliance monitoring visit. Susan has already booked Page Hall 212 for April 25th in anticipation that members of the review team will want to meet with members of the Planning Council.	for the Block Grant once it is known.
DMHAS Update Jim Siemianowski	• In response to the Governor's Executive Order, most providers have received 5% cuts and there are cuts to the RMHBs and RACs. It is possible that a vote today will result in a budget for the state. • Jim expects the RFP will be released early next week related to consolidating the RMHBs and RACs. It's a competitive process so he is limited in what he can share. There will be a bidder's conference. Irene expressed concern that this consolidation takes the state backwards and will serve to disconnect DMHAS from communities. It was reiterated that this move is in response to the Governor's Executive Order.	
DCF Update Mary Cummins	• The Block Grant Application was re-posted on the DCF website at the direction of SAMHSA • There is a CBAC meeting scheduled for tomorrow • Many retirements of key DCF positions are scheduled for October 1, 2017 and it is unclear whether they will be able to post for these vacated positions. • Attempts are still ongoing to close CJTS. • The next Joint Council meeting is scheduled for November 9th	
Next Joint Meeting:	November 9, 2017 at CVH Page Hall, Room 217 from 2 – 4 pm.	

Joint DMHAS/DCF Council Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, November 9, 2017, 2:00 – 4:00 PM	
Location:	Connecticut Valley Hospital, Page Hall – Room 217	
Attendance:		
Members Present:	Nan Arnstein, Lisa Jameson, Janice Bendall, Ellen Econs, Laura Watson, Doriana Vicedomini, Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley	
Staff Present:	Tim Marshall, Susan Bouffard, Chrishaun Jackson	
Guest	Erika Sharilh, Chris Bory, Vinod Srihari	
AGENDA ITEM		***ACTION***
Review of Minutes	The minutes of September 14, 2017 were accepted without correction.	
STEP Presentation Vinod Srihari	The STEP program began in 2006. Their capacity is 60-70 patients. A review of global data on psychiatric illnesses showed the impact of the disability on life years and quality of life. Less than 1/3 of persons diagnosed with schizophrenia recover in 5 years. However, early detection (shortening the duration of untreated psychosis – DUP) and intensive treatment with First Episode Services (FES)/Coordinated Specialty Care (CSC) during the first 2 – 5 years of schizophrenic illness can improve the trajectory of the patient's life. Intervening earlier has durable effects on patient outcomes and is cost-effective. At the STEP program, they carefully evaluate the patient to rule out the possibility that symptoms are due to another medical condition. Treatment is "phase specific" (acute, stabilization, and recovery) and is frequently re-assessed so as to offer the appropriate treatment to the current phase of the patient. IOL and STEP work collaboratively. There is interest in developing a third FEP program (preferably in the southwestern part of the state) in order to meet demand. Elements of FES/CSC are being offered in other programs and if FEP time/staff resources were available to provide consultation, these programs could be enhanced. The programs are building a network and want to implement research findings into their programs and develop policies/procedures that reflect this information. They want to shift the data collection from quantity measures to patient-reported outcomes. Next year they want to: • Further reduce DUP • Add cognitive remediation and refine the treatment model for added efficiency • Focus on what happens to patients after their maximum 2-years with STEP • Develop a tele-consultation model (this is not funded)	Email copies of Vinod's presentation to members of the Planning Council.

	• Develop the hub-and-spoke model (this is not funded) • Link CT to the National Learning Healthcare Network which is building outcomes STEP has worked in partnership with the Prime Clinic at CMHC since 1999. Prime offers services statewide to patients in the prodromal phase – before the first episode of psychosis. Patients are able to move between clinics when their needs change. STEP is holding discussions with insurance companies and NAMI about aspects of FES that are currently unbillable, like outreach efforts and calls to family members of persons with FEP.	
Beacon Presentation Erika and Chris	Beacon and DCF entered into contract July 2017. Beacon is in a unique position as an ASO with access to all claims data. There are more than 800,000 Medicaid clients in the state and millions of associated data points. Beacon hired one position (Intensive Case Manager) to conduct outreach and referral for 16-26 year old Medicaid members identified via claims data with: • Schizophrenia diagnosis in the past 6 months • An anti-psychotic prescription filled in the last 6 months • No such data in the prior two years The ICM receives a monthly list of members meeting the above criteria and if the member was not on the prior months' list, they are contacted. This approach netted 97 members the first month and numbers in the 80s for subsequent months. There are plans to test sensitivity and validity (false positives/false negatives) of the criteria and refine. Depending on the criteria selected, the "gate" can be widened or narrowed. If persons are identified and they are outside of the 16-26 year old age group, they can be provided other referrals by the ICM. Single case agreements are also possible. At Beacon, internal training of staff has been provided so if a member calls seeking FEP resources, they will be appropriately referred. Next steps include evaluating statewide capacity, including programs that may offer FES elements and resources. It was suggested that private insurance companies may be motivated to provide the same services because of the cost-savings.	Bring Beacon representatives back for periodic updates.
Block Grant Update Susan Bouffard	DMHAS is actively working on completing the following: • Annual MH and SU reports which are due December 1st • Annual Synar report which is due December 31st • Document request associated with the Compliance Monitoring visit scheduled for April of 2018 DMHAS and DCF participated in a phone call with SAMHSA regarding the document request for the Compliance Monitoring visit. The only selection of a provider site to visit so far is Intercommunity's Coventry House. It is expected that additional sites will be selected. It was also clarified during the phone call that the prevention representatives will participate in tobacco	

	merchant retailer inspections during their visit.	
DCF Update Tim Marshall	• CJTS is still expected to close July 1, 2018 with admissions stopping January 1, 2018. Funding that previously was directed to DCF for CJTS will be redirected to CSSD/Judicial. Funds were braided and have to be unbraided which may leave other programs with insufficient funding. It may take 1 – 2 years to complete this process and make adjustments. DCF funds have been reduced by 100 million dollars and another 70 million in reductions are anticipated.	
DMHAS Update Susan Bouffard	• Susan reported that DMHAS has been awarded year 2 of funding for the STR grant.	
Next Joint Meeting:	March 8, 2018 at CVH Page Hall, Room 217 from 2 – 4 pm.	

How was the Planning Council involved in the development and review of the state plan and report?

The Planning Council has been involved throughout the various stages of planning, development and review of all block grant required reports and plans. As can be seen in the attached meeting minutes, updates are provided at each Council meeting by the state planner, including information about upcoming webinars, opportunities for technical assistance, SAMHSA initiatives, Connecticut budget concerns, progress on block grant priorities, and any pending report/application requirements, revisions and deadlines. Time is made available for questions and discussions on anything related to the block grants. A summary of the content of the plans/reports is shared with the Council membership during regularly scheduled meetings, with particular focus on the selected priorities. When plans/reports are completed, they are shared electronically with the Planning Council and posted on the departments' website. The website invites all viewers to comment and make recommendations. In response to questions from the Planning Council, time has been devoted to explaining the parameters within which priorities are selected (e.g., required priority categories, the need for measurable indicators, etc.) Similarly, time has also been taken to explain the state's legislatively mandated Allocation Planning process for each federal block grant received by a state department. The completed Allocation Plans are presented by the Commissioners of the respective state departments in a public hearing to which all Planning Council members are invited to participate.

For the mini-app, the Council was informed about the due date and the information requested. The Planning Council has also been provided an update of the status of the 2018-2019 priorities for that point in time which precipitated questions and discussion about some of the priorities and the priority setting process and how it might evolve. This also led to a discussion of Council membership as well. The mini-app has been sent electronically to the Council members and has been posted on the departments' website inviting public comment.

The Planning Council was invited to participate earlier in 2018 when DMHAS had its routine compliance monitoring visit from SAMHSA and it was reported afterward that several members participated.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2019 End Year: 2020

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Nancy Alisberg	Providers		846 Wethersfield Avernue Hartford CT, 06114 PH: 860-297-4300	nancy.alisberg@disrightsct.org
Tiffanie Allain	Providers	PATH	277 South Street Brooklyn CT, PH: 860-412-0041	tallain@pathct.org
Nan Arnstein	Providers	Creative Arts for Developng Minds	141 Weston Street Hartford CT, 06142 PH: 860-834-3359	narnstein@creativeartsdm.org
Margaret (Peggy) Ayer	Parents of children with SED		151 Pond Road North Franklin CT, 06254-1224 PH: 860-642-4348	msayer7@comcast.net
Janice Bendall	Others (Not State employees or providers)		48 Barlett Hollow Road Middletown CT, 06457 PH: 203-645-3602	jnbendall@comcast.net
Eileen Bronko	Parents of children with SED		34 Fairfield Court Naugatuck CT, 06770 PH: 203-723-0875	ebronko1@snet.net
Craig Burns	State Employees	Dept. of Correction	24 Wolcott Hill Road Wethersfield CT, 06109 PH: 860-692-6262 FX: 860-730-8287	craig.burns@ct.gov
Erica Charles-Davey	Parents of children with SED		247 Coliins Street 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 Street West Haven CT, 06516 PH: 203-933-4272	
Michele Devine	Others (Not State employees or providers)		Eastern Regional Behavioral Health Action Organization Norwich CT, 06360 PH: 860-848-2800	serac.ed@sbcglobal.net
Deron Drumm	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Advocacy Unlimited	300 Russell Road Wethersfield CT, 06019-1346 PH: 860-667-0460 FX: 860-666-2240	ddrumm@mindlink.org
			North Central	

Marcia DuFore	Others (Not State employees or providers)		Regional Behavioral Health Action Organization Hartford CT, 06106 PH: 860-667-6388 FX: 860-667-6390	mdufore@ncrmhb.org
Ellen Econs	State Employees	Bureau of Rehabilitation Services	410 Capitol Avenue Hartford CT, 06134 PH: 860-308-4523 FX: 860-262-5852	ellen.econs@ct.gov
Kathy Flaherty	Others (Not State employees or providers)	Connecticut Legal Rights Project	CVH Middletown CT, 06457 PH: 860-262-5033 FX: 860-262-5035	kflaherty@clrp.org
Robert (Bob) Francis	Others (Not State employees or providers)		Southwest Regional Behavioral Health Action Organization Bridgeport CT, 06605 PH: 203-579-2727 FX: 203-333-9118	rfrancis@ryasap.org
Allison Fulton	Others (Not State employees or providers)		Northwest Regional Behavioral Health Action Organization Bethel CT, 06801 PH: 203-743-7741	allison.fulton@hvcasa.org
Ingrid Gillespie	Others (Not State employees or providers)	Connecticut Prevention Network	c/o LFRAC Stamford CT, 06901 PH: 203-391-7914 FX: 203-967-9476	igillespie@communities4action.org
Susan Graham	Parents of children with SED		141 High Street Thomaston CT, 06787 PH: 860-309-4322	sgraham141@yahoo.com
Natine Haley	Parents of children with SED		241 Jackson Avenue Stratford CT, PH: 203-345-1836	msj32361@yahoo.com
Gabrielle Hall	Providers	Beacon Health Options	500 Enterprise Drive Rocky Hill CT, 06067 PH: 860-707-1016	gabrielle.hall@beaconhealthoptions.com
William (Bill) Halsey	State Employees	Dept. of Social Services	25 Sigourney Street Hartford CT, 06106-5033 PH: 860-424-5077 FX: 860-424-4812	william.halsey@ct.gov
Josephine Hawke	Parents of children with SED		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		73 Governor Street East Hartford CT, 06108	brenetta.henry@yahoo.com
			49 Bogue Lane East	

Irene Herden	Others (Not State employees or providers)		Haddam CT, 06423-1442 PH: 860-873-1999 FX: 860-873-1999	evherd@comcast.net
Mui-Mui Hin-McCormick	Others (Not State employees or providers)	CT Council on Problem Gambling	100 Great Meadow Road Wethersfield CT, 06109 PH: 959-230-4034	muimuihm@ccpg.org
Lisa Jameson	Parents of children with SED		112 Bell-Aire Circle Windsor CT, 06096 PH: 860-623-5790	lisajameson22@gmail.com
Magdalena Lekarczyk	State Employees	CT Office of Policy & Management	450 Capitol Avenue Hartford CT, 06106 PH: 860-418-6405 FX: 860-418-6490	magdalena.lekarczyk@ct.gov
Ann Lenz	State Employees	Connecticut Valley Hospital	PO Box 351 Middletown CT, 06457 PH: 860-262-7208 FX: 860-262-5895	ann.lenz@ct.gov
Tim Marshall	State Employees	Dept. of Children & Families	505 Hudson Street Hartford CT, 06105 PH: 860-550-6531 FX: 860-556-8022	tim.marshall@ct.gov
Mary Martinez	Family Members of Individuals in Recovery (to include family members of adults with SMI)		7 Mary Shepard Place Hartford CT, 06120 PH: 860-719-5080	mryadvcomm35@gmail.com
Pamela Mautte	Others (Not State employees or providers)		South Central Regional Behavioral Health Action Organization Ansonia CT, 06401 PH: 203-892-6418 FX: 203-736-2641	pmautte@bhcare.org
Debbie McCusker	Parents of children with SED		35 Maywood Street Waterbury CT, 06704 PH: 203-757-7569	jamesmccusker@sbcglobal.net
George McDonald	Parents of children with SED		PO Box 2617 Hartford CT, 06146 PH: 860-794-6283	
Evelyn Melendez	Parents of children with SED		50 Larrabee Street Apt D East Hartford CT, 06108 PH: 860-890-2469	
Carol Meredith	State Employees	DMHAS - Prevention	410 Capitol Avenue Hartford CT, 06134 PH: 860-418-6826 FX: 860-418-6792	carol.meredith@ct.gov
Scott Newgass	State Employees	State Dept of Education (SDE)	25 Industrial Park Road Middletown CT, 06457 PH: 860-807-2044 FX: 860-807-2127	scott.newgass@ct.gov
			185 Silas Dean	

Daisy Olivo	Providers	FAVOR, Inc.	Highway Wethersfield CT, 06109 PH: 860-837-1436	dolivo@favor-ct.org
Maureen O'Neill-Davis	Parents of children with SED		Attachment Trauma Network Torrington CT, 06790 PH: 561-762-4747	maureenod65@gmail.com
Daisy Ortiz	State Employees	Court Support Services Division (CSSD)	Solnit Children's Center Middletown CT, 06457 PH: 860-704-4014	daisy.ortiz@jud.ct.gov
Commissioner Raul Pino	State Employees	CT Dept. of Public Health	410 Capitol Avenue Hartford CT, 06106 PH: 860-509-7101 FX: 860-509-7111	raul.pino@ct.gov
Nikki Richer	State Employees	DMHAS - Young Adults	CVH Middletown CT, 06457 PH: 860-262-6995 FX: 860-262-6980	nikki.richer@ct.gov
Barbara Roberts	Family Members of Individuals in Recovery (to include family members of adults with SMI)		42 School Street Woodbury CT, 06798 PH: 203-263-3250	barbara114@sbcglobal.net
Janine Sullivan-Wiley	Others (Not State employees or providers)		69 Stony Hill Rd Bethel CT, 06801 PH: 203-743-7741	jsw@nwrmhb-ct.org
Peter Tolisano	State Employees	Dept. of Developmental Services	460 Capitol Avenue Hartford CT, 06106 PH: 860-418-6086	peter.tolisano@ct.gov
Benita Toussaint	Parents of children with SED		45 Niles Street Hartford CT, 06105 PH: 860-249-4806	toussaintbenita@yahoo.com
Ofelia Velazquez	Parents of children with SED		180 Broad Street Hartford CT, 06114 PH: 860-313-9130	ovy4252@yahoo.com
Doriana Vicedomini	Parents of children with SED		9 Kingfisher Lane Suffield CT, 06078 PH: 504-259-4327	dmv35@aol.com
Laura Watson	State Employees	Dept. of Housing	505 Hudson Street Hartford CT, 06106 PH: 860-270-8169 FX: 860-706-5741	laura.watson@ct.gov
Margaret Watt	Others (Not State employees or providers)	Healthy Minds Connecticut	1 Park Street Norwalk CT, 06851 PH: 203-840-1187	mwatt@healthymindsCT.org
Cara Westcott	Providers	United Community and Family	UCF Health Center Norwich CT, 06360-2315 PH: 860-892-7042 FX: 860-886-6124	cwestcott@ucfs.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2019 End Year: 2020

Type of Membership	Number	Percentage
Total Membership	**54**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	1	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	15	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	12	
Total Individuals in Recovery, Family Members & Others	**35**	**64.81%**
State Employees	13	
Providers	6	
Vacancies	0	
Total State Employees & Providers	**19**	**35.19%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**9**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] 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,** , 2016 (P.L. 114-113) signed by President Obama on December 18, 2015[3].

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 a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification 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 modifying the 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[4]. 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[5]: 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 ServicesPrograms,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 when requesting a modification to the state?s 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017* 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
- Obtain State Project Officer Approval
- Collect **all** SSP information on **Table B** listed below to be reported in the FFY 2019 SABG report due December 1, 2018

End Notes

[1] 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 2016 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 an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2]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 persons who inject drugs (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.

[3] 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, 2016 (P.L. 114- 113)

[4] 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.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes a 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 of 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 a 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 a 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.

Footnotes:

Currently in Connecticut, the Department of Public Health (DPH) operates 7 Specialized Syringe Programs (SSPs) across the state. DMHAS is not proposing to use SABG funds for elements of SSPs.

DMHAS is not proposing to use SABG funds for elements of specialized syringe programs (SSPs).

Currently in Connecticut, the Department of Public Health (DPH) operates 7 SSPs:

AIDS CT	Hartford
Alliance for Living	New London
AIDS Project Greater Danbury	Danbury
Greater Bridgeport Harm Reduction Program (GBAPP)	Bridgeport
Greater Hartford Harm Reduction Coalition (GHHRC)	Hartford
New Haven Health Department	New Haven
Perception Programs	Willimantic

SSPs are an effective public health approach to decrease the spread of HIV/AIDS and other blood-borne diseases. Services include provision of clean syringes, collection of used syringes, harm reduction education, HIV and Hepatitis C screening, overdose prevention education, referrals to substance use treatment programs, STD screening and other ancillary services. For the first 6 months of 2018, DPH has collected the following data from its SSPs:

Syringes	**January**	**February**	**March**	**April**	**May**	**June**
Collected	20,922	17,260	15,379	19,149	21,467	19,168
Distributed	38,537	34,198	35,507	40,134	50,073	50,556

A total of 1,615 unduplicated clients were served in these SSPs from January – June 2018, 50% (806) of the clients were new.

The most recent data from the CT DPH on Hepatitis C rates shows:

	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2014**	**2015**	**2016**
# cases	20	19	54	36	47	34	9	15	18

Likewise, data from the CDC's HIV Surveillance Report, vol. 28 for the most recent years available shows:

2015						**2016**					
Adults/adolescents		**Children**		**Total**		**Adults/adolescents**		**Children**		**Total**	
#	**rate**	**#**	**rate**	**#**	**rate**	**#**	**rate**	**#**	**rate**	**#**	**Rate**
273	8.9	2	0.4	274	7.7	251	8.2	2	0.4	253	7.1

In summary, CT already possesses SSPs in its urban areas and they are effectively distributing and collecting syringes while they attempt to engage PWID in services. At the same time, rates for Hepatitis C have declined since they peaked nearly a decade ago and new HIV infections continue to decline as they have over the past several years.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

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

Footnotes:
Currently in Connecticut, the Department of Public Health (DPH) operates 7 Specialized Syringe Programs (SSPs) across the state. DMHAS is not proposing to use SABG funds for elements of SSPs.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table B

			[Please enter total number of individuals served]				
Syringe Service Program Name	**# of Unique Individuals Served**		**HIV Testing**	**Treatment for Substance Use Conditions**	**Treatment for Physical Health**	**STD Testing**	**Hep C**
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

Footnotes:

Currently in Connecticut, the Department of Public Health (DPH) operates 7 Specialized Syringe Programs (SSPs) across the state. DMHAS is not proposing to use SABG funds for elements of SSPs.

Environmental Factors and Plan

24. 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.

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

Footnotes: