Connecticut

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/29/2021 2.24.29 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 2022

End Year 2023

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 Michael

Last Name Girlamo

Agency Name Department of Mental Health and Addiction Services

Mailing Address P.O. Box 341431 410 Capitol Avenue

City Hartford

Zip Code 06134

Telephone 860-418-6919

Fax 860-418-6896

Email Address Michael.Girlamo@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 Michael

Last Name Girlamo

Agency Name Department of Mental Health and Addiction Services

Mailing Address	410 Capitol Ave
City	Hartford
Zip Code	06134
Telephone	(860) 418-6919
Fax	860-418-6896
Email Address	Michael.Girlamo@ct.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Michael
Last Name	Girlamo
Telephone	860-418-6919
Fax	860-418-6896
Email Address	Michael.Girlamo@ct.gov

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

Footnotes:

State Information

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

Fiscal Year 2022

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.

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

Footnotes:

State Information

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Fiscal Year 2022

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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**
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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.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

American Rescue Funding Plan
Center for Mental Health Services (CMHS)
State of Connecticut Department of Mental Health and Addiction Services (DMHAS)

1. **Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.**

Connecticut has identified a number of needs and gaps in our state's mental health service system for persons with serious mental illness. However, the state has decided to focus on addressing needs and gaps in two areas that are part of SAMHSA's set-aside requirements for the Center for Mental Health Services (CMHS). DMHAS will use American Rescue Plan Act (ARPA) Funding to meet requirements for First Episode Psychosis (10%) and will use the remainder of the funding to enhance the state's crisis response system. DMHAS will go well beyond the required crisis set aside (5%) and use the remainder of the ARP funding to address needs and gaps associated with developing a comprehensive crisis response system. Therefore, the needs and gaps that we will discuss are more limited and will only focus on two distinct need areas, FEP and Crisis Services. Needs and gaps associated with FEP will be discussed below while the needs associated with the development of our crisis response system will be discussed in Question 2 below since that question deals specifically with the needs and gaps that exist within our crisis service continuum.

First Episode Psychosis (FEP)

Individuals with FEP meet criteria for serious mental illness within the DMHAS service system. Clearly anybody dealing with FEP is struggling with a serious mental illness. Without early intervention, these individuals are likely to have pervasive, long-term negative effects associated with schizophrenia. DMHAS has been providing services to these individuals for almost ten years, aggressively working to intervene early in order to minimize negative aspects of the disease. Currently Connecticut has only been able to make formal FEP services available in two of our larger metropolitan areas, Hartford and New Haven. Funding that has previously been made available did not allow DMHAS to create additional FEP programs in other areas of the state due to the high cost of developing and staffing new programs. There are individuals struggling with FEP that are unable to travel to Hartford or New Haven to receive services or they may receive brief inpatient services at psychiatric hospitals in those areas. However, when they transition back to their communities of origin they do not have the support of trained staff that are familiar with the unique challenges of FEP. Across the state there is also a shortage of trained professionals capable of providing FEP services to those individuals unable to travel to Hartford or New Haven for services. As a result of this shortage, there is a need to increase training and technical assistance, expand workforce development activities, and increase data analysis to better understand where the greatest needs exist. The data analysis is an important component of our FEP service spectrum as it allows us to target services more effectively.

The need for FEP services has been demonstrated through a collaborative effort between the State's Department of Children and Families (DCF) and Beacon Health Options. DMHAS has worked with these partners on an innovative data harvesting project to better understand the need in the state for FEP services. Beacon uses Medicaid claims data along with other information to identify those individuals who appear to be having a first episode psychosis. Since this began in September 2017, over 330 individuals across the state have been identified as being part of this cohort. In the most recent annual report provided to DCF, Beacon identified 166 individuals that received FEP coordination services.

This data only reflects Medicaid claims so the number of individuals experiencing first episode psychosis is estimated to be significantly higher. Many of these individuals do not reside in the greater Hartford or New Haven metropolitan areas and are in need of the specialized supports that a FEP program can provide. In the absence of a unique program, they minimally need to be served by staff that understand the unique needs of those suffering with first episode psychosis.

The pandemic also negatively impacted persons with FEP that were already enrolled in our FEP programs because services were restricted due to social distancing requirements. Group activities, an important component of our FEP programs, could not be provided because of these restrictions. FEP services, like all outpatient mental health services in the state were restricted and limited. Vocational opportunities and core services like transportation were restricted as well.

2. **Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.**

The pandemic has also increased the demand for crisis services in the state. This has been demonstrated in increased volume in crisis services and in increased calls to the state's 211 call line. In Fiscal Year 2020, DMHAS Mobile Crisis Teams served a total of approximately 5,176 clients. Of those clients 46% were female and 54% were male. Of the total clients served 51% were Caucasian, 19% were African American, 1% were Asian, 17% were of unknown ethnicity and 10% were documented as "other" ethnicity. In terms of age, 16% were between the ages of 18-25, 19% were between the ages of 26-34, 17% were between the ages of 35-44, 19% were between the ages of 45-54, 17% were between the ages of 55-64 and 10% were age 65 or over.

Data pulled from DMHAS' Enterprise Data Warehouse (EDW) shows that the number of unduplicated clients served in the first 6 months of FY 21 has increased by 41% when compared to the same period in FY 20. This increased need has also been demonstrated in increased call volume to 211, the state's information and referral service. When the pandemic began to spread in Connecticut, the state increased their contract with 211. Data provided to DMHAS from United Way 211 show that calls increased considerably in 2020. 211 responded to 72,158 calls in 2020 compared to 61,873 in 2019. This is an almost 17% increase from 2019.

While Connecticut has essential components of a comprehensive crisis system, needs and gaps do exist. The adult crisis service system in the State of Connecticut is comprised of a 24/7 crisis call center, the

Adult Crisis Telephone Intervention and Options Network (ACTION line); 18 mobile crisis teams (MCT) available to respond to individuals in distress where they are located at the time of crisis; and, 16 crisis respite programs which are located across the state. There are over 100 respite beds in the state. The ACTION line is available 24 hours a day, 7 days a week and services include telephonic support, referral to the MCT of the area through a three-way call, information about resources/services, afterhours telephonic coverage for some MCTs and if needed, direct connection to 911. More staffing is needed to increase capacity of the ACTION Line and the National Suicide Prevention Lifeline (NSPL) which is operated by The United Way of CT.

The greatest need exists in the call center where answer rates for crisis calls and wait times are well in excess of recommended standards. Between January 2021 through May 2021, the United Way of CT contact specialist answered 4,402 NSPL calls and 14,553 ACTION line calls. With the implementation of 988, we suspect an increase in call volume as well as a need to staff NSPL chat and text lines. Another factor to consider is the intent and work being done to divert calls from 911 to 988 which will also increase call volume. The current NSPL in-state answer rate is 67% which will need to increase to 90% according to the requirements of the 988 Implementation and Planning Grant awarded by Vibrant. The ACTION line became available in August 2020 and has developed warm transfers protocols for each mobile crisis team as of mid-December 2020. Wait times for the ACTION line between January 2021 and May 2021 average 4.8 minutes, much longer than then 30 seconds recommended by Crisis Now.

Another need that exists is related to our adult mobile crisis teams. The adult mobile crisis teams respond to individuals in distress located in their catchment area made up of various cities and towns throughout the State. However, most of the MCTs do not operate 24/7. The mission of the mobile crisis teams is to provide persons in distress (crisis) immediate access to a continuum of crisis response services of their choice including, mobile clinical services, peer support services and community supports; to promote the prevention of crises among persons and families; and to provide postvention activities that support persons in developing a meaningful sense of belonging in their communities. While the mobile crisis teams offer many of the same services and supports including outreach and education, risk assessments, evaluation of needs, telephone support, information and referral, follow up services, crisis/safety planning and other prevention and postvention efforts, the teams differ in size, staffing and hours of operation. Ideally, all 18 mobile crisis teams would be available to individuals in crisis, their family and friends, law enforcement and all citizens 24/7. While DMHAS has made enhancements to our MCT's, this is another aspect of our crisis continuum that needs to be further strengthened in order to be able to respond 24/7. Additionally, the MCTs do not consistently respond to community crisis calls in pairs of two, as recommended in the SAMHSA National Guidelines for Behavioral Health Crisis Care. These last two issues will not be the focus of how ARP funds will be used.

3. **Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.**

Connecticut intends to use this round of funding in a very targeted manner, focusing solely on our required set-asides. DMHAS allocates 30% of these funds to our sister agency, the Department of Children and Families (DCF) for mental health services to children with SED. DCF will be submitting a

separate plan and need analysis regarding how their funds will be spent. Connecticut DMHAS intends to use the funds to address FEP needs while enhancing our crisis system in order to address deficiencies specifically related to our call center. Our plan is organized around these two areas and the activities are designed to address these gaps over the four-year period of the funding. DMHSA will use 10% of the grant for FEP and the remainder of the adult-specific funds will be directed at gaps within our crisis service continuum.

The table below shows how our plan is organized around these areas with specific activities and funding designed to address these gaps. A brief explanation of the activities that will be used to address the need is included as a component of the Table. These activities not only meet requirements for set-asides but they clearly align with activities suggested by SAMHSA in the notification letter for these American Rescue Funds. The table below shows the major areas of need, the proposed activities to address those areas, and the projected costs for each activity in Years 1 through Year 4 of the American Rescue Funding.

The plan also includes a major Need Area for Children's Services. As stated previously, DMHAS allots 30% of all Mental Health Block Grant funds to the state Department of Children and Families. They are submitting a separate needs assessment and spending plan that will be included with this submission. The other need area has been separated out to show spending for the FEP set-aside. Please note that DMHAS is proposing to spend more than the required $% Crisis set-aside. Crisis services that DMHAS plans to include in our Plan are grouped under the Crisis Services Need Area in the table below.

Major Need/Set Aside Area	**Activity**	**Cost Y1**	**Cost Y2**	**Cost Y3**	**Cost Y4**
Child Services DCF (30% of total supplemental funds	See Separate plan and needs assessment	$1,037,983	$1,037,983	$1,037,983	$1,037,983
FEP	Expand FEP services by providing support for the devpt. Of an FEP Early Intervention center which will provide TA and consultation to underserved areas of the state, learning collaborative,	$242,196	$242,196	$242,196	$242,196
Crisis Services					
Crisis Services Funding meets and exceeds our required set-aside	Provide funding to United Way 211 to significantly increase call center staffing	$2,179,765	$2,179,765	$2,179,765	$2,179,765

	in order to reduce call wait times for crisis services.				
Total CT DMHAS		$2,421,961	$2,421,961	$2,421,961	$2,421,961

4. **Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.**

As stated earlier, Connecticut intends to use these funds in a more targeted manner to address required set asides and deficits that exist within our crisis response system. Our plan to address FEP will be discussed under Question 6 below which is focused on FEP. Our primary focus for the remainder of ARP funds is to ensure that our crisis response system is responsive to the needs of persons with SMI and SED. The supplemental funding provides additional resources to assist Connecticut to enhance crisis services bringing them more in line with the National Guidelines for Behavioral Health Crisis Care. The Best Practice Toolkit describes four essential components of care as follows:

Regional or statewide crisis call centers coordinating in real time;

Centrally deployed, 24/7 mobile crisis;

23-hour crisis receiving and stabilization programs; and

Essential crisis care principles and practices.

Connecticut has worked to systematically enhance our crisis response system. Prior funding opportunities have permitted us to enhance our mobile crisis teams by increasing staffing and hours of operation within our mobile crisis teams. Previous funding has also been directed at increasing staffing in our statewide crisis call center but that funding was insufficient to address call response times and wait times which were significantly below industry standards. When one considers our respite programs, Connecticut has each of the components described in the National Guidelines Toolkit but needs and gaps exist within the continuum we have developed. This is especially true in relation to our Call Center which does not meet standards for call answer rates and response times. The activities we plan to fund will specifically target this gap as Connecticut will provide significant funding to United way 211 to enable them to increase staffing to meet the demand they are experiencing. The funds will be provided to United Way in each of the 4 years of the grant, significantly improving our crisis continuum.

As stated in Section 2 above, one of the major need areas was increased demand for crisis services. Our plan includes a range of activities that are consistent with the essential components listed above. In Connecticut, an adult crisis call center has been established to provide 24/7 telephone support, screening, assessment and referrals to mental health and substance use services. The United Way of CT (UW) is the provider of the adult crisis call center, otherwise known as the Adult Crisis Telephone Intervention and Options Network or ACTION line. The UW is also the single National Suicide Prevention

Lifeline (NSPL) center in our State. Funding towards additional staffing for the NSPL line, especially during the 988 implementation process, will ensure CT's capacity to meet the projected increased demand and the very first essential element of an ideal crisis system. Crisis call lines are an entry point into the crisis service continuum and it is critically important to ensure they are easily accessible and responsive to the needs of individuals in distress.

The increased staffing for the call center will increase our answer rates which are only 67% at this time. The staffing increase will help us to better respond to increased call volume that resulted from the pandemic. The additional staff will also help to reduce wait times in order to bring us more in line with industry standards. This funding address a major need associated with our crisis system. We have been able to use previous funding to enhance our mobile crisis teams and this round of funding ensures the further development of our crisis continuum of care.

5. **Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.**

The CT Department of Mental Health and Addiction Services collaborates with many departments and agencies in all areas of work. Specific to crisis services, we have a bifurcated system in CT and our sister agency, The Department of Children and Families (DCF), offers crisis services to youth in our State under the age of 18. We have partnered with DCF and the UWC around the planning and implementation of 988. Additionally, a 988 coalition was formed and has been meeting monthly. The coalition includes representatives from peer-run, peer-support service provider agencies, individuals with lived experience with suicide loss, Crisis Intervention Team (CIT), law enforcement, higher education, providers of crisis respites and adult and youth mobile crisis teams, state oversight body of the 9-1-1 system, state suicide prevention coordinator, individuals from the African Caribbean American community, Tribal representative, major state mental health advocacy groups, Regional Behavioral Health Action Councils, and Veteran Suicide Prevention. The purpose of the coalition is to identify needs and to develop in the areas we are required to expand in terms of the NSPL and the continuum of crisis services and to make recommendations. The mobile crisis team providers meet monthly to increase education and training, with emphasis on training and education to foster the adoption of person-centered, family-oriented, strength based, and culturally competent practices that will strengthen the ability for teams to connect individuals to an array of services and supports in their local communities. The goal is to enhance crisis services by understanding and implementing essential principles and practices, such as the ones recommended by the National Alliance for Suicide Prevention in the Crisis Now document and the SAMHSA Guidelines for Best Practice in Crisis Care, embracing recovery, significant role for peers, trauma-informed care, suicide safer care, safety/security for all and crisis response partnerships with law enforcement. The Learning Collaborative also serves as a venue to create crisis stakeholder workgroups for the purpose of developing concise standards and practics for crisis services.

Since 2003, DMHAS has contracted with the Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE), to provide training on the Crisis Intervention Team (CIT) model to police officers, State police, and campus/university police. CIT is a best practice designed to provide a collaborative and integrative approach that offers law enforcement the knowledge and resources to connect people who are

experiencing behavioral health symptoms to supports and services that will best meet their needs and divert them from arrest and/or incarceration, promote safety for persons in crisis, the community, and the police officers who respond to crisis calls. CIT training is also available to MCT clinicians of all 18 teams.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

As described earlier there are areas of the state without FEP programs due to the costs associated with creating these programs. In addition, there is a shortage of trained clinical staff that can take on a more active leadership role in developing and delivering FEP services in these underserved areas. In addition, there is a need to better understand geographic areas where the greatest needs exist. DMHAS will provide all of the adult portion of FEP funds to the STEP program to assist with workforce development, FEP model dissemination, and data analysis. STEP is a nationally recognized FEP program located in New Haven

The time-limited (2021-24) supplement will be used to leverage an existing Public-Academic collaboration to provide more durable impact on the large unmet need in the State with respect to new onset psychotic disorders. The STEP Program will (i) significantly amplify ongoing activities in workforce development, informatics and care model dissemination and (ii) work closely with DMHAS to assess gaps in care that can inform targeting of resources across the State and proposals for necessary additional sources of funding (philanthropy, CSR, foundation grants) that will be necessary to fill these gaps. This will be done by creating an FEP Early Intervention Center that will provide the activities that are listed below. Since its inception, the STEP Program has innovatively combined funding to provide needed services. The FEP Early Intervention Center will use ARP funds along with other sources of support in order to create and sustain this Early Intervention Center. The activities the Center will provide are described in greater detail below.

A. Workforce development: STEP has piloted a statewide learning health collaborative (https://www.ctearlypsychosisnetwork.org) that provides (i) community education; (ii) family support and (iii) workforce development (with ECHO style case-based learning). Additionally, STEP has developed a structured curriculum for those clinicians who wish to take on a more active, leadership role in delivering FEP services. *ARPA/FEP funding will be used to amplify these activities and allow deliberate recruitment of clinicians to represent all LMHA based regions of the State*.
B. Dissemination of Population Health (PH) model: STEP Program staff will be leveraged to present to and collaborate with leaders across State LMHAs to develop a strategy that has the 4 core PH elements:
    - Regionally specific: models of early detection and treatment that are responsive to local needs and resources;
    - Includes all relevant stakeholders within and outside the healthcare system (e.g. education, clergy, consumer organizations, criminal justice, etc.);
    - Focus on equity, including social and structural determinants of health, in addition to medical care;
    - Focus on measuring and addressing disparities in access and care quality.

Specific activities will depend on the needs identified in each LMHA, but will include webinars, technical assistance to individual agencies, evidence-based training materials and ongoing consultation. Also, activities to extract and analyze databases (e.g. ACPD, EMRs, other State databases) to assess burden of illness and unmet need across the State will permit targeting of dissemination activities. Finally, peer-support models will be explored with established partners of STEP to explore broader application within the Learning Health Collaborative.

C. Informatics: STEP has developed a freeware platform ('ONE') to enable collection of standard data elements during the course of care delivery, regular review of population outcomes via curated data analysis and visualizations with the overall goal of enabling performance improvement across PH relevant domains. *ARPA/FEP funding will enable STEP to assist services in implementing this informatics approach to monitor and improve care.*

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

The state plans to concentrate these funds on the required set-asides (FEP and Crisis Services) and will use the remaining funds to focus solely on enhancing the crisis system, especially in relation to our Call Center which has high call volume and response wait times that do not meet requirements for call center response times.

8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section. Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload

This question does not apply to our Plan. We do not plan to use funds for any IT projects.

State Information

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

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program as
authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
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 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**
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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee[1]: 

Title: Governor Date Signed: 08/25/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents. OMB

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

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

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

Footnotes:

Children's plan Step I
Assess the strengths and needs of the service system to address the specific populations. Include a discussion of the current service system's attention to the priority population children with SED.

Section I State Information

Overview
Connecticut
Geographically, Connecticut is a small state and is ranked 48th in size by square area with approximately 5,500 square miles. Connecticut is the 29th most populated state with 3.6 million residents of whom 735,969 (or 20.6 are children and youth). Children with Serious Emotional and Disturbance are estimated at 10% or over 73,500 children. Approximately 24% or 868,332 are youth under age 20; 51% are male and 49% female. The racial breakdown includes: .3% American Indian, 4% Asian, 12% Black/African American, 6% other, 6% biracial, and 69% White. Additionally, 22% of our youth identify as Hispanic/Latino. Nationally 2.4% of youth identify as gay or lesbian and 8% as bisexual, or about 8,600 CT youth. The median household income in CT is $71,755, with 14% of children under 18 living in poverty. Approximately 40% of CT's children are Medicaid eligible. The contrast in Connecticut is of some of the largest gaps between the richest and poorest residents.

Geographically, Connecticut is a small state and is ranked 48th in size by square area with approximately 5,500 square miles. Connecticut is the 29th most populated state with 3.6 million residents of whom 856,306 (or 20.4% are children and youth). Children with Serious Emotional and Disturbance are estimated at 10% or over 73,500 children. Approximately 24% or 868,332 are youth under age 20; 51% are male and 49% female.

The racial breakdown includes: .6% American Indian, 5% Asian, 12% Black/African American, 6% other, 6% biracial, and 77% White. Additionally, 16% of our youth identify as Hispanic/Latino. Nationally 2.4% of youth identify as gay or lesbian and 8% as bisexual, or about 8,600 CT youth. The median household income in CT is $81,215, with 13.8% of children under 18 living in poverty. Approximately 40% of CT's children are Medicaid eligible. The contrast in Connecticut is of some of the largest gaps between the richest and poorest residents.

While approximately 10% of Connecticut (CT) youth have SED and need intensive mental health services, the use of restrictive services remains too high and there is a need for more services/supports to occur through integrated community based care. In 2018, CT Medicaid paid for 2,320 youth inpatient psychiatric stays, for a total number of 27,262 inpatient days; and 195 psychiatric residential treatment facilities (PRTF) admissions for a total number of 33,909 days. In addition, there were over 14,000 behavioral health emergency department (ED) visits. In 2017, CT experienced 3 suicides per 100,000 youth.

With lifetime prevalence of schizophrenia spectrum disorders at 1 percent, an estimated 600 CT emerging adults annually need evidence-informed early psychosis services.

The Department of Children and Families (DCF)

DCF's central focus is working together with families and communities to improve child safety, ensure that more children and youth have permanent families, and to advance the overall well-being of children, youth and families DCF protects children who are being abused or neglected, strengthens families through support and advocacy, and builds on existing family and community strengths to help children and youth who are facing emotional and behavioral challenges.

DCF, established under Section 17a-2 of the Connecticut General Statutes, is one of the nation's few agencies to offer child protection, behavioral health and prevention services. This comprehensive approach enables DCF to offer quality services regardless of how a child's problems arise. Whether children and youth are abused and/or neglected, or have emotional, mental health or substance abuse issues, the Department can respond to these children and youth in a way that draws upon community and state resources to help. DCF recognizes the importance of family and strives to support children and youth in their homes and communities. When this is not possible, a placement that meets the child's individualized needs in the least restrictive setting is pursued. When services are provided out of the child's home, whether in foster care, residential treatment or other facilities, they are designed to return children safely and permanently back to the community.

DCF supports in-home and community-based services through contracts with service providers. In addition, the Department runs two facilities on three campuses:

The ***Albert J. Solnit Psychiatric Center*** has a North and South campus that serve children with complex serious emotional disturbances. The North Campus in East Windsor has a Psychiatric Residential Treatment Facility (PRTF) with two units for males. The South Campus located in Middletown has both inpatient units for males and females and a PRTF that serves females;

The Wilderness School, a prevention, intervention, and transition program for adolescents from Connecticut. The program is supported by the State Department of Children and Families (DCF) in addition to a tuition fee program utilizing a significant private funding base. The Wilderness School offers high impact wilderness programs intended to foster positive youth development.

Designed as a journey experience, the program is based upon the philosophies of experiential learning and is considered therapeutic for the participant. Studies have documented the Wilderness School's impact upon the self-esteem, increased locus of control (personal responsibility),

and interpersonal skill enhancement of adolescents attending the program experiential program for troubled youth.

Behavioral Health Assessment and Plan – Children's Services

Organizational Structure - State Level (DCF)

The Department has four mandated areas which include child welfare, children's behavioral health, education and prevention. In addition to the operated facilities, the Department consists of a Central Office and thirteen Area Offices that are organized into six regions. At any point in time, the Department serves approximately 36,000 children and 15,000 families across its programs and mandated areas of service. The average number of full-time employees is 3,237. DCF's recurring operational expenses total around $793,487,519.

In January 2019 there was a change in Connecticut Governor and change in DCF administration including a new Commissioner. DCF was asked to conduct an organizational assessment to determine if the structure of the Department supported the outcomes expected by the new Administration. Governor Lamont's transition team was an integral part of the assessment and considered the work and recommendations of the policy committees established at the Governor's Policy Summit.

DCF's Commissioner Vannessa Dorantes, established an organizational assessment team, mixing experienced Child Welfare executives with external technical assistance from Casey Family Programs and the Harvard Government Performance Lab. The organizational assessment team used both a series of interviews with leaders of other child welfare systems, agencies and organizations, and several seminal organizational assessment and change management resources to arrive at a two-phased approach to the assessment. This approach was intended to give space for external input to help set the vision and strategic goals of the agency and align the executive team around those goals first, ahead of diving into the detail of the structure of each division. The team also developed an overall framework for what should be produced out of both phases. The team's achievements to date include:

• Secured major initiatives in 2019-20 State budget – Integrated Care Coordination – Centralized transportation unit – Behavioral health services
• New Legislation - Additional mandated reporters - Transparency bill - Solnit licensure - Children in Care Bill of Rights and Siblings Bill of Rights
• Recalibrating relationships & communications – Strong interagency collaboration – FFPSA readiness – Legislature – Advocacy groups including OCA – Stakeholder partnership alignment (foster parents, police chiefs, school superintendents, chief court administrators, state's attorneys, AAGs…) – Provider collaboratives – Media outlets
• Progressed needed practice changes – Supervision refocus – SALA/TFC review – Supervised visitation practice guidance
• Finalized the Federal Program Improvement Plan (PIP)

DCF's overall strategy is: ***"Partnering with communities and empowering families to raise resilient children who thrive."***

DCF Strategic Goals:

- Keep children and youth safe, with focus on most vulnerable populations Engage our workforce through an organizational culture of mutual support Connect systems and processes to achieve timely permanency.
- Contribute to child and family wellbeing by enhancing assessments and interventions
- Eliminate racial and ethnic disparate outcomes within our department.

These strategic goals will help to focus DCF's attention, effort and resources as an agency – so that leaders and staff across all divisions are all working toward a common vision. Under each of these broad goals would then sit a number of more concrete metrics and prioritized activities DCF intends to pursue in the different domains and functions to achieve each goal. The vision and strategic goals are the foundation to move from a child welfare agency to a Child Welfare System. This is the foundation for our sister agencies to join together and support and serve the families in Connecticut in an efficient and effective way.

The Commissioner's team heard strong feedback from its external advisors both on DCF's strengths to build on, as well as where the agency needs to progress.

Organizational Values
The strategy is about what DCF aims to do, but it is just as important to set the aspiration for how DCF will work to achieve its goals. To this end, it is important that agency's 3200 staff members work with purposeful pride and passion for practice, and people. Valuable and innovative work being done, but inconsistent across regions – previous structure made it difficult to scale up best practices, with result of families receiving different types of service & support depending upon their region • Room to reduce duplicate or redundant efforts – particularly in reviews and reports, to free up staff time to focus on forward-looking quality improvement support for line staff • Staffing not yet balanced across offices – need to carefully match staffing with volume • Huge potential in the Systems work – currently stretched across foster care, services, and community engagement

This means:

- We work with purpose – we each believe in the vision, and we each know how we can contribute to it
- We work with pride – we publicly advocate for the good work we do
- We work with passion – we see this line of work as more than a job; we see it as a calling
- We prioritize practice - we deliver high quality in what we do
- We prioritize people – we see the humanity in everyone, and work to bring out the best in colleagues and the families and children we serve.

The DCF vision statement mirrors the Substance Abuse and Mental Health Services Administration's (SAMHSA's) four major dimensions that support a life of recovery - health, home, purpose and community.

Role of the State Mental Health Agency for Children: Connecticut Department of Children and Families Statutory Authority:

The Connecticut Department of Children and Families (DCF) has statutory authority to provide for children's mental health services in the state. With this statutory mandate DCF plays a key leadership role in both providing mental health services for children, youth and families across Connecticut, and in developing, planning, coordinating and overseeing children's mental health services.

Children's Behavioral Health Plan:

Connecticut continues to use the behavioral health plan developed in the fall of 2014 as the blueprint to develop a comprehensive and integrated behavioral health system that meets the behavioral health need so CT children and to prevent and or reduce the long term negative impact for children with mental, emotional and behavioral health issues. The Behavioral Health Plan specifically focused on DCF addressing the following areas:

- Identify, prevent, address and remediate the mental, emotional and behavioral health needs of all children within the State of Connecticut
- Coordinate and expand services that provide early intervention for young children, specifically home visiting services and the CT Birth to Three program
- Expand training in children's mental, emotional and behavioral needs for school resource officers, pediatricians, child care providers and mental health professionals
- Understand whether the lack of appropriate treatment for children and young adults may lead to placement within the youth or adult justice systems
- Seek funding for public and private reimbursement for mental, emotional and behavioral health services

The behavioral health/mental health plan developed out of this process resulted in seven broad thematic areas, each with specific goals and strategies for significantly improving Connecticut's children's behavioral health/mental health service system. The Plan includes a continuing timeline for implementation that focuses on the development of the infrastructure and the planning of the array of services that will comprise the CT system of care. The seven broad themes identified in the plan are:

- System Organization, Financing and Accountability
- Health Promotion, Prevention and Early Identification
- Access to a Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Health Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce Development

Since 2015, DCF continues to implement the behavioral health/mental health plan, in partnership with eleven other state agencies, numerous private agencies and children and families of Connecticut. Central to the development of the CT Children's
Behavioral Health Plan is ongoing feedback from consumers and providers across the state. The Department and all of the state partners benefits from the courage of families who share their stories and offer valuable feedback to what is working well and where improvements are needed. The feedback sessions are held annually and have continued involving over 300 adults and youth. These sessions are essential in allowing us to continuously examine the service system and make necessary adjustments and improvements.

Over the last 4 years, each of the twelve agencies named has actively engaged in the design, planning, implementation and evaluative components of this work, and while the work continues, advances have been made but challenges remain. The system has seen areas of improved integration between behavioral health, pediatrics and education as well as additional investments in community-based services, all this despite budgetary constraints and organizational shifts in mandates and oversight, the impact of which is yet to be determined.

The Children's Behavioral Health Plan outlines key themes, which when taken as a whole, are designed to support a public health framework that supports child well-being through promotion and prevention efforts; recognizes the importance of early identification, access to innovative and best practices; and embraces the importance of building a culturally competent and responsive system that fully promotes family and youth engagement.

Over the last two years there was demonstrable progress building on the foundation of work. The Department engaged with partners to develop a fiscal mapping template and applied fiscal mapping to all twelve agencies named in the legislation. Notably, the majority of funding was spent in the Prevention, Promotion and Treatment categories, with less in Support and Care. On its face this was promising news; however, additional analysis and information are needed to fully understand what that means for children and families. To that end, the work had limitations and challenges: agencies define the service system differently; access to Medicaid data is inconsistent; and a health equity lens is not uniformly applied to help us understand who is or is not served and who is or is not better off. Despite these limitations, this data, for the first time, provides a

much clearer picture of the multiple funding streams and how well they do or do not connect to the broader vision of a comprehensive, integrated children's behavioral system. When we know more, we do better.

In the coming two years CT hopes to fully examine the service system and the funding in real time rather than retrospectively. Such examination is critical to better inform investments and considerations to shift mandates or organizational structures. Areas that should remain at the forefront of our work include continued collective commitment to fiscal mapping through a health equity lens, increased data submissions to the Governor's Open Data Portal and consideration of increased coordination through the CT Behavioral Health Partnership of all named agencies for planning purposes. These efforts inevitably impact investments in services that yield better outcomes for children and their families.

Children's Mental Health Oversight:
The Commissioner of DCF, Vannessa L. Dorantes, and her staff work closely with the Office of the Governor, the Connecticut State Legislature, consumers and family members, advisory groups, advocacy groups, service providers, and state/federal agencies in meeting the mental health needs of children, youth and families. This includes ongoing collaboration with a diverse array of stakeholders around the state to solicit multiple perspectives in identifying unmet needs and priority areas.

DCF staff lead and participate in numerous committees and workgroups focused on a broad range of issues to meet the mental health needs of children, youth and families in Connecticut. These activities include: Promoting family outreach, engagement and retention throughout the period of care; improving the quality of care through early identification and comprehensive assessment; disseminating and sustaining evidence based practices; addressing the needs of traumatized children, youth and their parents/caregivers; enhancing the knowledge, skills and competencies of the workforce; improving data collection, analysis and reporting systems; integrating plans of care across multiple systems; and enhancing the role of families and other caregivers in all aspects of system design, planning, monitoring and evaluation.

In its oversight role DCF partners with several state advisory committees, boards and service organizations in addressing the mental health needs of children, youth and families. These partnerships include the following.

> ***State Advisory Council*** (SAC): At the statewide level, the State Advisory Council (SAC) is a 17-member body, with 11 members appointed by the Governor, and representation from all six DCF Regional Advisory Councils (RAC), to advise the Commissioner on all matters pertaining to services for children and families. The membership includes parents, adult caregivers, and persons representing a variety of sectors and

professions, including attorneys, a physician, psychiatrist and community providers.

The primary duties of the Council are to: review policies; recommend programs, legislation or other matters that will improve services for children, youth and families; review and advise the Commissioner on the proposed agency budget; perform public outreach to educate the community regarding policies, duties and programs of the Department and issue any reports it deems necessary to the Governor and the Commissioner. The SAC also assists in the development of, review and comment on the strategic plan for the Department; and it also reviews quarterly status reports on the plan, independently monitors progress and offers an outside perspective to DCF.

Children's Behavioral Health Advisory Committee (CBHAC): Established by Connecticut Public Act 00-188, CBHAC's charge is to promote and enhance the provision of mental health services for all children and youth in the state of Connecticut. The committee supports DCF's efforts in meeting the mental health needs of children, youth and families.

The committee meets monthly and evaluates and submits an annual report on the status of the local systems of care, reviews the practice standards for each service type, and submits recommendations to the Commissioner of DCF on children and families. It submits biannual "recommendations concerning the provision of mental health services for all children in the state" to DCF, and the legislature. The committee advises on the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. CBHAC members also participate in the CT Joint Behavioral Health Block Grant Planning Council.

The committee has four (4) ad hoc sub-committees to address recurring areas of focus which are: (1) expansion of the mental health service array; (2) recruitment, training and retention of family members in various system roles; (3) educational advocacy and (4) creation of a statewide council, or network, of community collaboratives. The majority of CBHAC members must be "parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child" and appointed members being limited to two two-year terms. CHBAC is chaired by two persons from its membership, at least one of which is a parent of a child with serious emotional disturbance.

Youth Advisory Boards: DCF staff work in partnership with and solicit input from local Youth Advisory Boards around the state and the statewide

Youth Advisory Board (YAB). The boards empower children and youth to directly participate in and advocate for mental health and related system changes and development. Approximately 150 children and youth in "out-of-home care" participate on the boards throughout Connecticut over the course of a year, with an additional 190 youth participating in YAB sponsored events. Over the past year, the YAB members produced a new DCF policy that offers the opportunity for an additional three months of support for youth transitioning out of DCF care who are graduating from postsecondary educational programs. They also wrote, helped produce, and starred in a Foster and Adoptive Parent Recruitment video series entitled Meet Me Where I'm At, and participated in a forum for youth in care to discuss the importance of race and culture to their experiences in foster care placement. The YAB is preparing for a statewide Youth Summit to take place in August 2019. Youth have created several presentations to be offered as breakout sessions.

Connecticut Community Non Profit Alliance (The Alliance): This member based association represents Connecticut organizations that provide services for children, adults and families in the areas of mental health, substance use disorders, developmental disabilities, child and family health and well-being, and other related areas. The association's mission is to achieve service system change, represent the voices of its members at local, state and federal levels, and support the delivery of high quality, efficient and effective services. Member organizations deliver services to around 500,000 Connecticut residents each year. The Alliance collaborates with DCF in addressing the mental health needs of Connecticut's children, youth and families.

State Agency Collaborations

The Commissioners from DCF and the Department of Mental Health and Addiction Services (DMHAS), Department of Developmental Services (DDS), the Connecticut Judicial Branch, Court Support Services Division (CSSD), Department of Social Services (DSS), Department of Public Health (DPH), State Department of Education (SDE) and others meet and dialogue routinely and share in a number of joint activities, Memorandum of Understanding (MOUs) and shared projects regarding cross-cutting mental health issues of importance to each of the agencies. Some of these activities, MOUs and projects include the following:

1. Alcohol and Drug Policy Council (DMHAS)
2. Transitioning Young Adults (DMHAS)
3. CT Strong (DMHAS)
4. Project Safe (DMHAS)
5. Project Safe RSVP, (DMHAS) - a family court diversion program.

6. Joint State Behavioral Health Planning Council (DMHAS)-to develop and evaluate the Block Grant Application and Plan as well as the Implementation Report each year
7. Management of Public Health Behavioral Health System for Medicaid Recipients (DMHAS, DSS)
8. Birth to Three Services (DDS)
9. Policy improvements and transportation issues related to foster children (SDE)
10. The shared dissemination of evidence-based practices such as Multi-Systemic Therapy and Multi-Dimensional Family Therapy (CSSD)
11. Adolescent Community Reinforcement Approach (CSSD)
12. School Based Diversion Initiative (CSSD)
13. IMPACT (CSSD)
14. FBR evaluation (UCONN Health Center)
15. Supportive Housing and Homelessness (DOH)
16. Elm City Project Launch (DPH)

Administrative Service Organization Partnership

In its mental health oversight role DCF collaborates with the Departments of Social Services (DSS) and Mental Health and Addiction Services (DMHAS) as the Connecticut Behavioral Health Partnership (CT-BHP). Beacon Health Options is the administrative service organization (ASO) for the CT BHP and a number of other initiatives and activities addressing the mental health needs of children, youth and families. Services covered under the CT BHP include Enhanced Care Clinics (ECC). The ECC's are specially designated Connecticut based mental health and substance abuse clinics that serve children and/or adults. They provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other services for CT-BHP members. ECCS are required to develop and implement MOUs with pediatric primary care providers such as pediatricians and provide co-occurring mental health and substance use services when necessary.

Since the pediatric primary care providers often have first contact with children and youth with mental health service needs the CT-BHP and DCF have worked to forge relationships between pediatric primary care and behavioral health providers through the Enhanced Care Clinics. The MOU's with pediatric primary care providers is designed to improve care coordination through the phases of referral, treatment and discharge planning. A "train the trainer" program has been developed and disseminated for use by ECC staff to assist pediatric primary care providers to increase opportunities for collaborative care. The training includes a toolkit with in-service training modules. The Symptom Checklist is also promoted as a tool for use in primary care settings to promote integrated care.

Licensing Mental Health and Related Services

As part of its ongoing responsibilities in overseeing mental health services for children, youth and families in Connecticut, DCF licenses a number mental health and related services for children, youth and families, including child placing agencies, outpatient psychiatric clinics for children, extended day treatment programs; short-term assessment and respite programs, short-term family integrated treatment programs, therapeutic foster care, therapeutic group homes, residential treatment programs, and psychiatric residential treatment facilities.

Credentialing Mental Health and Related Services

DCF oversees a number of community based mental health services to meet the individual needs of children, youth and families through a credentialing system. DCF has contracted with Advanced Behavioral Health, a Connecticut service organization, to administer a system for credentialing individuals and organizations that provide direct mental health and related services to children, youth and families. These services are funded by DCF, are available to DCF involved families, are provided in the community and include: After school clinical support services for children and youth, assessment services including assessments for perpetrators of domestic violence, behavior management services, supervised visitation services, and temporary care services. The credentialing process includes:

- Reviewing background information that is submitted with the individual's application including criminal records, child protective service registry and sex offender registry
- Reviewing the Federal Office of the Inspector General's website registry of professional healthcare providers and entities excluded from participation in federal healthcare programs
- Receiving and recording complaints regarding provider service quality and performance
- Conducting quality site visits for all After School programs to assure the program is offered in a safe and secure setting

Mental Health Services Oversight

For all community based and congregate care mental health services that are contracted, credentialed, licensed and provided by DCF for children, youth and families there are specific ongoing activities that are conducted to ensure effectives services and outcomes. In addition to staff dedicated to licensed and credentialed programs DCF has dedicated staff to oversee the department's contracted mental health programs and services. These staff are called "Program Development and Oversight Coordinators" (PDOC). The mental health services oversight conducted by assigned DCF staff include site visits; qualitative reviews; provider meetings, data discussions, (including data on consumer satisfaction); quality improvement plans; remediation activities and other continuous quality improvement activities.

Description of the State Mental Health Service System for Children:

The Connecticut Department of Children and Families mental health service system is based on the core values and principles of the System of Care: ***"all treatment, support and care services are provided in a context that meets the child's psychosocial, developmental, educational, treatment, and care needs. The treatment environment must be safe, nurturing, consistent, supervised, and structured."***

The DCF Practice Standards for the System of Care Community Collaboratives affirms that all children's mental health services should be:

- Child-centered, family-focused with the needs of the child and family dictating the types and mix of services provided
- Community-based/least restrictive with the focus of services as well as the management and decision-making resting at the community level
- Cultural and linguistically competent, with agencies, programs and services that are responsive to the cultural, racial, ethnic and linguistic differences of the populations they serve

The intended outcomes of the DCF "Strengthening Families Practice Model" include the following:

- Fewer families need DCF Services through prevention efforts
- Children remain safely at home, whenever possible and appropriate
- Children who come into DCF care achieve more timely permanency
- Improved child well-being; all children in our care and custody are healthy, safe and learning; that they are successful in and out of school, and that we help them find and advance their special talents and to give something back to their communities
- Youth who transition from DCF are better prepared for adulthood

Cultural and Linguistic Competence

Another core principle for DCF is that all children and families are affirmed and valued for their unique identities and qualities. The agency believes in the inclusion of diverse experiences from all people. As such, there is acknowledgement of the injustices made by our dominant society whereby racism has permeated through many of our social systems. This has led DCF towards becoming a racially just organization. All DCF policies, practices, initiatives and services are aligned with these principles. This assures that the diverse needs of children and their families, regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social-economic status, or language are met.

The DCF Division of Multicultural Affairs is charged with developing, implementing, and sustaining diversity initiatives and policies designed to meet these needs. DCF has been focused on the issue of racial justice for many years. Its formal journey began in 2005 as a participant in the national Breakthrough Series Collaborative focused on disproportionality and disparities sponsored by Casey Family Programs. After a series of leadership and organizational changes,

the Department renewed its focus on these issues in 2011 by bringing in the People's Institute for Survival and Beyond. This resulted in two external consultants (Heidi Brooks and Jen Agosti) being contracted in February 2012. This facilitation continues with both statewide and regional specific support.

The shifts in racial, ethnic, linguistic, religious, special needs, disability, and gender orientation diversity in Connecticut have required that the Department develop approaches and skills that will enable its staff and all service providers to effectively work with people from diverse backgrounds. Training initiatives and case practices for DCF staff are focused on cultural awareness, knowledge acquisition and skills development. Cultural awareness includes a process of self-exploration that results in a clear understanding of the worldview that directs interactions with children and families who are different than the staff providing services for them. Knowledge acquisition includes an expectation that staff are to be thoroughly familiar with the language of multiculturalism and culturally competent practices. Skills development includes trainings focused on what are, and how to apply multi-culturally competent practices, and ongoing self-assessments. All DCF contracts with service providers require the delivery of culturally competent services and supports. Quality assurance mechanisms are in place to review and assure the delivery of culturally competent services by providers. The following is an example of DCF contract language:
"The Contractor shall administer, manage and deliver a culturally responsive and competent program. This shall, at a minimum, be evidenced by equity and parity in access to services, consumer satisfaction, and outcomes for clients served, regardless of race, ethnicity, language, religion, gender, sexual orientation, economic status and/or disability. Policies, practices and quality improvement activities shall be informed by the needs and demographics of the community served or to be served by the program. The Contractor shall include access, consumer satisfaction and outcomes as elements of its program review and monitoring."
"The Contractor shall recruit, hire and retain a professional and paraprofessional staff that is culturally and linguistically diverse. Staff development to support cross-cultural competency shall occur both pre- and in-service. Furthermore, as a means to facilitate culturally competent service delivery, issues of diversity and multiculturalism shall be included in treatment/service planning, discharge planning, case reviews, grand rounds, analysis and review of program data, and staff supervision."

As part of the Connecticut Network of Care Transformation (CONNECT) SAMHSA System of Care grant, a workgroup was developed to plan and implement a statewide process for incorporating enhanced Culturally Linguistically Appropriate Services (CLAS) standards within the children's Network of Care in Connecticut. With a goal to partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.

The outcomes and results were that cohorts were formed to participate in *Connecting with CLAS*. Additionally, state and agency partners support, the recruitment efforts of the *Connecting with CLAS Team.* Over 40 agencies participated and 38 agencies complete their *Health Equity Plans*. Technical Assistance is provided to review progress, support their efforts, and receive guidance or recommendations for next steps. This included four quarterly learning collaborative meetings and monthly calls. DCF continues to work with providers to monitor their implementation of their HEP, offering ongoing training to support growth in this area.

Consistent with its diversity principles and practice DCF has implemented the Safe Harbor Project which has the following mission statement: ***"The Safe Harbor Project seeks to ensure the safety, support and nurturance of all children and youth, regardless of their race, inherent sexuality, gender identity or expression by ensuring culturally competent, unbiased and affirming service by all DCF staff and its contracted providers."***

The Safe Harbors Project is supported and implemented by having specialized liaisons in all DCF regional service offices and DCF operated facilities. The Safe Harbors Project liaisons are subject matter experts in the area of culturally competent and relevant service delivery for children, youth and families who identify as gay, lesbian, bisexual, transgender, intersex and those questioning their sexuality and gender identify. There is a Safe Harbors Project website which contains relevant information and resources for children, youth, families, DCF staff and service providers.

Access to Services:

Children and youth with serious emotional disturbance and their families often find themselves in need of services and/or supports that they are unable to afford and for which there is no other method of payment. To address this service access need DCF has implemented a program of flexible funding for non-DCF involved children, youth and their families involved in care coordination.

The target population for DCF's Care Coordination and flexible funding of services is children or youth with serious emotional disturbance who are at risk of out-of-home placement, have limited resources or have exhausted resources including commercial insurance, have complex needs that require multi-agency involvement; and have no formal involvement with child welfare or juvenile justice.

The DCF flexible funding:

- Supports the wraparound child and family team meeting process and are tied to an objective in a child's Individualized Plan of Care. These may include a variety of non-traditional and unique services, supports or care.

- Supports families with children who have significant behavioral health needs. Assists the child and family in achieving the therapeutic goals outlined in the Plan of Care (POC).
- Helps children remain in their home and community; and achieve the highest level of functioning and life satisfaction possible as its ultimate goal.
- Must be the payer of last resort. In the case of funding for clinical services that would otherwise be reimbursed by third parties - Medicaid, private insurance, etc.

Diverse Mental Health Service Array:
A wide range of over ninety clinical and non-traditional services, programs and rehabilitative supports are available across the state, including services to address trauma and co-occurring disorders. (Please refer to the Connecticut Service Array for details of DCF services.)

The continuum of services provided by DCF is characterized by: Data driven planning and decision making; a balance of promotion, prevention, early intervention and treatment services; attention to the child's development and the developmental appropriateness of interactions and interventions; and collaboration across a broad range of formal and informal systems and sectors to develop comprehensive strategies and effective mental health services.
The Department uses a structured process to review strengths of the service array, identify service gaps, needs and challenges; contract management and oversight issues; performance; and service system expectations and outcomes. The use of Results Based Accountability (RBA) reports for DCF's contracted services are a central component. This structure is a primary vehicle for how the Department assesses ongoing service needs in line with the Connecticut budget process.

The working group consists of representatives from the following:
- Grants and Contracts Specialists
- Fiscal
- Contracts Managers
- Director of Performance Management
- Program Development Oversight Coordinator (PDOC)
- Systems Program Directors
- Administrative Case Review Manager
- Revenue Enhancement Manager
- Directors from Clinical and Community Consultation and Support Division

DCF, in partnership with the Connecticut Child Health and Development Institute, service providers and academic institutions has disseminated a range of evidence-based and best practice mental health service models. These community based

service models result in improved service outcomes for children, youth and families. They include

1. **Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC)**
2. **Care Coordination (using the evidence based wraparound process)**
3. **Child and Family Traumatic Stress Intervention (CFTSI)**
4. **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**
5. **Early Childhood Services - Child FIRST**
6. **Functional Family Therapy (FFT)**
7. **Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)**
8. **Multidimensional Family Therapy (MDFT)**
9. **Multidimensional Treatment Foster Care (MDFC)**
10. **Multi-systemic Therapy (MST)**
11. **Multi-systemic Therapy - Building Stronger Families**
12. **Multi-systemic Therapy - Family Integrated Transitions (MST-FIT)**
13. **Multi-systemic Therapy - Problem Sexual Behavior**
14. **Multi-systemic Therapy – Transitional Age Youth (MST-TAY)**
15. **Parenting Support Services (Triple P)**
16. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
17. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**
18. **Wrap Around New Haven (Care Coordination)**

(For a full description of the Evidence Based Practices (EBPs) see below)
Reflecting the diverse array and full range of mental health services provided to children, youth and families, DCF also operates two mental health facilities in the state. The Albert J. Solnit Center North Campus is a Psychiatric Residential Treatment Facility (PRTF) serving adolescent males with serious emotional disturbances. The Albert J. Solnit Center South Campus has both in-patient psychiatric units and PRTF units serving child and adolescent females and males with serious emotional disturbances. Both facilities are funded by DCF and serve all children and youth across Connecticut.

DCF has worked to ensure that its mental health services meet the emerging needs of children, youth and families and are consistent with current clinical research and practice. The department's work specifically in the area of human trafficking and trauma informed care is highlighted below as an example.

Connecticut's Human Ant trafficking Response Team (HART) is coordinated by the Department of Children and Families (DCF). DCF includes child trafficking under its mandated reporting guidelines requiring all cases be called into the DCF Careline. This structure uniquely affords all child victims of trafficking the resources needed to ensure safety and service provision. Public Awareness is a key component of the work conducted through HART. Over the past four years, we have provided 600 trainings and reached over 14,000 individuals. We have also offered over 25 TOTs in our various curriculums resulting in over 200 trainers in

the State. We currently offer 10 training curricula for professionals, youth and community members.

The number of referrals to the department of suspected child victims of trafficking have been remaining steady over the last 3-years with approximately 200 unique youth each year. In 2018, 210 referrals were received with 27 of them being for boys which is the highest number of males served over the last four years. DCF has put forth efforts to end the trafficking of our children and youth. These efforts fall within three categories:
1) Identification and Response; 2) Awareness and Education; 3) Restoration and Recovery

There are six HART Teams in Connecticut. These are inter-disciplinary teams lead by experienced HART liaisons and include; the child's treatment team, specialized providers and legal representation if indicated. The HART liaisons work with the local multidisciplinary Team ensuring that the victims are afforded all the resources needed to maximize prosecutions while ensuring the youth and their families are provided the appropriate mental health and medical services required.

Organizational Structure – Community Level
As the result of a SAMHSA CONNECT federal System of Care grant and Connecticut legislation DCF is providing leadership at the regional and local level to more formally operationalize and develop local and regional behavioral networks of care. Traditionally, DCF used its contracted provider network to distinguish its system of care, but feedback from stakeholders and families guided the Department to be more inclusive of all cross child-serving sectors and informal, smaller grass-roots and faith-based organizations. This also includes a focus on better integration of primary care and behavioral health, better connections and relationships between school districts and the behavioral health system, and the development of more access to a broader array of services for all children, youth and families in the state.

Community Based Services versus Congregate Care Services
In 2011, DCF began the process of instituting a number of practice changes to ensure that children and youth with mental health and related service needs grow up in families and receive their services in the community. This meant increasing the state's capacity to serve children and youth in families and the community and reducing the use of more restrictive and costly congregate care.
Historically, Connecticut had one of the highest rates of children and youth placed in congregate care in the nation. For example, in December 2010, DCF had 367 children and youth placed in congregate care settings outside of the state, and in years prior to 2010 there were times when there were more than 500 children and youth placed outside of the state. During this same period, the number of children and youth placed in congregate care settings within Connecticut were at an all-time

high. Additionally, use of foster and relative families was well below the national average.

During the period of high congregate care rates, the department's mental health expenditures were disproportionately spent on children and youth in congregate care settings rather than on evidence based, timely and flexible family and community based services that intervene early, promote development and resilience, and provide timely community treatment services in support of maintaining children and youth in families. In 2011, DCF obtained consultation from the Annie E. Casey Foundation as one of the steps in developing and implementing the changes needed to ensure that more children and youth grow up families. The consultation partnership assisted DCF in the areas of reducing the use of congregate care placements and shifting those funds saved to develop community based services in support of improving permanence and other long-term outcomes for children and youth.

DCF has continued to amplify its work on having children and youth reside in biological, relative and foster families, rather than in congregate care. This work has included the implementation of policy and practice changes that divert children 12 and under from congregate care placements; that reduce the overall use of congregate care; that reduce the length of stay when congregate care is utilized; and implements a system of performance management. In parallel, DCF's behavioral health program development has focused on the repurposing of existing congregate care resources to develop and foster community-based care and interventions.

- The Department currently has 3,030 children in placement under age 18.
- As of 8/25/2021, 5% of all children in care under age 18 are in congregate care.
- As of 8/25/2021, 4% of children are placed with kin.
- As of 8/25/2021, 4 children are placed outside of Connecticut in congregate care programs, compared to 9 on July 1, 2019.

Connecticut Children's Behavioral Health Service Array
Connecticut Children's Behavioral Health Service Array
DCF Community Based Services for Children, Youth and Families

Prevention & Early Identification/Intervention Services

Intensive Care Coordination (ICC) - ICC serves children and youth, ages 10-18, with serious behavioral or mental health (SED) needs returning to their home or community from congregate care or other restrictive treatment settings (emergency departments/inpatient hospitals, residential treatment, etc.) or who are at risk of removal from home or their community. The CME provides direct services and administrative functions. At the direct service level, the CME employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence-based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the

administrative level, the CME assists DCF in developing local and regional networks of care, which includes the CONNECT federal System of Care grant activities.

Care Coordination - This evidence-based service provides high fidelity "Wraparound" care using the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths, ages 018, with serious or complex need. The primary goal of Care Coordination is to support and maintain youth exhibiting serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

Caregiver Support Team - This service seeks to prevent the disruption of foster placements and increases stability and permanency by providing timely in-home interventions involving the child (ages 0-18) and their caregiver/family. For kinship families, this intensive in-home service is provided at the time the child is first placed with the family. The service is available at critical points for the duration of the placement as additional supports are deemed necessary.

Child Advocacy Centers (CACs) – A Child Advocacy Center (CAC) is a child-focused, facility-based program where professionals from many disciplines, many whom are members of the MDT (see below) including child protection, law enforcement, prosecution, forensic interviewing, mental health, medical professionals, and victim advocates work together as a team to provide coordinated and well-informed decisions Connecticut's CACs are legislatively required to meet the National Children's Alliance (NCA) Standards. Best practice includes both the Forensic Interview and Medical at the same site to support the family; Connecticut is working toward this best practice. When the MDT effectively collaborates on the investigation the potential substantiation/ prosecution of child abuse cases increases.

The Child Abuse Centers of Excellence - this service is provided by board certified Child Abuse Pediatricians who provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff and external partners to help ensure the safety and well-being of children.

Child First Consultation and Evaluation - This service provides home-based assessment and parent-child therapeutic interventions for high-risk families with children under six (6) years of age and ensures fidelity to the Child First model. The service delivers training, provides reflective clinical consultation, analyzes data, provides technical assistance, ensures continuous quality improvement, and certifies sites maintain the Child First model standards.

Community Support for Families - This service engages families who have received a Family Assessment Response from DCF and helps connect them to concrete, traditional and non-traditional supports and services in their community. This collaborative

approach and partnership place the family in the lead role of its own service delivery. The provider assists the family in developing solutions, identifying community resources and supports, and promotes permanent connections for the family with an array of supports and resources within their community.

Connecticut ACCESS Mental Health - This is a consultative pediatric psychiatry service available to all pediatric and family physician primary care provider practices ("PCPPs") treating children and youth, under 19 years of age irrespective of insurance coverage. The primary goal of the service is improving access to treatment for children with behavioral health or psychiatric problems, and to promote productive, ongoing relationships between primary care and child psychiatry increasing the access to a scarce resource of child psychiatry. The program is designed to increase the competencies of PCPPs to identify and treat behavioral health disorders in children and adolescents and to increase their knowledge/awareness of local resources designed to serve the needs of children and youth with these disorders.

DCF-Head Start Partnership - All DCF Offices providing services to children, youth and families have established and strengthened a working partnership with Head Start and Early Head Start programs. The goal of the partnership is to ensure children's access to high-quality early care and education, enhancing stability and supports for young children and families, and preventing family disruptions and foster care placements. This supports the prevention of serious emotional disturbance in children and youth and serious mental illness in adults.

Early Childhood Consultation Partnership (ECCP)/Mental Health Consultation to Childcare - The ECCP provides statewide mental health consultation program to preschools, Head Start, and service providers funded by DCF. The service is designed to meet the social/emotional needs of children birth to five by offering support, education and consultation to those who care for them. This includes the early identification of young children's social emotional needs and intervention with appropriate services and referrals. The program provides support, education, and consultation to caregivers in order to promote enduring and optimal outcomes for young children. All CT towns and cities have access to this consultation. ECCP is backed by three random control trials contributing to an evidence base for preschool, as well as Infant/toddler Early Childhood Mental Health Consultation (ECMHC) (Gilliam 2007 & 2010).

Elm City Project Launch (ECPL) - ECPL promotes the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. ECPL develops, implements and studies the effectiveness of an integrated and collaborative health and mental health service system for children ages 0-8 and their families in New Haven, Connecticut. The program is designed to strengthen and enhance the partnership between physical health and mental health systems at the federal, state and local levels. ECPL uses a public health approach to promote children's health and wellness with efforts that promote prevention, early identification and intervention.

Extended Day Treatment - This service is a site-based, before and/or after school, treatment and support service for children and youth with behavioral health needs who have returned from out-of-home care or are at risk of out-of-community placement due to mental health issues. For an average period of up to six months, a comprehensive array of clinical services supplemented with psychosocial rehabilitation activities are provided to the child/youth and their family/caretaker. A treatment plan is developed cooperatively with the family/caretaker. Transportation is provided by or through the direct service provider or Local Education Authority (LEA). Parents and DCF are full collaborative partners in all aspects discharge planning.

Fatherhood Engagement Services (FES) – FES provides intensive outreach, case management services and 24/7 Dad© group programming to fathers involved with an open DCF case. Through advocacy and support, fathers become more involved in DCF case planning and services, resulting in improved parenting capacity and more timely permanency for children in care.

Intensive Care Coordination (ICC) - ICC serves children and youth, ages 10-18, with serious behavioral or mental health (SED) needs returning to their home or community from congregate care or other restrictive treatment settings (emergency departments/inpatient hospitals, residential treatment, etc.) or who are at risk of removal from home or their community. Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) use an evidence-based wraparound Child and Family Team process to develop a Plan of Care for each child and family.

Juvenile Review Board (JRB) - This service supports community-based Juvenile Review Boards, panels composed of community volunteers, who recommend services and supports to be implemented as a diversion from the juvenile justice system, first time misdemeanor or Class D Felony offenders and other qualifying children and youth who are beyond parents' control, truant or in defiance of school rules. The service allows for the collaboration among community service providers and interested adults, empowering them to take responsibility for the well-being of the youth in their community. Referrals primarily come from schools and local police.

Therapeutic Child Care Center(Trauma-Informed) This program is designed to promote, develop, and increase the social, emotional development and cognitive capacities of children, ages 2 years 9 months - 5 years who have been adversely affected by abuse and/or neglect, are presenting with behavioral health issues, and require a therapeutic and trauma-informed program to address these behavioral challenges. The program will be housed within a licensed childcare facility and will also offer support services to parents to increase positive behaviors and promote parent bonding. It is the goal of the Trauma-Informed Therapeutic Child Care Center that children will successfully transition to a less intensive educational setting as a result of the services offered.

Child, Youth and Family Evaluations

Child Advocacy Centers (CACs) – A Child Advocacy Center (CAC) is a child-focused, facility-based program where professionals from many disciplines, many whom are members of the MDT (see below) including child protection, law enforcement, prosecution, forensic interviewing, mental health, medical professionals, and victim advocates work together as a team to provide coordinated and well-informed decisions about services and supports to child victims and non-offending family members. All of Connecticut's CACs are legislatively required to meet the National Children's Alliance (NCA) Standards. Best practice includes both the Forensic Interview and Medical at the same site to support the family; Connecticut is working toward this best practice. When the MDT effectively collaborates on the investigation the potential substantiation/ prosecution of child abuse cases increases.

The Child Abuse Centers of Excellence - this service is provided by board certified Child Abuse Pediatricians who provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff and external partners to help ensure the safety and well-being of children.

Multidisciplinary Examination (MDE) Clinic - This service provides a comprehensive multidisciplinary evaluation including medical, dental, mental health, developmental, educational, psychosocial and substance abuse screening for children placed in DCF care for the first time. A comprehensive summary is compiled by the multidisciplinary team and written report provided for each child referred for service. Referral(s) to a specialized service are made as indicated by the findings.

Support Services for Children & Youth, with Mental Health & Related Needs, And Their Families/Caregivers

Adopt A Social Worker - This is a statewide, faith-based outreach program linking an "adopted" DCF Social Worker with a faith-based or "covenant organization" focusing on meeting the basic material needs of DCF-involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children may include, for example, providing beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.

Family Support - This service provides coordination and facilitation of five parent support groups focusing on peer support, parenting skill training and support, and education for effective coping strategies. The five groups consist of (1) the CT Chapter of the National Alliance for the Mentally Ill (NAMI-CT), (2) a support group for mothers who have experienced sexual assault in their pre-parenting years, (3) "Parents Night Out" a parent education group, (4) a parent/child play group for parents with children age birth to three years old that includes an "in-home" education component, and (5) a Gamblers Anonymous support group.

Foster and Adoptive Parent Support Services - This agency-based service both supports and trains foster and adoptive parents. Services include but are not limited to: First contact for recruitment through the "Kid-Hero" phone line; a buddy system; post-licensing training; an annual conference; periodic workshops; respite care authorization, a quarterly newsletter as well as a fiduciary role for open adoption legal services. In addition, support staff ("Liaisons") are situated in most DCF Area Offices in order to assist foster and adoptive families who call with questions or require resolution of individual issues. The Liaisons also assist DCF staff with area recruitment and retention activities for foster and adoptive homes and serve on committees where a foster/adoptive parent perspective is needed.

Foster Care and Adoptive Family Support Groups - This service provides both a venue and childcare support for group meetings for foster care and adoptive families to aid in the retention of foster homes and placement stability for children and youth within foster and adoptive family settings.

Foster Family Support - This service provides a variety of support services to children in DCF care who are living with foster and relative families. The support services include, but are not limited to: Individual, group and/or family counseling; crisis intervention, social skills development, educational activities, and after school and weekend activities.

Foster Parent Support for Medically Complex - This service, staffed primarily by a group of volunteers, provides foster care recruitment, respite and support focused on maintaining and growing the number of foster and adoptive parents who work with medically complex children in the Waterbury and Torrington areas of the state. There is a childcare/activity component to the program and money available for participating foster parents as well as two yearly celebrations fostering a peer community for the families.

Intimate Partner Violence (IPV-FAIR) – The goal of the service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant, and responsive to the unique strengths and concerns of the family. This four (4) to six (6) month service provides a supportive service array of assessments, clinical interventions, case management and linkages to services to address the needs of families impacted by intimate partner violence. Safety planning will be at the center of the IPV-FAIR service provision.

Juvenile Review Board (JRB) - Support and Enhancement - Juvenile Review Board Support and Enhancement provides funding to local Juvenile Review Board's to create, support and enhance services delivered to youth served by the JRB.

Multidisciplinary Team and Child Advocacy Center – This service promotes the coordination of investigations of and interventions for cases of child abuse/neglect

among agencies, including DCF, police, medical, mental health, victim advocates, and prosecutors. Cases are referred to the regularly scheduled team meetings by DCF, law enforcement or other agency members of the team. A team Coordinator assumes the coordination and administrative responsibilities in addition to being an active member of the team. Training in aspects of child abuse and the investigation process is provided to the team members. In 2014, state statute changed to include that human trafficking cases must have an MDT response. A Child Advocacy Center(CAC) is a child-focused, facility-based program where professionals from many disciplines, including child protection, law enforcement, prosecution, forensic interviewing, mental health, medical professionals, and victim advocates work together as a team to make coordinated, well-informed decisions about the investigation, treatment, case management and prosecution of child abuse cases. CAC's are designed to meet the unique needs of a community. This is where the forensic interview, and sometimes the medical exam, for a victim will be conducted.

Permanency Placement Services Program (PPSP) - This is a permanency placement program dedicated to DCF-committed children to support placement through adoption or guardianship. Services include recruitment, screening, home studies and evaluations, pre- and post-adoption, guardianship placement planning and support or reunification services with identified parents. A written service agreement, mutually developed between DCF and the provider, is made prior to the commencement of services, and includes the type(s) of service(s) to be provided and time to be spent on each service. The program is time limited with 132 hours the maximum number of service hours available per child.

Respite Care Services - This service provides brief and temporary home and community-based respite for children and youth, receiving care coordination who have serious emotional disturbance (SED). This service is offered to families in order to provide relief from the continued care of a child or youth's complex behavioral health care needs, to limit stress in the home environment and to prevent family disruption and/or the need for out-of-home care for a child or youth with SED and is part of an integrated behavioral health care plan. Up to 45 hours of respite can be given to a family within a 12-week period with any extension based upon DCF approval.

Reunification and Therapeutic Family Time – Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for families with children (from birth to age 17) who were removed from their home due to protective service concerns. These three service types are available to families as three separate components based on the needs of the family. Families can be referred for this service immediately following a child's removal from the home or at any time during their placement.

Reunification Readiness Assessment uses a standardized assessment tool to develop service plan. Therapeutic Family Time is made available for families and assists the provider in assessment by using the Visit Coaching model. This component provides

feedback and recommendations to the Department regarding the family's readiness for reunification

Reunification Services also uses a standardized assessment tool to develop the service plan, delivers a staged reunification model to support families throughout the reunification process, adopts the Wraparound Model design to engage the family and build their networks of support, delivers Therapeutic Family Time component using the Visit Coaching model and offers a Step Down option, if families require additional supports.

Therapeutic Family Time – Uses the Visit Coaching Model and focuses on coaching parenting behaviors to meet the needs of their child(ren), improving parental capacity, helping to preserve or restore parent/child attachment, facilitates permanency planning and emphasizes a continuity of relationships.

School-Based Diversion Initiative (SBDI) - Funded by the Connecticut Judicial Branch and the CT Department of Education, with DCF as a partner. the SBDI model brings training to school staff for recognizing mental health needs, including trauma exposure, and accessing services and supports in the school and the community. SBDI aims to reduce the number of children who are arrested for relatively minor behavioral incidents that can be addressed through in-school discipline and access to mental health services rather than formal processing through the juvenile justice system. Secondarily, SBDI seeks to reduce the number of youths who are expelled or receive out of school suspension when these students can be held accountable while remaining in school.

Sibling Connections Camp - This service is designed to engage, support and reconnect siblings who are placed in out-of-home care by providing a weeklong overnight camp experience focused on strengthening sibling relationships and creating meaningful childhood memories.

Statewide Family Organization - **FAVOR -** DCF funds FAVOR (not an acronym), an umbrella statewide family advocacy organization that has been created to educate, support and empower families. FAVOR's mission is to provide family-focused, advocacy based, and culturally sensitive community services that improve outcomes and family wellbeing. The Statewide Family Organization provides three levels of service and support to families who have children with serious behavioral or mental health needs. At the direct service level: Community Family Advocates provide brief and long-term support to parents and caregivers using a wraparound Child and Family Team meeting approach and a peer support/assistance framework. At the regional level: Family System Managers work closely with DCF Regional Offices and the Connecticut Behavioral Health Partnership (CT BHP) to assist them in developing linkages between local community groups and identifying and supporting informal support and service networks for families. At the statewide level: Citizen Review Panels provide feedback to DCF regarding child protection services and provide training and disseminate information to service providers and the public to enhance the ways families can positively impact the child protection and child treatment systems.

START – The START program provides an array of services for youth ages 16-24 who are at-risk of homelessness. Services will include outreach and survival supports for homeless youth in crisis or youth who have unstable housing in the Hartford area for up to two years with intensive case management support.

Supportive Housing for Families - This service provides subsidized housing and intensive case management services to DCF families statewide whose inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the areas of economic, social, and health needs. Permanent housing is established through DCF's partnership with the Department of Housing (DOH). The DOH provides a Housing Choice Voucher (formally "Section 8" - federal program) or Rental Assistance Program (RAP-state program) Certificate. The network of services in the following areas: Economic, social, and health. Housing is secured in conjunction with the family and use of a Section VIII voucher from the Department of Social Services (DSS).

Supportive Work, Education & Transition Program (SWETP) - This service is a community-based, stand-alone, staffed apartment program that serves DCF-committed adolescents ages 16 and older. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to: Inter-personal awareness, community awareness and engagement, knowledge and management of medical conditions; and maximization of education, vocation and community integration. On-site supervision is provided 24 hours a day, seven days a week. Activities involving resident youth are supervised and managed at a level consistent with the nature of the activity and the individual needs of the involved youth.

Therapeutic Foster Care (Medically Complex) - This service approves, provides specialized training and support services and certifies families to care for children with complex medical needs. The population served is DCF-referred children and youth with complex medical needs ages 0-17. A child with complex medical needs is one who has a diagnosable, enduring, life-threatening condition, a medical condition that has resulted in substantial physical impairments, medically caused impediments to the performance of daily, age-appropriate activities at home, school or community, and/or a need for medically prescribed services.

Wendy's Wonderful Kids - This service is an evidence-based, child-focused model that has demonstrated positive outcomes regarding adoptions of DCF children in the following specialized groups: older children, children with specialized needs, and sibling groups. The provider engages in child specific adoption readiness and recruitment activities to help move Connecticut's longest waiting children from foster care into adoptive families.

Work to Learn Youth Program - This youth educational/vocational program provides supportive services to assist youth and young adults, ages 16-23, to successfully transition into adulthood. The program provides training and services in the following

areas: Employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing. Youth may also take part in an on-site, youth-run businesses providing an additional opportunity to utilize and strengthen their skill set.

Zero to Three – Safe Babies – The Zero to three Safe Babies Project, provides coordination of services to parents and children younger than 36 months in order to speed reunification or facilitate another permanency goal. The children involved in the program have been placed outside of their home for the first time via court order. The service coordination involves facilitating communication and cooperation among a "zero to three team" of stakeholders (e.g. court services, infant mental health, protective services, developmental screening) and the parent(s) to develop and expedite a case specific plan of action toward reunification.

Mental Health Treatment Services

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - CBITS is a skill-based, group intervention focused on decreasing symptoms of Post-Traumatic Stress Disorder (PTSD) and generalized anxiety among children and youth who have experienced trauma. This school-based treatment model enhances the school's mental health service array to support student's learning potential and build resiliency. CBITS minimizes developmental disruption and promotes child recovery and resiliency for students through a cognitive-behavioral therapy approach involving components of psychoeducation, relaxation, exposure, social problem solving, and cognitive restructuring.

Community Support Team - This service is provided in conjunction with the DCF New Haven Area Office and focuses on assessment, treatment and support for children and youth in out-of-home levels of care transitioning back to the community. Services include but are not limited to: In home clinical interventions and supports; delivery of therapeutic services that facilitate and support family problem solving; family education and guidance; and linkage to natural supports.

Enhanced Care Clinics (ECC's) - Connecticut established Enhanced Care Clinics (ECC's), which are specially designated mental health and substance abuse clinics that serve adults and/or children. The ECC's provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other routine outpatient services for Medicaid members. The overall goal of the Enhanced Care Clinics initiative is to provide adults and children who are seeking behavioral health services and supports with improved timeliness of access to behavioral health care as well as improved quality of care. ECC's must also be able to meet special requirements starting with access and the ability to see clients in a timely fashion depending on their level of urgency. Currently under this model, ECC's must adhere to the following access standards: The capability to see clients with emergent needs within two hours of arrival at the clinic, the capability to see clients with urgent needs within two days of initial contact, the capability to see clients with routine needs within two

weeks of initial contact. Following an initial face-to-face clinical evaluation those clients who are determined to be clinically appropriate to receive outpatient services must be offered a follow-up appointment within 2 weeks of the initial evaluation. ECC's must also provide extended coverage outside of normal business hours. Evidence of collaboration and coordination with primary care providers around medication management and general medical issues as well as screening, evaluation and treatment of co-occurring mental health and substance use disorders are additional requirement of all ECCs.

Family and Community Ties – This foster care model combines a wraparound approach to service delivery with professional parenting support for children and youth with serious psychiatric and behavioral health problems. This service is differentiated from other foster care services by (a) the frequency and intensity of clinical contact and (b) flexibility in providing "whatever it takes" to preserve the placement of a child or youth in a family setting. Within this program, foster parents serve as full members of the treatment team and complete intensive training in behavior management.

Intensive Family Preservation (IFP) - IFP provides an intensive, in-home service designed to intervene quickly in order to reduce the risk of out-of-home placement and or abuse and/or neglect. Coverage is provided to families 24 hours per day, seven days a week with a minimum of 2 home visits per week for the first month of the intervention and a minimum of 1 home visit per week for the remaining weeks of service. Based on the needs of the family the program can increase the amount of contacts per week. Staff work a flexible schedule, adhering to the needs of the family. A standardized assessment tool is used to develop a treatment plan. If indicated, families are linked to other therapeutic interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.

Intensive In-Home Child and Adolescent Psychiatric Services IICAPS - (Consultation and Evaluation) - This service provides program development, training, consultation, and clinical quality assurance for DCF-approved Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) providers. The IICAPS statewide providers work with children and youth with behavioral health needs who have returned or are returning home from out-of-home care and who require a less intensive level of treatment, or are at imminent risk of placement due to mental health issues or emotional disturbances.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - This service is a curriculum-based treatment model for children and adolescents with a DSM-V Axis I diagnosis who have complex behavioral health needs. The primary goal is to divert children and adolescents from psychiatric hospitalizations or to support discharge from inpatient levels of care. This intensive, home-based service is designed to address a child's specific psychiatric disorders while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's

ability to function. This service offers five levels of intervention, from as little as 1-3 hours per week to as much as 12-20 hours per week as indicated.

Multidimensional Family Therapy (MDFT) is an evidence based, comprehensive and multisystemic family-based in-home program for adolescents using substances, adolescents with co-occurring substance use and mental health disorders, and those at high risk for continued substance use and other problem behaviors. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. MDFT looks to address four interdependent treatment areas to achieve effective clinical outcomes: the adolescent, the parent, the family, and systems such as school and juvenile justice. Interventions include weekly sessions of individual therapy with the adolescent, therapy with the parent(s), and family therapy to address adolescent and family issues specific to this youth. When indicated, services include urine drug screens, case management, and/or a parent-adolescent HIV/STD prevention group. Interventions also focus on promoting communication and relationship-building among the family members.

Multidimensional Family Therapy (MDFT) Consultation and Evaluation - This service provides program development, training, clinical and programmatic consultation to MDFT providers statewide which integrate the standards and practices consistent with MDFT requirements and quality improvement programming. Additionally, this service provides program development, training and clinical consultation for the Family Substance Abuse Treatment Services (FSATS) teams serving youth who are criminally involved.

Multi-systemic Therapy: Consultation and Evaluation - This service provides for clinical consultation to state-wide Court Support Services Division (CSSD) and DCF funded Multisystemic Therapy (MST) providers in order to integrate the standards and practices consistent with MST Network Partnership requirements and MST quality improvement programming. In addition, the service provides training in the theory and application of MST for clinicians, supervisors, administrators, policy makers employed by DCF, CSSD and their contracted MST providers.

MST – Intimate Partner Violence (MST-IPV) –This service, building upon a national evidence-based treatment model, provides intensive family and community-based treatment to families that are active cases with DCF due to the physical abuse and/or neglect of a child in the family and identification of intimate partner violence in the family. This new model takes a family-oriented, comprehensive, and integrated treatment model approach for family members involved in households with IPV that emphasizes both short- and long-term safety, protects children from witnessing violent incidents, and address the individualized risk factors for IPV including co-morbid substance use. Core services include clinical services, trauma treatment, empowerment and family support services, medication management, crisis intervention, and case management. Average length of service is 6 - 9 months per family.

New Haven Trauma Coalition - The New Haven Trauma Network is a collaboration headed by the Clifford Beers Clinic which has four components: (1) Care Coordination (2) short-term assessment; (3) screening and direct service for children; and (4) trauma informed training & workforce development. These components provide a trauma informed collaborative network of care to address adverse childhood experiences. The network involves the Greater New Haven community and is focused on: a) Creating a safer, healthier community for children and families; b) reducing community violence; c) reducing school failure and dropout rates; d) improving overall health of children and families; and, e) development of a coalition or network infrastructure support.

Outpatient Psychiatric Clinic for Children (aka Child Guidance Clinic) - This service provides a range of outpatient mental health services for children, youth and their families. Services are designed to promote mental health and improve functioning in children, youth and families and to decrease the prevalence of and incidence of mental illness, emotional disturbance and social dysfunction. DCF-involved children; referred through local systems of care, care coordinators, and Emergency Mobile Services; children who are the victims of trauma and/or physical and/or sexual abuse and/or neglect and/or witness to violence in the home or external to the home and/or who have experienced multiple separations from loved ones; children who are at risk of psychiatric hospitalization or placement into residential treatment; children being discharged from psychiatric hospitals or residential treatment; children with severe emotional disturbances such as conduct disorders and oppositional defiant disorders; children with significant, persistent psychiatric conditions; children who are court involved; children whose families are financially unable to obtain mental health services elsewhere in the community; children experiencing Reactive Attachment Disorders; children who experience Post Traumatic Stress Disorder; children who exhibit sexually reactive behaviors and children who exhibit sexually predatory behavior.
DCF referrals receive priority consideration. The severity of each referral determines whether an appointment be given that same day, within 3 business days, within 14 calendar days or within 30 calendar days.

Therapeutic Foster Care - This service is an intensive, structured, clinical level of care provided to children with serious emotional disturbance (SED) within a safe and nurturing family environment. Children in a TFC placement receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing and/or ameliorating a child's mental/behavioral health issues, and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan, and facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or guardianship).

Substance Abuse Treatment Services

ASSERT Treatment Model (ATM) is a service that is being piloted and introduced within four (4) existing Connecticut Multidimensional Family Therapy (MDFT) teams.

ATM provides treatment for adolescents and young adults 16-21 years old with opioid use problems. ATM combines three services: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Management Checkups and Support (RMCS) to reduce opioid use and commonly associated substance use problems and offers up to 12 months of support after treatment ends.

MDFT is an intensive, family-centered treatment for youth with substance use and co-occurring mental health problems. **MAT** for opioid use problems will be available within ATM for those youth who need and want it**. Recovery Management Checkups & Support (RMCS)** provides post-MDFT monitoring and rapid re-entry to services through periodic assessment, linkages to community programs, and helping youth to enter and stay in treatment.

SAFE Family Recovery (SAFE-FR) provides three (3) evidence-based approaches to identify, engage in substance use treatment, and support parents/caregivers impacted by substance use. The three services are:

a. Screening, Brief Intervention, and Referral to Treatment (SBIRT) identifies adult parent/caregivers with substance use indicators who may need a full assessment and/or treatment.
b. Multidimensional Family Recovery (MDFR) addresses the complex, multigenerational challenges facing families affected by parental substance use and child welfare system involvement.
c. Recovery Management Check-ups and Support (RMCS) provide support and ongoing assessment, facilitate involvement with pro-recovery peers and activities, detect return to use and other concerns, assertively link to services as needed, and promote positive family relationships.

SAFE Family Recovery will also collect and process hair tests for adult parent/caregivers meeting strict criteria.

Family Based Recovery (FBR) is an intensive, in-home clinical treatment program for families with infants or young children (birth to 71 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance use. The overarching goal of the intervention is to promote stability, safety, and permanence for these families. Treatment and support services are family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance use treatment for the parent(s) and attachment-based parent-child therapy.

Evidence Based Treatment Programs

Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC) is an evidence-based substance use outpatient substance use treatment program for adolescents ages 12 through 17 years and their caregivers. The model

provides a combination of clinic, community, and home-based services, based on the individualized need of the youth and family served.

ACRA is a behavioral therapy that seeks to use social, recreational, familial, school, or vocational reinforcers and skill training so that non-substance using behaviors are rewarded and can replace substance use behavior (Meyers & Smith, 1995). It uses a positive, non-confrontational approach, while emphasizing engagement in positive social activity, positive peer relationships, and improved family relationships. The intervention consists of 19 procedures delivered over a period of three (3) months where therapists draw upon the menu of procedures based on individualized client needs and goals. There are three types of ACRA sessions: youth alone, parents/caregivers alone, and youth and parents/caregivers together.

ACC is designed to follow a primary episode of treatment to help sustain recovery. ACC uses ACRA procedures to structure sessions; however, more emphasis is placed on helping youth follow-through with needed education/GED services, juvenile justice compliance, accessing healthcare, among others. ACC and case management services are delivered in the home and community and are seamless from the ACRA phase of treatment. Case management activities with youth are included to increase recovery support through linkage and transportation services to assist them in participating in recovery-enhancing activities. During this phase of treatment therapists continue to meet weekly with youth and/or their caregivers/parents for another 3-month period.

Care Coordination - This evidence-based service provides high fidelity "Wraparound" care using the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths, ages 018, with serious or complex need. The primary goal of Care Coordination is to support and maintain youth exhibiting serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

Child and Family Traumatic Stress Intervention (CFTSI)
CFTSI focuses on two key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - The evidence based Cognitive Behavioral Intervention for Trauma in Schools program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events,

such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters.

Early Childhood Services - Child FIRST - This evidence based service provides home based assessment, family plan development, parenting education, parent-child therapeutic interventions, and care coordination/case management for high-risk families with children under six years of age (including pregnant women) in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect. Child First is an evidenced based model of treatment with strict fidelity to the Child First model.

Early Serious Mental Illness ESMI-ICM– This service will provide early identification of FEP, rapid referral to evidence-based and appropriate services, and effective engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders.

Functional Family Therapy (FFT) – FFT is an evidenced-based practice providing an intensive period of clinical intervention, family support and empowerment, access to medication evaluation and management, crisis intervention and case management in order to stabilize children at risk of out-of-home placement due to mental health issues, emotional disturbance or substance abuse, or to assist in their successful return home from an alternative level of care. Length of service averages approximately 4 months. The tenets of the FFT model provide for flexible, strength-based interventions and are offered primarily in the client's home as well as in community agencies, schools and other settings natural to the family.

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) – This is an evidence-based treatment designed for children ages 7 - 15. Unlike most treatment approaches that focus on single disorders, MATCH is designed for multiple disorders and problems, including anxiety, depression and posttraumatic stress, as well as disruptive conduct such as the problems associated with ADHD (Attention Deficit Hyperactivity Disorder).

Multidimensional Family Therapy (MDFT) is an evidence based, comprehensive and multisystemic family-based in-home program for adolescents using substances, adolescents with co-occurring substance use and mental health disorders, and those at high risk for continued substance use and other problem behaviors. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. MDFT looks to address four interdependent treatment areas to achieve effective clinical outcomes: the adolescent, the parent, the family, and systems such as school and juvenile justice. Interventions include weekly sessions of individual therapy with the adolescent, therapy with the parent(s), and family therapy to address adolescent and family issues specific to this youth. When indicated, services include urine drug screens, case management, and/or a parent-adolescent HIV/STD prevention group.

Interventions also focus on promoting communication and relationship-building among the family members.

Multisystemic Therapy (MST) is an evidence-based program that empowers adolescents and families to improve functioning over the long term. MST works within the network of systems including family, peers, school, and neighborhood. MST teams have small caseloads and provide services in the home at times that are convenient to the family for approximately 3-5 months. All treatment, care, and support services are provided in a context that is adolescent-centered, family-focused, strength-based, culturally, and linguistically appropriate, and responsive to each adolescent's psychosocial, developmental, and treatment care needs. The target population for this program are adolescents between the ages of 12-18 years who present with significant behavioral health needs (mental health and substance use) impacting the family, school/work, community domains, and reside in a family setting.

Multi-systemic Therapy - Building Stronger Families - Using a national evidence-based treatment model, intensive family and community-based treatment is provided to families that are active DCF cases due to the physical abuse and/or neglect of a child in the family and abuse of or dependence upon marijuana and/or other substance misuse by at least one caregiver in the family. Core services include clinical services, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 9 months per family.

MST- Emerging Adults (MST-EA) – This service provides intensive individual and community based treatment to transition-aged youth with multiple co-occurring disorders and extensive system involvement with the goal of reducing the young adult's substance use and mental illness symptoms, and promote gainful activity such as school, work, housing and positive relationships. In addition to clinical work with a therapist, an MST-EA coach serves as a positive mentor and engaged the young adult in prosocial, skill building activities. Treatment duration averages 7-8 months, with an additional 2-4 months (average) with the MST-EA coach. Sessions with the client occur 3-5 times weekly, depending upon the client's needs. In addition to increasing positive transition age role functioning, this approach seeks to reduce symptoms of SMHC, and seek abstinence or reduction of substance misuse.

MST – Intimate Partner Violence (MST-IPV) –This service, building upon a national evidence-based treatment model, provides intensive family and community-based treatment to families that are active cases with DCF due to the physical abuse and/or neglect of a child in the family and identification of intimate partner violence in the family. This new model takes a family-oriented, comprehensive, and integrated treatment model approach for family members involved in households with IPV that emphasizes both short- and long-term safety, protects children from witnessing violent incidents, and address the individualized risk factors for IPV including co-morbid substance use. Core services include clinical services, trauma treatment, empowerment and family support services, medication management, crisis intervention, and case management. Average length of service is 6 - 9 months per family.

Multi-systemic Therapy - Problem Sexual Behavior - This service provides clinical interventions for youth who are returning home from the Connecticut Juvenile Training School (CJTS) or a residential treatment program after having been identified as being sexually abusive, sexually reactive and/or sexually aggressive behaviors. The youth have been identified as needing sexual offender specific treatment. The service is based upon an augmentation of the standard MST team model, an evidence based clinical model with an established curriculum, training component and philosophy of delivering care. The average length of service is 6-8 months per youth/family. All clients referred receive a comprehensive evaluation resulting in a multi-axial diagnosis and individualized treatment plan.

Parenting Support Services – (previously known as Triple P) This service is for families with children 0-18 years-of-age to support and enhance positive family functioning. Families receive one or more of the PSS interventions along with case management services using the Wraparound philosophy and process. PSS offers the evidenced-based model, Level 4 Triple P (Positive Parenting Program®) and the Circle of Security Parenting© intervention. Triple P helps parents become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Circle of Security Parenting (COS) is designed to build, support, and strengthen parents' relationship capabilities so they are better equipped to provide a quality of relationship that is more supportive of secure attachment.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Detailed information about implementing SBIRT is available in SAMHSA's Technical Assistance Publication Series 33.
SBIRT uses valid and reliable screening tools to assess the presence and level of substance use problems. Screening provides opportunities for early intervention with persons who are at-risk of substance use problems, or to engage persons with more severe substance use into treatment. The Department desires to achieve the following goals with SBIRT:

- Quickly assess substance use severity to determine which (if any) referrals should be made to substance use treatment providers and/or other services.
- Increase the person's insight and awareness of substance use problems and motivation toward entering treatment through brief intervention.
- Reduce unnecessary referrals for toxicology screening, evaluation, and treatment through better identification of needs, and more targeted referrals to providers.
- Provide those identified as needing more extensive treatment with quicker access to care.

The Department supports the use of Adolescent SBIRTs through Mobile Crisis, outpatient clinics, school settings, medical providers, and others.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - Trauma-Focused Cognitive Behavioral Therapy is an evidence-based treatment for children and

adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.

Crisis Services

Mobile Crisis Intervention Services - Mobile Crisis is an intervention for children experiencing behavioral health or psychiatric emergencies. The service is delivered through a face-to-face mobile response to the child's home, school or other location preferred by the family. Telehealth and telephonic intervention are available if/when appropriate.

Mobile Crisis Intervention Service System - Statewide Call Center – The Statewide Call
Center is the entry point for access mobile crisis services for all children and youth in Connecticut. The Statewide Call Center receives calls, collects relevant information from the caller, determines the appropriate initial response, and links the caller to the information or service indicated. In addition to these primary functions, the Statewide Call Center also collects data regarding calls received, triage responses and referrals to Mobile Crisis contractors. The Statewide Call Center operates 24 hours per day, 365 days per year. The Call Center analyzes statewide data and compiles reports for DCF, the Statewide Call Center, Mobile Crisis contracted service providers, and other entities as determined by DCF.

Performance Improvement Center - This service supports and sustains the delivery of high-quality Mobile Crisis Services and, Care Coordination throughout the state of Connecticut by directing and implementing quality improvement activities and standardized training to Mobile Crisis, and Care Coordination contractors. Quality Improvement activities include the collection, analysis, and reporting of quality improvement data provided by the Mobile Crisis Call Center (211) and Mobile Crisis contractors (and sub-contractors). Monitoring and supporting Mobile Crisis quality is provided by a combination of consultation, satisfaction surveys, fidelity ratings, and other activities. Training and workforce development activities for, Care Coordination and Mobile Crisis include the provision of pre-service, in-service and special topic training in the core competencies necessary to operate a quality service.

DCF Congregate Care Services for Children, Youth and Families
Mental Health Treatment Services

Career Enhancement Training - This service is a training program, known as, Manufacturing in Motion. It is designed to develop job-related learning opportunities in a collaboration between Goodwin College and Touchstone School staff and faculty. These learning experiences will complement the formal academic program by adding career building skills and vocational education. The content of this career enhancement

training will focus on areas such as customer service, office support, and personal finance, computer-aided design, manufacturing principles, allied health opportunities and career skills.

Short Term Assessment and Respite Home (STAR) – STAR is a temporary congregate care program that provides short-term care, evaluation and a range of clinical and nursing services to children and youth removed from their homes due to abuse, neglect or other environments which are high-risk. Staff provide empathic, professional childcare, and develop and maintain a routine of daily activities like a nurturing family structure. The children and youth receive assessment services, significant levels of structure and support, and care coordination related to family reunification, or matching with a foster family or a congregate care setting, as indicated.

Therapeutic Group Home - This service is a small (4-6 bed) staffed home within a local community designed for youth with psychiatric/behavioral issues (must have a specific Axis I diagnosis). Youth entering these homes come primarily from larger residential facilities. Therapeutic techniques/strategies are utilized in the relationship with the child, youth and family, primarily through group and milieu experiences. The service provides an intensive corrective relationship in which therapeutic interactions are dominant, thereby assisting the children and youth in improving relationships at school, work and/or community settings. Appropriate linkages with alternative or transition services are in place prior to a child or youth's discharge.

Substance Abuse Treatment Services

Multidimensional Family Therapy (MDFT) Group Home.
This service utilizes the MDFT model in a 4-month in-care setting. Services include intensive clinical interventions for children with significant behavioral health service needs who are returning home from a residential level of care. After a comprehensive evaluation, a strength-based Individualized Service Plan is developed to include goals, interventions, services and supports that address the issues and problems threatening the return of the child to the home. Significant behavioral health needs and either alcohol or drug related problems or are at risk of substance use are focus areas of this program.

Crisis Services

Crisis Stabilization - This service provides short term, residential treatment for children and youth with a rapidly deteriorating psychiatric condition, in order to reduce the risk of harm to self or others and divert children and youth from admission into residential or inpatient care. Interventions focus on stabilization of the child and youth's behavioral health condition including addressing any contributing environmental factors and enhancing existing outpatient services available.

Short-Term Family Integrated Treatment (S-FIT): This is a short-term residential treatment option providing crisis stabilization and assessment, with rapid reintegration

and transition back home. The primary goal of the program is to: Stabilize the child, youth and family (adoptive, biological, foster, kin, or relative) and strengthen their extended social system; assess the family's current strengths and needs; identify and mobilize community resources; and, coordinate services to ensure rapid reintegration into the home. S-FIT is an alternative to psychiatric hospitalizations and/or admissions to higher levels of care and seeks to stop placement disruptions. The program serves DCF involved children and adolescents ages 12- 17 (with an option to seek a waiver through DCF licensing for children under the age of 12). Many of these children and youth will have experienced multiple disruptions or a particularly traumatic event and have significant mental health and/or medical and high-risk behavior management needs.

DCF Behavioral Health System Strengths

Connecticut's behavioral health system has a number of strengths, but the following eight are noteworthy: First, Connecticut has a strong and robust system with an impressive statewide capacity across a diverse service array. (See above description of CT service array) Second, Connecticut has one of the strongest evidence-based service arrays in the nation. (See list and description above) Third, Connecticut has a strong trauma informed care system. (See description below) Fourth, Connecticut has adopted the system of care approach, and as a result we have a large family involvement component and the strength based, family-driven approach is well established (See description below). Fifth, Connecticut strongly promotes prevention health and wellness. Sixth Connecticut has a strong family-centered child welfare practice model. Seventh, Connecticut has a number of infant and early childhood mental health initiatives. (See below description) Finally, Connecticut has engaged and developed strong partnerships with many stakeholders including the behavioral health community providers, families, schools, pediatric primary care providers, faith-based institutions and small informal grass-roots organizations.

System of Trauma-Informed Care

The Connecticut Department of Children and Families has been building a statewide system of trauma informed care for children, youth and families. This is based on the knowledge that the DCF staff and providers of service must be both trauma-aware and trauma-informed to address the multiple challenges that traumatized children, youth and their families bring with them. Children and youth who are involved with and receive services through DCF have typically experienced or been exposed to traumatic events such as physical abuse, sexual abuse, chronic neglect, sudden or violent loss of or separation from a loved one, domestic violence, and/or community violence. Often these children and youth have emotional, behavioral, social and mental health 42 challenges that require special care and treatment. This has significant implications for the delivery of services. The DCF trauma aware and trauma-informed system seeks to change the engagement paradigm with children, youth and families from one that asks, "What is wrong with you?" to one that asks, "What has happened to you?"

Trauma-informed care is an overarching framework for DCF, which incorporates trauma awareness and guides general practice with children, youth and families who have been impacted

by trauma. Trauma awareness is acknowledging the presence of trauma symptoms in individuals with histories of trauma and understanding the role that trauma has played in their lives. The DCF trauma informed care system promotes healing environments and prevents re-traumatization by embracing "key" trauma informed principles of safety, trust, collaboration, choice, and empowerment. In addition, the trauma informed care system requires the use of evidence-based trauma specific services and treatments. The trauma-informed approach implemented by DCF incorporates the following basic strategies:

- Maximize the child, youth and family's sense of physical and psychological safety
- Identify the trauma-related needs of children, youth and families
- Enhance the child, youth and family's well-being and resiliency
- Partner with families and system agencies
- Enhance the well-being and resiliency of the DCF workforce

DCF has taken a number of steps in building a system of trauma informed care. Beginning in 2007, DCF utilized a combination of DCF state funds, Mental Health Block Grant funds and a federal grant from the Administration for Children and Families to partner with a coordinating center, the Child Health and Development Institute (CHDI) to disseminate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in community-based children's outpatient clinics across Connecticut. This is an evidence-based practice for children and youth ages 4 through 21 and their caregivers who have experienced a significant traumatic event and are experiencing chronic symptoms related to the trauma exposure. TF-CBT is a time limited intervention, which usually lasts five to six months and involves outpatient sessions with both the child and caregiver. There are currently over 35 clinics in Connecticut, over 72 total sites and an additional 62 clinicians were trained this year to bring the total to 950 clinical staff trained to provide TF-CBT.

In 2014 DCF began implementation of the evidence based “Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and/or Conduct Problems” (MATCH) for children, youth and their caregivers. MATCH is a mental health assessment and treatment model designed to deal with multiple problems and disorders encompassing anxiety, depression, posttraumatic stress, and conduct problems. Children and youth can initially present with anxiety, depression, or behavioral issues that belie underlying trauma. MATCH allows the flexibility to deal with both the overt and underlying cases of trauma. The MATCH treatment model 43 works to ensure that children and youth with less overt “developmental” trauma are identified and receive effective and comprehensive trauma treatment services. Last year 472 children received a MATCH intervention. An additional 4 agencies were trained in MATCH this past year, bringing the total to 27 agencies statewide. An additional 40 clinicians were trained this year, bringing the total number of clinicians trained to 181.

DCF continues to expand access to Cognitive Behavioral Intervention for Trauma in Schools (CBITS); an evidenced based treatment model for children suffering from post- traumatic stress symptoms as a result of trauma experiences in their lives. Eighteen school districts and over 50 schools are offering CBITS across the state. To date, more than 800 students have received treatment in school and the vast majority have successfully completed the intervention with an additional 10% partially completing the treatment course. One percent were referred on to other treatment options. There was a 41% reduction in PTSD symptoms, a 19% reduction in behavior problems from pre to post assessment, indicating significant improvements.

The statewide Mobile Crisis Service that DCF funds and oversees has staff trained in trauma principles and conducting trauma screening. This infuses trauma informed care in the state's crisis intervention. DCF has also been involved in providing pediatric primary care providers, school personnel and police with training on identifying and responding to child and youth trauma.

As part of the federal grant from the Administration on Children and Families, in 2013 DCF implemented a statewide trauma training and universal trauma screening. All DCF regional office service staff were trained in using the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit. The staff were also trained to administer a brief, standardized trauma screening tool. Now all children involved with DCF are screened for trauma exposure and traumatic stress symptoms, and those deemed at risk are referred for further assessment by clinicians trained in trauma assessments and trauma-focused treatments. The goal is to identify children suffering from traumatic stress symptoms as early as possible and to connect them to appropriate services. Providers are also now utilizing the screening tool for both clinical and non clinical services

Infant Mental Health

In 2011, The CT Department of Children and Families (DCF) was awarded the Early Childhood Child Welfare grant, "Strengthening Families, Infant Mental Health" through a partnership with the CT Head Start State Collaboration Office, Head Start/Early Head Start and the Connecticut Association for Infant Mental Health, which provided an intensive series of eight trainings on infant mental health in the Hartford/Manchester DCF Region.

The trainings were designed to create a shared knowledge base for staff, to promote a unified approach for working with families with complex needs and to enhance working relationships among staff from the various disciplines.

The eight full day training series has, of this year, been delivered to DCF staff and Community Providers in all six regions. The training's focus is on working with young children and their families who are dealing with unresolved loss and trauma and how that impacts relationships, particularly their relationships with their infants and toddlers. The topics will be related to the Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

An average of 40-50 DCF staff and their partners have attended each series. Topics included "Understanding Infant/Toddlers and Their Families;" attachment, brain development, temperament, separation, sensory integration, the Challenges of Unresolved Loss and Traumas; Reflective Practice; Infusing a Trauma Lens into Infant Mental Health Practice; Cultural Sensitivity in Relationship-Focused Settings; Assessments and Referrals and Successful Visitation for parents and infants/toddlers. Continuing education credits have been offered by the Academy to social workers. In addition, reflective supervision training was provided and practice in reflective supervision was offered through face-to-face coaching sessions.

The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department are planning to offer two statewide training eight session training series in the coming year.

Family/Caregiver Involvement

Connecticut has long-term, well-organized and effective consumer, family, and advocacy organizations. These include, but are not limited to: FAVOR our statewide behavioral health family organization, Children's Behavioral Health Advisory Council (CBHAC), State Advisory Council (SAC), Youth Advisory Boards and others. (Please refer to Section 1 for details). The Mental Health Block Grant (MHBG) state plan is informed by CBHAC and its MHBG subcommittee. Families and consumers also participate in reviewing bidder proposals for new or re-procured programs and services, learning collaboratives such as the family engagement and TF-CBT collaboratives for outpatient clinics, and various committees to evaluate programs, develop new services and initiatives, and implement plans.

At the direct service level, there are care coordinators, family engagement specialists, intensive care managers (CT BHP), child-specific team meetings for non-DCF involved children, child and family team meetings for DCF-involved children, and other resources to assist families in successfully connecting with and effectively utilizing appropriate resources.

Collaboration Within and Across Agencies and Systems

Efforts aimed at coordinating services at the community level occur across child welfare, juvenile justice, adult and children's behavioral health, developmental, and healthcare service systems. The goal is to promote more efficient and integrated service delivery. At the state level several councils and boards exist to assist in the planning and coordination of behavioral health services.

Husky A (Medicaid) and Husky B (CHIP - Child Health Insurance Program)

Husky A and B are the cornerstone of Connecticut's health care infrastructure for children, parents, and pregnant women whose income are near or under 185% of the Federal Poverty line. CT continues to directly reimburse providers for health care but utilizes a private, not-for-profit contractor (Community Health Network of Connecticut) as the Administrative Service organization (ASO), to provide administrative support functions, such as assisting families in accessing healthcare, conducting outreach to enroll providers, and tracking utilization of and access to services. Connecticut continues its relationship with Value Options as the ASO for behavioral health services for adults and children with Medicaid. Value Options is an integral part of the Connecticut Behavioral Health Partnership (CTBHP) with DCF, Department of Social Service, and (state Medicaid dept.) Department of Mental Health and Addiction Services, and a legislative oversight committee that provides for a systems-of-care, data informed and innovative approach to behavioral health care for children and youth in Connecticut. In 2018, CT Medicaid paid for 2,324 youth inpatient psychiatric stays, for a total number of 27,262 inpatient days; and 195 psychiatric residential treatment facilities (PRTF) admissions for a total number of 33,909 days. In addition, there were over 14,000 behavioral health emergency department (ED) visits. In 2017, CT experienced 3 suicides per 100,000 youth. Medicaid provides health insurance for 357,525 low income children in Connecticut. The youth Medicaid membership has remained

stable by age group. For families of four in Connecticut, children are eligible for Medicaid with family income up to $51,758. The uninsured rate for CT children is over 3%.

State of Connecticut
Combined MHBG/SABG Block Grant Application/Plan
Federal Fiscal Year 2022 - 2023

Adult Services

Introduction

The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) prepared the State of Connecticut FFY 2022-2023 combined block grant application and plan. DCF contributed only to the development of the Community Mental Health Services Block Grant (MHBG), as Connecticut has a consolidated child welfare agency. Both the Substance Abuse Prevention and Treatment (SABG) and MHBG components were developed in close collaboration with Connecticut's State Behavioral Health Planning Council (BHPC) which encompasses both mental health and substance use.

DMHAS' purpose is to assist persons with psychiatric and substance use disorders to recover and sustain their health through delivery of high-quality services that are person-centered, value-driven, promote hope, improve overall health (including physical), and are anchored to a recovery-oriented system of care. DMHAS' system of care is predicated on the belief that the majority of people with mental illness and/or substance use disorders can and should be treated in community settings, and that inpatient treatment should be used only when necessary to meet the best interests of the client. Since the merger of Connecticut's mental health and addiction services agencies in July 1995, DMHAS has expanded its vision to incorporate the growing body of promising behavioral health practices. During that time, DMHAS has invested its collective energy in promoting a behavioral health service system that is culturally competent and rooted in evidence-based services.

DMHAS is responsible for providing a full range of behavioral health treatment services to adults (age 18 and older). This includes inpatient hospitalization and detoxification, residential rehabilitation, outpatient clinical services, 24-hour emergency care, day treatment and other partial hospitalization, psychosocial and vocational rehabilitation, restoration to competency and forensic services (including jail diversion programs), outreach services for persons with serious mental illness who are homeless and comprehensive community-based behavioral health treatment and recovery support services. The department manages a network of Local Mental Health Authorities (LMHAs) and community-based private nonprofits to deliver behavioral health treatment and supports at the community level. It also maintains close working relationships with its statutorily defined planning entities, the Regional Behavioral Health Action Organizations (RBHAOs) which are responsible for mental health, substance use and problem gambling, as well as advocacy agencies, families, consumers/persons in recovery, and other state agencies in its efforts to deliver the most effective treatment and recovery support services needed.

During state fiscal year (SFY) 2018, DMHAS provided and/or funded behavioral health services to over 100,000 individuals, through its inpatient, outpatient, and recovery support programs. Over 100,000 persons were recipients of prevention and health promotion activities in the Institute of Medicine (IOM) categories of selected and indicated, while over a million persons were potential target recipients of some form of universal prevention efforts conducted within the state.

Community-based Treatment Services

The department's **Community Services Division (CSD)** has direct responsibility for overseeing most DMHAS contracted services, which includes funded Local Mental Health Authorities (LMHAs) for behavioral health services as well as all funded community nonprofit addiction service providers. CSD activities are listed below. These activities are done in conjunction with the Evidence-Based Practices Unit that is part of CSD:

- Monitoring the contracted private nonprofit providers that make up the DMHAS system of behavioral health, including private nonprofit substance use treatment providers and LMHAs, and some state operated programs are monitored for fidelity (e.g., ACT, CSP, mobile crisis) to ensure contract compliance and adherence to best practice models;
- Identifying service gaps, new services, and system changes that enhance efficiency, increase access, and support people living successfully in recovery;
- Facilitating the implementation of department initiatives intended to enhance or create service capacity to increase service effectiveness;
- Collaborating with the department's Evaluation, Quality Management and Improvement (EQMI) division to monitor provider data, including admission and discharge information, demographics and services delivered, and client outcomes;
- Responding to and resolving consumer and family questions and concerns;
- Facilitating access to services for clients and their families; and
- Coordinate, write and submit most discretionary grant applications for DMHAS, in collaboration with other DMHAS divisions and partners.

CSD provides oversight to the seven private nonprofit contracted LMHAs and ensures they receive information regarding department policies and system initiatives. CSD provides a consistent approach in its collaboration with LMHAs to operationalize fiscal, administrative, and clinical responsibilities, as well as DMHAS initiatives, at the local level. CSD monitors the activities of the LMHAs in allocating resources among programs and facilities in response to system needs providing a link between LMHAs and DMHAS' Office of the Commissioner. This organizational structure recognizes variations in local needs and provides the essential framework for achieving DMHAS' objectives and operations. The six state-operated LMHAs report directly to the DMHAS Assistant to the Commissioner, and some state-operated programs are included in CSD monitoring activities for a statewide perspective (e.g., ACT, CSP). CSD Regional Managers coordinate with the state-operated LMHAs regarding their nonprofit affiliate agencies in order to assure access and coverage to mental health services.

LMHA functions include:

- Service coordination and care and case management in a recovery-oriented environment
- Critical linkages with other agencies for service needs, such as housing and entitlements
- Crisis intervention
- Program development and management
- Implementation of DMHAS initiatives
- Budget development and management
- Contract oversight of their affiliates
- Utilization review/quality assurance (QA)/quality improvement (QI)
- Information system management
- Community relations and education, and consumer/family input into service system evaluation and planning

In addition to DMHAS-operated and –funded programs, behavioral health services in Connecticut are delivered through other public and private providers such as:

- Private mental health/substance use practitioners
- Private nonprofit mental health providers not funded by DMHAS
- DOC for prison inmates and parolees
- Board of Pardons and Paroles for persons paroled into the community
- Judicial Branch- Court Support Services Division (JB-CSSD) for probationers
- Federally Qualified Health Centers, Health Maintenance Organizations, and primary care physicians
- U.S. Department of Veterans' Affairs, including inpatient psychiatric beds, and outpatient and counseling services at two VA medical centers, six community-based outpatient clinics and four Veterans' Centers
- Volunteer-run, peer supported services and self-help groups

Mobile Emergency Crisis Services

Mobile Emergency Crisis Services are defined as mobile, readily accessible, rapid response, short term services for individuals eighteen (18) or older and their families experiencing episodes of acute behavioral health crises. These services are delivered with appropriate safety measures in safe settings through the Local Mental Health Authority (LMHA) and one other community agency through the use of mobile emergency crisis teams. Mobile emergency crisis services provide concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, stabilize psychiatric symptoms, behavioral, and situational problems, and whenever possible, avert the need for hospitalization. Mobile emergency crisis services focus on evaluation, stabilization and supports and activities may include: assessment, evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further continuous care and assistance as required. Mobile emergency crisis clinicians collaborate with and assist local police officers to de-escalate crises and provide diversion to alternative settings rather than incarcerations. DMHAS has implemented the Crisis Intervention Team (CIT) model, a best practice designed to promote safety for persons in crisis, the community, and the police officers who respond to crisis calls. The CIT trained clinicians work collaboratively with police departments and, when available, respond to crisis calls with the police.

Crisis Respite Services

DMHAS provides Crisis Respite Services on a statewide basis and 100 beds in total These programs provide a structured community bed setting staffed 24/7 for individuals age 18 and older, with access to licensed prescribers and clinical staff. Services include: medication monitoring, stabilization activities, and an array of outpatient interventions. Crisis Respite services provide further crisis supports to those in behavioral health/psychiatric distress and/or are having extreme conflict in their current living situation that is of such intensity or duration that it may require such services in order to avoid hospitalization. Crisis Respite beds are available for use within the Mobile Crisis Services programming and as part of the continuum of care in order to stabilize individuals, avert psychiatric inpatient hospitalization, and return persons to their current residence and optimum recovery.

Outpatient Services

Outpatient services are professionally directed services that include evaluations and diagnostic assessments; biopsychosocial histories, including identification of strengths and recovery supports; a synthesis of the assessments and history that results in the identification of treatment goals; treatment activities and interventions; and recovery services. Such services are provided in regularly scheduled sessions and nonscheduled visits as needed, and include individual, group, and family therapy, as well as medication management.

Group Homes

Group Homes are congregate community residences that are staffed 24/7 and provide a set of residential and rehabilitative services. Individuals residing in the group home have significant skill deficits in the areas of self-care and independent living as a result of their psychiatric disability requiring a non-hospital, structured and supervised community-based residence. A written plan of care or initial assessment of the need for services is recommended by a physician or other licensed practitioner. Group homes are intended primarily as a step-down service from inpatient hospitalization.

Intensive Residential Mental Health Treatment

Intensive Residential Mental Health Treatment is a highly structured setting that provides a set of recovery-oriented residential and rehabilitative services with 24-hour staff supervision. Some individuals admitted may also have co-occurring medical conditions, such as diabetes and obesity, which are complicated by an adjunct psychiatric disorder. Admissions come directly from a state-operated inpatient facility and must be approved through the department's Medical Director or his designee.

Persons with Mental Illness who are Homeless

In an effort to decrease the number of homeless individuals with SMI, or with co-occurring substance use disorders, DMHAS has continued to apply for and receive federal formula funds from Projects for Assistance in Transition from Homelessness (PATH). PATH serves persons with SMI or who are dually diagnosed with SMI and a co-occurring substance use disorder that are experiencing homelessness or at risk of becoming homeless. The PATH funded staff are scattered across the state in urban, suburban, and rural settings. In addition to PATH providers, DMHAS worked to create a network of social service and rental subsidy providers to produce approximately 4500 units of permanent supportive housing. These units include housing subsidies with case management services and are dedicated to individuals who are experiencing homelessness and have a mental health or co-occurring substance use disorder with the goal of stabilizing the individual in the community.

Assertive Community Treatment (ACT)

Assertive Community Treatment services are evidence-based practices provided by mobile, community-based staff operating as multidisciplinary teams of professionals, paraprofessionals and recovery support specialists who have been specifically trained to provide ACT services. ACT services include intensive engagement, skill building, community support, crisis services and treatment interventions. There are 10 ACT teams across the state (5 state-operated and 5 PNP).

Community Support Programs (CSP)

Community Support Programs are available statewide to assist adults who are interested in skill building and/or need more **Targeted Case Management (TCM)** services). CSP services focus on building and maintaining a relationship with the individual while delivering the following services through approximately 35 CSP programs

- Targeted case management (TCM)
- Rehabilitative, skill building interventions and activities
- Facilitating connections to the individual's community recovery supports
- Emphasizing individual choice, goals and recovery
- Providing peer support

Mental Health Bed Registry

DMHAS launched a real-time bed availability website for all DMHAS operated and funded mental health beds in 2020. It includes over 1700 beds across 45 agencies and is updated at least weekly by providers. CSD maintains this website with a vendor.

Mental Health Recovery Support Services

Social Rehabilitative Services –

Social Rehabilitative Services provide supportive, flexible environments and activities to enhance daily living skills, interpersonal skill building, life management and pre-vocational skills that are necessary for successful integration into a community environment. Pre-vocational activities may include temporary, transitional, or volunteer work assignments. Activities assist clients in accessing peer groups and developing relationships.

Recovery Support Specialists –

Recovery Support Specialists are persons in recovery who have received training to become certified to work as part of multi-disciplinary community-based treatment teams along with psychiatrists, social workers, and case managers to assist individuals with mental illness who have not been responsive to traditional forms of treatment. Recovery Support Specialists provide outreach, support, and follow-up

services to individuals in the community including, but not limited to, locations such as emergency rooms, jails, homeless shelters, and outpatient services.

Recovery Support Training Program -

The Recovery Support Training Program provides consumer-operated recovery/advocacy training academies that train persons with lived experience in the following technologies: Certified Recovery Specialist Training; General System & Legislative Advocacy (in English and Spanish); Peer Bridging; Wellness Recovery Action Planning (WRAP); Intentional Peer Support (IPS); and Pathways to Recovery. Classes are conducted in self-esteem and in developing networks of support and specialized classes are offered in Certified Hearing Voices Support Group Facilitation and Peer Support in Forensic Facilities. These services provide a way for consumers to identify their resources and develop wellness strategies, to make proactive crisis plans when not in crisis; as well as to prepare them to conduct educational presentations in their communities and organizations. Training is overseen by Advocacy Unlimited (AU).

Peer Support – Vocational Services – 2 programs

Peer Support – Vocational Services provide peer-based vocational supports to individuals with psychiatric disabilities. Through the use of trained peer mentors, individuals in recovery are provided opportunities that aid in the development and pursuit of vocational goals consistent with the individual's recovery. Supports include: assistance with finding, obtaining, and maintaining stable employment; and promoting an environment of understanding and respect in which the individual is supported in their recovery. These services foster peer-to-peer assistance to support individuals in recovery toward stable employment and economic self-sufficiency.

Consumer Peer Support in General Hospital Outpatient Departments -

Consumer Peer Support in General Hospital Outpatient Departments is directed at improving the quality of services and interactions experienced by individuals with psychiatric disabilities who seek outpatient treatment in general hospitals. Using consumers who have completed a training program, these peer advocates assist individuals accessing outpatient care in understanding hospital policies and procedures, and assuring that individuals' rights are respected.

Intensive, Community-Based Peer Bridging Services –

Intensive, community-based Peer Bridging Services are services contracted through Advocacy Unlimited in which certified Recovery Support Specialists with lived psychiatric experience provide outreach, engagement and support in the community to adults with SPMI who are at risk for, or currently involved with, the Probate Court system. Peer Bridgers operate in hospitals, emergency rooms, jails or other community locations where their services are needed. The Peer Bridgers develop relationships with community resources and supports and function as liaisons for the program participants, including providing transportation. The Peer Bridgers provide long-term support for persons with SPMI to function optimally in the community.

Parenting Support and Parental Rights Services – Carol M

Parenting Support and Parental Rights Services maximize opportunities for parents with psychiatric disabilities to protect their parental rights, establish and/or maintain custody of their children, sustain recovery through individualized, home-based services and supports, and to promote the utilization of temporary guardianships.

Special High School Education Services – Amy Marracino

DMHAS is mandated by state and federal statutes to provide education and related services (vocational, speech, occupational and physical therapy, and physical education) to all "special education" eligible 18 – 22-year-old residents of DMHAS facilities, who have not graduated from high school and are interested in continuing their education while in residence. Accomplishment of this task requires the screening of all 18 – 22-year-old inpatient admissions to DMHAS facilities.

A large number of students who turn 18 who are in need of acute care at one of DMHAS' adult psychiatric facilities are those transitioning from DCF, Beacon, or CSSD.

DMHAS Special Education Services continues to be effective in designing unique and successful post-recovery education programs that are then implemented in the community. There is a high level of collaboration between DMHAS Special Education Services and DMHAS Young Adult Services as 18 – 22 year-old clients are discharged to supportive community settings.

Supportive Housing – Alice

Permanent Supportive Housing programs provide in-home wrap around services to individuals and families with children who are experiencing homelessness and are diagnosed with a mental health and/or substance use disorder. Services include assistance with securing permanent housing, education about appropriate tenancy skills, knowledge of tenants' rights and responsibilities, money management and household budgeting. Based on an individual needs assessment, the services offered include access to clinical, medical, social, educational, rehabilitative, employment and other services essential to achieving optimal quality of life and community living. Various levels of support are available to program participants and are offered indefinitely, as needed. Additionally, DMHAS follows the "housing first" model which states that there are no conditions placed on an individual or family before entering housing. There are no additional provisions related to disability or services added to any lease or housing contract; to remain housed a person must comply with the lease.

Continuum of Substance Use Treatment Services -

Overview

Treatment and rehabilitation programs utilize a variety of strategies, all of which seek to provide appropriate services to address substance use disorders. These strategies include:

- **Pre-Treatment**: services and activities necessary for a client to become engaged in and/or enter treatment
- **Medication Assisted Treatment and Ambulatory Drug Detoxification**: medication assisted services (MAT), counseling and management of withdrawal for alcohol, heroin and other opioids in a non-residential setting
- **Residential Detoxification**: medical management of the withdrawal from alcohol and drugs along with, MAT, case management linkages to treatment
- **Residential Rehabilitation**: treatment services in a structured, therapeutic environment for individuals who need assistance in developing and establishing a drug free lifestyle in recovery. Such services include various levels of residential care, from intensive to long-term.
- **Outpatient (standard and intensive)**: individual, group and family counseling services for individuals with substance use or co-occurring substance use and psychiatric disorders, and families and significant others, including office-based MAT (i.e., buprenorphine, naltrexone).
- Opioid Treatment Programs (OTPs): outpatient methadone treatment programs that include counseling for individuals with opioid use disorders.
- **Treatment Support Services**: ancillary services that support an individual's engagement and/or retention in treatment and recovery, including case management, transportation, housing and vocational services
- **Continued Care and Recovery Support Services**: supportive services that provide post-treatment assistance to those individuals working on and in recovery such as housing, transportation, employment services and relapse prevention. In addition, supports provided include telephone peer support and Recovery Centers. Mutual help organizations, e.g., 12-step programs, provide a supportive network, which encourages individuals in their efforts to maintain a substance-free lifestyle in the community.

The above treatment modalities are intended to focus on the following service priorities:

- Services geared to the medical management of the withdrawal from alcohol and other drugs
- Residential services intended to impact significant levels of the personal and social effects of substance use disorders
- Ambulatory services to assist the individual in re-entering or remaining in the community
- Services for individuals who are opioid dependent are intended to provide opioid replacement therapy along with supportive rehabilitative services to facilitate successful lives in recovery

The above treatment modalities are also intended to serve the Substance Abuse Prevention and Treatment Block Grant priority populations of:

- Pregnant women (PW) and Women with dependent children (WDC)
- Persons who inject drugs (PWID)
- Persons with or at risk for HIV/AIDS
- Persons with or at risk of Tuberculosis (TB)

Members of these priority populations will receive care based on what is recommended for them as determined by assessment combined with their preferences. Pregnant women are given priority access to treatment and will receive prenatal care directly by the provider or through referral. Pregnant women

and women with dependent children have specialized “Women and Children’s” programs available along with supportive services. Persons with opioid use disorders who inject drugs can access MAT which has expanded services to meet needs resulting from the current opioid epidemic. Services are available for persons with TB and HIV/AIDS including screening, counseling, treatment and referrals for care and the data for both these populations reflect a trend of decreasing numbers of new infections.

Detoxification Services

Medically Managed Detoxification (4.2)

Medically managed detoxification services, provided in a private freestanding psychiatric hospital, general hospital or state-operated facility, are medically directed treatments of a substance use disorder, where the individual’s admission is the result of a serious or dangerous substance dependence that requires a medical evaluation and 24/7 medical withdrawal management. For individuals who have co-occurring psychiatric and substance use disorders, assessment and management are available. These programs are increasingly using methadone, buprenorphine and naltrexone to start people on long-term use of these medications for OUD.

Medically Monitored (Residential) Detoxification (3.7D)

Medically monitored detoxification is provided in a residential facility licensed by the Department of Public Health (DPH) to offer residential detoxification and evaluation; it involves treatment of substance use dependence when 24-hour medical and nursing oversight is required. Comprehensive evaluations and withdrawal management are provided as well as short-term counseling, connections to treatment, and referrals to other supports. These programs are increasingly using methadone, buprenorphine, and naltrexone to start people on long-term use of these medications for OUD.

Residential Rehabilitation Services

Intensive Residential Rehabilitation – Co-Occurring Enhanced (3.7E)

Intensive Residential Rehabilitation – Co-Occurring enhanced services are residential services provided in a facility licensed by the DPH to offer intensive residential treatment, or in a state-operated facility that provides medically and behaviorally-directed concurrent treatment of co-occurring psychiatric and substance use disorders where an individual’s admission requires continued stabilization of psychiatric symptoms as well as substance use treatment. The program is utilized when 24-hour medical and nursing supervision are required to provide evaluation, medication management, and symptom stabilization. Other intensive services include those of a rehabilitative nature such as illness education and self-management and other skill building. Length of stay can be up to 45 days.

Intensive Residential Rehabilitation (3.7)

Intensive Residential Rehabilitation treatment for substance dependence or co-occurring disorders is a residential service provided in a facility licensed by DPH to offer intensive residential treatment, or in a state-operated facility. These services are provided in a 24-hour setting and are intended to treat individuals with substance use or co-occurring disorders who require an intensive rehabilitation program. Services are provided within a 15 to 30-day period and include assessment, medical and psychiatric evaluation if indicated, and an intensive regimen of treatment modalities including individual

and family therapy, specialty groups, psychosocial education, orientation to AA or similar support groups, and instruction in relapse prevention.

Intermediate/Long-Term Residential (3.5)

Intermediate or long-term residential treatment for substance use disorders is a service provided in a facility licensed by DPH to offer intermediate or long-term treatment or care and rehabilitation. These residential services are intended to address significant problems with functioning in major life areas due to a substance use disorder or a co-occurring psychiatric and substance use disorder with the goal of community re-integration and establishing a life in recovery. A minimum of twenty hours per week of treatment and services in a structured recovery environment is provided to individuals who generally remain in treatment for 3 to 6 months.

Long-Term Residential Care (3.3)

Long-term residential care for substance use disorders is a service provided in a facility licensed by DPH to offer intermediate or long-term treatment or care and rehabilitation. This service is intended for individuals with significant impairment and long-term difficulties with functioning in major life areas due to a substance use disorders or a co-occurring psychiatric and substance use disorder. Services are provided in a structured recovery environment with 24/7 staff supervision, and may include vocational exploration as well as life skills training intended to assist individuals with re-integration into the community and establishing a life in recovery. Individuals generally remain in treatment for 6 months.

Transitional/Halfway House (3.1)

Transitional Living and Halfway Houses are licensed by DPH to offer intermediate, long-term treatment, care and rehabilitation. They are licensed to provide at least 4 hours of treatment per week to each individual. These services are intended for individuals who have experienced significant problems with their behavior and functioning in major life areas due to a substance use disorder, or a co-occurring psychiatric and substance use disorder, and who are ready to re-integrate back into the community and establish a life in recovery. Services are provided in a structured recovery environment with the focus being on obtaining employment and community re-integration.

Ambulatory (Outpatient) Services

Intensive Outpatient Services

Intensive outpatient services offer intensive mental health or substance use disorder treatment for a minimum of three hours per day, three days per week. Services include individual and group therapy, therapeutic activities, case management and a range of other rehabilitative activities.

Veterans Recovery Center (VRC) at Fellowship House

A collaborative effort between DMHAS and the Connecticut Department of Veterans' Affairs (DVA) is the Veterans Recovery Center providing outpatient and an optional four-week intensive outpatient (required 12 hours per week) programs for veterans. Services provided by DMHAS include relapse

prevention, 12-step groups, anger management groups, and meditation classes. The Fellowship House is located on the grounds of the DVA under the auspices of DMHAS. The program is designed to assist and support veterans with substance use disorders to achieve their recovery goals. The VRC interfaces with other services on the DVA grounds, including educational and vocational referrals, employment counseling and job placement assistance.

Standard Outpatient

Standard outpatient services provide professionally directed evaluation, treatment and recovery services. Services are provided in regularly scheduled sessions and include individual, group, family therapy, and psychiatric evaluation and medication management. If the program focuses on the needs of seniors (those age 55 and over), information related to older adult services and substance abuse is provided. These senior services are delivered in homes, senior centers, and nursing homes as necessary.

Medication Assisted Treatment –

Methadone Maintenance
Methadone maintenance is a non-residential, medically necessary service provided in a state-operated facility, or in a facility licensed by DPH to offer medically necessary chemical maintenance treatment. Methadone maintenance involves regularly scheduled administration of methadone, prescribed at individual dosages, and includes a minimum of one clinical contact per week. More frequent clinical contacts are provided if indicated in the individual's recovery plan. Medical and nursing supervision are provided.

Buprenorphine and Naltrexone Maintenance
Buprenorphine maintenance is a non-residential, medically necessary service provided in a state-operated facility, or in a facility licensed by DPH to offer medically necessary chemical maintenance treatment. Buprenorphine maintenance involves regularly scheduled administration of Buprenorphine, prescribed at individual dosages, and usually includes adjunct clinical/counseling services. More frequent clinical contacts are provided if indicated in the individual's recovery plan. Medical and nursing supervision are provided. In response to the opioid crisis, DMHAS has applied for and received SAMHSA grant funds which have allowed it to expand buprenorphine and naltrexone access by assisting prescribers in its facilities with obtaining the DATA waiver to prescribe, providing guidelines for infrastructure development related to buprenorphine prescribing, and hiring recovery coaches to assist in the process.

Ambulatory Detoxification
Ambulatory detoxification is a non-residential service provided in a private freestanding psychiatric hospital, general hospital or facility licensed by DPH to offer ambulatory chemical detoxification. This service uses prescribed medication, as indicated, to alleviate adverse physical or psychological effects that result from withdrawal from continuous or sustained substance use by an individual who has been evaluated as being medically able to tolerate an outpatient detoxification. Services also include an assessment of needs, including those related to recovery supports and motivation of the individual regarding his/her continuing participation in the treatment process.

Substance Use Support Services

Recovery House

Recovery Houses are intended for individuals in recovery from substance use or co-occurring disorders who would benefit from a sober living environment to support their recovery. These transitional living environments provide 24-hour temporary housing and support services for persons who present without evidence of intoxication, withdrawal or psychiatric symptoms that would suggest inappropriateness for participation in such a setting. The length of stay for residents is generally less than 90 days. Recovery houses are not licensed and do not offer treatment services.

Sober Housing

Supported Recovery Housing Services (SRHS) are non-clinical, clean, safe, drug and alcohol-free transitional living environments with **on-site case management services** available at least 8 hours per day, 5 days per week. SRHS provide 24-hour temporary housing and support services for persons with a substance use or co-occurring substance use and psychiatric disorder who present without evidence of intoxication, withdrawal or psychiatric symptoms that would suggest inappropriateness for participation in such a setting. Advanced Behavioral Health (ABH), the department's Administrative Services Organization (ASO), credentials SRHS providers and contracts with them to provide housing and case management services to persons in recovery. In order to be credentialed, an organization must meet certain minimum standards and the homes must maintain certain minimum house rules. Case management services include assessment, recovery planning, and discharge planning with the goal of linking residents to substance use and mental health treatment services, entitlements, employment, permanent housing, and other community supports that promote autonomy. The length of stay for residents is generally less than 90 days. Recovery or "sober" houses are not licensed and do not offer treatment services.

Standard Case Management

Standard case management programs provide a range of activities to individuals with substance use disorders or co-occurring psychiatric and substance use disorders. Services include linking individuals to necessary clinical, medical, social, educational, rehabilitative, employment, and other services and recovery supports.

Intensive Case Management (ICM)

Intensive case management programs provide a range of activities to individuals with severe substance use disorders or co-occurring psychiatric and substance use disorders. Services include linking individuals to necessary clinical, medical, social, educational, rehabilitative, and vocational or other services. Services may also include intake and assessment, individual recovery planning and supports, medication monitoring and evaluation. Services are intensive and may be provided daily or multiple times a week if necessary. Intensive case management services are generally short in duration with individuals receiving services for 30 to 90 days.

Outreach and Engagement

Outreach and engagement programs provide a range of activities to individuals with behavioral health disorders who are homeless. Activities may be provided utilizing a team model, which includes behavioral health workers and clinical, nursing, and psychiatric staff, and utilizes a wide range of engagement strategies. Activities are directed toward helping individuals acquire necessary clinical, medical, social, educational, rehabilitative, vocational and other services in hopes of achieving optimal quality of life and lives in recovery in the community. Services include intake and assessment, individual service planning and supports, intensive case management services, counseling, medication monitoring and evaluation.

Employment Services

Employment services are an array of activities that assist individuals to identify and select employment options consistent with his/her abilities, interests, and achievements. Services facilitate finding employment as well as supports to attain specific employment and educational objectives.

Transportation

Transportation services are provided to individuals receiving services from a funded service provider. Transportation services for persons receiving substance use services are primarily utilized to deliver individuals at an emergency room or department-funded provider agency to another treatment location as well as any individual who may require transportation from one level of care to another. DMHAS has expanded transportation coverage for persons with substance use disorders in general and specifically for persons with opioid use disorder across the state When persons with opioid use disorder contact the statewide access line (see below), not only will a phone assessment and referral be provided, but transportation as needed to bring the person to the treatment location providing “treatment on demand”.

Access Line

Persons with a substance use disorder who are interested in accessing treatment can call 1-800-563-4086 on a statewide 24/7 basis for initial screening, referral, and transportation if needed, to treatment. This service, which was previously only available to one region of the state, has been expanded in response to the opioid crisis. The goal is to connect persons struggling with Opioid Use Disorders (OUDs) and other SUDs rapidly to treatment.

Real Time Bed Registry

DMHAS launched a real-time bed availability website for all DMHAS operated and funded SUD beds in 2017. This website is updated daily by providers and facilitates access for clients, families and other providers. CSD maintains this website with the assistance of a vendor.

Evidence-Based and Best Practices

DMHAS-operated and –funded mental health and addiction treatment providers are supported in the use of the following evidence-based and best practices, including:

Assertive Community Treatment (ACT)

Assertive Community Treatment services are a set of evidence-based practices provided by mobile, community-based staff operating as multidisciplinary teams of professionals, paraprofessionals and recovery support specialists, who have been specifically trained to provide ACT services. ACT services are recovery-oriented, and include intensive engagement, skill building, community support, crisis services, and treatment interventions. There are 10 ACT teams. DMHAS uses the Tool for Measurement of Assertive Community Treatment (TMACT) as a fidelity measure. DMHAS received on-site training and technical assistance from Dr. Lorna Moser, funded by SAMHSA block grant TA, on the administration of this tool.

Integrated Treatment for Individuals with Co-Occurring Disorders

DMHAS knows that a large number of individuals served by the department have both a mental health and a substance use disorder. Mental health and addiction treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders. Specialized staff training, consultation, and pilot treatment projects for persons with co-occurring disorders have been put in place over the last twenty years to address the treatment needs of individuals with co-occurring disorders. The 13 LMHAs have implemented the Integrated Dual Disorders Treatment (IDDT) model and addiction treatment providers have used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index to guide integrated care for individuals with co-occurring disorders. Some mental health programs have also gravitated to using the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) instead of the IDDT model to guide their integration efforts. DMHAS created two co-occurring enhanced residential treatment programs that were procured in 2009 and continue today. A third residential treatment program has reached co-occurring enhanced status. DMHAS contracted with an IDDT consultant from Dartmouth Medical School for 9 years (2002 – 2011) and with Dr. Mark McGovern (also from Dartmouth) for about 10 years to train and consult with DMHAS providers on the DDCAT. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and addiction treatment agencies on a combined Co-Occurring and Supervision model for a couple of years. Due to declining resources, DMHAS has had to suspend the Co-Occurring Practice Improvement Collaborative meetings and those specific fidelity reviews, but continues to include a co-occurring focus in all activities carried out by the department.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy continues to be implemented by providers. The Connecticut Women's Consortium, as part of its contract with DMHAS, provides DBT trainings.

Supported Employment (SE)

Using the Individual Placement and Support (IPS) model, SE is implemented in thirty programs throughout the state. This evidence-based model is described in contract language as the scope of work.

Fidelity reviews continue to support high fidelity implementation. DMHAS continues to participate in the international supported employment collaborative convened by Westat. In fall 2014, DMHAS was awarded a 5-year SAMHSA Supported Employment grant to strengthen and expand SE services across the state, particularly for Latinos and individuals with criminal justice involvement.

Supported Education

DMHAS contracts with five regionally-based providers to provide supported education. The department has adopted and uses SAMHSA's Supported Education Fidelity Scale from the EBP toolkit.

Supportive Housing

Supportive Housing continues with high quality fidelity monitoring and implementation.

Trauma-Informed and Trauma-Specific Services

DMHAS contracts annually with the Connecticut Women's Consortium to provide training, consultation and implementation support for DMHAS' mental health and addiction treatment agencies. The Consortium trains professionals annually on trauma-informed care and trauma-specific services, such as Seeking Safety, TREM, M-TREM, EMDR, Beyond Trauma, and Helping Men Recover. Gender-responsive services are also part of these offerings.

Medication Assisted Treatment (MAT)

Medication Assisted Treatment is provided through a strong network of methadone providers statewide. The availability of buprenorphine and naltrexone has increased. DMHAS continues to support the implementation of MAT throughout all services, so that, for example, individuals with SMI served in our LMHAs have access to FDA-approved medications for substance use disorders.

Other Evidence Based Practices (EBPs)

Other EBPs, such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT), are supported and embedded in several other EBPs (e.g., IDDT, DDCAT, and ACT) and other levels of care (e.g., outpatient, residential).

Alternative Services

DMHAS has an integrative Medicine Committee at Connecticut Valley Hospital as well as a statewide committee. The first annual conference was held in December 2016. There is increased emphasis in this area relative to the opioid crisis (e.g., alternative pain management strategies). A webpage was created on the DMHAS website documenting the committee's work and information on this topic: https://portal.ct.gov/DMHAS/Initiatives/Integrative-Medicine/IM-Integrative-Medicine.

Alternative treatments and initiatives targeting Wellness have become more generally accepted and are providing opportunities for clients with mental health, substance use and co-occurring conditions to empower themselves by taking control of their own recovery. Healthy activities related to diet, exercise, meditation, etc. are offered in group settings which also provide an opportunity for positive social interactions and the forming of friendships with peers. DMHAS funds the Toivo Center of Advocacy

Unlimited in Hartford. At Toivo, people in recovery from mental health and substance use issues operate the programs and engage others in their activities which include yoga, mindfulness and other creative ventures.

EBP Governance Committee

In FY 2011, DMHAS created an Evidence-Based and Best Practices Governance Committee which continues to meet on a quarterly basis. The Governance Group consists of executive staff, state operated CEOs, and office of the Commissioner Division Directors. In 2010, DMHAS designated a new position in the Office of the Commissioner: Director of Evidence-Based Practices (EBPs). This position provides staff support to the Governance Group along with other functions that promote the adoption of evidence-based practices throughout the system of care. Four managers report to the Director of EBPs, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system. In 2015, this division also took on the federal grants coordination role, which includes leading the writing and submission effort for many of the SAMHSA discretionary grant DMHAS submits. These grants are often a vehicle for incorporating EBPs into the system.

The EBP Division created a series of webpages on the DMHAS website that describe different EBPs and various publications available to help implement the practices. This is a valuable resource for providers, consumers and families**:** https://portal.ct.gov/DMHAS/Initiatives/Evidence-Based/EvidenceBased--Best-Practices.

Targeted Services and Populations

Trauma Services

Trauma responsivity is a governing principle of DMHAS. Services within the system meet the needs of individuals who have experienced trauma by establishing an environment that is safe, protecting privacy and confidentiality, and eliminating the potential for re-victimization. DMHAS promotes recovery by understanding trauma and its effects on individuals and their families, and by offering a trauma-responsive system of care with approaches which are both trauma-specific and trauma-informed. Standardized screening tools for trauma are used and staff training is available.

Connecticut adopted a Trauma Services Policy in April 2010, to foster a health care system that employs and practices principles that are trauma-informed and trauma-responsive to individuals served by DMHAS and funded agencies. DMHAS contracts with the Connecticut Women's Consortium (CWC) to provide training and consultation on trauma-informed (TI), trauma-specific (TS), and gender-responsive (GR) services to DMHAS-operated/funded agencies in a variety of formats:

- The Consortium releases a Training Catalogue three times a year with many TI,TS and GR workshops and training events: https://www.womensconsortium.org/training-catalogs Trainings cover over 100 topics including aging & geriatric, diversity & gender, healing arts, substance use & addiction and trauma models & trauma informed care such as: Seeking Safety, TREM, M-TREM, Helping Women Recover, Helping Men Recover, Beyond Trauma, and Eye Movement Desensitization Reprocessing, among others. Certain trauma-specific trainings

provide a copy of the manual for each participant. DMHAS-operated facilities are allotted two free staff training slots for each trauma event. The cost for DMHAS-funded participants is subsidized by DMHAS funding.

- The Trauma and Gender (TAG) Learning Collaborative bimonthly meeting is co-chaired by DMHAS and the CWC and promotes best practices in trauma- informed and gender-responsive behavioral healthcare in Connecticut by providing recommendations, tools, trainings, national/local experts and networking opportunities to **all** DMHAS funded and operated agencies.
- The Women's Services Practice Improvement Collaborative (WSPIC) is a partnership of the CWC, DMHAS and women's specialty service providers. The collaborative meets bi-monthly and offers all women's services providers with an opportunity to learn from each other in a collaborative environment. Expert speakers are brought in to enhance learning and provide education on evidence based practices, new DMHAS initiatives and current trends related to women's healthcare. Recent topics include implementation of reproductive health interventions "One Key Question" curriculum, breastfeeding in recovery, maternal and infant attachment, Child Abuse Prevention and Treatment Act (CAPTA), education/vocational interventions in substance use disorder programming and best practices for families experiencing homelessness and housing instability. Additionally, a case study is presented each month by a treatment provider, and feedback and resources are shared by the group to enhance clinical practice.
- The Consortium publishes a *Trauma Matters* newsletter quarterly which is widely distributed: www.womensconsortium.org/trauma-matters .
- The Consortium maintains a statewide Trauma Directory of trauma services of DMHAS-operated and funded agencies to update this directory: https://www.womensconsortium.org/ct-trauma-services-directory
- DMHAS maintains a Trauma Initiative webpage: https://portal.ct.gov/DMHAS/Initiatives/Evidence-Based/Trauma-Initiative

Women's Services

The Department of Mental Health and Addiction Services (DMHAS) provides a number of resources and supports for pregnant and parenting women throughout our state. These include direct service contracts for *case management/ recovery coaching, outpatient, intensive outpatient and residential programs*. Additionally, DMHAS participates in a number of vital interagency collaborations aimed at strengthening the response from providers when working with women and reducing barriers for treatment access and stigma.

All contracted women's specialty programs provide directly or through a referral the following services:

- Primary health care and prenatal care including reproductive health and access to Doula services;
- Primary pediatric care including immunizations for children of women in treatment;
- Mental health services, including evaluation, treatment, and medication prescribing and monitoring;
- Linkages to coordinate and integrate support services with substance use services and prenatal services;

- Non-emergency transportation to medical and social services for pregnancy-related care;
- Access to voluntary Human Immunodeficiency Virus (HIV) and tuberculosis (TB) testing and counseling;
- Child care and child development services which facilitate mother-child bonding and teach/enhance parenting skills;
- Overdose prevention and harm reduction planning;
- Identification and provision of services for children with prenatal exposure to drugs and alcohol;
- Random urine or breathalyzer testing;
- Discharge planning and aftercare, including referrals to appropriate services and supports, relapse prevention and referrals to housing; and
- Access to the following services: Vocational rehabilitation, family planning, sexual assault crisis services, intimate partner violence services, school-based health clinics, parent aid services, birth-to- three programs, life skills training, nutrition and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs through written cooperative agreements with other agencies.

Since 2010, DMHAS revised its Priority Access and Interim Services protocol to improve access and ensure quality of care. While all SAPT Block Grant funded programs continued to follow the same protocol in terms of ensuring Priority Access and Interim Services for women within 48 hours of requesting treatment, the Department instituted a centralized referral line for providers to manage placement and capacity issues.

Women's Specialty Services

Within the seven substance use residential programs for pregnant and parenting women, individuals receive twenty hours of treatment per week attending to issues of trauma, intimate partner violence, 12 step support groups, individual, group and family counseling, relapse prevention, psychoeducation groups on mental health/co-occurring disorders, as well as information on infant mental health, neonatal abstinence syndrome, attachment and bonding, parenting, and sexuality and reproductive health. Infants/children reside with their mother and participate in Early Head Start programming. All of the programs can accommodate women on medication assisted treatment. As part of the treatment service, women are also connected to the **Women's Behavioral Health Program** which provides holistic case management services to maximize the likelihood of a woman's success as she reintegrates into the community after discharge from a residential program. Women receive up to 6 months of ongoing case management services following discharge from residential substance use treatment.

67 Bed Capacity – Pregnant & Parenting Women Substance Use residences

Agency	Residential Program	Location
Liberation Programs	Families in Recovery Program	Norwalk
Connection, Inc.	Hallie House	Middletown
Connection, Inc.	Mother's Retreat	Groton
APT Foundation	Amethyst House	New Haven

Community Health Resources	New Life	Putnam
InterCommunity	Coventry House	Hartford
Wellmore Behavioral Health	Women & Children's Program	Waterbury

In 2021, a step down program for pregnant and parenting program was created to allow women access to a less restrictive residential setting prior to accessing the community. The **Women's Recovery Support Program** (WRSP) is a 7 bed program located in Bridgeport, CT. This program focuses on recovery supports and assists with coordinating community based medical, behavioral health and recovery needs.

Women's Outpatient Services

DMHAS also funds community based substance use outpatient and intensive outpatient programs where women can bring their children to treatment with them to reduce barriers around childcare. All programs provide gender-specific and trauma-informed services.

Agency	Outpatient Program	Location
CASA, Inc.	Project Courage	Bridgeport
Wheeler Clinic	Lifeline	New Britain
MCCA	Women & Children's Program	Danbury
Connection, Inc.	Connection Counseling Center	Norwich
APT Foundation	Access Center	New Haven
Wellmore Behavioral Health	Wellmore Counseling Center	Waterbury

Effective March 1, 2019, DMHAS launched its **Women's Recovery Engagement Access Coaching and Healing (REACH) Program** which provides statewide, community based case management and recovery coaching services delivered by *Women's Recovery Navigators*. Navigators are women with lived experience of substance use or co-occurring disorders who also assume a key role in helping pregnant women develop their Plan of Safe Care in line with federal and state Child Abuse Prevention and Treatment Act (CAPTA) legislation. Through development of community relationships within the healthcare network, recovery community and social service system, linkages are established to ensure women are aware of the support resources available to them to help support and sustain a safe and healthy path for women and their families.

15 Women's Recovery Navigators statewide – 3 per region

Women's REACH Program Agency	Locations Served
CASA, Inc.	Region 1 (Bridgeport, Norwalk & Stamford)

The Connection, Inc	Region 2 (Middletown, Meriden & New Haven)
Advanced Behavioral Health	Region 3 (Norwich, New London & Willimantic)
The Village for Families & Children	Region 4 (Hartford, New Britain & Manchester)
The McCall Center for Behavioral Health	Region 5 (Danbury, Waterbury & Torrington)

Parents Recovering from Opioid Use Disorder (PROUD)

Women's oversees the DMHAS PROUD program which is funded by a three-year, $2.7 Million SAMHSA grant awarded to DMHAS in August 2020. The goal of PROUD is to engage 480 Pregnant or Parenting women (PPW) with Opioid or other substance use disorders (OUD/SUD) in services over the course of the three years. PROUD began accepting referrals to the program on January 1, 2021. PROUD targets a geographic area in central CT where data reveals disproportionate racial, social and economic disparities as compared to other areas of CT. Intercommunity and Wheeler Clinic are the direct service providers of the PROUD initiative. Each site has a multidisciplinary team of staff including: clinicians, care coordinators/case managers, and peer recovery coaches to work with the PPW and any members of her household who may benefit from services and/or referrals. To reduce barriers, PROUD site teams work with women and families in the home, in the community, and at the 2 program sites, based on client need and preference; virtual services are also offered. Additionally, the providers provide wrap-around services to PPW and their family members to support whole-person health, including: behavioral health, primary care, Medication Assisted Treatment, and pediatric care. The PROUD teams work closely with birthing hospitals to promote individualized and recovery-oriented discharge planning for women and infants impacted by substance use, and ensure that hospital personnel are educated on CAPTA/Plans of Safe Care.

A portion of PROUD SAMHSA funding is designated to provide training and education to healthcare professionals on topics related to best practices in working with PPW with OUD/SUD. As such, DMHAS contracts with the **Connecticut Hospital Association** (CHA) to provide virtual educational sessions to professionals within their network. In addition to CHA, DMHAS has partnered with The Connecticut Women's Consortium to continue efforts to train DMHAS providers on topics related to reproductive health and the **One Key Question** model. Lastly, a small amount of funds has been utilized to support the creation and dissemination of marking materials by the **O'Donnell Group**.

Key Interagency Collaborations

SEI/FASD Initiative

This initiative is funded by DMHAS and DCF. The mission of the initiative is to improve the capacity of professionals to diagnose, treat and prevent prenatal substance exposure, including Substance Exposed Infants (SEI) and Fetal Alcohol Spectrum Disorder (FASD), and through education, policy, and increase coordination of services that engage and support families impacted by substance use. In 2015, the **NAS/FASD Statewide Coordinator** position was established. The SEI coordinator is tasked with implementing the five-year strategic plan developed by DMHAS and DCF while determining ongoing mutual priorities with project partners related to screening and assessment, engagement and retention in treatment, and data and information sharing.

CT Women and Opioids Workgroup (CT-WOW)

This workgroup was created in 2016 following an invitational symposium sponsored by the US DHHS, Office of Women's Health. The interagency workgroup has established partnerships and a strategic plan to address the Child Abuse Protection and Treatment Act (CAPTA) which requires the notification by healthcare settings of substance exposed infants to DCF, incorporation of reproductive health education for women with substance use disorders and further investigation of evidence-based practices for pain management for women with substance use disorders**.**

Since 2004, the **Women's Services Practice Improvement Collaborative (WSPIC)** has provided ongoing training and technical assistance to women's behavioral health programs. WSPIC's goal is to improve the quality of behavioral health services for women so that they are trauma-informed, gender-specific, holistic, and promote self-determination. The WSPIC collaborative meets bi-monthly.

The **Trauma and Gender Practice Improvement Collaborative (TAG)**

This collaborative includes representation from DMHAS, the Connecticut Women's Consortium (CWC) and Connecticut's private nonprofit providers to promote recovery-oriented, trauma-informed, gender-responsive care. The Collaborative meets bi-monthly to review best practices, identify tools, share information, work with nationally-known trainers/consultants, and connect agencies. The Collaborative has worked to establish a standardized screening process to identify individuals with co-occurring disorders and their treatment needs, regardless of where the individual presents for care. As a result of these efforts, three new programs that are co-occurring enhanced have been created not only for women, but for men as well.

Every Woman Connecticut (EWCT)

Every Woman Connecticut is an initiative that focuses on addressing improvements in care for individuals of childbearing age, recognizing that physical, emotional, and social health are vital to overall wellbeing. A primary intervention promoted by EWCT is **"One Key Question© (OKQ)."** DMHAS has provided extensive training on this curriculum and has successfully implemented it throughout our service system.

Two-Generation Interventions (2 Gen)

The Department has partnered with sister agencies in the adoption of a two-generation focus in the PPW programs by creating programming and interventions that support a women's role as caregiver and as an integral component of the family unit. One such intervention is the partnering of DMHAS' Pregnant and Parenting Women Substance Use residences with the Office of Early Childhood/Early Head Start. Early Head Start has been offered to all women and children in the PPW residential programs since 2015 to provide access to comprehensive services and support for all low-income children. Each program has developed a memorandum of agreement with a local Early Head Start provider and several had the opportunity to participate in Infant Mental Health and Circle of Security Training to help women and children improve attachment, recover from trauma and understand the interaction of these topics within the parent-child relationship and family system.

The CT Hospital Association (CHA) goals for **Neonatal Abstinence Syndrome Comprehensive Education and Needs Training (NASCENT)** are to initiate standardized approaches for the recognition and treatment of NAS across hospitals and to improve early recognition of substance use disorders in pregnant women. Messaging throughout the training supports the premise that recovery is possible and attainable with the appropriate treatment course and NAS is treatable and has not been associated with long-term adverse consequences.

Child Abuse Prevention and Treatment Act (CAPTA) Stakeholder Group

This stakeholder group has met regularly to guide the implementation of the federal mandate in the state of CT. In partnership with other state agencies, community partners and hospitals, DMHAS has facilitated ongoing trainings on the impact of CAPTA on women with substance use disorders and their families, specifically facilitating the inclusion of the women's voice in the decision making process. Ongoing efforts will continue to evaluate data generated and support recommendations to reduce stigma and healthcare disparities.

Young Adult Services – Amy Marracino

Early intervention with young adults experiencing significant behavioral health challenges can improve overall quality of life, increase the potential for productive adulthood, and avoid life-long service costs and other adverse outcomes. The Young Adult Services (YAS) division at DMHAS continues to serve some of the most psychiatrically complex young people within Connecticut with a focus on those youth transitioning from DCF, CSSD and Beacon Health Options. DMHAS Young Adult Services clients are more likely to display complex psychiatric issues including developmental trauma, significant neurocognitive difficulties, and impairments in life skills. As a result, the youth being referred benefit from the intensive services offered within YAS which foster a supportive, safe, and structured environment that allows them to learn the skills that they need in order for them to transition to more independent living in the community.

In an effort to provide these levels of care that are age and developmentally appropriate and trauma-informed, DMHAS YAS not only focuses on the clinical aspects of care, but also the practical aspect of skill development and basic needs to improve quality of life. In addition, YAS continues to identify programs and initiate projects to support the treatment and recovery needs of these high risk youth and

young adults. YAS has also established peer mentoring and young adult advisory boards and continues to provide training and support on the inclusion of families in the person-centered planning process. YAS has also enhanced programming opportunities around strengthening employment skills and employment experiences in youth businesses.

In 2009, YAS established the young parents' service program in recognition of the need to assist and inform staff and young adults on the principles of positive parenting, parent-child attachment, and the effects of trauma on children and adults. Goals of the program are to support staff and to teach young adults to make informed choices, form healthy relationships, and to learn about sexuality and parenting. The YAS parenting program provides prenatal care, labor and delivery support, and postpartum supports, in addition to in-home parenting education. By supporting the pregnant young woman during her pregnancy, the chances that she and her child will experience a healthier relationship are increased.

Over the past year and a half, the Offices of the DMHAS Medical Director, Statewide Services, and Young Adult Services collaborated to plan and conduct statewide trainings from a nationally recognized expert, Dr. Barent Walsh, in the understanding and treatment of severe self-injury. The trainings emphasized current research and evidence-based practices for individuals whose symptoms resulted from severe childhood maltreatment and trauma. Young Adults Services also conducted planning to train YAS clinicians statewide in the Cognitive Restructuring for PTSD (CR PTSD) evidenced-based trauma treatment model designed for individuals with early childhood trauma who cannot tolerate treatment interventions that emphasize direct exposure of past trauma. The training model will be initiated in the next fiscal year and include a direct training phase coupled with clinical supervision by Dr. Walsh. Block Grant dollars were allocated to fund the trainings/consultations provided by Dr. Walsh to date.

Prevention Services – Carol Meredith

Prevention services are within the Office of the Commissioner and under the oversight of the Director of Prevention and Health Promotion. The Prevention & Health Promotion Division oversees and administers the prevention set-aside funds for the Behavioral Health Block Grant, the implementation of the Synar amendment, and a number of federal discretionary grants that are earmarked for specific issues. The Prevention and Health Promotion Division is strategically aligned with SAMHSA's Strategic Prevention Framework (SPF) and its five steps comprised of 1) conducting needs assessments, 2) mobilization and capacity building, 3) planning, 4) implementing evidence-based strategies, and 5) monitoring and evaluation. The division is organized to provide accountability-based, developmentally appropriate, and culturally sensitive behavioral health services based on evidence-based models and best practices, through a comprehensive system that matches services to the needs of the individuals and local communities.

The DMHAS prevention goal is to promote emotional health and reduce the likelihood of substance use and mental illness. The DMHAS prevention statewide system of services and resources are designed to provide an array of evidence-based universal, selected, and indicated programs and promote increased prevention service capacity and infrastructure improvements to address prevention gaps.

DMHAS SAPTBG –funded prevention programs are organized into two major categories: (1) Direct Service Programs that focus on tobacco prevention and enforcement, underage alcohol use prevention, the prevention of non-medical use of prescription drugs and opioid overdoses, mental health promotion, and programs that link substance use, mental health and other problem prevention; and (2) The prevention resource links that undergird and support prevention service capacity and infrastructure improvements to address prevention gaps. They include:

Governor's Prevention Partnership – is an organization comprised of public/private partnerships focused on building a strong, healthy future workforce by providing mentoring programs, violence prevention programs, underage drinking programs and other drug and alcohol programs. They also raise awareness of issues through their partnership with several media outlets across the state and nationally.

Training and Technical Assistance Services Center – provides training workshops that focus on prevention skills development, application of these skills, mental health promotion, and violence and substance use prevention. They also assess the workforce training needs and ensure that trainings align with Prevention Certification.

Center for Prevention Evaluation and Statistics (CPES) – operated through a contract with the University of Connecticut's Health Centers' Department of Community Medicine, the purpose of this center is to collect, manage, analyze and disseminate data from our prevention projects; provide training and technical assistance to the prevention field on data and evaluation related topics; and help us with the development and administration of data. The CPES also administers the ***State Epidemiological Outcomes Workgroup (SEOW)***. An interagency group of data experts, the SEOW is charged with compiling indicators or substance use and related consequences, tracking data trends over time, and promoting the use of data to continually focus and strengthen alcohol, tobacco and other drug prevention efforts statewide.

Connecticut Clearinghouse – is a statewide library and resource center for information on substance use and mental health disorders, prevention and health promotion, treatment and recovery, wellness and other related topics. In addition, they assist with coordinating and delivering specific training and operate a listserv for Prevention. They are also instrumental in providing educational materials for the tobacco merchant education program which discourages the selling of tobacco products to minors. Lastly, they manage a statewide group of college/university personnel who have come together to address campus substance use and they administer mini-grants to these campuses.

Regional Behavioral Health Action Organizations (RBHAOs) - These private non-profit organizations comprised of a board of directors of community stakeholders are the primary entities responsible for a range of planning, education, and advocacy of behavioral health needs and services for children and adults within each of DMHAS' five uniform regions. Every two years, the RBHAOs conduct comprehensive analyses of their region's substance abuse and mental health needs and response capacity, and produce Regional Profiles that identify priorities, resources and assets and make recommendations on addressing gaps and needs.

Direct service programs include:

- ***Local Prevention Councils (LPCs) -*** Through the RBHAOs, all 169 cities/towns throughout Connecticut receive mini grants to support local, municipal-based alcohol, tobacco and other drug (ATOD) use prevention councils. The intent of this grant program is to facilitate the development and/or implementation of ATOD use prevention initiatives at the local level with the support of the chief elected officials. The specific goals of LPCs are to increase public awareness of ATOD prevention and stimulate the development and implementation of local prevention activities primarily focused on youth. Funds have been used to leverage more resources and can be used to support activities to increase awareness of opioid problems in this region.
- ***Prevention in CT Communities (PCCs)-*** A total of 11 community-based programs/coalitions implement the5-step Strategic Prevention Framework (SPF) planning model to reduce substance use in youth. Two coalitions will implement 3 of the 5 steps to develop a plan to address a SA priority uncovered in their communities that address 12-17 year-olds. The remaining 9 coalitions will apply all 5 steps of the planning framework to plan for and implement evidence based programs that reduce alcohol use in 12-20 year-olds.
- Under the oversight of the CT Clearinghouse, a ***Statewide Healthy Campus Coalition*** is comprised of Connecticut colleges and universities who participate in, and occasionally receive funds for activities to address the reduction of ATOD use and abuse amongst their student populations.

The prevention infrastructure of programs and services links to several state advisory bodies that provide advice, direction and coordination for its initiatives.

Patient Confidentiality and Privacy Liz Taylor

The DMHAS Compliance and Privacy Officer is appointed by the Commissioner and reports regularly the status of Compliance and Privacy Programs to the department's Executive Compliance Steering Committee, which is comprised of members of the Commissioner's Executive Group and other key department staff. Each DMHAS facility has a designated Facility Compliance Officer who reports to their individual facility oversight committee and/or their CEO. The Agency's Compliance and Privacy Officer's functions include:

- Overseeing the implementation of the DMHAS Compliance Plan by working with each facility and assessing risk areas;
- Analyzing the laws and regulations pertinent to the DMHAS health care environment;
- Reviewing and establishing recommendations for new and existing policies;
- Establishing policies and procedures to comply with federal and state requirements;
- Promoting the Compliance Program through education and training;
- Ensuring that the seven elements of a Compliance Plan are addressed in each facility;
- Encouraging manager and employees to report fraud or other improprieties without fear of retaliation;
- Training and educating new employees and existing employees through workshops, web-based training, and seminars;
- Conducting unauthorized PHI disclosure analysis to determine breach status;
- Supporting the DMHAS facilities in privacy investigations and researching complaints; and

- Responding and documenting “Alert Line” inquiries and/or problems and issues.

The Agency Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities, including but not limited to, patient records, billing records, contract agreements, etc. This authority allows the Agency Compliance Officer to monitor agency controls as well as detect and intervene with potential compliance issues across the DMHAS state system of care.

Recovery Services

The Director of Recovery Community Affairs (RCA) is appointed by the Commissioner to act as a liaison to people in recovery, their family, friends, and other allies, grassroots and statewide recovery organizations, as well as represent DMHAS in national organizations and events. This role assures meaningful contact, input, and dialogue with diverse representatives of the recovery community and plays a significant role in guiding policy decisions and strategic planning to promote a person and family centered, recovery oriented system of care. Within the purview of this role is responsibility for the development, support and expansion of community-based peer support in the state, e.g., the Connecticut Hearing Voices Network. This role is also responsible for the management of Connecticut’s peer workforce, including policy development, contract management, and project coordination, as well as collaboration with grass roots peer organizations and the Connecticut Department of Correction.

A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. As of 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) were participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons were trained in person-centered planning by Yale PRCH.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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

Footnotes:

2022-2023 Combined Block Grant

Behavioral Health Needs Assessment

The behavioral health needs assessment for Connecticut is based on a variety of quantitative and qualitative data sources including the National Survey on Drug Use and Health (NSDUH) Connecticut State Report based on the 2018 and 2019 federal NSDUH Reports; the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Report for SFY 2020; the Connecticut Behavioral Health Barometer, volume 6 (published 2020); The regional Priority Setting Reports submitted to DMHAS June 2021; DMHAS Enterprise Data Warehouse (EDW) data; data from the Connecticut Office of the Chief Medical Examiner (OCME); and US Census Data for July 1, 2019.

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

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

Prevalence and Treated Prevalence

Mental Health

Any Mental Illness (AMI)

In SFY 2020, the DMHAS Annual Statistical Report, which reflects services provided by DMHAS funded and operated programs, reported more than 52,000 persons served in mental health programs only. Seventy-one percent of clients had a single mental health program admission. Nearly equal percentages of males and females received DMHAS mental health services. Most clients served were White/Caucasian (60%), followed by Black/African American (18%) and "Other" (13%). Twenty percent of clients served in DMHAS mental health programs were of Hispanic/Latino origin. Comparing percentages receiving mental health services to state census percentages, White/Caucasian clients were underrepresented (comprising 70% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 17% of the state population, respectively). The average age of clients receiving mental health services was 46.3 years (± 15.7).

Any Mental Illness in the Past Year (NSDUH 2018 – 2019)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	19.86%	27.85%	18.60%
Northeast	19.45%	28.27%	18.10%
Connecticut	18.85%	28.73%	17.27%

Connecticut residents had similar percentages as regional and national estimates for any mental illness and for receiving mental health services in the past year.

Received Mental Health Service in the Past Year (NSDUH 2018 – 2019)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	15.57%	16.19%	15.48%
Northeast	16.96%	18.01%	16.80%
Connecticut	17.50%	18.33%	17.36%

According to the Connecticut Behavioral Health Barometer, volume 6, there was no significant difference in the annual average percent of persons with AMI who received services in the past year from 2008-2010 (46.1%) to 2017-2019 (46.3%). The annual average prevalence for 2017-2019 of 46.3% was similar to both the regional average (51.0%) and national average (43.6%).

Serious Mental Illness (SMI)

Data from the Annual Statistical Report SFY 2020 revealed that nearly two-thirds of the clients served (62%) in the DMHAS system met criteria for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, major depression, and PTSD.

Serious Mental Illness in the Past Year (NSDUH 2018 – 2019)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	4.91%	8.14%	4.40%
Northeast	4.64%	8.14%	4.10%
Connecticut	4.50%	8.54%	3.86%

Connecticut's most recent Behavioral Health Barometer reported no change in the annual average percentage of adults with SMI in the past year from 2008 – 2010 (4.1%) to 2017-2019 (4.1%).

Depression

Connecticut percentages for depression were similar to the national and northeastern estimates for all age categories.

Major Depressive Episode in the Past Year (NSDUH 2018 – 2019)

	Age 12 - 17	Ages 18 - 25	Ages 18 +
U.S.	15.08%	14.48%	7.51%
Northeast	13.62%	14.43%	7.22%
Connecticut	14.41%	15.26%	7.06%

Data from the Annual Statistical Report of clients treated by the DMHAS system indicated that 17% of clients had depressive disorders and 11% had bipolar and related disorders, together accounting for nearly a third of all diagnoses treated.

The Behavioral Health Barometer, volume 6 for Connecticut, reported past year depression care for Major Depressive Episode (MDE) in adolescents as 44.2%, similar to regional (48.5%) and national (41.4%) averages for 2015 – 2019.

Suicide/Suicidal Thoughts

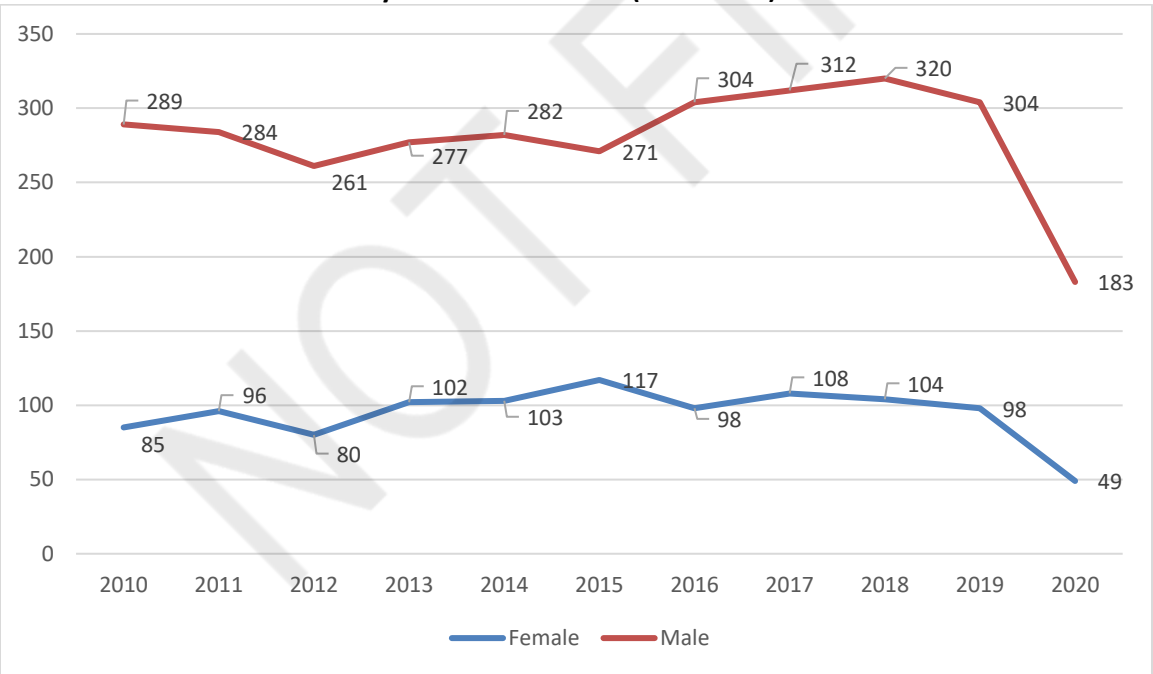
Connecticut rates for serious suicidal thoughts are slightly higher for young adults compared to national and regional estimates.

Serious Thoughts of Suicide in the Past Year (NSDUH 2018 – 2019)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	4.58%	11.39%	3.51%
Northeast	4.44%	11.34%	3.39%
Connecticut	4.46%	12.36%	3.21%

There had been a slight upward trend in suicides in Connecticut over the past decade until 2020 along with a pattern of male to female suicides of 3:1. However, there appears to have been a dramatic drop in suicides in 2020 to approximately half of the previous year's figures, likely related to the pandemic. Of interest, despite this drop, the ratio of males to females was 3.7: 1.

Suicides by Sex in Connecticut (2010-2020) from OCME Data



Substance Use

Over 54,000 persons were treated in substance use programs only by DMHAS based on the Annual Statistical Report for FY 2020. Sixty-eight percent of clients had a single substance use program admission. Twice as many males (66%) as females (33%) received DMHAS substance use services. Most clients served were White/Caucasian (63%), followed by "Other" (16%), and Black/African American

(14%). Twenty-two percent of clients served in DMHAS substance use programs were of Hispanic/Latino origin. Comparing percentages receiving substance use services to state census percentages, White/Caucasian clients were underrepresented (comprising 70% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 17% of the state population, respectively). The average age of clients receiving substance use services was 40.3 years (± 12.9).

Alcohol

Connecticut residents of all ages continue to consume alcohol and to binge use alcohol at higher percentages than national and regional estimates. Rates of underage drinking are notably above regional and national estimates.

Alcohol Use in the Past Month (NSDUH 2018 – 2019)

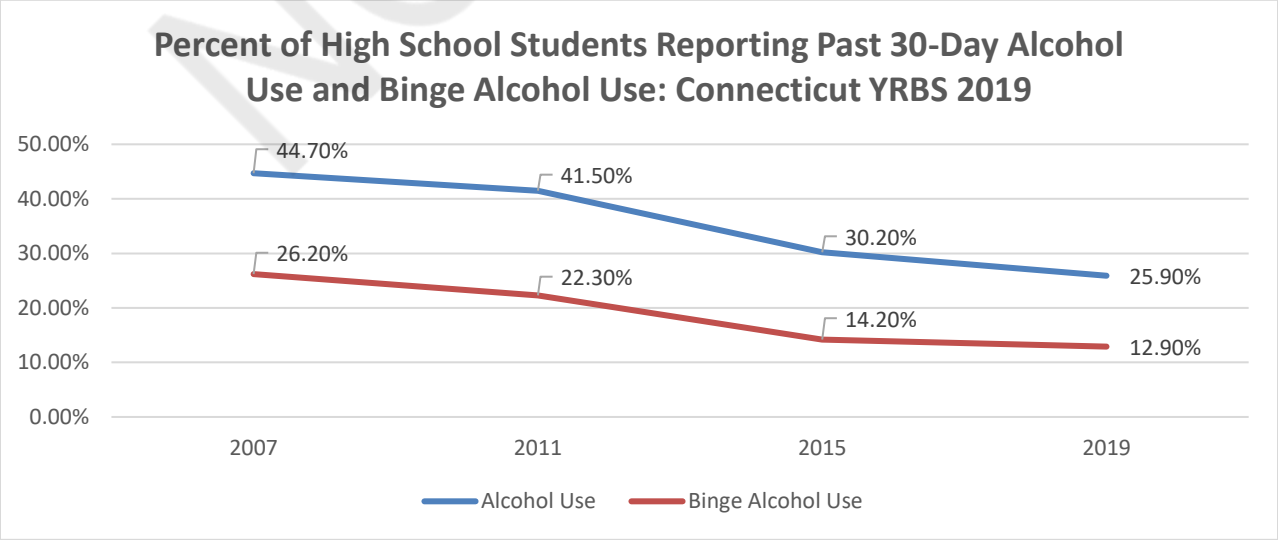
	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	9.19%	54.72%	55.09%
Northeast	9.80%	58.93%	57.98%
Connecticut	11.24%	65.61%	64.73%

Binge Alcohol Use in the Past Month (NSDUH 2018 – 2019)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	4.78%	34.58%	26.15%
Northeast	5.04%	39.69%	27.00%
Connecticut	5.42%	47.60%	30.25%

Underage (12 - 20) Alcohol Use and Binge Use in the Past Month (NSDUH 2018 – 2019)

	Alcohol Use in the Past Month	Binge Alcohol Use in Past Month
U.S.	18.67%	11.24%
Northeast	20.33%	12.83%
Connecticut	27.31%	18.50%



The National Drunk Driving Statistics Map reported 115 alcohol-involved vehicle fatalities for Connecticut in 2018. Seven of these fatalities were of persons under the legal drinking age of 21. Alcohol-involved vehicle fatalities accounted for 39.1% of all vehicle fatalities.

As the table below reflects, persons needing but not receiving specialized treatment for alcohol use in Connecticut are at similar rates to the region and the nation, except for young adults where the need is greater.

Needing but Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year (NSDUH 2018 – 2019)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	1.60%	9.33%	5.44%
Northeast	1.64%	9.81%	5.28%
Connecticut	1.72%	11.34%	5.98%

Cigarettes

Connecticut residents smoke cigarettes less than the regional or national averages; and the numbers have reflected this for some time. However, the use of e-cigarettes and Electronic Nicotine Delivery Systems (ENDS) has more than compensated for these positive reductions.

Cigarette Use in the Past Month (NSDUH 2018 – 2019)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	2.50%	18.34%	18.35%
Northeast	2.14%	17.65%	16.63%
Connecticut	1.53%	15.82%	15.10%

E-Cigarettes/Electronic Nicotine Delivery Systems (ENDS)

In recent years, Connecticut has taken legislative action in an attempt to curb the dramatic rise in the use of e-cigarettes/electronic nicotine delivery systems (ENDS). Despite this, use of these products remains a concern. According to the 2019 YRBS, 44.8% of high school students ever used an electronic vaping product and 27.0% percent were current users.

Illicit Substances

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

Illicit Drug Use in the Past Month (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	8.37%	24.40%	12.73%
Northeast	8.56%	26.58%	13.25%
Connecticut	8.81%	28.94%	14.69%

Illicit drug use percentages for Connecticut exceeded both the national and regional estimates, but the greater proportion of illicit drug use is accounted for by marijuana.

Illicit Drug Use Other than Marijuana in the Past Month (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	2.37%	6.07%	3.41%
Northeast	2.12%	6.26%	3.23%
Connecticut	2.24%	7.05%	3.68%

Percentage of past year illicit drug use disorder among persons 12+ for 2017 - 2019, according to data from the Connecticut Behavioral Health Barometer volume 6, was 3.1%, similar to the regional average (3.4%) and the national average (2.9), and a decrease from the 4.1% reported for 2015 – 2017.

Needing but Not Receiving Treatment at a Specialty Facility for Illicit Drug Use in the Past Year (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	2.99%	7.09%	2.67%
Northeast	2.78%	7.29%	2.72%
Connecticut	2.59%	7.40%	2.65%

Per the chart above, Connecticut residents needing treatment for illicit drug use fare about as well as others in the region and nation.

Marijuana

Marijuana continues to be the primary illicit drug used in the state. With neighboring states and now Connecticut legalizing recreational marijuana use, use is expected to increase as perception of risk associated with smoking marijuana monthly continues to decline.

Marijuana Use in the Past Month (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	7.02%	22.54%	11.17%
Northeast	7.37%	24.88%	11.79%
Connecticut	7.46%	27.22%	12.81%

Percentages for Connecticut for monthly marijuana use exceed the national and regional averages for all age categories. In concert with this finding, estimates of perceived risk from smoking marijuana are lower for Connecticut than the national and regional percentages across the board. Nearly one in ten persons (9.7%) admitted to substance use services in FY 2020 identified marijuana/hashish/THC as their drug of choice compared to 25.2% of persons admitted to mental health services.

Perception of Great Risk from Smoking Marijuana Once a Month (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	23.67%	11.87%	24.56%
Northeast	22.71%	11.59%	23.88%
Connecticut	19.01%	9.33%	19.23%

Heroin

The opioid crisis, which has taken a heavy toll on the northeast, continues, despite the pandemic. Reported heroin use in Connecticut is similar to the regional and national averages.

Heroin Use in the Past Year (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.02%	0.36%	0.31%
Northeast	0.02%	0.45%	0.39%
Connecticut	0.01%	0.38%	0.36%

For persons admitted to substance use programs in FY 2020, the Annual Statistical Report noted that 33.2% identified heroin as their primary drug of choice, although an additional 6.2% of admissions reported other opiates and synthetic opiates as their primary drug of choice.

In calendar year 2020, Connecticut's Office of the Chief Medical Examiner (OCME) reported a total of 1374 accidental drug-related deaths, 93% of which involved opioids. This means that nearly every death in Connecticut involved an opioid and for 84% of cases, that meant the involvement of illicitly manufactured fentanyl. Stimulant use, particularly in the form of cocaine, has also been on the rise to the extent that 39% of fatal overdoses involved cocaine. As in previous years, most fatal overdoses involved multiple substances and Connecticut continues to report a wide range of substance use, including Xylazine, a veterinary tranquilizer.

OCME Data of Accidental Overdose Deaths (2012-2020)

2012	2013	2014	2015	2016	2017	2018	2019	2020
357	495	568	729	917	1038	1017	1200	1374

Pain Reliever Misuse

Percentages related to misuse of prescription opioids are similar to the regional and national percentages. For FY 20, 6.2% of persons admitted for substance use services reported "other opiates and synthetics" as their primary drug of choice.

Pain Reliever Misuse in the Past Year (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	2.53%	5.33%	3.69%
Northeast	1.90%	4.67%	3.21%
Connecticut	2.12%	4.85%	3.43%

Stimulants

In Connecticut, cocaine use is well within the range of the regional and national averages. Based on the Annual Statistical Report FY 2020, 7.8% of admissions to substance use services were for a primary cocaine problem.

Cocaine Use in the Past Year (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.42%	5.54%	2.16%
Northeast	0.38%	6.35%	2.38%
Connecticut	0.37%	6.21%	2.15%

Methamphetamine use is also within the same range, but less than the regional and national averages. Prevalence of methamphetamine use is too low to warrant it being an individual category of primary drug of choice at admission for DMHAS.

Methamphetamine Use in the Past Year (NSDUH 2018 – 2019)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.17%	0.81%	0.76%
Northeast	0.16%	0.52%	0.43%
Connecticut	0.14%	0.43%	0.39%

Co-Occurring Mental Health and Substance Use

One-third (33%) of the persons treated by DMHAS in FY 2020 had both a mental health (SMI) and substance use diagnosis. Nearly 7,000 persons (6,983) received services from both mental health and substance use programs during the same fiscal year. These clients were more male (62%) than female (38%). Most were white/Caucasian (58.9%), 19.6% were black/African American and 15.9% were "other". Compared to substance use and mental health only clients, co-occurring clients do not appear to be significantly different demographically than the other two groups of clients. Twenty-two percent were Hispanic/Latino. The average age of persons receiving both mental health and substance use services was 42.5 years (± 12.1).

Persons Served in DMHAS Programs

The following data is from the FY 20 Annual Statistical Report available at: https://portal.ct.gov/-/media/DMHAS/EQMI/AnnualReports/DMHASAnnualStatisticalReportSFY2020.pdf. During SFY 20 (July 1, 2019 – June 30, 2020), DMHAS served a total of 99,715 people; 54,620 were treated in substance use programs and 52,078 were treated in mental health programs. These totals include 6,983 co-occurring clients who received services from both mental health and substance use treatment services, but are included as a separate category in the demographic table below. An almost equal number of males and females received mental health services, while twice as many males than females participated in substance use services. Most clients were White/Caucasian (61%), followed by Black/African American (16%), and Other Race (15%). Twenty-one percent of DMHAS clients were of Hispanic/Latino ethnicity, primarily of Puerto Rican origin (14%). Younger clients were more likely to receive substance use services (average age 40.3 years) while older clients were more likely to receive mental health services (average age 46.3 years).

The most utilized level of care was Outpatient with 99% of mental health clients and 92% of substance use clients receiving these services. For mental health clients, Outpatient services include standard outpatient (61%), Case Management (13%), Social Rehabilitation (12%), and Crisis Services (11%). For substance use clients, Outpatient services include Standard Outpatient (37%), Pre-Trial Intervention (29%), and Medication Assisted Treatment (29%). Residential services were the next most utilized, with 5% of mental health clients and 17% of substance use clients receiving these services. Inpatient levels of care were received by 2% of mental health clients and 4% of substance use clients. Some clients participated in more than one level of care during the fiscal year. DMHAS Young Adult Services (YAS) serves the most acute, high-risk cohort of young adult in the state of Connecticut between the ages of 18 and 25. In SFY 20, YAS programs served 1,160 persons (10.8% of the total 18-25 DMHAS population).

Substance-related and addictive disorders were the most frequently diagnosed condition among those receiving any services from DMHAS at 40%. The largest mental health category diagnosed outside of

substances was Depressive Disorders (17%), followed by Schizophrenia Spectrum and Other Psychotic Disorders (14%) and Bipolar and Related Disorders (11%). Sixty-two percent of the clients met criteria for SMI (serious mental illness) with a diagnosis that included one or more of the following: schizophrenia (and related disorders), bipolar (and related disorders), major depression, and PTSD. Two out of three clients (68%) met criteria for a substance use disorder. One-third of clients (33%) met criteria for a co-occurring disorder (both SMI and a substance use diagnosis).

Among admissions to substance use programs, alcohol was the most frequent primary drug at admission (38.5%) with heroin second at 33.2%, however, if the category of "other opiates and synthetics" in the amount of 6.2% of admissions is added to the heroin category, then overall admissions for "opiates" rises to first place at 39.4%.

Demographics of Clients Served

	Substance Use		Mental Health		Both		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Gender								
Female	15,675	32.9%	22,300	49.5%	2,666	38.2%	40,641	40.8%
Male	31,530	66.2%	22,739	50.4%	4,315	61.8%	58,584	58.8%
Transgender	-	0.0%	21	0.0%	-	-	21	0.0%
Unknown	432	0.9%	35	0.1%	2	0.0%	469	0.5%
Total	47,637	100.0%	45,095	100.0%	6,983	100.0%	99,715	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Race								
American Indian/Alaska Native	230	0.5%	267	0.6%	45	0.6%	542	0.5%
Asian	401	0.8%	549	1.2%	24	0.3%	974	1.0%
Black/African American	6,632	13.9%	8,218	18.2%	1,370	19.6%	16,220	16.3%
Native Hawaiian/ Pacific Islander	103	0.2%	137	0.3%	21	0.3%	261	0.3%
White/Caucasian	29,857	62.7%	27,136	60.2%	4,116	58.9%	61,109	61.3%
More than one race	255	0.5%	214	0.5%	46	0.7%	515	0.5%
Unknown	2,612	5.5%	2,685	6.0%	252	3.6%	5,549	5.6%
Other	7,547	15.8%	5,889	13.1%	1,109	15.9%	14,545	14.6%
Total	47,637	100.0%	45,095	100.0%	6,983	100.0%	99,715	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Ethnicity								
Hispanic-Cuban	119	0.2%	62	0.1%	15	0.2%	196	0.2%
Hispanic – Mexican	380	0.8%	239	0.5%	14	0.2%	633	0.6%
Hispanic-Other	4,030	8.5%	3,956	8.8%	555	7.9%	8,541	8.6%

Hispanic – Puerto Rican	5,861	12.3%	4,617	10.2%	960	13.7%	11,438	11.5%
All Hispanics	10,390	21.8%	8,874	19.6%	1,544	22.1%	20,808	20.8%
Non-Hispanics	31,149	65.4%	32,897	73.0%	5,012	71.8%	69,058	69.3%
Unknown	6,098	12.8%	3,324	7.4%	427	6.1%	9,849	9.9%
Total	47,637	100.0%	45,095	100.0%	6,983	100.0%	99,715	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age								
18 – 25	5,328	11.2%	5,106	11.3%	498	7.1%	10,932	11.0%
26 – 34	13,277	27.9%	7,526	16.7%	1,663	23.8%	22,466	22.5%
35 – 44	11,916	25.0%	7,680	17.0%	1,773	25.4%	21,369	21.4%
45 – 54	8,299	17.4%	8,568	19.0%	1,643	23.5%	18,510	18.6%
55 – 64	6,297	13.2%	10,364	23.0%	1,224	17.5%	17,885	17.9%
65+	1,801	3.8%	5,571	12.4%	181	2.6%	7,553	7.6%
Unknown	719	1.5%	280	0.6%	1	0.0%	1,000	1.0%
Total	47,637	100.0%	45,095	100.0%	6,983	100.0%	99,715	100.0%

Workforce Development and Shortages

According to the HRSA Fact Sheet FY 2019 for Connecticut, the state is short 41 Primary Care Providers, 32 Mental Health Professionals, and 37 Dental Health Professionals. HRSA designated Health Professional Shortage Areas, Medically Underserved Areas (MUA) and Populations (MUP) data follows.

Health Professional Shortage Area	
Connecticut County	**Number and Type of Shortage**
Fairfield	0
Hartford	0
Litchfield	1 – Mental Health
Middlesex	1 – Mental Health
New Haven	0
New London (Region 3)	1 – Mental Health
Tolland (Region 3)	1 – Mental Health
Windham (Region 3)	1 – Mental Health
Medically Underserved Areas	
Connecticut County	**Number and Type of Shortage**
Fairfield	3 – Primary Care
Hartford	5 – Primary Care
Litchfield	0
Middlesex	1 – Primary Care
New Haven	6 – Primary Care
New London	2 – Primary Care
Tolland	0
Windham	0

Medically Underserved Populations	
Connecticut County	**Number and Type of Shortage**
Fairfield	3 – Primary Care for Low Income
Hartford	2 – Primary Care for Low Income
Litchfield	1 – Primary Care for Low Income
Middlesex	0
New Haven	1 – Primary Care for Low Income
New London	1 – Primary Care for Low Income
Tolland	1 – Primary Care for Low Income
Windham	1 – Primary Care for Low Income

Statewide Priority Setting Process

DMHAS is committed to supporting a comprehensive, unified planning process across its state-operated and funded mental health and substance use services at local, regional, and state levels. The purpose of this planning process is to develop an integrated and ongoing method to: 1) determine unmet mental health and substance use treatment and prevention needs; 2) gain broad stakeholder (persons with lived experience, advocates, family members, providers, and others) input on service priorities and needs; and 3) monitor ongoing efforts that result in better decision-making, service delivery, and policy-making. A description of the most recent priority setting process reported in June 2021 follows.

Background:
The priority setting process historically conducted by the Regional Behavioral Health Action Organizations (RBHAOs) has been evolving in a cooperative effort with DMHAS' Prevention Unit and Block Grant State Planner in addition to staff from the State Epidemiological Outcomes Workgroup (SEOW) and Center for Prevention Evaluation and Statistics (CPES) at University of Connecticut Health Center. Processes have been reorganized into a unified activity comprehensively assessing the entire DMHAS behavioral health service system. The basic steps in the process are:

- **Quantitative Data Collection** based on a wide array of local, state, and national surveys and assessments
- **Qualitative Data Collection** from multiple stakeholders (consumers, families, town officials, law enforcement, providers, etc.) in community conversations, focus groups, routine meetings, community events, etc.
- **Workgroup ranking** of the list of behavioral health conditions based on the dimensions of magnitude, impact and burden
- **Profiles of substance use** unique for each region
- **Completion of regional reports** inclusive of all the elements above into a structured format along with strengths, identified needs/gaps/barriers, and recommendations
- **Completion of an integrated statewide report** which integrates information from all 5 regional reports

Regional Priority Ranking Matrix Results - June 2021:

		Priority 1	Priority 2	Priority 3
Region 1	**MH**	Mental Health*	Suicide	Problem gambling
	SU	Alcohol	Marijuana	Tobacco/ENDS
Region 2	**MH**	Anxiety	Depression	ESMI**

				Suicide
	SU	Heroin/Fentanyl	Marijuana	Alcohol
Region 3	**MH**	Suicide	Depression** Anxiety	Trauma
	SU	Alcohol** Heroin/Fentanyl	Prescription drugs** ENDS	Marijuana
Region 4	**MH**	Depression	Anxiety	Suicide
	SU	Heroin/Illicit Drugs	Prescription drugs	Marijuana
Region 5	**MH**	Suicide	Anxiety	Depression
	SU	Alcohol	Heroin/Fentanyl	ENDS

Note*: In the body of the report it indicated that the greatest mental health concern was teenage anxiety.
Note**: Multiple items in one cell of the table indicate a "tied" score in the rankings

Based on the results above, the top three mental health priorities for Connecticut 2021 in order are: anxiety, suicide and depression; and the top three substance use priorities for the state in order are: heroin/fentanyl, alcohol and marijuana.

Substance Use Priority 1: **Heroin/Fentanyl**: While the National Survey on Drug Use and Health (NSDUH) reported that less than one percent of Connecticut residents age twelve and older used heroin in the past year, this statistic fails to reflect the impact of opioids on the state. The number of overdose deaths involving heroin has decreased since 2016, but has been more than compensated for by the increase in fentanyl-related overdose deaths. In 2020 there were 1374 drug-related overdose deaths – a 15% increase over 2019 figures. Eighty-four percent of these overdose deaths involved fentanyl.

Substance Use Priority 2: **Alcohol**: Connecticut continues to have one of the highest alcohol use rates in the country and this has been especially true for young adults. Reported declines in underage drinking have been reported across the nation, including Connecticut, since 2008-2009, yet 26% of Connecticut's high school students claimed alcohol use in the past month, and half of these reported binge drinking. Increased use of alcohol during the pandemic, including by youth as part of live remote socializing via internet audiovisual platforms, has been reported.

Substance Use Priority 3: **Marijuana**: The Connecticut legislature approved use of recreational marijuana for those ages 21 and older as of July 1, 2021. Connecticut already had rates of marijuana use higher than the national average for all reported age groups for the past two decades. 2019 school survey results indicated that 22% of high school students were current marijuana users. Increased availability along with a diminishing perception of risk associated with marijuana use pose new threats for the state.

Mental Health Priority 1: **Anxiety**: Eleven percent of adults reported anxiety issues in the 2018 BRFSS, but since the pandemic, behavioral health providers who work with youth and young adults report an increase in persons presenting with anxiety-related symptoms. Increased anxiety is not surprising given the range of stressors posed by COVID-19.

Mental Health Priority 2: **Suicide**: Up until 2020 in Connecticut when a dramatic decrease was reported by the OCME, the number of suicide deaths had increased annually each year since 2008. Findings from the 2019 BRFSS reported that 13% of high school students seriously considered attempting suicide in the past year.

Mental Health Priority 3: **Depression**: The percentage of high school students reporting feeling sad/hopeless almost every day for two weeks or more in the past year such that they discontinued usual activities was 31%. Past year episodes of major depression were reported as 15% for young adults, 14% for youth, and 6% for adults.

The COVID pandemic appears to have exacerbated each of the priority areas identified above except for suicide. Stressors, such as financial challenges, isolation from social supports, and physical and psychiatric health concerns, were magnified by the pandemic. Concerns over increasing rates of anxiety and depression in young people in the last few years reached new heights during 2020. It is clear that anxiety, depression and suicide are strongly linked with each other and often present together along with an increased probability of a co-occurring substance use disorder.

Consumer Satisfaction Survey Measures

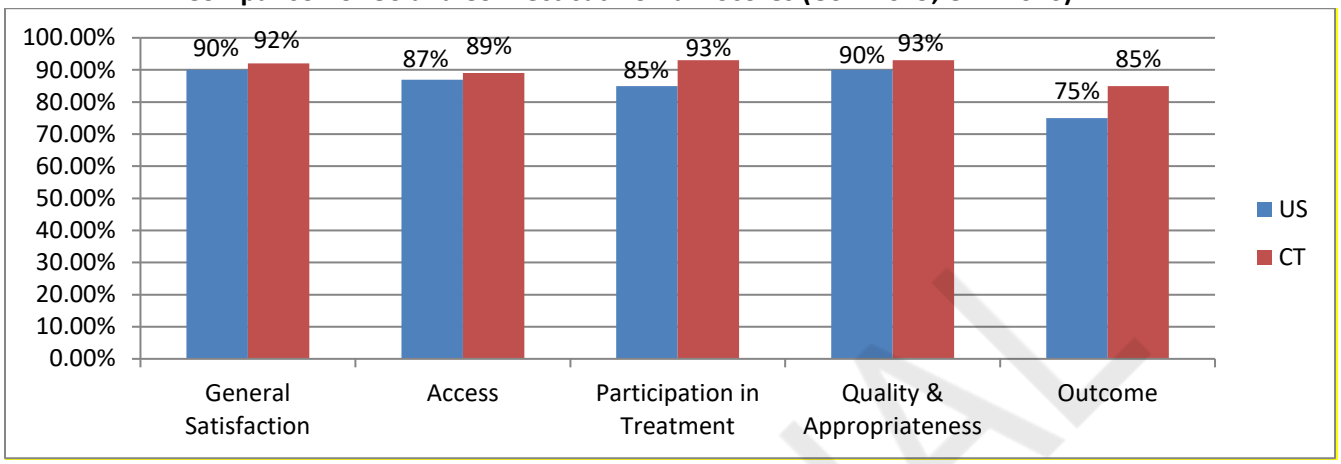
DMHAS conducts an annual consumer satisfaction survey in order to better understand consumers' experiences with the public state-operated and community-funded service delivery system, as well as to use these data for quality improvement. The Consumer Survey has been administered annually since 2000,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

The survey is offered to consumers/individuals in recovery within the context of their treatment for behavioral health issues. Most levels of care are required to participate in the survey. State-operated and private nonprofit providers are required to collect and report results to the Office of the Commissioner, where the data is collated, analyzed and synthesized into an annual report. For FY 2020, despite the pandemic, over 23,000 surveys from 86 providers within the DMHAS behavioral health system were received. The FY2020 full report is at: https://portal.ct.gov/-/media/DMHAS/ConsumerSurvey/Reports/CS2020-report.pdf
Since 2005, DMHAS has been utilizing a *Recovery* Domain that was added to the survey. The Recovery domain is comprised of five questions which assess perception of "recovery oriented services". The recovery questions were developed in collaboration with the Yale Program for Recovery and Community Health. This addition provides DMHAS with valuable information regarding its success in implementing a recovery-oriented service system. DMHAS also uses an additional *Respect* Domain to collect information about perceived respect towards people in recovery. Two other instruments are included in the survey. The first is the WHOQOL-BREF Quality of Life (QOL) instrument which is a widely used, standardized quality of life tool developed by the World Health Organization. This 26-item tool measures consumer satisfaction with the quality of the person's life in physical, psychological, social and environmental domains. DMHAS received 1,052 QOL responses. The other tool added is the 8-question Health Outcomes Survey which includes items from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). These questions ask about body mass index (BMI), chronic health conditions, overall health from a physical and psychological perspective, and drinking habits. A total of 1,288 surveys were received on these Health Outcome Measures. The national emphasis on the integration of behavioral health and primary health care underscores the importance of these optional tools.

Of the 20,731 surveys returned, 22% were from outpatient programs, 4% from intensive outpatient, 26% from Medication Assisted Treatment programs, 7% from Case Management, 11% from residential programs, 9% from employment or social rehabilitation programs, and 21% from either other levels of care or from respondents who didn't identify the program type. Most consumers were satisfied with the treatment services that were being provided to them through the DMHAS provider network.

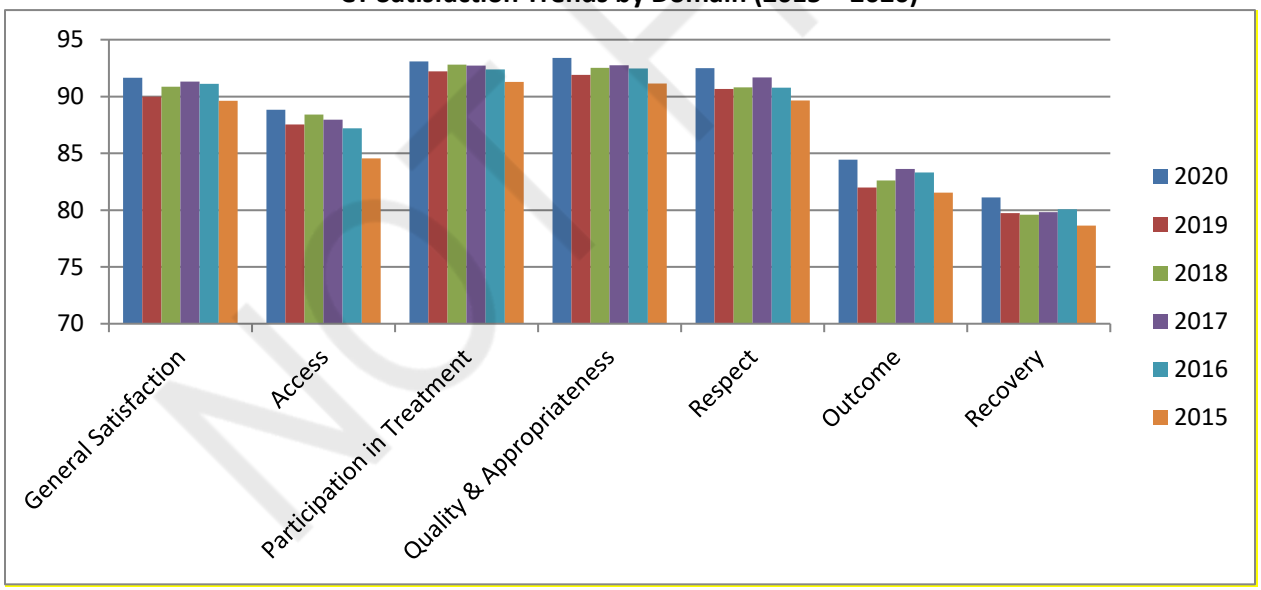
Connecticut respondents reported levels of satisfaction higher than the national averages in all Consumer Satisfaction Survey domains.

Comparison of US and Connecticut Domain Scores (US – 2019; CT – 2020)



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

CT Satisfaction Trends by Domain (2015 – 2020)



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

- More clients in mental health programs reported satisfaction in the Access, General Satisfaction and Respect domains while more clients in substance use programs reported satisfaction in the Outcome and Recovery domains.

- Across all programs, more women reported satisfaction with services in the Access, Appropriateness, General Satisfaction, Participation in Treatment and Respect domains while more men reported satisfaction in the Outcome and Recovery domains.
- Across all programs, white respondents were more satisfied than those in the Black or Other Race categories in the participation in Treatment and Respect domains.
- Across all programs, Non-Hispanic clients were more satisfied than Hispanics in the Outcome, Participation in Treatment and Recovery domains.
- In the Access and General Satisfaction domains, older clients were more satisfied with services than younger clients.
- In the Outcome domain, more clients who received medication assisted treatment services were satisfied than clients who received any type of service except social rehabilitation.

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

Results on the QOL survey found that clients served in mental health programs reported a significantly better quality of life in the Environment domain compared to clients in substance use programs. Additionally, persons receiving services for more than 5 years also reported better QOL in the Environment domain than clients receiving services for less than one year. Consumers who identified themselves as Black reported better quality of life in the physical health, psychological, social and general QOL domains. Consumers in Employment programs reported better QOL than consumers in other programs.

Quality of Life Scores across DMHAS Subpopulations

	Physical Health	Psychological	Social	Environmental	General QOL
All Programs	65.1	66.4	63.5	66.9	69.6
Substance Use	63.5	66.1	62.5	59.0	69.5
Mental Health	65.5	66.4	63.9	69.2*	70.7

*a significant difference (p<.10)

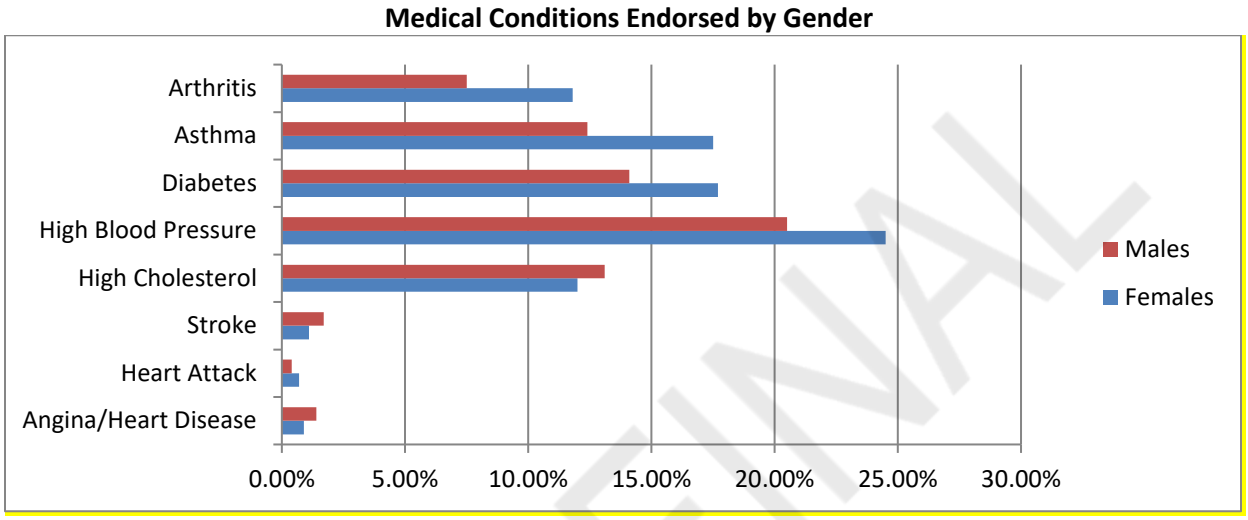
- respondents less than 35 years of age reported significantly better General QOL
- Men, Black clients, those less than 55, and those involved in Employment services reported significantly better Physical Health QOL
- Men reported significantly better Psychological QOL
- Those receiving mental health services and non-Hispanics reported significantly better Environment QOL

As part of the FY 20 Consumer Satisfaction Survey process, DMHAS providers had the option to administer an 8-question Health Outcome Survey. The survey is available in English and Spanish. Body Mass Index (BMI), cardiovascular/respiratory/diabetes disease, overall health from physical and psychological perspectives, and smoking and drinking habits are all items. A total of 1,288 surveys were completed. Seventy-three percent of the responses were from clients in mental health programs and 15% were from clients in substance use programs. Twelve percent were submitted at the provider level and thus were not attributed to a specific program type. BMI could be calculated for 72% (923) of the respondents. The average BMI for clients was 31.2 (± 8.1) with the women's average at 31.1 (± 8.3) and

the men's average at 31.3 (+ 7.9). According to the CDC, BMI categories for adults (ages 20 and older) indicate that all these averages reported fall into the Obese BMI category:

Underweight BMI	Normal BMI	Overweight BMI	Obese BMI
1%	21%	28%	50.0%

Respondents endorsed the following list of medical conditions:



Slightly less than half (48%) of the clients surveyed indicated that they do not smoke, while 49% of the clients indicated that they did smoke. Smoking status was unknown for 3%. There were no significant differences between smokers and non-smokers in reporting frequency of any of the medical conditions.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Infection Control

Priority Type:

Population(s): EIS/HIV, TB

Goal of the priority area:

50% of all nurses in SAPT Block Grant - Infectious Diseases Learning Collaborative trained on Syndemic TB/HIV/STIs/Other Infectious Diseases and Substance Use Disorders.

Strategies to attain the goal:

Who will provide training: Individuals/Representatives from the Local Public Health Agencies or State Public Health Department

What: The type of Attendees –
• All agencies that are part of the block grant funding and participate in Infectious Diseases Collaborative are expected to attend.

When: The schedule for the training:
• 1st training will be delivered in year one, 2nd training in year two.
• The training will be virtual to allow for increased access to encourage participation/attendance from all regions within the state.

Why: The intent/purpose of the training –
The purpose of the training is to continue to increase awareness and provide education on Infectious Diseases to providers and community partners.

Measures: How do we know the training happened and was the training helpful?
Roll Call – Individual participants will "check-in" during the roll call at each training session. If the training is in-person, the participants with "sign-in" on a sign-in sheet.

Pre and Post Training Survey: At the first training, individuals will complete a Survey Questionnaire using a 5 point Likert Scale on rating their current knowledge of Infectious Diseases. After the second training, individuals will complete the same survey. This is to assess participants' pre and post training knowledge on Infectious Diseases.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Two trianings to be provided that will trainin 50% of infectious disease nurses who work for SAPT BG Providers and participate in the Infectious Disease Control Learning Collaborative

Baseline Measurement: N/A

First-year target/outcome measurement: 1st of 2 training will be conducted in Year 1

Second-year target/outcome measurement: 2nd of 2 trainings will be conducted in Year 2

Data Source:

The attendance sign in sheets.

Description of Data:

The attendance sign-in sheets will reflect percentage trained.

Data issues/caveats that affect outcome measures:

None anticipated.

Priority #: 2

Priority Area: Prevention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce the number of minors across the state who use Electronic Nicotine Devices (ENDs).

Strategies to attain the goal:

Strategy: ENVIRONMENTAL - Pass legislation to increase access age to tobacco and electrnoic cigarrette products to 21. Annualy produce a valid random sample of outlets that sell tobacco and electronic cigarrette products. Conduct unannounced inspections of the random sample of ENDs vendors across the state. Establish a failure rate for non-compliant vendors. Take enforcement action for vendors who are non-compliant with the laws. Strategies: INFORMATION DISSEMINATION and EDUCATION - Produce and distribute educational and awareness materials regardign tobacco laws to tobacco and electronic cigarrette merchants. Increase public awareness on youth tobacco issues and form coalations to mobilize community support.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of ENDs merchants who sell to minors under 21 years old.

Baseline Measurement: 16%

First-year target/outcome measurement: 13%

Second-year target/outcome measurement: 10%

Data Source:

The Department of Mental Health and Addiction Services' Tobacco Intervention and Enforcement Unit.

Description of Data:

Annual analysis of the inspections of a random sample of ENDs vendors to access the non-compliant rate.

Data issues/caveats that affect outcome measures:

Availability of and gender and racial diversity for youth investigators.

Indicator #: 2

Indicator: Percentage of students who report ever using an electronic cigarrette

Baseline Measurement: 14.70%

First-year target/outcome measurement: less than 14%

Second-year target/outcome measurement: less than 14%

Data Source:

Youth Risk Behavior Surveillance System (aka CT School Health Survey)

Description of Data:

Self report survey that measures health related behaviors among youth in middle and high schools across the state.

Data issues/caveats that affect outcome measures:

Survey is conducted every 2 years and results may not be available in time for BG funding.

Priority #: 3

Priority Area: CHILDHOOD TRAUMA

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Ensure that children and youth in Connecticut (CT) who have experienced trauma, as well as their caregivers, receive effective treatment services to meet their needs. This includes ensuring that children and youth with less overt “developmental” trauma are identified and receive effective and comprehensive trauma treatment services.

Strategies to attain the goal:

Strategies to attain the objective:
1. DCF and the Child Health and Development Institute of Connecticut (CHDI), have partnered to implement EBP's in CT through systems development and staff training.
2. Train clinical staff in outpatient clinics and schools in the MATCH model, CBITS and TF-CBT.
3. EBP dissemination will be facilitated through a Learning Collaborative (LC) implementation model that includes:
• Building providers’ capacity to implement evidence based services with fidelity for youth through application of the LC methodology and the creation of a sustainable learning community;
• Developing collaborative and cooperative relationships between outpatient providers, clinicians, caregivers, and other community systems to assure effective referral, assessment, and treatment of children; and
• Building providers' capacity to utilize data and implement evidence-based practices through application of a LC methodology and the creation of a sustainable learning community.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of children and youth who receive MATCH, CBITs and TF-CBT.

Baseline Measurement: 3200

First-year target/outcome measurement: 3300

Second-year target/outcome measurement: 3400

Data Source:

Thee Child Health and Development Institute of Connecticut (CHDI) and PIE

Description of Data:

CHDI will provide data

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Increase the number of clinical staff trained in providing MATCH, CBITS and TF-CBT to children and youth.

Baseline Measurement: 300 Clinicians Trained

First-year target/outcome measurement: Train an additional 25

Second-year target/outcome measurement: Train an additional 25

Data Source:

The Child Health and Development Institute of Connecticut (CHDI)

Description of Data:

Report of actual numbers.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: ESMI Intervention

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Earlier identification and intervention for those with ESMI

Strategies to attain the goal:

Beacon Health Options(ASO), through the ESMI ICM, will provide early identification of ESMI, rapid referral to evidence-based and appropriate services, and effective outreach engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: The percentage of young persons identified with ESMI who agree to engage in treatment

Baseline Measurement: 15% of young persons identified with ESMI will agree to engage in treatment.

First-year target/outcome measurement: 18% of young persons identified with ESMI will agree to engage in treatment.

Second-year target/outcome measurement: 20% of young persons identified with ESMI will agree to engage in treatment.

Data Source:

Beacon Health Options-ASO, POTENTIAL and STEP program

Description of Data:

Number of youth identified, referred and engaged in treatment

Data issues/caveats that affect outcome measures:

Refusals to engage by young persons and/or their caregivers.

Priority #: 5

Priority Area: FAMILY ENGAGEMENT

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase family voice.

Strategies to attain the goal:

a) Support Family System Managers (FSMs), Family Peer Support Specialists (FPSS) positions and Youth and Family Engagement Specialists at FAVOR.
b) FSMs to recruit, train and support youth and families
c) Increase number of families that participate in committees, advisory bodies, policy reviews, and other venues

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increasing the number of families interfacing with the family system organization through

support servcies, support groups, trainings, events and then participating in follow up activities

Baseline Measurement: 5900 points of interface with families

First-year target/outcome measurement: 6000

Second-year target/outcome measurement: 6100

Data Source:

Provider Information Exchange (PIE) and FAVOR reports

Description of Data:

Totals of participants at training, support groups and outreach activities. Total families served by FPSS's.

Data issues/caveats that affect outcome measures:

Integrity of PIE data source and other data tracking methods

Priority #: 6

Priority Area: WORKFORCE DEVELOPMENT

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To promote the development of a more informed and skilled workforce who have interest and solid preparation to enter positions that deliver evidence-based treatment programs.

Strategies to attain the goal:

Strategy 1: Provide funding and other support to the Higher Education Partnership on Intensive Home-Based Services Workshop DevelopmentSustainability Initiative through contract with Wheeler Clinic.
Strategy 2: Expand the pool of faculty and programs credentialed to teach the Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut curriculum and promote accurate implementation of course content that is current and up-todate.
Strategy 3: Maintain and promote teaching partnerships between higher education and providers delivering evidenced-based treatments through ongoing coordination and assignment of provider and client/family guest speakers for the curriculum

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain the number of faculty trained in the curriculum

Baseline Measurement: 65 students to receive certificates

First-year target/outcome measurement: 65 students to receive certificates

Second-year target/outcome measurement: 65 students to receive certificates

Data Source:

Wheeler Clinic provider report

Description of Data:

Actual number of students who received certificates by completion of course and required certification process

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Suicide Reduction

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Prevent and reduce attempted suicides and deaths by suicide among high risk populations

Strategies to attain the goal:

Strategy 1. Implement awareness campaigns that include informational e-mails, a Department website, and suicide prevention brochures.
Strategy 2. Continue to engage in collaborative partnerships with DMHAS, schools, and first responder agencies to share delivery of the prevention training
Strategy 3 Use evidence-based curricula, ASIST, QPR and Safe Talk to train youth, families, Department staff, and first responder agency staff, through contracts with United Way and Wheeler Clinic.
Strategy 4. Use evidence-based curricula, Assessing and Managing Suicide Risk (AMSR) to train clinicians who deliver Mobile Services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Distribution of social marketing materials throughout the state of Connecticut

Baseline Measurement: 125,000 items distributed

First-year target/outcome measurement: 130,000 items distributed

Second-year target/outcome measurement: 135,000 items distributed

Data Source:

CT Suicide Advisory Board, United Way and Wheeler Clinic. Report the total number of outreach activities and numbers of suicide prevention materials disseminated

Description of Data:

Reports of actual numbers with the numbers sent to those serving the SED and SMI populations delineated.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Increase the number of individuals serving the SMI and SED populaitons receiving suicide prevention/crisis response training

Baseline Measurement: 230 Individuals trained

First-year target/outcome measurement: 235 Individuals trained

Second-year target/outcome measurement: 240 Individuals trained

Data Source:

United Way and Wheeler Clinic. Report the total number of individuals

Description of Data:

Reports of actual numbers

Data issues/caveats that affect outcome measures:

None

Priority #: 8

Priority Area: Increase participation of individuals with SMI in their communities

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increased integration of individuals with SMI as citizens within their communities

Strategies to attain the goal:

DMHAS is funding and co-facilitating a Recovering Citizenship Learning Collaborative with 13 Local Mental Health Authorities, Connective Valley Hospital and Whiting Forensic Hospital. Simultaneously, DMHAS is redesigning the social rehab level of care, with the goal of increasing community integration activities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of services provided in the community.

Baseline Measurement: Current percentage of services provided in the community

First-year target/outcome measurement: Identified levels of care will show a 3% increase in services provided in the community.

Second-year target/outcome measurement: Identified levels of care will show a 6% increase in services provided in the community.

Data Source:

Enterprise Data Warehouse

Description of Data:

Percentage of services provided in the community

Data issues/caveats that affect outcome measures:

None anticipated.

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Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$26,924,968.00		$0.00	$25,382,179.00	$177,241,928.00	$0.00	$15,047,797.00		$14,737,870.00	$7,171,337.00
a. Pregnant Women and Women with Dependent Children[c]	$8,076,147.00			$105,402.00	$4,020,034.00		$315,120.00		$1,359,500.00	$1,917,000.00
b. All Other	$18,848,821.00			$25,276,777.00	$173,221,894.00		$14,732,677.00		$13,378,370.00	$5,254,337.00
2. Primary Prevention[d]	$9,502,946.00		$0.00	$15,412,827.00	$7,546,686.00	$0.00	$968,634.00		$2,310,096.00	$200,000.00
a. Substance Abuse Primary Prevention	$9,502,946.00			$15,412,827.00	$7,546,686.00		$968,634.00		$2,310,096.00	$200,000.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately					$21,502,671.00					
10. Crisis Services (5 percent set-aside)										
11. Total	**$36,427,914.00**	**$0.00**	**$0.00**	**$40,795,006.00**	**$206,291,285.00**	**$0.00**	**$16,016,431.00**	**$0.00**	**$17,047,966.00**	**$7,371,337.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$762,986.00		$810,474.00	$11,137,200.00		$885,573.00	$296,250.00		$200,000.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$1,394,397.00		$0.00	$0.00		$0.00	$560,876.00		$240,000.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$146,199,026.00	$3,095,002.00	$491,109,596.00		$3,644,522.00			
7. Other 24-Hour Care		$1,505,440.00	$137,585,928.00	$78,282.00	$220,338,233.00		$303,058.00			
8. Ambulatory/Community Non-24 Hour Care		$9,562,352.00	$0.00	$82,141,867.00	$823,916,955.00		$5,925,179.00	$4,043,500.00		$450,000.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$21,601.00	$0.00	$0.00	$96,879,400.00		$0.00			
10. Crisis Services (5 percent set-aside)[g]		$697,198.00	$0.00	$0.00	$0.00		$0.00	$1,635,438.00		$4,941,150.00
11. Total	**$0.00**	**$13,943,974.00**	**$283,784,954.00**	**$86,125,625.00**	**$1,643,381,384.00**	**$0.00**	**$10,758,332.00**	**$6,536,064.00**	**$0.00**	**$5,831,150.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,713	459
2. Women with Dependent Children	5,059	3,303
3. Individuals with a co-occurring M/SUD	35,894	20,577
4. Persons who inject drugs	7,692	8,783
5. Persons experiencing homelessness	165	5,688

Please provide an explanation for any data cells for which the state does not have a data source.

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Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$13,462,484.00	$14,737,870.00	$7,171,337.00
2 . Primary Substance Use Disorder Prevention	$4,751,473.00	$2,310,096.00	$200,000.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)			
6. Total	**$18,213,957.00**	**$17,047,966.00**	**$7,371,337.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 (SABG); 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 published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	**IOM Target**	**FFY 2022**		
		SA Block Grant Award	**COVID-19[1]**	**ARP[2]**
1. Information Dissemination	Universal	$363,337	$266,682	$230,317
	Selective	$13,937	$10,229	$8,834
	Indicated	$15,311	$11,238	$9,705
	Unspecified	$0	$0	$0
	Total	**$392,585**	**$288,149**	**$248,856**
2. Education	Universal	$1,142,101	$838,280	$723,969
	Selective	$43,808	$32,154	$27,770
	Indicated	$48,127	$35,325	$30,508
	Unspecified	$0	$0	$0
	Total	**$1,234,036**	**$905,759**	**$782,247**
3. Alternatives	Universal	$45,632	$33,493	$28,926
	Selective	$1,750	$1,285	$1,110
	Indicated	$1,923	$1,411	$1,219
	Unspecified	$0	$0	$0
	Total	**$49,305**	**$36,189**	**$31,255**
4. Problem Identification and Referral	Universal	$30,565	$22,434	$19,375
	Selective	$1,172	$861	$743
	Indicated	$1,288	$945	$816
	Unspecified	$0	$0	$0
	Total	**$33,025**	**$24,240**	**$20,934**
	Universal	$2,280,756	$1,674,032	$1,445,755

	Selective	$87,484	$64,212	$55,456
5. Community-Based Process	Indicated	$96,110	$70,543	$60,923
	Unspecified	$0	$0	$0
	Total	**$2,464,350**	**$1,808,787**	**$1,562,134**
6. Environmental	Universal	$442,548	$324,822	$280,528
	Selective	$16,975	$12,459	$10,760
	Indicated	$18,649	$13,688	$11,821
	Unspecified	$0	$0	$0
	Total	**$478,172**	**$350,969**	**$303,109**
7. Section 1926 Tobacco	Universal	$100,000	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$100,000**	**$0**	**$0**
8. Other	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$4,751,473**	**$3,414,093**	**$2,948,535**
Total SABG Award[3]		**$18,213,957**	**$0**	**$0**
Planned Primary Prevention Percentage		**61.02 %**		

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]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: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$3,336,009	$2,397,035	$2,070,166
Universal Indirect	$1,061,479	$762,708	$658,703
Selective	$168,677	$121,200	$104,673
Indicated	$185,308	$133,150	$114,993
Column Total	**$4,751,473**	**$3,414,093**	**$2,948,535**
Total SABG Award[3]	**$18,213,957**	**$0**	**$0**
Planned Primary Prevention Percentage	**26.09 %**		

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☐	☐
Heroin	☑	☑	☑
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Bath salts, Spice, K2)	☑	☐	☐
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☐	☐
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

Planning Tables

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

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems				$335,000.00	$150,000.00
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education				$275,000.00	$30,000.00
8. Total	**$0.00**	**$0.00**	**$0.00**	**$610,000.00**	**$180,000.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Planning Tables

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

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$200,000.00	$100,000.00		$50,000.00	$100,000.00	
2. Infrastructure Support	$450,000.00	$162,500.00	$62,500.00	$450,000.00	$162,500.00	$62,500.00
3. Partnerships, community outreach, and needs assessment	$100,000.00			$10,000.00		
4. Planning Council Activities (MHBG required, SABG optional)	$15,000.00			$15,000.00		
5. Quality Assurance and Improvement	$80,000.00			$65,000.00		
6. Research and Evaluation	$0.00			$0.00		
7. Training and Education	$75,000.00	$462,500.00	$240,000.00	$65,000.00	$462,500.00	$240,000.00
8. Total	**$920,000.00**	**$725,000.00**	**$302,500.00**	**$655,000.00**	**$725,000.00**	**$302,500.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

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[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

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[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

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[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The state has been actively working to integrate mental health and primary health care. Several years ago, DMHAS initiated Behavioral Health Homes (BHHs) in 14 agencies across the state. This includes all the Local Mental Health Authorities (LMHAs) and one other private agency. The BHHs are an innovative, integrated healthcare service delivery model that is recovery-oriented, person and family-centered and promises better patient experiences and outcomes than those achieved in traditional services. he BHH service delivery model is an important option for providing cost-effective, longitudinal "homes" to facilitate access to an interdisciplinary array of behavioral health care, medical care, and community-based social services and supports for both children and adults with chronic conditions. The services are designed to achieve the triple aim of improving individual experience of care, improve population health, and reduce per capita health care costs. These services are funded by DMHAS and Medicaid and include care management and coordination, health and wellness activities, and referral to community support services. DMHAS serves approximately 10,000 individuals through these services annually.
Integration also occurs outside of these BHHs. Various mental health providers across the state have developed relationships with local medical providers. In some instances the medical services are co-located at community mental health centers. This integration may also occur in other ways. One LMHA is a Federally Qualified Heath Center (FQHC) Look Alike and delivers integrated services. In addition to these activities, DMHAS was awarded the Promoting Integration of Primary and Behavioral Health Care Integration Grant (PIPBHC) which is allowing Connecticut to further expand our integration efforts.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

Connecticut has long recognized that mental health and substance use conditions often occur in the same individuals, consequently, DMHAS has been providing integrated services for co-occurring clients since the 1990s. Mental health and addiction treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders. Specialized staff training, consultation, and pilot treatment projects for persons with co-occurring disorders have been put in place over the last twenty years to address the treatment needs of individuals with co-occurring disorders. Historically, the thirteen LMHAs implemented the Integrated Dual Disorders Treatment (IDDT) model and addiction treatment providers used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index to guide its integrated care for individuals with co- occurring disorders. Some mental health programs also gravitated to using the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) instead of the IDDT model to guide their integration efforts. DMHAS created two co-occurring enhanced residential treatment programs that were procured in 2009 and continue today. Since then, two additional residential treatment programs have reached co-occurring enhanced status for a total of four programs in the PNP sector.

DMHAS contracted with an IDDT consultant from Dartmouth Medical School for 9 years (2002-2011) and with Dr. Mark McGovern (also from Dartmouth) for about 10 years to train and consult with DMHAS providers on the DDCAT. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and addiction treatment agencies on a combined Co-Occurring and Supervision model for a couple of years.
Additionally, as part of the system change to ensure that mental health and substance use treatment providers were considering all relevant conditions, DMHAS instituted a policy in 2009 that all providers had to conduct co-occurring screenings at the time of admission and this process continues. These client-level screening data are collected through DMHAS' statewide data collection system.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

Access Health CT (AHCT) is responsible for monitoring access for plans sold on the exchange. The Office of the Health Care Advocate (OHA) monitors access through complaints received and the Clearinghouse. From a managed care perspective, the Connecticut Insurance Department (CID) has oversight over insurers' plan, design, network, formulary and regulatory compliance for fully insured plans. The Connecticut Department of Labor's (DOL) Employee Benefits Security Administration regulates the remainder of the commercial plans.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii) hypertension (●) Yes ( ) No

iv) high cholesterol (●) Yes ( ) No

v) diabetes (●) Yes ( ) No

c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (●) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

For the Medicaid population, Connecticut utilizes an Administrative Services Organization (ASO) designed to create an integrated behavioral health service system. Oversight of this ASO is an alliance among the Connecticut DMHAS, DSS (Medicaid authority) and DCF (Department of Children and Families), together creating the legislatively mandated Behavioral Health Partnership. The partnership works in conjunction to ensure parity for behavioral health services authorization and delivery. An example of an issue occurred a few years ago when authorization parameters for intermediate care for behavioral health services were changed to mirror the authorization parameters for medical health services, ensuring parity.
As for non-Medicaid covered services, DMHAS has representation on a workgroup chaired by the Commissioner of the Connecticut Insurance Department to review the practices of all payers in Connecticut.

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

No

Please indicate areas of technical assistance needed related to this section

None

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	(•) Yes ( ) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes ( ) No

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

Since 2003 there have been ongoing efforts to utilize the Office of Multicultural Health Equity (OMHE) to identify and remediate disparities in behavioral health care. This process uses data from a variety of sources (DMHAS, Yale University and Beacon Health Options - DMHAS' ASO) and responds with targeted activities.
The Organizational Multicultural Assessment (OMCA) is an initiative in which facilities are evaluated every 2 years with respect to meeting CLAS standards. Results are analyzed and then reviewed with facilities which are then provided training and technical assistance to implement CLAS standards. The MEP initiative has focused on state-operated programs, but interested private nonprofits are welcome to participate.
Multicultural Advisory Council (MCAC) brings together state-operated local and regional facilities' multicultural committees statewide to strategize ways to enhance implementation of CLAS standards. Some of the activities that have occurred are facility (Lunch and Learns), and community conversations, "Chicago Dinners" about health disparities held in each DMHAS region of the state. We have worked with faith-based organizations on community building with cultural relevance, to transform and expand the Connecticut crisis response capacity to be a fully person and family-centered, trauma informed, and culturally responsive array of easy to access, readily available, continuous services and community supports that offer a range of pre-crisis, & post crisis options, from which persons may choose those most effective in meeting their needs wherever they may be in their recovery process.

We are providing training throughout the DMHAS system of care on Diversity, Equity & Inclusion to enhance understanding of difference and provide skill building opportunities to better engage with clients and staff. We have provided system-wide training through the services of Kaleidoscope Group to provide a Training of Facilitators program in Diversity, Equity, and Inclusion. We are currently cascading this training to all DMHAS staff, in which the newly certified facilitators are providing the training.

As part of the Connecticut Network of Care Transformation (CONNECT) SAMHSA System of Care grant, a workgroup was developed to plan and implement a statewide process for incorporating enhanced Culturally Linguistically Appropriate Services (CLAS) standards within the children's Network of Care in Connecticut. With a goal to partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.

The outcomes and results were that cohorts were formed to participate in Connecting with CLAS. Additionally, state and agency partners support, the recruitment efforts of the Connecting with CLAS Team. 61 agencies agencies participated and 48 agencies completed their Health Equity Plans. Technical Assistance is provided to review progress, support their efforts, and receive

guidance or recommendations for next steps. This included four quarterly learning collaborative meetings and monthly calls. The count of total RJ CLAS training participants to date is 457.

Please indicate areas of technical assistance needed related to this section

None.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

CT DMHAS has embarked on the operational transformation of the SUD Residential Service System to ASAM 3rd edition as well as changing primary payer for these services to Medicaid. This has included extensive collaboration with the Medicaid Authority, the Children's Behavioral Health Authority, service providers, those who use/used services and their families regarding clinical standards, staffing and rates.
Along with the transformation of SUD residential services, CT is working with various stakeholders to implement Medicaid value based payment for lower levels of care, with a particular focus on transitions between levels of care.

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

None

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

DMHAS funds 2 programs providing CSC for persons with FEP/ESMI with the 10% set-aside: 1) STEP Program at CT Mental Health Center/Yale University and 2) Potential Program at Institute of Living/Hartford Hospital. Evidence-based practices include: outreach and engagement, multidisciplinary team approach, targeted services for young adults, TOIVO community -based programming providing integrated whole person care focusing on wellness, SBIRT, TurningPointCT.org website designed by/for young persons with behavioral health issues providing support and connection, management of psychotropic medications, CBT, mobile crisis, CIT-crisis intervention team training of law enforcement on behavioral health issues and/or mental health personnel on crisis/911 calls, supported education and vocational rehabilitation, and family education and support.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

- DMHAS has been supporting operated and funded mental health and substance use treatment providers in use of the

following evidence-based and best practices, including: assertive community treatment (ACT), Integrated Treatment for Individuals with co-occurring disorders (IDDT), DDCAT, DBT, Supported Employment using Individualized Placement and Support (IPS), Supported Education, Supportive Housing, Housing First, Trauma-informed and Trauma-specific (and gender-responsive) services, MAT, MI, and CBT. Alternative Services Statewide Integrative Medicine Committee has been established and more information is available from the DMHAS website at http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=580236.
- DMHAS and DCF support 2 programs providing specialized FEP services (STEP and Potential)
- DMHAS provides young adult services (YAS) specially designed for young adults, most of whom are aging out of DCF and transitioning to the adult system
- Alternative treatments and initiatives targeting wellness have become more generally accepted and are providing opportunities for clients with behavioral health issues to empower themselves and take control of their own recovery. Healthy activities related to diet, exercise, meditation, etc. are offered in group settings that also provide an opportunity for positive social interactions and the forming of friendships with peers. TOIVO is one such entity in Hartford, where persons in recovery operate programs and engage others in yoga, mindfulness and other creative activities.
- Since 2011, DMHAS has a Director of Evidence Based Practices (EBPs) and that team has grown to include 5 managers. This unit promotes the adoption of EBPs throughout the system of care. The EBP division created a series of webpages on the DMHAS website that describe different EBPs and various available publications to help implement the practices. This is a valuable resource for providers, consumers and families: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The Coordinated Specialty Care (CSC) model continues to be provided.
EBPs include: peer support, cognitive remediation (individual & group treatment), CBT for psychosis (individual & group treatment), outreach and engagement, expert diagnostic assessment, family education and support, medication management, social cognition intervention therapy (SCIT) based groups, case management, and supported education and employment.
Additionally, the STEP program is providing:
- implementation of a performance improvement system to monitor and improve rates of engagement post-discharge
- beta testing of informatics platform to allow periodic dashboards of population outcomes
- training of CSC clinicians in personal therapy approach to supportive psychotherapy

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

Potential program: expanding staffing to respond to increased requests for services.
STEP: 1) Due to COVID this was delayed and will be pursued this year: will initiate a statewide forum to include a wide range of stakeholders to develop a system of care to meet the needs of areas currently less able to access specialty services for early psychosis. Activities will include hosting educational workshops and meetings that will focus on how to leverage existing resources across the state and the 2 funded CSCs to expand access and quality of care; explore policies that will enable better reimbursement of this care and collaborations with non-healthcare sectors (e.g., education, criminal justice) to improve pathways to and through care; 2) STEP will refine its model of care by testing approaches to improving cognitive deficits, improving referrals from PCPs and improving follow up upon transfer to community care after 2 years in its CSC specialty service; 3) STEP will pursue alternative payment models, including bundled payments with commercial insurance provides to help develop sustainable business models to enable expansion of EIS across the state.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Both programs submit data on admissions, discharges, discharge status, service hours, NOMS - including social support, stable living situation and employment status.
Potential Program - also collects duration of untreated psychosis (DUP) and Brief Psychiatric Rating Scale (BPRS) data.
STEP: STEP completed the first US-based randomized controlled trial in 2013 with NIH-funding demonstrating the effectiveness of this approach. STEP has continued to collect comprehensive measures reported in that study (Srihari et. al., Psychiatric Services, 2015) including symptoms, functioning, quality of life, and healthcare utilization. Since 2014, STEP has added measures of Pathways to Care and Duration of Untreated Psychosis (DUP). In 2019, STEPlaunched an online informatics platform that enables dashboards of population outcomes to enable performance improvement. STEP has published on this approach (Srihari et. al., JAMA Psychiatry, 2016).

10. Please list the diagnostic categories identified for your state's ESMI programs.

schizophrenia schizophreniform
all primary psychotic illnesses in the schizophrenia spectrum

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

None

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Footnotes:

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

NA

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. Starting in 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) were participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons were trained in person-centered planning by Yale PRCH. More recent initiatives related to person-centered planning include a multi-state agency workgroup that DMHAS is participating in and a pilot project with PRCH across several CSP teams called Recovery Roadmap.

4. Describe the person-centered planning process in your state.

A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. Starting in 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) were participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons were trained in person-centered planning by Yale PRCH. More recent initiatives related to person-centered planning include a multi-state agency workgroup that DMHAS is participating in and a pilot project with PRCH across several CSP teams called Recovery Roadmap.

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

None.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The DMHAS Local Mental Health Authority (LMHA) in the southeastern part of the state near the Mashantucket and Mohegan tribes continues to participate in regional coordinating/collaborative meetings with tribal leadership as part of the Regional Human Services Coordinating Council; the Southeastern Connecticut Health Improvement Collaborative; Eastern Connecticut Health Collaborative and Mashantucket Pequot Annual Children's Mental Health Awareness Day in May. There has not been formal "consultation" provided.

2. What specific concerns were raised during the consultation session(s) noted above?

   The Mashantucket and Mohegan tribes continue to provide behavioral health services to their members who typically do not seek DMHAS services. However, ongoing efforts to coordinate and collaborate continue.

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

   No.

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

   NA

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

demographic data, qualitative provider and stakeholder data

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

US Census; HIDTA National Drug Threat Assessment, CT Office of the Chief Medical Examiner

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [x] Communities that Care
- [x] State - developed survey instrument
- [x] Others (please list)

Surveys and other data collected from community based organizations, service organizations universities and special studies

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Priorities identified in regional needs assessment reports are used to inform funding decisions

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

The Connecticut Certification Board manages the Certified Prevention Specialist (CPS) credentialing

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

The CT Prevention Training & Technical Assistance Service Center (TTASC) provides targeted training and technical assistance for substance abuse prevention efforts. Utilizing the SPF process, the TTASC conducts a workforce needs assessment, creates a strategic plan and implements workforce development strategies that include the delivery of targeted technical assistance and training (in person, and web based).

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

The CT Center for Prevention Evaluation & Statistics (CPES) at the University of CT is funded to implement a biennial Community Readiness Survey (CRS) in CT that assesses community readiness to address substance abuse throughout the state. The last survey was conducted in 2020.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☑ Other (please list):

  Finance component, evaluation component
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Evidence Based Workgroup meets bi-monthly and provides guidance for the selection of evidence based strategies based on a number of factors including SAMHSA guidance, and research conducted by evaluators. The Evidence Based Workgroup developed an array of Fidelity Tools for the most commonly used strategies that will allow communities the ability to assess the efficacy of the selected strategy.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☑ Other (please describe)

  Directly implements tobacco merchant inspections and education for the Synar requirement

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

CT Clearinghouse Patron Services Clearinghouse/Information Resource Center Health Fairs
Health Promotions
A/V Material Disseminated Printed Material Disseminated Periodicals Disseminated
Public Service Announcements Disseminated Media Campaigns Conducted
Speaking Engagements
Telephone/Email/Website Information Requests

b) Education:

ATOD Coalition Education
Youth engagement/Peer Advocacy
Competency-based ATOD training to prevention professionals Parent focused education and outreach
Tobacco retailer awareness and education

c) Alternatives:

ATOD-Free Social/Recreational Events
Community Services Activities

Youth/Adult Leadership Functions

d) Problem Identification and Referral:

Student Assistance Programs

e) Community-Based Processes:

Accessing Services and Funding
Systematic planning
Community Funds Distribution
Coalition Building
Coalition Capacity Building
Monitoring and Evaluation
Assessing Community Needs
Community/Volunteer Services - Training
Training Services
Technical Assistance
Systematic Planning

f) Environmental:

Enforcement of Alcoholic Beverage Laws or Policies
Enforcement of Illicit Drug Laws or Policies
Preventing Underage Sale of Tobacco--Synar Amendment
Preventing Underage Alcoholic Beverage Sales
Public Policy Efforts

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ○ Yes ◉ No

If yes, please describe

The state provides funds through competitive bids for infrastructure services that provide prevention training, TA, youth development, needs and gap assessment, data collection, analyses , evaluation, information disseminations, etc., as well as evidence based programs directly to target populations. The funding opportunities are usually informed by the process described in the assessment section. The state only funds prevention efforts but does not ensure that recipients have no other means of funding. If this is necessary, guidance from SAMHSA on how to ensure this is needed.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [ ] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [ ] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use
- [x] Binge use
- [x] Perception of harm
- **c)** [x] Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Prevention and Health Promotion Division

Strategic Plan
2021-2024

Authored by: DMHAS Prevention and Health Promotion Division




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Prevention and Health Promotion Division Strategic Plan 2021

INTRODUCTION

As a state, Connecticut has a long history of investing into prevention resources. The DHMAS Prevention and Health Promotion Division has evolved the system to meet the needs of Connecticut residents, leveraging local, state, and federal resources to support evidence-based prevention and health promotion efforts across the state.

The Prevention and Health Promotion Division has invested in an infrastructure to support these efforts. The Division follows a public health planning process, the Strategic Prevention Framework (SPF), at the state-level as a means to identify strengths and weaknesses of the overall system at every step of the SPF – assessment, capacity-building, planning, implementation, and evaluation. Sustainability and cultural responsiveness are key components to this as well. By going through this process, the Division has a clear understanding of the needs and enhancements it can support to bolster prevention efforts, while not duplicating efforts put in place by other partners.

This document outlines that process and how it translated into an actionable plan. The plan is a blueprint of goals, objectives and measures informed by needs and gaps, meant to transform current services and improve the health of the citizens of the state. Key components include financing and sustainability – two components which are key to the successful growth of our efforts. This plan identifies ways in which the Division can continue to be responsive to the needs of the state's most vulnerable residents, a population that has also disproportionally been impacted by COVID-19. As with any plan, this one cannot be static. If the lessons of the last few months have taught us anything, we need to continue to identify ways we can improve and support our local communities' health and well-being. To that end, the plan will be reviewed and updated at the end of each fiscal year.

STATE STRATEGIC PREVENTION FRAMEWORK PROCESS

The SPF process was applied to effectively address the goals and objectives of the strategic plan, ensuring that diverse population groups are contributors to and beneficiaries of prevention services.

Each SPF step was applied in the following way:
Assessment: The State Epidemiological Outcomes Workgroup (SEOW) identified and collected data that are used to assess priority needs for services and evaluate the impact of policies and programs. They systematically reviewed and analyzed data related to six substances and two behavioral health

problems that the state has identified as priorities. They work collaboratively with local-level providers, such as the Regional Behavioral Health Action Organizations (RBHAOs), to collect data and enter it into the SEOW Prevention Data Portal. This also enables the SEOW to identify gaps and needs in the state's data collection efforts and data system. The data provided in section 3 reflect these data. These data sets are also used to identify gaps and needs within the Prevention system, such as those identified within the Resources and Gaps Section below. For example, identifying data gaps, and gaps in prevention services and access to prevention services, as a way to measure equitable distribution of resources is key to understanding how existing social determinants of health may be impacting access to prevention services. *Please refer to page 10 for more information on the SEOW and RBHAOs.*

Capacity: The DMHAS organizes its Prevention and Health Promotion Division to be consistent with federal guidelines and provide accountability-based, developmentally-appropriate and culturally sensitive behavioral health services based on scientific models and best practices, through a comprehensive system that matches the services to the needs of the individuals and 169 local communities. The DMHAS uses 5 subdivisions across Connecticut as the geographic basis for prevention services and activates a network of statewide service delivery agents to provide technical assistance, training, and prevention-related service delivery. The Prevention Service Providers have all received SPF training and have been implementing the process in their programming since 2016. Every two years, we assess our capacity and identify resource gaps and needs, to help address the behavioral health concerns facing Connecticut's residents. *Please refer to the Infrastructure section beginning on page 9 for more information on these entities.*

Planning: The DMHAS Prevention and Health Promotion Division: identified state and local prevention partners, federal and state priorities and direction; reviewed SEOW data and strategic plans from providers and; prioritized the state's behavioral health prevention and promotion needs as part of the development of this strategic plan. In this process, DMHAS established prevention goals identified during the needs assessment and capacity-building processes. These goals are both substance-specific and infrastructure focused.

Implementation: To address priorities, DMHAS has re-bid a portion of Block Grant funds competitively, selected sub-recipients for discretionary funding and have required the remaining providers to adopt a practice improvement approach. This approach allows for the examination and redirection of funding to ensure best practices and consistency with prevention goals, while maintaining and, in some cases, increasing funding levels. An Evidence-Based Workgroup has also been established to assist in identifying and selecting evidence-based interventions for prevention service providers. Representatives on this workgroup are comprised of content experts in prevention science, data collection and evaluation as well as community program providers. The group's responsibilities include reviewing and approving community plans and logic models to ensure appropriate fit and updating and disseminating an approved list of evidence-based practices, policies and programs by populations, geography and substance for use within the state. *Please refer to page 10 for more information on the Evidence-Based Workgroup.*

Evaluation: Connecticut DMHAS will use a three-tiered approach to monitoring performance of ATOD prevention initiatives:

- Use the MOSAIX IMPACT Data Collection System to capture how prevention providers implement evidence-based strategies to address identified ATOD risk factors. These data are used for federal and state reporting, to track performance and make mid-course corrections.
- Maintain an annual DMHAS Prevention and Health Promotion Division Scorecard that tracks annual progress in meeting its goals and objectives. The information provided by the score card will inform ongoing training and technical assistance priorities as well as opportunities to expand prevention partnerships as external conditions continue to change (e.g., funding climate, regional).
- Publish information briefs on ATOD indicators and survey data and make them available to prevention partners. These data result from valid and reliable methodologies that align with federal and state surveillance and reporting mandates.

DEMOGRAPHICS

According to the US Census Bureau, CT's population is comprised of 3.57 million people (2018) and its racial makeup is becoming increasingly diverse. The five largest ethnic groups in Connecticut are White (Non-Hispanic) (66.3%), Black or African American (10%), Other (Hispanic) (5.15%), and Asian (Non-Hispanic) (4.61%). 22.1% of people in Connecticut speak a non-English language, and 93.2% are US citizens. CT has two federally recognized tribal nations, the Mashantucket Pequot Nation (pop. 785), and the Mohegan Tribe (pop. 1,700); and three state recognized tribal nations, the Eastern Pequot Nation (pop 920), the Golden Hill Paugusset Tribe (pop. 100), the, and the Schaghticoke Indian Tribe (pop. 300).

BEHAVIORAL HEALTH DATA

DMHAS uses data that informs its substance misuse prevention priorities. The epidemiological profiles below are summaries of the top mental health problems and legal and illegal substances affecting the state's population. The summaries reflect consumption, consequence and some risk factor data that informed this strategic plan.

Alcohol: Alcohol is the most commonly consumed substance in Connecticut, and the state's use rates are higher than the national average (NSDUH, 2017-2018). Among high school students, females are more likely than males to report current drinking (29.2% vs. 22.8%) and binge drinking (14.4% vs. 11.5%). Non-Hispanic white and Hispanic students had the highest prevalence of current drinking (29.6% and 26.0%, respectively) and binge drinking (15.8% and 12.8%, respectively) among all racial/ethnic categories (CSHS, 2019). Among high school students, 11.7% reported having their first drink before age 13 (YRBS, 2019). Rates in Connecticut were higher among students 15 years and younger (14.5%), 9th grade students (16.2%), as well as Hispanic/Latino (16.0%), Black (14.9%), and students with multiple races (14.0%). In 2013, underage drinking cost Connecticut $664.9 million in medical care, criminal justice, property damage, and work loss, as well as pain and suffering associated with multiple problems resulting from the use of alcohol by youth (*Underage Drinking in Connecticut: The Facts*, PIRE). In 2019, 14.1% of CT high school students reported riding a car with a driver who had been drinking alcohol at least once in the past 30 days. This represents a decline from 26.7% in 2009 (CSHS, 2019).

Prescription Drugs and Heroin: In 2019, of the 1,200 overdose-related deaths, 387 deaths involved Heroin (up from 174 in 2012), and 979 involved Fentanyl (up from 15 in 2012). Almost half of heroin treatment admissions in 2017 were for individuals between the ages of 25-39 years old. Of all Connecticut treatment admissions in 2017, 35.8% were for heroin as the primary substance (Connecticut Department of Mental Health and Addiction Services, 2019). The majority of accidental deaths involving prescription drugs occurred among non-Hispanic white males (CT Office of Chief Medical Examiner, 2019). Overall in Connecticut, the prevalence of lifetime heroin use is slightly higher among males, and among Black and Hispanic students (YRBSS 2019).

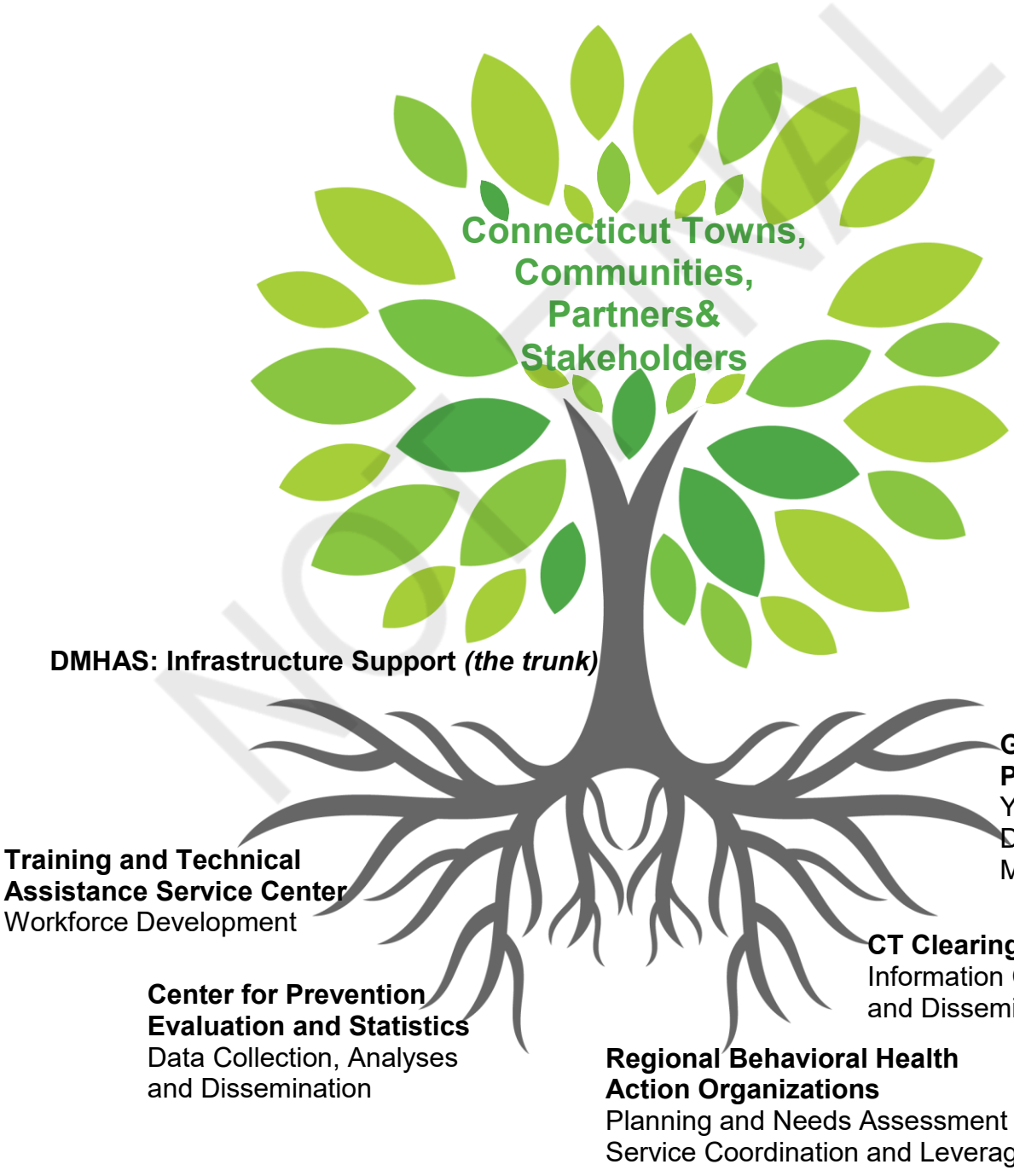
Tobacco and ENDS: Connecticut and the nation experienced a spike in under age use (27% in CT 27.7% nationwide) of Electronic Nicotine Delivery Systems (ENDS) commonly known as electronic cigarettes or e-cigarettes. Because most ENDS contain nicotine Connecticut and the federal government regulates ENDS in the same way as tobacco products are regulated. As such, ENDS are categorized as a tobacco product and includes ENDS in the data collected in the Biannual Youth Tobacco Survey Report. The spike in underage ENDS use in Connecticut caused the overall increase in underage use of "tobacco products" reported in the 2019 Youth Tobacco Survey (YTS). All other underage tobacco use in Connecticut remained flat or decreased slightly (6.3% overall). The Connecticut 2019 YTS reported an overall increase of tobacco (28.7%) when ENDS is included. ENDS data: Percentage of High School Students Who Currently Used an Electronic Vapor Product,* by Sex,† Grade,† and Race/Ethnicity,† 2019, Overall (27%) White (30%) Hispanic (26%) and Black (19.4%). Use is defined as the use of any ENDS Products **once** in the last 30 days.
Tobacco and ENDS data combined: Percentage of High School Students Who Currently Smoked Cigarettes or Cigars or Used Smokeless Tobacco or Electronic Vapor Products,* by Sex,† Grade,† and Race/Ethnicity,† 2019. Use is defined as the use of **any** tobacco or ENDS Products **once** in the last 30 days. Overall (28.7%) White (31.8%) Hispanic (27.5%) and Black (21.7%).

Marijuana: Marijuana remains the second most commonly used drug in Connecticut (CSHS, 2019). Marijuana usage in the state remains higher than the national average. Among 18-25 years olds in Connecticut 30.1% reported past month marijuana use compared to 22.1% nationally. Among youth 12-17 in Connecticut 16.1% reported past year use, and 8.4% reported past month youth—also higher than their national peers (NSDUH, 2017-2018). Current marijuana use among high school students is highest among students from multiple races (24.7% and Hispanic/Latino students (24.3%), compared to White students (22.4%), Black students (15.5%), and students of all other races (16.6%) (CSHS, 2019).

Suicide: Suicide and related risk factors remain a concern, especially among those under 25. Of students in grades 9 – 12, almost 31% have felt sad or hopeless almost every day for at least two consecutive weeks in the past year (CSHS, 2019), and 12.7% have had serious thoughts of suicide in the past year (CSHS, 2019). Of those aged 18 – 25, almost 14% have had a major depressive episode in the past year (NSDUH, 2017 – 2018). However, between 2016 and 2018, there have been over 4, 500 suicide attempts across all ages in the state (CHiME Hospital Discharge Data). The CT Office of the Chief Medical Examiner reported 424 deaths by suicide in the state in 2019.

RBHAOs conducted an assessment of their regional priorities in 2019. Of the five regions, all five prioritized the need to address mental health, three identified alcohol as a priority, and two regions each identified suicide, prescription drugs and heroin as needs. The low perception of harm for substances such as alcohol, ENDS, and marijuana was identified as a concern across the regions, as was the increased use of cannabis. Suicidal ideation and death by suicide were also identified as priorities. Detailed data tables are included in Appendix 1.

INFRASTRUCTURE:



In Connecticut, several state agencies as well as statewide, regional, and local efforts support prevention and health promotion. The DMHAS Prevention and Health Promotion Division staff members guide the implementation of Connecticut's strategic prevention initiatives. The DMHAS organizes its Prevention and Health Promotion Division to provide accountability-based, developmentally-appropriate and culturally sensitive behavioral health services based on scientific models and best practices, through a comprehensive system that matches services to the needs of the individuals and 169 local communities. DMHAS uses five regions across Connecticut as the geographic basis for prevention services.

Certain essential components of a behavioral health infrastructure need to be in place in communities to help them combat the problems posed by substance use and mental health disorders. These components include but are not limited to: 1) an ongoing planning process that uncovers needs and gaps; 2) a well informed and educated prevention workforce; 3) coordination of substance use and mental health efforts across multiple sectors; and 4) data systems and processes that facilitate prevention program monitoring and evaluation. The figure on the previous page shows a visual metaphor of the statewide Prevention Infrastructure. The visual metaphor uses the image of a tree to show: the fundamental components of the infrastructure (i.e., roots); the major investors in the infrastructure, like DHMAS, (i.e., trunk); the state's investment of programs and services (i.e. branches); and how the infrastructure supports partnerships at the community level (i.e. leaves).

When environmental factors within the state are favorable (i.e., increased protective factors, political will, adequate funding, etc.), the ATOD infrastructure is stronger, promotes growth and is more likely to achieve outcomes. Conversely, when there are unfavorable environmental conditions (i.e., increased risk factors, leadership changes, economic downturns, losses of funding), the system remains stagnant and less likely to achieve measurable gains. The visual metaphor remains a work in progress by the DMHAS and will undergo additional refinements during the implementation period of this plan. Connecticut has created a prevention infrastructure that supports efforts on the state, regional and local levels. This investment ensures that the system can respond to evolving needs and resources to allow the key functions of prevention to continue, building a foundation for collaboration across the continuum of care. This infrastructure includes not just the entities listed below but also the human resources that conduct the work, and the partnerships that enable the work to continue.

The key partners and drivers within CT's prevention infrastructure include:
Four Statewide Service Delivery Agents that support prevention programs statewide:

- DMHAS Prevention Training and Technical Assistance Services Center's (TTASC) goal is to increase prevention workforce competencies, utilizing the SAMHSA Strategic Prevention Framework five-step process, training and technical assistance for improved access by prevention workers most relevant, responsive and culturally appropriate prevention education, and training resources in collaboration with Department staff. It accomplishes this goal by organizing events such as learning communities, facilitating access to professional development offerings, providing customized technical assistance, and promoting individual and organizational networking.
- The Connecticut Clearinghouse/Connecticut Center for Prevention, Wellness and Recovery (CCPWR) is the State's premier information resource center that disseminates thousands of pamphlets, posters, fact sheets, books, e-books, and curricula on prevention, substance use, mental health

promotion and a variety of other topics to individuals statewide. The mobile resource van allows materials to be easily accessible at local events across the state. Clearinghouse staff administer the comprehensive DMHAS statewide prevention listserv, the Change the Script opioid awareness campaign, and the drugfreect.org website. They provide logistical support and the coordination of activities related to the successful implementation of the Tobacco Merchant Education campaign, the Healthy Campus initiative, the Community Readiness Survey, Mental Health First Aid trainings, and National Prevention Week.

- The Governor's Prevention Partnership (GPP) is a statewide organization comprised of partnerships designed to change the attitudes and behaviors of youth and adults toward substance misuse. The GPP provides ongoing training, technical assistance and programs that promote healthy communities, safe school environments and increased youth and adult connections. Additionally, the GPP builds awareness of youth prevention programs through its partnerships with television, print and broadcast media across the state.
- The DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health collects, manages, analyzes and disseminates epidemiological and evaluation data through their SEOW Prevention Data Portal, an interactive repository for behavioral health data, epidemiological profiles, presentations and products. The CPES convenes the Statewide Epidemiological Outcomes Work Group (SEOW), comprised of representatives from state agencies and organizations connected in various ways to Connecticut's data infrastructure. The SEOW meets quarterly to prioritize and share data, with an emphasis on ATOD prevention and use data and mental health promotion data, and those efforts inform and expand the content and functionality of the Portal. The CPES also provides TA and training on data and evaluation topics to prevention partners and providers statewide.

Five Regional Behavioral Health Action Organizations (RBHAOs) operate as subcontractors to DMHAS to carry out ATOD prevention initiatives, among their other mission-driven objectives. These private non-profit organizations, comprised of a board of directors of community stakeholders, and staff build capacity of communities to identify gaps and coordinate and leverage resources for behavioral health services. Working closely with the Local Prevention Councils in their region, the RBHAOs may conduct comprehensive analyses of community needs, provide support to build data capacity and produce Sub-Regional Profiles to establish local substance abuse prevention priorities. The RBHAOs are:

- The Hub: Behavioral Health Action Organization for Southwestern CT
- Alliance for Prevention Wellness - BHCare
- Supporting and Engaging resources for Action and Change (SERAC)
- Amplify, Inc
- Western CT Coalition

Other entities integral to the DMHAS Prevention infrastructure include:

- State Epidemiological Working Group (SEOW): DMHAS first established the SEOW in 2005 under the SPF-SIG initiative funded by SAMHSA, CSAP to conduct careful data reviews and analyses on the causes and consequences of substance use to guide prevention decision making. The SEOW facilitates dissemination and sharing of data and assists in supporting the work of prevention practitioners across the state planning and monitoring prevention strategies. Its membership consists of several state agencies, local community evaluators and other Prevention professionals.

- The Evidence-Based Workgroup is a DMHAS-convened volunteer workgroup of prevention and evaluation specialists who reviews the research behind prevention programs to ensure local entities are implementing programs that address the needs and conditions in a way that is supported by the research.
- 156 Local Prevention Councils (LPCs) address primary prevention in the 169 communities throughout the state of Connecticut. The LPCs include representatives who are elected officials, police officers, educators, faith/spiritual leaders, business leaders, social and human service providers, and parents, among others. These multi town coalitions and related local-level entities ensure that community-led prevention efforts are accessible to residents across the state. The support these local entities have from the CT Clearinghouse, RHBAOs, TTASC and CPES helps create a cost-effective, strategic use of resources, align priorities across the system.
- Campus/Community-Based ATOD Prevention Initiatives including:
  1. The 10 CT SPF Coalitions (CSC's), which are community-based programs/coalitions charged with implementing evidence-based strategies to prevent underage drinking. The CSC programs use the SPF 5 Step process to address youth alcohol use in addition to other priority substances such as marijuana and prescription drug abuse.
  2. A statewide Healthy Campus Coalition comprised of Connecticut colleges and universities who are participating in activities to address the reduction of ATOD use and abuse amongst their student populations.
  3. The SPF for Prescription Drugs (SPF-Rx) is awarded to 4 health districts to reduce non-medical use of prescription drugs and prevention opioid overdoses. The SPF-Rx programs focus on raising awareness about the dangers of sharing medications for individuals age 12 and over and work with prescribers and dispensers to be aware of the risks of overprescribing through the Academic Detailing for Opioid Safety (ADOPS) initiative.
- A SAMHSA/CMHS-funded Statewide Network of Care (SNC) for suicide prevention, intervention and response initiative that implements an intensive community-based effort to reduce non-fatal suicide attempts and suicide deaths among at risk youth age 10-24. The SNC is comprised of five regional, and one community-level network that will be the focus of an intensive community-based effort to put into practice sustainable evidence-based suicide prevention and mental health promotion policies, practices and programs at institutions of higher education throughout the state for students up to age 24.
- The Tobacco Prevention and Enforcement Program (TPEP) utilizes DMHAS prevention staff to implement the Synar Amendment requirements. TPEP's primary mission is to enforce state and federal youth access laws. Activities include completion of the Annual Synar Report, un-announced inspections of retail outlets to ensure compliance with age and photo identification and advertising/labeling restrictions. State inspectors enforce state youth access laws and federal inspectors enforce federal youth access laws. TPEP also administers the Merchant Education and Awareness Campaign.

The MOSAIX Impact prevention data collection system that captures each of these provider activities across the 5 SPF steps.

The Prevention Infrastructure efforts are advised and informed by other State Advisory Councils such as the Connecticut Alcohol and Drug Policy Council (ADPC) and the CT Suicide Advisory Board (CTSAB).

Established in 1996 via Executive Order of the Governor, the ADPC is comprised of key state agencies with ATOD prevention and treatment resources and charged with recommending strategies to reduce the harmful effects of substance abuse. The ADPC's Prevention Subcommittee serves as the Advisory body for several federally funded prevention initiatives including the SPF Rx and is the conduit for moving forward recommendations. Key stakeholders including youth, parents, and consumers, form the cornerstones of CT's prevention infrastructure and are active contributors and participants at every step of the state's prevention planning process.

The CTSAB is tri-chaired by the CT Department of Mental Health and Addiction Services and the Department of Children and Families, and CT Chapter of the American Foundation for Suicide Prevention and is the single state-level advisory board in Connecticut that addresses suicide prevention, intervention and response across the lifespan. The CTSAB seeks to eliminate suicide by instilling hope across the lifespan through a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion.

The CTSAB is responsible for developing and promoting the Connecticut Suicide Prevention Plan 2025 (PLAN 25). Members and partners align their own strategies and activities to address the goals and objectives of PLAN 2025 to reach the five-year long-term outcomes noted in table. Multiple DMHAS initiatives contribute to this effort.

There are a number of other interagency bodies on which the DMHAS PHP staffs participate. These groups are engaged in similar efforts to coordinate and enhance prevention service planning and delivery across the state.

RESOURCES/GAPS

Despite a comprehensive prevention infrastructure, as with any system, there are also gaps. These gaps can impact the quality of, and access to programming for certain populations. Following are some of the crucial areas being addressed in order to close programming gaps.

Local-Level Data

Collecting data at the local-level is challenging in many communities. When communities are unable to fund local surveying, for example, they often lack the specific knowledge about which risk and protective factors – and other local conditions – impact the behavioral health concerns within the community. In a recent data prioritizing process led by the RHBAOs, practitioners identified several gaps, including access to data to effectively identify community priorities.

Community Readiness

In some communities, this lack of data also translates into a lack of readiness to engage in behavioral health prevention efforts. Developing community readiness and buy-in could lead to the development

of an infrastructure to improve data collection, which would help local communities make the connections between risk and protective factors for substance misuse and outcomes such as violence. These efforts could also unearth assets within the community, such as community resources that support resilience. By increasing readiness to address behavioral health outcomes, the state could better support these communities, linking the current outcomes with behavioral health outcomes using frameworks such as the research-based Adverse Childhood Experiences framework. DMHAS will continue to consider how it might be able to realign prevention priorities to address gaps such as community readiness.

Resource Inequities

Simultaneously, shifts in priorities at the federal-level have exacerbated some of the existing inequities. As communities with higher levels of readiness and capacity can apply for federal funds that are now made available directly to communities, many prevention resources become concentrated in specific communities. DMHAS hopes to work more collaboratively with its federal partners to increase communication about these efforts, support more equitable distribution of resources and enhance the sustainability of resources across the state.

Population-reach Inequities

The above mentioned RHBAO prioritization process also identified gaps in collaboration and coordination in community-led efforts. These include coordinating media campaign and enforcement efforts, as well as engaging families in prevention efforts. In addition, they identified a lack of coordination of behavioral health issues in schools and the capacity to conduct prevention efforts with specific populations of youth who may be at higher risk for negative health outcomes, such as LGBTQ and youth who are not able to access current prevention efforts. Using RBHAO data, data supported by CPES, as well as Prevention staff and expertise, DMHAS could identify gaps in its prevention infrastructure, as defined by lack of service being provided in specific geographic areas, or lack of accessibility due to barriers such as transportation, lack of culturally appropriate services, and/or community disenfranchisement.

Emerging Health Priorities

Finally, emerging health emergencies, such as COVID-19 have laid bare other gaps in the prevention system. For example, as alcohol delivery became a political priority, the state's ability to enforce the drinking age of 21 decreased. The need for continued partnership-building and collaboration across systems is vital. DMHAS will continue to work with state leadership to ensure they understand the impacts of changing existing regulations related to substance use.

VISION:

A STATEWIDE BEHAVIORAL HEALTH PREVENTION SYSTEM THAT PROMOTES HEALTHY LIFESTYLES FOR CONNECTICUT'S CITIZENS

MISSION:

REDUCE THE INCIDENCE OF PROBLEM BEHAVIOR AND IMPROVE THE WELL-BEING OF CONNECTICUT'S CITIZENS BY DISCHARGING A COMPREHENSIVE, COORDINATED, EFFECTIVE AND ACCOUNTABLE SYSTEM OF PREVENTION SERVICES

DHMAS PREVENTION GOALS

Based on available data, and Connecticut's needs, DHMAS identified the following prevention goals:

1. Reduce current alcohol, tobacco and other drug use by youth under age 21.
    a. Objective 1: To decrease percent of students who report first drink/use of tobacco before age 13.
    b. Objective 2: To increase perception of harm of alcohol, tobacco, and other drug use among youth and their peers.
    c. Objective 3: To decrease the negative consequences of substance use among those 20 and under.
    d. Objective 4: Increase the perception of harm of misusing prescription drugs among school-age youth and their families.
2. Reduce deaths from opioids among Connecticut residents.
    a. Objective 1: Prevent non-prescription opioid use and the progression from use of prescription opioids to the use of readily accessible and inexpensive heroin through multi-faceted prevention strategies.
    b. Objective 2: Increase understanding of how to reduce the harm of prescription opioids and the importance of a comprehensive overdose response program among the general population.
    c. Objective 3: To increase access to behavioral health services by residents who suffer from opioid use disorder and experience barriers to services.
3. Enhance the capacity and retention of the Connecticut behavioral health workforce to effectively engage all Connecticut residents and to implement evidence-based strategies with fidelity.

   a. Objective 1: Identify the capacity-building needs of the Connecticut behavioral health workforce.
   b. Objective 2: Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations
   c. Objective 3: Retain experienced prevention professionals by providing strong professional development opportunities and increasing pay equity and other benefits.
4. Enhance the capacity of programs addressing behavioral health promotion to use data to guide their strategic planning processes to better identify the populations most at risk of behavioral health disorders, understand the impacts of Social Determinants of Health on those risk factors and select strategies that will reduce risk factors and increase protective factors .
   a. Objective 1: To identify existing data sources both within the department across other departments, and at the local level to effectively identify the drivers of substance use and other behavioral health concerns
5. Advance the goals and objectives of PLAN 2025 to reduce suicide attempts and deaths by 10% across the lifespan in CT by 2026.
   a. Objective 1. Co-Chair the CT Suicide Advisory Board (CTSAB) with the CT Department of Children and Families, and one organization representing survivorship to build the CTSAB's infrastructure capacity.
   b. Objective 2. Ensure the CT National Suicide Prevention Lifeline (NSPL) 988 services are securely funded.
   c. Objective 3. Co-direct the five-year "Comprehensive Suicide Prevention in CT Grant" funded by the Centers for Disease Control and Prevention, administered by the CT Department of Public Health (DPH), and co-directed by DPH, DMHAS, and the Department of Children and Families (DCF).
   d. Objective 4. Provide operational support and guidance to the CT Office of Early Childhood for their 3-year "Preventing Adverse Childhood Experiences Grant" funded by the Centers for Disease Control and Prevention.

On the pages that follow is a detailed implementation plan of how priorities and objectives are being addressed. The plan lays out the outcomes, strategies and timelines for each priority and reflects utilization of the DMHAS-funded programs and initiatives that address them.

IMPLEMENTATION PLAN

Implementation Plan Goal 1: Reduce Underage Alcohol and other Substance Use

Assessment Summary:
Alcohol is the most commonly used substance in Connecticut, and 11.7% of Connecticut high school students had their first drink of alcohol before the age of 13 years old. Past year underage alcohol use has been increasing among 11- 25 year olds, and past month alcohol use among 12 – 17 year olds has increased slightly since 2014. Current use of tobacco has also increased among high school students, and while marijuana use among high school students in stable, it is the second most commonly used substance in Connecticut (second to alcohol). However, the Connecticut State Department of Education has reported an increase in substance-related disciplinary incidents in schools since 2014. Research indicates a link between substance use and later issues in life, and with mental health conditions and suicide.

Problem Statement (with direct target populations):
Alcohol is the number one substance used by those under 21 in Connecticut. Early initiation of alcohol use is linked to increased risk of substance use disorder, as well as other negative behavioral health outcomes. By postponing early initiation of substance use, we can reduce the societal costs of substance use disorder.

Goal (with target populations):
Reduce in current alcohol tobacco and other drug use by youth under age 21.

Long-Term Outcome:
• Reduce youth 30-day use of alcohol, marijuana, tobacco, and vaping

Objective (with indirect target populations): To decrease percent of students who report first drink/use of tobacco before age 13.

Intermediate Outcome:
- Increase age of first use for tobacco and alcohol

Immediate Outcomes	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Reduce retail access to alcohol and tobacco	Enforcement of Underage Drinking Laws	Alcohol and tobacco compliance checks	Ongoing		Prevention Coalitions, RHBAOs	# of checks
	Enforce State Tobacco and ENDS access laws	Tobacco and ENDS compliance inspections	Ongoing		SYNAR-Tobacco Prevention and Enforcement Program	# of inspections
Reduce social access to alcohol	Enforcement of Underage Drinking Laws	Party Patrols	Ongoing		Prevention Coalitions	# parties patrolled
		Reduce 3rd party transactions	Ongoing		Prevention Coalitions	# of transactions inspected

Understand the dangers of alcohol and drug use	Positive Youth Development	Presentations	Ongoing	Courage to Speak Foundation	# of presentations # of students served
	SADD Chapters/Prevention Youth Advisory Board	Prevention Messaging	Ongoing	Governor's Prevention Partnership	# of students who receive messages
		Youth Engagement	Ongoing		# of SADD/Youth Advisory Board youth members
	Increased coordinated messaging on ATOD in the media, schools, workplaces and about treatment(?)	Media, including disseminating Partnership for Drug Free Kids resources	Ongoing, at least monthly	Governor's Prevention Partnership	# of ATOD messages distributed
		Website	Ongoing	Courage to Speak Foundation, Inc	#of visits to the website
		Enhanced ATOD Materials	Ongoing	Wheeler Clinic/Connecticut Clearinghouse	# of new or updated materials
	Educational Strategies	Healthy Campus Initiative	Ongoing	Wheeling Clinic/Connecticut Clearinghouse	# of campuses funded #of of in-person events #of virtual events #of participants at all events
Increased awareness of dangers of prescription drug misuse and non-prescription opioid use	Family Engagement	Parenting through the Opioid Crisis and Beyond Online Training Parent Education Resources	Ongoing	Courage to Speak Foundation Prevention Training & Technical Assistance Service Center (TTASC)	#of outreach to parents to market the training # of trainings hosted

					# of family units attended trainings #of individuals served

Objective (with indirect target populations) : To increase perception of harm of alcohol, tobacco, and other drug use among youth and their peers

Intermediate Outcome:

- Reduce the ATOD incidents reported by State Dept of Ed.
- Increase perception of harm of alcohol use
- Increase peer perception of harm of alcohol use

Immediate Outcomes	Programs/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start date	End date		
Increased parent communication about the dangers of alcohol and drug misuse and abuse	School-based strategies SADD Chapters	Prevention Messaging	Ongoing		Governor's Prevention Partnership	# of students who receive messages
		Youth Engagement	Ongoing			# of SADD youth members
Understand the dangers of alcohol and drug use	Educational Strategies	Change the Script/www.drugfreect.org	Ongoing		Connecticut Clearinghouse (SOR)	# of page views # of users Average # of page views per day # of Households who received mailings
		Develop consistent school guidance around substances and substance use	Ongoing, Annually		CTSERC	# of schools who adopt consistent guidance
Increased awareness of dangers of prescription drug	Trainings to improve school climate		Ongoing		Governor's Prevention Partnership	# of schools that engage in a training

misuse and non-prescription opioid use					# of school personnel trained # of school that change policies related to school climate
	College AIM/CORE	Student Engagement and assessment	Ongoing	Connecticut Healthy Campus Initiative	# of students assessed for alcohol use disorder #of students successfully completed interventions

Objective (with indirect target populations): To decrease the negative consequences of substance use among those 20 and under.

Intermediate Outcome:

- Reduce binge use of alcohol
- Reduce the number of youth riding in a car with someone who has consumed alcohol– student health survey data

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Identify trusted adults to talk about the problems, pain, stress, and secrets	Positive Youth Development	Presentations	Ongoing		Courage to Speak Foundation	# of presentations # of students served
	Mentoring Programs		Ongoing		Governor's Prevention Partnership	# of new mentors engaged # of new mentees # of mentor/mentee sessions

Education on the dangers of binge drinking	College AIM/CORE	Implementation of interventions focused on binge-drinking	Ongoing	Connecticut Healthy Campus Initiative	# of information awareness events #of students participating
Increased coordinated messaging on ATOD in the media, schools, workplaces and treatment	Training school staff	Education of school-based personnel	Ongoing	CTSERC	# of trainings # of school staff trained
	Coordinated Media Messaging	Change the Script/www.drugfreect.org	Ongoing	Connecticut Clearinghouse	# of page views # of users Average # of page views per day # of Households who received mailings

Objective (with indirect target populations): Increase the perception of harm of misusing prescription drugs among school-age youth and their families

Intermediate Outcome:

- Decrease social access to prescription drugs (need to find indicator)

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Increase number of adults who understand the importance of proper storage and disposal	Educate about social access	Promoting public education messaging	Ongoing		CT Clearinghouse	# of messages promoted # of billboards # of persons viewing billboards

					# of participants who use/download tools and resources
	Safe storage and disposal	Promoting prescription drug disposal and storage	Ongoing	Community Coalitions (SOR) Local Health Districts (SPF-Rx)	# of coalitions funded #of messages promoted
Reduced number of students who report prescription drug and opioid misuse	Educational Strategies	Academic Detailing Initiative	Ongoing	Local Health Districts (SPF-Rx and SOR)	# of health districts implementing modules # of modules implemented #of prescribers successfully completed modules #of pharmacists successfully completed modules
		K-12 Curriculum	Ongoing	CT SERC	# of districts adopting professional development learnings # of educators engaged in professional learnings # of educators reporting using the content in their classrooms

Implementation Plan Goal: Reduce substance-related deaths

Assessment Summary: In recent years, Connecticut has seen an increase in accidental deaths due to prescription drugs and heroin use. The deaths often include a mix of substances including illicit opioids, and a variety of prescription medications, including methadone, tramadol, and benzodiazepines. While the majority of these deaths are among non-Hispanic White males, Black and Hispanic students have slightly higher lifetime prevalence of heroin use. Heroin accounts for over 35% of treatment admissions, and almost half of those are for individuals between 25 and 39 years old.

Problem Statement (with direct target populations)(1):
Prescription opioid misuse is linked with illicit opioid use. In Connecticut, accidental overdoses and treatment admissions are related to opioid misuse more than half the time.

Goal (with target populations):
Reduce deaths from alcohol, tobacco and other drugs, including opioids among Connecticut residents.

Long-Term Outcomes:

- Enhanced and expanded statewide program infrastructure to reduce prescription drug misuse and opioid overdoses
- Stronger partnerships among key stakeholders to increase collaboration and coordination of efforts and create successful, comprehensive solutions

Objective (with indirect target populations) :
Prevent non-prescription opioid use and the progression from use of prescription opioids to the use of readily accessible and inexpensive heroin through multi-faceted prevention strategies.

Intermediate Outcome: (align with Change the Script Evaluation)

1. Decrease the number of people who progress from misusing prescription drugs to opioids
2. Increase in heroin admissions to treatment system and opioid overdose deaths and reversal
3. Lack of awareness of the dangers of sharing medications, the risks of overprescribing and overdose death prevention strategies

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Increased awareness of dangers of prescription drug misuse and non-prescription opioid use	Tracking and monitoring	Promoting use of and information about the benefits of using the Prescription Monitoring Program	Ongoing		Prescription Monitoring Program (SPF-Rx)	Increased use of Prescription Monitoring by providers
		Academic Detailing Initiative	Ongoing		Local Health Districts (SPF-Rx and SOR)	# of health districts implementing modules

					# of modules implemented #of prescribers successfully completed modules #of pharmacists successfully completed modules
	Safe storage and disposal	Promoting prescription drug disposal and storage	Ongoing	Community Coalitions/RBHAO's/CT Clearinghouse	# of coalitions funded #of messages promoted
Increased use of naloxone/reduced fatal overdoses	Harm reduction/OEND	Overdose Follow-up	Ongoing	How Can We Help Initiative/ Recovery Coaches(SOR)	# of outreach events # of first responder engagements
		Mobile Library	Ongoing	Connecticut Clearinghouse (SOR)	# of library stops # of patrons # of Naloxone inquiries
Raising awareness of the dangers of medication, heroin	Multimedia Strategy	Academic Detailing Initiative	Ongoing	Local Health Districts (SPF-Rx)	# of health districts implementing modules

addiction, and overprescribing					# of modules implemented #of prescribers successfully completed modules #of pharmacists successfully completed modules
	Online trainings		Fall 2020, Ongoing	Connecticut Clearinghouse/TTASC	# of trainings # of participants

Objective (with indirect target populations) : Increase understanding of how to reduce the harm of prescription opioids and the importance of a comprehensive overdose response program among the general population.

Intermediate Outcome:
Increase treatment admissions for heroin and decrease overdose deaths

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Lack of awareness of the dangers of sharing medications, the risks of overprescribing and overdose death prevention strategies	Safe Storage and Disposal	Drug disposal programs	Ongoing		RHBAOs Local Health Districts (SPF-Rx)	# of disposal sites # of inquiries/referrals to disposal sites # of pounds of medications disposed of

		Promoting prescription drug disposal and storage	Ongoing	Community Coalitions (SOR)	# of coalitions funded #of messages promoted
	Multimedia Strategies	Change the Script	Ongoing	Connecticut Clearinghouse Local Health Districts (SPF-Rx)	# of page views # of users Average # of page views per day # of Households who received mailings
	Engage doctors in understanding patients' medical histories	Prescription Monitoring	Ongoing	Local Health Districts (SPF-Rx and SOR)	# of doctors enrolled in PMP # of new providers enrolled in PMP # of providers using PMP
Increased access to naloxone and awareness of treatment	Harm Reduction/Overdose Education and Naloxone Distribution	Overdose follow-up	Ongoing	How Can we Help Initiative (SOR)	# of overdoses identified for follow-up # of follow-ups completed # of follow-ups where they resulted in some sort of referral

	Overdose Education and Naloxone Distribution (OEND)	Connecticut Healthy Campus Initiative	Ongoing	Clearinghouse/Wheeler Clinic	# of campuses funded #of of in-person events #of virtual events #of participants at all events # of naloxone kits distributed

Objective (with indirect target populations) : To increase access to behavioral health services by residents who experience barriers to services.

Intermediate Outcome:
Increase in service usage of treatment and mental health services by different populations (race, social-economic, etc) who don't seek out services.

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Reducing stigma and barriers	Multimedia Strategy	Change the Script	Ongoing		RBHAOs (SOR)	# of page views # of users Average # of page views per day # of Households who received mailings
	Harm Reduction/OEND	Overdose follow-up	Ongoing		How Can we Help Initiative (SOR)	# of overdoses identified for follow-up

					# of follow-ups completed # of follow-ups where they resulted in some sort of referral
Increase access to evidence-based treatment	Provide evidence-based training	Multi-Dimensional Family Therapy and Recovery Check-up Training	Ongoing	Department of Children and Families	# of trainings # of participants training
	Increase knowledge of substance use treatment and support services	Referral and support services	Ongoing	National Suicide Prevention Lifeline/United Way of CT	# of calls to NSPL # of referrals to support services

Implementation Plan Goal: Recruit and Retain a well-trained, diverse workforce
Assessment Summary: Recruiting a diverse workforce, and retaining an experiences workforce is challenging. Prevention and Health Promotion are often not promoted as a career path, and often requires knowing about the work of the field. In addition, there are few opportunities for professional growth to ensure workforce retention, and few resources to support that growth. Developing a comprehensive Prevention Workforce Development System may help address these gaps.
Problem Statement: There is a lack of a clear, strategic plan for prevention professionals that increases the diversity and enhances the skills of practitioners in the field **From existing strategic plan; Problem Statement (with direct target populations):** Few career pathways exist for prevention professionals; there are recruitment and retention gaps; trainings do not always align with the functions or requirements for prevention initiatives. It is necessary to address these gaps and advance the field of Prevention and Health Promotion in Connecticut by establishing a state of the art Prevention Workforce Development System.
Goal (with target populations): Enhance the capacity and retention of the Connecticut behavioral health workforce to effectively engage all Connecticut residents and to implement evidence-based strategies with fidelity.
Long-Term Outcome: Increase workforce recruitment and retention

Increase diversity of the workforce

Objective (with indirect target populations):

a. Objective 1: Identify the capacity-building needs of the Connecticut behavioral health workforce needs.
b. Objective 2: Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations
c. Objective 3: Retain experienced prevention professionals by develop providing strong professional development opportunities and increasing pay equity and other benefits.

Intermediate Outcome:
Engage new prevention practitioners;
Develop a path to support advancement in the field

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
A comprehensive workforce development plan that supports both new prevention practitioners as well as more experienced ones.	Identify training needs of the prevention workforce	Conduct a workforce development survey	Annually		TTASC	Implementation of workforce development survey # of surveys completed
	Identify existing training and workforce development opportunities for prevention practitioners	Review existing resources	Ongoing		TTASC	Comprehensive list of resources for prevention practitioners # of total resources availability
	Identify capacity-building needs of the prevention workforce and trainings to support that	Develop a workforce development plan	Annually		TTASC	Completed workforce development plan

Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations	Build connections with high schools and higher education to promote prevention as a viable career pathway	Recruit early by promoting prevention in youth development programs as a viable career path	Ongoing	TTASC	# of key stakeholder interviews completed to identify methods to engage education # of key stakeholders who identify prevention as a potential career pathway
		Engage funded peer advocates in identifying opportunities for further growth	Annually	CSC	# of youth peer advocates who identify opportunities # of opportunities identified
		Recruit for increased diversity by employing targeted recruitment strategies and providing incentives (IE, recruiting at two and four-year colleges with diverse student bodies, reimburse for college credit)	Annually	TTASC	Identified strategies Implement at least 2 of those strategies

Retain experienced prevention professionals by develop providing strong professional development opportunities and increasing pay equity and other benefits.	Retain youth peer advocates in the prevention field	Develop additional leadership opportunities among youth advocates	Annually	GPP, TTASC	# of additional leadership opportunities for youth advocates
		Engage youth advocates in other prevention efforts after completing their terms on the Youth Advisory Board	Annually	GPP	# of youth advocates engaged after their term is over
		Identify incentives to continue engaging youth advocates	Ongoing	GPP	# of incentives identified #of incentives implemented
	Explore alternate ways to compensate prevention professionals by exploring creative use of existing resources	Target incentives that prevention professionals will value, such as loan forgiveness and/or opportunities to further their education/credentials and training	2020 2021	TTASC GPP	# of incentives identified Development of a plan to implement incentives
		Provide existing staff with opportunities to continue pursuing educational opportunities and certification by reimbursing for	Annually	All Prevention Entities	Development of a comprehensive list of professional development opportunities

		expenses, and allowing for worktime studying for the certification exam				
		Develop minimum guidelines for salaries and benefits for positions funded with DMHAS funding	2020	2024	DMHAS	Identification of minimum guidelines Dissemination of minimum guidelines Accountability for minimum guidelines
		Identify opportunities for additional leadership, mentoring, and soft skills development via learning communities, etc	2020 + Annually thereafter	2024	PTTC, DMHAS, TTASC	Identification of opportunities # of CT prevention staff who engage in the opportunities
		Promote connections across the system of care to provide access to other certifications/credentials by ensuring learning communities are open to the workforce across the continuum	2020	2024	TTASC, SOR	# of opportunities to engage across the continuum % of participants engaged in opportunities from each part of the continuum

	Improve access to comprehensive professional development	Increase training and access to training on data gathering, analysis, and reporting	Ongoing	TTASC	# of trainings on data gathering, analysis and reporting # of participants in those trainings
		Increase the availability of relevant, and more advanced trainings	Ongoing	TTASC	# of advanced trainings # of participants in the advanced trainings

Implementation Plan Goal: Increase use of data to identify prevention priorities
Assessment Summary: DHMAS and CPES have developed a dashboard that identifies and uses data sources from multiple data sources. A complete dashboard such as this also makes it easier to identify gaps in data. Comprehensive, consistent local-level data on behavioral health disorders is greatly dependent on a local provider's resources to assess for these needs, meaning that in some communities where these data could be incredibly help in identifying the local conditions that could best be addressed to improve behavioral health outcomes.
Problem Statement (with direct target populations): There is limited access to data to help inform behavioral health priorities and needs is a gap in Connecticut's behavioral health promotion and prevention Division at the local level, and there are few resources to help manage data collection and reporting. Data should be used to support strategy selection and implementation.
Goal (with target populations): Enhance the capacity of programs addressing behavioral health promotion to use data to guide their strategic planning processes to better identify the populations most at risk of behavioral health disorders, understand the impacts of Social Determinants of Health on those risk factors and select strategies that will reduce risk factors and increase protective factors
Long-Term Outcome: Increased use of data to understand local conditions impacting behavioral health outcomes
Objective (with indirect target populations): To identify existing data sources both within the department and across other departments, and at the local level to effectively identify the drivers of substance use and other behavioral health concerns.
Intermediate Outcome: Increase data sharing + understanding Increase local-level data

Immediate Outcomes	Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Increased understanding of existing data	Increase data sharing and data use	SEOW Meetings	Ongoing, Quarterly		SEOW, CPES	# of meetings # of members/new members
		Updated Epidemiological profiles	Every 2 years		SEOW, CPES	Updated Profile
		Data presentations to the Alcohol and Drug Policy Council	Every 2 years		DHMAS	# of presentations #of participants engaged in the presentations
		Develop and update state-level logic models based on Epi Profiles	Every 2 years		CPES	Logic Model
		Enhance data-sharing across state agencies	Ongoing		SEOW, DHMAS, additional agencies not represented on the SEOW	# of agencies sharing data # of data indicators
	Data Gap (Risk/Protective Factors, Social Determinants) Analysis	Review Epi profile and Logic Model to identify local and state data gaps	Ongoing		CPES	List of data gaps List of potential sources for missing data
More effective use of data	Enhance Data Collection	Develop a plan for collecting missing data	Ongoing		CPES, SEOW	An action-oriented plan to fill data gaps
Increased understanding of need	Enhancing community-level knowledge	Support community-level surveying	Ongoing		CPES	# of requests for support

for more local-level data					# of proactively identified supports
		Identify additional archival data available at the community level	Ongoing	CPES	# of communities supported to identify archival data sources
Increased local-level capacity for using data to inform efforts	Workforce development to use data	Provide trainings to local level prevention practitioners	As scheduled	CPES, with TTASC	# of trainings # of participants
		Support local-level logic model development	Ongoing	CPES	# of TA sessions
	Use data to inform decisions	Monitor and analyze revenant MOSAIX Impact Data	Ongoing, Monthly	CPES	# of monthly reports
Increased capacity at the local-level to evaluate efforts	Local-level evaluation	Support local evaluator workgroup	Ongoing, six times/year	CPES	# of sessions # of participants
		TA to individual communities to engage in local-level evaluation		CPES	# of communities receiving TA # of communities identifying additional evaluation resources
		Increased community-level reporting of evaluation data		CPES	# of additional communities reporting evaluation results

Implementation Plan Goal 5: Reduce suicide among Connecticut residents

Assessment Summary:

Suicide and related risk factors remain a concern, especially among those under 25. Of students in grades 9 – 12, almost 31% have felt sad or hopeless almost every day for at least two consecutive weeks in the past year (CSHS, 2019), and 12.7% have had serious thoughts of suicide in the past year (CSHS, 2019). Of those aged 18

– 25, almost 14% have had a major depressive episode in the past year (NSDUH, 2017 – 2018). However, between 2016 and 2018, there have been over 4, 500 suicide attempts across all ages in the state (CHiME Hospital Discharge Data). The CT Office of the Chief Medical Examiner reported 424 deaths by suicide in the state in 2019.

Problem Statement (with direct target populations):
Suicide remains the most concerning behavioral health outcome in the state. While resources exist to reduce risk factors and consequences of suicidal ideation for younger populations in the state, death by suicide remains a concern across the lifespan.

Goal (with target populations):
Advance the goals and objectives of PLAN 2025 to reduce suicide attempts and deaths by 10% across the lifespan in CT by 2026.

Long-Term Outcome:
• Reduce suicide among Connecticut residents.

Objective (with indirect target populations): Increase collaborative efforts to address death by suicide and suicidal ideation among Connecticut residents across the lifespan.

Intermediate Outcome:
- Increase resources to address death by suicide across the state.

Objectives	Program/Strategy/Activities	Timeline		Entity Responsible	Outputs
		Start Date	End Date		
Co-Chair the CT Suicide Advisory Board (CTSAB) with the CT Department of Children and Families, and one organization representing survivorship to build the CTSAB's infrastructure capacity.	Formalize the Regional Suicide Advisory Boards in DMHAS contracts	Contracts Updated by 2021		DHMAS	# of contracts signed
	Host CTSAB meetings virtually to increase access.	Monthly		DHMAS	# of virtual meetings # of participants per meeting
	Identify and engage speakers for CTSAB meetings to provide membership continuing education.	Monthly		DHMAS	# of speakers
	Engage diverse key stakeholders to join the CTSAB and partner to advance suicide prevention	Ongoing		DHMAS	# of new stakeholders engaged
	Collaborate with other state plan developers and implementers to ensure integration of suicide prevention, mental health promotion and lived experience supports as they pertain to the content, especially behavioral health, social emotional learning, health equity, social	Ongoing		DHMAS	# of plans developed # of new collaborations

	determinants of health, trauma, and adverse childhood experiences (ACEs). Existing plans include, but are not limited to the CT Healthy People-State Health Improvement Plan and the Children's Behavioral Health Plan.			
	Update the CTSAB website to make it more user friendly.	By October 2022	DHMAS	Updated website # of new users to the website
	Support the development of and access to a database of evidence-based training, prevention, and media campaigns to help interested groups find appropriate resources.	By October 2025	DHMAS	# of potential database examples Development of the database
	Expand 1 WORD marketing campaign to increase knowledge of resources and assess its impact.	By October 2022	DHMAS	# of new ways the campaign is disseminated # of exposures to the campaign
	Develop a "core" CTSAB presentation that members may adapt to easily share CTSAB resources and basic suicide prevention information to the community	By October 2021	DHMAS	Development of core presentation
	Work with state departments and non-profit agencies to report annual numbers of suicide prevention activities provided (e.g. trainings, support groups, awareness campaigns).	By October 2024	DHMAS	Development of process to report annual numbers
	Increase CT Suicide Prevention Advocacy via a functioning Advocacy Subcommittee.	By October 2021	DHMAS	Development of Advocacy Subcommittee
	Identify, support and promote suicide prevention policy priorities.	Ongoing	DHMAS	Identify prevention policy priorities # of policies supported

	Engage key stakeholders who will support suicide prevention policy.	Ongoing	DHMAS	# of key stakeholders supporting policies
	Build capacity to respond to legislative requests and queries.	Ongoing	DHMAS	# of materials to support policies
	Acquire funding for a statewide Suicide Prevention Coordinator position.	By October 2025	DHMAS	New funds
	Amend CT state legislation to reflect the current state of the CTSAB administration and to ensure it covers the lifespan, rather than only children and youth.	October 2025	DHMAS	Amended legislation
	Host the CT Zero Suicide Learning Community as a subcommittee of the CTSAB to engage and support health and behavioral healthcare providers in the adoptions of the Zero Suicide approach and recommended evidence-based strategies.	Ongoing	DHMAS	# of Learning Communities # of providers who adopt Zero Suicide
	Develop and implement a web-based core competency suicide prevention continuing education training for clinical professionals in collaboration with CT clinical association representatives based on national guidance.	By October 2022	DHMAS	Identified continuing education trainings # of trainings held
	Facilitate the availability of suicide prevention gatekeeper training for peers supporting persons at increased risk of suicide and overdose statewide.	By October 2022	DHMAS	Increased access to gatekeepers
	Engage the CTSAB Lethal Means Subcommittee to distribute lockboxes and materials co-promoting the 1 WORD campaign and Change the Script to	By October 2022	DHMAS	# of lockboxes distributed # of materials developed

	partnering health and behavioral healthcare sites so they may share them with persons at risk of overdose and their partners and family members during lethal means counseling and means safety conversations.			
Ensure the CT National Suicide Prevention Lifeline (NSPL) 988 services are securely funded	Collaborate with DMHAS Divisions and other state agencies, including but not limited to, DCF, DPH and the CT Department of Emergency Services and Public Protection (DESPP) to establish a new telecommunications fund to support the NSPL 988 line.	By July 2021	DHMAS	Development of a fund
	Ensure the new telecommunications fund collects fees for one year in advance of 988 implementation.	By July 2021	DHMAS	Number of dollars set aside
	Advocate that the 988 funds support staff, continuing training and education, administration, and crisis response.	By July 2021	DHMAS	# of advocacy initiatives
Co-direct the five-year "Comprehensive Suicide Prevention in CT Grant" funded by the Centers for Disease Control and Prevention, administered by the CT Department of Public Health (DPH), and co-directed by DPH, DMHAS, and the Department of Children and Families (DCF).	Provide operational support and guidance to the DPH and sub-contractors to address the goals and objectives of the CDC grant.	Ongoing until October 2025	DHMAS	Development of guidance Dissemination of guidance Adoption of guidance
	Collaborate with DPH and DCF to ensure all CDC deliverables are met in a timely manner.	Ongoing until October 2025	DHMAS	Identify deliverables Identify timelines
	Utilize data to drive strategic decision-making and funding of resources statewide and at the regional level.	Ongoing October 2025	DHMAS	Identify data to use Identify how to use data to inform strategic decision-making
	Support the utilization and further evaluation of "Gizmo's Pawesome Guide to Mental Health" Elementary Curriculum.	Ongoing until June 2025	DHMAS	Identify opportunities to use the evaluation for the curriculum

	Support the utilization and evaluation of "Gizmo's Pawesome Pledge for Mental Health."	Ongoing until October 2025	DHMAS	Identify opportunities to use the evaluation for the pledge
	Expand resources related to "Gizmo's Pawesome Guide to Mental Health."	Ongoing until October 2025	DHMAS	Identify additional resources
Provide operational support and guidance to the CT Office of Early Childhood for their 3-year "Preventing Adverse Childhood Experiences Grant" funded by the Centers for Disease Control and Prevention.	Provide support and guidance to the OEC sub-contractors to address the goals and objectives of the CDC grant and ensure the integration of suicide prevention.	Ongoing until October 2023	DHMAS	Identify needs in order to address goals and objectives
	Collaborate with OEC and partners to ensure all CDC deliverables are met in a timely manner.	Ongoing until October 2023	DHMAS	Identify collaborative opportunities
	Support the utilization of the "Gizmo's Pawesome Guide to Mental Health" and "Gizmo's Pawesome Pledge for Mental Health" to promote positive social and family norms.	Ongoing until October 2023	DHMAS	Identify increased opportunities to utilize the existing guides.

Long-Term Measures

Domain	Indicator	Data Source	Population	Baseline*	Five Year Target*
ALCOHOL					
Consumption	30-day alcohol use	NSDUH 2017-2018	Ages 12-17	12.6%	TBD
			Ages 18-25 year-olds	68.4%	TBD
			Ages 26 and older	66.7%	TBD
	First drink before age 13	YRBS 2019	Grades 9-12	11.7%	TBD
	Binge Drinking	NSDUH 2017-2018	Ages 12-17	6.2%	TBD
			Ages 18-25	47.0%	TBD
			Ages 26 and older	28.9%	TBD
Risk Factors	Perception of harm from having five or more drinks once or twice a week	NSDUH 2017-2018	Ages 12-17	43.6%	TBD
			Ages 18-25	33.4%	TBD
			Ages 26 and older	44.7%	TBD
	Rode in car when driver been drinking in past 30 days	Connecticut School Health Survey, 2019	Grades 9-12	5.6%	TBD
Consequences	Prevalence of Past Year AUD	NSDUH, 2017-2018	Ages 12-17	1.9%	TBD
			Ages 18-25	12.1%	TBD
			Ages 26 and older	5.5%	TBD
	% of driving fatalities involving alcohol-impairment	NHTSA, 2018	All		TBD
PRESCRIPTION DRUGS					
Consumption	Non-medical use of prescription drugs (NMUPD)- Pain relievers	NSDUH, 2017-2018	Ages 12-17	2.3%	TBD
			Ages 18-25 year-olds	7.0%	TBD
			Ages 26 and older	3.4	TBD
	Taking OTC to get high	YRBS, 2019	Grades 9-12	4.4%	TBD
	Taking OTC to get high	YRBS, 2019	Grades 9-12	6.2%	TBD
			Ages 18-25	47.0%	TBD
			Ages 26 and older	28.9%	TBD
Consequences	Accidental deaths involving prescription drugs	Connecticut Office of Chief Medical Examiner (CT OCME), 2019	All ages	1,038	TBD
HEROIN AND OPIOIDS					
Consumption	Lifetime heroin use	YRBS, 2019	Grade 9-12	1.8%	TBD
					TBD

Domain	Indicator	Data Source	Population	Baseline*	Five Year Target*
					TBD
	Past year use of Heroin	NSDUH, 2017-2018	Ages 12-17	0.1%	TBD
			Ages 18-25	0.6%	TBD
			Ages 26 and older	0.4%	TBD
Risk Factors	Perception of risk from trying Heroin once or twice	NSDUH, 2017-2018	Ages 12-17	68.8%	TBD
			Ages 18-25	84.8%	TBD
			Ages 26 and older	90.2%	TBD
Consequences	Heroin-involved overdose deaths	CT Office of Chief Medical Examiner, 2019	All ages	387	TBD
	Fentanyl-involved overdose deaths			979	TBD
	Percent of treatment admissions for heroin as primary substance	Connecticut Department of Mental Health and Addiction Services, 2019	All ages	37.0%	TBD
ALL FORMS OF TOBACCO & ELECTRONIC NICOTINE DELIVERY SERVICES					
Consumption	First use before age 13	YRBS, 2019	Grades 9-12	5.0%	TBD
	Current tobacco use			17.9%	TBD
	Current cigarette use			3.7%	TBD
	Current cigar use			3.9%	TBD
	Current e-cigarette use			27.0%	TBD
	Among those using tobacco, using e-cigarettes	Connecticut Youth Tobacco Survey, 2017	Grades 9-12	54.0%	TBD
	Among those using tobacco, using cigars			40.9%	TBD
	Among those using tobacco, using hookahs			33.9%	TBD
	Among those using tobacco, using cigarettes			25.4%	TBD
Risk factors	Of students reporting trying tobacco, percent reporting first trying e-cigarettes	Connecticut Youth Tobacco Survey, 2017	Grades 9-12	50%	TBD
	Of students reporting trying tobacco, percent reporting first trying cigarettes			24%	TBD

Domain	Indicator	Data Source	Population	Baseline*	Five Year Target*
	Of students reporting trying tobacco, percent reporting first trying cigars			13%	TBD
	Of students reporting trying tobacco, percent reporting first trying different products			13%	TBD
	Percent successfully buying tobacco product under age 18	Connecticut Youth Tobacco Survey, 2017	Grades 9-12 and under 18	19.4%	TBD
CANNABIS					
Consumption	30-day marijuana use	NSDUH 2017-2018	Ages 12-17	8.4%	TBD
			Ages 18-25 year-olds	30.1%	TBD
			Ages 26 and older	9.6%	TBD
	First use before age 13	Connecticut School Health Survey, 2019	Grades 9-12	3.8%	
Risk Factors	Perception of risk from smoking marijuana	NSDUH 2017-2018	Ages 12-17	20.6	TBD
			Ages 18-25	9.3%	TBD
COCAINE					
Consumption	Past year marijuana use	NSDUH 2017-2018	Ages 12-17	0.4%	TBD
			Ages 18-25 year-olds	6.2%	TBD
			Ages 26 and older	1.6%	TBD
	Lifetime use of any form of cocaine	Connecticut School Health Survey, 2019	Grades 9-12	2.6%	
Consequences	Overdose deaths involving cocaine	CT Office of Chief Medical Examiner, 2019	All ages	463	TBD
	Treatment admissions for cocaine as primary substance	Connecticut Department of Mental Health and Addiction Services, 2019	All ages	3,378	TBD
SUICIDE					
Risk Factors	Felt so sad or hopeless almost every day for two or more weeks in a row	Connecticut School Health Survey, 2019	Grades 9-12	24.1%	TBD
		CT YRBS, 2019	Grades 9-12	12.7%	TBD

Domain	Indicator	Data Source	Population	Baseline*	Five Year Target*
	Had serious thoughts of suicide in past year	NSDUH 2017-2018	Ages 18-25 year-olds	11.7%	TBD
			Ages 26 and older	3.3%	TBD
	Major depressive episode in the past year		Ages 12-17	14.2%	TBD
			Ages 18-25 year-olds	13.7%	TBD
			Ages 26 and older	5.9%	TBD
Consequences	Suicides	CT Office of Chief Medical Examiner, 2019	All ages	424	TBD
OTHER CONSEQUENCES ACROSS SUBSTANCES					
Consequences	Disciplinary incidents related to drugs, alcohol, and/or tobacco	CT Department of Education, 2017-2018	Grades K-12	4,964	TBD
	DUI Crashes	Connecticut Department of Transportation (CT DOT), 2017	All ages	3,210	TBD
	DUI-related injuries		All ages	917	TBD
	DUI-related deaths		All ages	46	TBD
SUICIDE DATA					
Domain	**Indicator**	**Data Source**	**Population**	**Baeline***	**Five year Target ***
Risk Factors	A. Felt sad or hopeless almost daily for >=2 consecutive weeks in past year	Connecticut School Health Survey, 2019	Grades 9-12	30.6%	27.5%
	Of A., got help needed			24.1%	26.6%
	Attempted suicide in past year			6.7%	6%
	Seriously considered attempting suicide in past year			12.7%	11.4%
	Had thoughts of suicide in past year	NSDUH 2017-2018	Ages 18-25 year-olds	11.7%	10.5%
			Ages 26 and older	3.3%	3%
	Major depressive episode in the past year		Ages 12-17	14.2%	12.8%
			Ages 18-25 year-olds	13.7%	12.3%
			Ages 26 and older	5.9%	5.3%
Consequences	Suicide attempts	CHIME Hospital Discharge Data (2016-2018)	**Ages**	**# (Rate/100K**	**5 yr-10% Reduction (Rate/100K)**
			All ages	4,658	4,192

				(130/100K)	(117/100K)
			Ages 10-17 year-olds	1,048 (285/100K)	943 (256/100K)
			Ages 18-24 year-olds	872 (253/100K)	784 (228/100K)
			Ages 35-64 year-olds (Non-Hispanic, White, males)	542 (108/100K)	487 (97/100K)
	Suicide deaths	CT Violent Death Reporting System (2016-2018)	**Ages**	**# (Rate/100K)**	**5 yr-10% Reduction (Rate/100K)**
			All ages	403* (11/100K)	363 (10/100K)
			Ages 10-17 year-olds	10* (3/100K)	9 (2/100K)
			Ages 18-24 year-olds	34* (10/100K)	31 (8/100K)
			Ages 35-64 year-olds (Non-Hispanic, White, males)	147* (29/100K)	132 (26/100K)
Key: *Annual average					

FINANCE PLAN

DMHAS' finance plan includes using federal and state dollars as well as other local foundation and charitable resources to reach its goals. Each of these goals are supported not just by the financial resources, but also the infrastructure that exists both within the DMHAS Prevention and Health Promotion Division and in partner agencies previously outlined. The organizational capacity and partners who help ensure the specific objectives are met, and initiatives implemented, are key to ensuring the state's commitment to excellent fiscal stewardship/responsibility.
In summary, each of the major financial resources are used in the following ways:

1. **Substance Abuse Prevention and Treatment Block Grant (SAPTBG):** 20% of the overall BG funds are used to prevent substance misuse through implementing evidence-based strategies identified through the Strategic Prevention Framework process by the Connecticut SPF Coalitions and Local Prevention Councils. Implementation is supported by enhancing data capacity via the CPES and through technical assistance and workforce capacity-building via TTASC, as well as through the Governor's Prevention Partnership, Regional Behavioral Health Action Organizations, Wheeler Clinic/Connecticut Clearinghouse, and the MOSAIX data system.
2. **State Opioid Response Grant (SOR) (2022):** These funds are focused on reducing opioid use disorder and fatal opioid overdoses. Funds are focused on increasing the use of naloxone and harm reduction strategies, prescription drug disposal strategies, as well as educational strategies on the dangers of misusing prescription drugs and opioids. These are supported by the Prescription Monitoring Program, and initiatives focused on reducing barriers to treatment and stigma relating to opioid use, such as the Live Loud and How Can We Help Campaign.
3. **Strategic Prevention Framework for Prescription Drugs (SPF-RX) (2021):** This initiative focuses on promoting cross-state partnerships to increase awareness of the risks of misusing prescription drugs and increase prescriber and dispenser use of the Connecticut Prescription Monitoring and Reporting System (CPMRS). Activities include promoting the state-wide campaign, Change the Script and Academic Detailing for Opioid Safety (ADOPS).
4. **FDA Tobacco Control Program:** These funds are focused on reducing access to tobacco by minors and reducing the impacts of tobacco smoking on Connecticut residents.
5. **State Funds**: These funds are used to support the overall infrastructure of the Prevention and Health Promotion's work and fill gaps in BG funding.

The table below summarizes the funds and how they support the Division's Prevention Goals.

Goal	Infrastructure Support	Funding Source
Reduce in current alcohol tobacco and other drug use by youth under age 21.	Prevention Coalitions	SAPTBG
	Courage to Speak Foundation	SAPTBG
	Governor's Prevention Partnership	SAPTBG, State Funds
	Wheeler Clinic/Connecticut Clearinghouse	SAPTBG, State Funds
	CHCI, RBHAO's, Wheeler Clinic/CT Clearinghouse	SOR
	RHBAOs	SAPTBG
Reduce deaths from alcohol, tobacco and other drugs, including opioids	Tracking, Monitoring, OEND, Multimedia	SOR
	Change the Script	SPF-RX, SOR
	Access to Treatment	SOR

Enhance the capacity and retention of the Connecticut behavioral health workforce to effectively engage all Connecticut residents and to implement evidence-based strategies with fidelity.	TTASC	SAPTBG, SOR
Enhance the capacity of programs addressing behavioral health promotion to use data to guide their strategic planning processes to better identify the populations most at risk of behavioral health disorders, understand the impacts of Social Determinants of Health on those risk factors and select strategies that will reduce risk factors and increase protective factors	CPES	SAPTBG
	MOSAIX	SAPTBG

Funding Gaps

The Prevention and Health Promotion Division at DHMAS relies heavily on federal discretionary funding to address both emerging needs and gaps in prevention efforts. In the past, these discretionary dollars have enabled the Division to focus resources on building a strong foundation to address binge drinking, prescription opioid misuse, and suicide among college students, among others. These efforts have often led to identifying specific populations being impacted disproportionately by these emerging behavioral health concerns. Once the discretionary funds built the foundation, on-going funding, such as the SABG funds, can be used to sustain these efforts.

However, over the last several years, the federal government reduced the availability of these discretionary funds which impacted the state's capacity to identify and respond to emerging issues. The current focus of these funds will also exacerbate disparities among communities, where those with resources will be able to obtain additional funding, and those without will not receive funding from either the state or the federal government. While the impacts of this are felt by specific communities in the short-term, in the longer-term this will reduce the state's ability to understand and respond to these emerging needs, increasing funding disparities between communities (the "haves" versus the "have nots"), will also lead to great health inequities across communities.

SUSTAINABILITY PLAN

Notwithstanding the reduction in federal discretionary funds, DMHAS has used the Strategic Prevention Framework to address sustainability throughout its planning. Decades-long partnerships have enabled DMHAS to create successful, comprehensive, and sustainable behavioral health solutions and to institutionalize aspects of its infrastructure as specific funding types have gone away. The Prevention Division has leveraged both financial and other resources to secure buy-in and engagement from key stakeholders in support of state and local prevention efforts.

To this end, the state funding has been leveraged to obtain other (often federal) funding to address emerging needs and priorities. At the local level, this has translated into community-based efforts that have been positioned to seek out other funding when the community-level work has reached a certain maturity. For example, with the recent end of Partnerships for Success 2015 funding, half of the

funded entities were able to apply for either Drug Free Communities or CSAP-funded Partnerships for Success funding opportunities. The SSDAs have also been instrumental in building capacity, readiness, and collaborative partnerships at the local level to seek additional resources. At the state-level, partnerships are also a critical component to the sustainability of prevention efforts. Collaborations with other state agencies with behavioral health resources have created an integrated network of programs, improved access to services by our clientele and facilitated wide scale adoption of prevention practices. These close partnerships, and the ongoing communication between them, are key to ensuring outcomes of programs are sustained.

Finally, as the DMHAS begins looking at its next funding cycle, it will examine the funding formulas currently in use to ensure that the funding is directed towards those entities who have few resources to this end. By using the existing resources strategically (i.e., by providing funding to unfunded communities), DMHAS will increase the overall capacity of its infrastructure and focus its resources where there is the greatest need.

The table below reflects specific actions DMHAS and its partners will take to ensure the sustainability of state- and local-level prevention efforts:

Objective	Task	Responsibility
Identify outcomes (such as changes in risk/protective factors) to sustain	Review annual reports and scorecards to identify previous years' outcomes	CPES, SEOW, DMHAS
	Identify which outcomes to sustain	DHMAS
	Identify what resources are necessary to sustain those efforts	DHMAS
	Develop a sustainability plan	DHMAS
Identify processes (such as collecting survey data) to sustain	Review annual reports and scorecards to identify previous years' processes	CPES, DMHAS
	Identify the existing infrastructure that contributes to the effectiveness of certain processes	DHMAS
	Identify which processes to sustain	DHMAS
	Identify what resources and infrastructure components are necessary to sustain those processes	DHMAS
	Add action steps relating to sustaining effective processes to sustainability plan	DHMAS
Identify new financial prevention resources flowing into the state (for example, new DFC grantees)	Identify which entities/communities have received new funding for enhanced prevention strategies	DMHAS
	Determine how this funding impacts the state funding provided to the community/entity	DHMAS, Alcohol & Drug Policy Council, CTSAB
	Identify communities with no	DMHAS, Alcohol & Drug Policy

Increase capacity of communities without prevention funding to develop a prevention infrastructure	prevention resources	Council, CTSAB, RBHAO's
	Identify communities with negative behavioral health outcomes (IE, high suicide rates, high SUD treatment rates)	CPES, SEOW
	Identify the overlap between the above two types of communities	DHMAS
	Work with the community to identify readiness level to address behavioral health prevention efforts	DMHAS, CPES, Clearinghouse, RBHAO's
	Identify potential resources for the communities with a medium level of readiness to engage in building prevention infrastructures	DHMAS, CTSAB
	Working with the community, develop a plan to conduct a needs and resource assessment	DHMAS, TTASC, CPES
Increase capacity of the workforce to engage in sustainability	Identify state requirements for community sustainability work	DHMAS, TTASC
	Identify workforce sustainability (training) needs	TTASC
	Develop a plan for responding to the needs of the workforce, incorporating the state's requirements	TTASC
	Develop a sustainability plan outline for communities	DHMAS, TTASC
	Identify workforce sustainability needs and provide appropriate training for existing grantees.	TTASC
	Require communities to develop a sustainability plan	DHMAS

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

- Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings.
- Mobile emergency crisis services intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert as appropriate from inpatient stays.
- Crisis Intervention Team (CIT) training trains law enforcement officers in responding to mental health emergencies so as to deescalate situations and access appropriate services; in addition, mental health professionals may be asked to assist law enforcement in responding to behavioral health calls.
- Many types of services are provided to persons living in the community with mental health conditions to support their ability to continue to reside in the community (e.g., ACT, CSP, Supported Employment, Supported Education, Clubhouses/Social Rehabilitation, Outpatient Treatment, Supportive Housing)
- For children with SED, EMPS-Mobile Crisis Service is available 24 hours a day 365 days a year. Care Coordination and Intensive Care Coordination (over 85 FTEs) are available to all children in Connecticut to provide in-home, family driven services to prevent residential institutional care and hospitalization and/or reduce hospital and institutional care stays.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

NA

3. Describe your state's case management services

Case management services are provided across a variety of levels of care within the DMHAS system. Persons with mental health conditions living in the community that receive supportive housing services, include case management that assists them with training, guidance and support to meet their needs and allow them to continue to reside in the community. Services provided are "wrap around" as needed to support the client. Case management is provided to homeless individuals in an attempt to engage them and have them willing to be connected to services. LMHAs provide case management services and strive to match clients

optimally to the level of care needed. The LMHAs meet with key stakeholders weekly to optimize client placement within the DMHAS system. Case management services are also typically provided within residential levels of care. Medicaid funded Targeted Case Management (TCM) services are provided in several levels of care. In 2010, DMHAS converted most of its mental health case management services to Community Support Program (CSP) teams that include a combination of TCM, non-TCM case management, and an emphasis on skill-building interventions. The ACT teams include TCM and non-TCM case management services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

- Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings.
- Mobile emergency crisis services intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert as appropriate from inpatient stays.
- Crisis Intervention Team (CIT) training trains law enforcement officers in responding to mental health emergencies so as to deescalate situations and access appropriate services; in addition, mental health professionals may be asked to assist law enforcement in responding to behavioral health calls.
- Many types of services are provided to persons living in the community with mental health conditions to support their ability to continue to reside in the community (e.g., ACT, CSP, Supported Employment, Supported Education, Clubhouses/Social Rehabilitation, Outpatient treatment, Supportive Housing).
- For children with SED, EMPS-Mobile Crisis Services is available 24 hours a day 365 days a year. Care Coordination and Intensive Care Coordination (over 85 FTEs) are available to all children in Connecticut to provide in-home, family driven services to prevent residential institutional care and hospitalization and/or reduce hospital and institutional care stays.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	116,357	43,958
2.Children with SED	72,732	49,385

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

DMHAS continues to examine the need, accessibility and availability of behavioral health services in rural areas. Past efforts to develop local systems of care has taken into account issues such as lack of transportation. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices. The federally funded State opioid Response (SOR) and State Targeted Response (STR) grants have increased capacity for MAT services and recovery supports provided by agencies serving rural communities across the state. Newly funded services include recovery coaches, located at 23 hospital EDs, many of which serve patients from nearby rural towns.

b. Describe your state's targeted services to the homeless population.

In an effort to decrease the number of homeless individuals with SMI or with co-occurring substance use disorders (SUDs), DMHAS established Homeless Outreach and Engagement Teams. These teams provide outreach, assessment, engagement, and case management services to homeless individuals. DMHAS is a recipient of federal formula funds for Projects for Assistance in Transition from Homelessness (PATH) that serves persons with SMI and co-occurring SUDs who are homeless or at risk of becoming homeless. The Homeless Outreach teams are scattered across the state in urban, suburban and rural settings.

c. Describe your state's targeted services to the older adult population.

DMHAS' Long Term Services and Supports (LTSS) unit continues to broaden its statewide partnerships with providers of services to older adults. The LTSS Clinical Director has an active role in the Office of Policy and Managements' Long Term Care Planning Committee,
Medicaid Long Term Services and Rebalancing Committee, the DSS Medicaid Academy and the Elder Justice Coalition. The Elder Justice Coalition is comprised of a multi-disciplinary group of public and private stakeholders that works to prevent elder abuse and protect the rights, independence, security and wellbeing of vulnerable older adults. The coalition created a virtual symposium: Advocating through Adversity in May 2021 that had over 100 participants.

DMHAS LTSS also manages the Senior Outreach and Engagement Program that serves older adults with SUDs and mental health needs. Five private nonprofit agencies in Connecticut, representing the 5 DMHAS regions, focus on outreach and engagement of older adults who are in need of treatment, but aren't receiving services. Through the process of engagement, staff refer individuals to various treatment services that address their unique needs at that time. Case Managers provide a range of services such as assessment, consultation, and outreach by utilizing proactive approaches to identify, engage, and refer seniors for various individually-tailored community treatment options. Services include education, support, counseling (including in-home counseling), referrals to senior service networks, and referrals for treatment. The Senior Outreach and Engagement Program complements and collaborates with existing DMHAS programs, such as the Nursing Home Diversion and Transition Program, which focuses on diverting older adults from long term care and developing home and community based services to assist seniors with aging in place.
The Senior Outreach and Engagement Program also provides education and consultation to local agencies across the state to promote integration and collaboration of services for seniors and to develop a system of aftercare for older adults identified by the program.

Another program that assesses for appropriate level of care is the Nursing Home Diversion and Transition Program (NHDTP). The NHDTP assists with the transformation of the long-term care system in CT for persons with Serious Mental Illness (SMI). Through collaboration with DMHAS-funded agencies, the NHDTP was established with 2 goals: 1) to divert clients from nursing home placement unless absolutely necessary; and 2) to assist clients already in nursing homes to return to the community with ongoing support services. The NHDTP nurse clinicians and case managers located throughout the state, work directly with community providers, nursing home staff, and hospital discharge planners to identify the appropriate level of care for people and assist in community planning to help older adults aging in place. The programs described above identify individuals who are institutionalized or at risk of being institutionalized and attempt to provide them with the least restrictive setting for long term care.
There is ongoing collaboration with the state's Money Follows the Person Demonstration Project and the Medicaid Home and Mental Health Waiver Program as well as with Residential Care Homes across the state.

The State of CT Department of Mental Health and Substance Abuse (DMHAS) adheres to the Substance Abuse and Mental Health Services Administrative (SAMHSA) Evidence-Based Practice Seven (7) Dimensions of Permanent Supportive Housing (PSH) guidelines which combines decent, safe and affordable housing with individualized support services. The program offers participants who are diagnosed with serious mental illness, chronic substance use disorders or dually diagnosed and are experiencing homelessness a non-time limited housing subsidy and in-home housing and tenancy supports. The primary focus of PSH is to assist individuals or families to live independently in the community and meet the obligations of tenancy. All tenants of this housing must have access to flexible, individualized services for as long as they are needed in order to achieve and retain

permanent housing, increase their life skills and income, and achieve greater self-determination.

DMHAS awards private, non-profit agencies service funding to provide an array of supports to persons exiting homeless for community inclusion and
integration. The program provides each participant access to individual apartment units, their own leases with community landlords and assistance and support that is not time limited and is determined by the individual or family. The tenant has access to a flexible array of comprehensive services, which may include medical and wellness, mental health, substance abuse management and recovery, vocational and employment, money management, coordinated support (case management), life skills, household establishment and tenant advocacy. Following the federal Department of Housing and Urban Development's (HUD) Housing First guidelines, the tenant's use of services or programs is not a condition of tenancy. This program promotes community inclusion and integration for individuals and families exiting homelessness

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Block grant funds are a relatively small part of DMHAS' budget for mental health and substance use prevention and treatment services. The entire continuum of care is supported by DMHAS whose target population are the medically indigent. Even with the ACA/Medicaid Expansion, there continue to be persons who are underinsured and, at least periodically, uninsured.
The Behavioral Health Planning Council conducts a priority setting process and annually evaluates the DMHAS system for strengths, needs/gaps, and recommendations. The results are shared with DMHAS leadership for planning purposes and the State Planner organizes this regional information into a statewide report to inform the block grant application and priorities. The results are also part of the annual DMHAS MHBG and SABG Allocation Plans which describe how block grant funds will be spent. These plans require approval from the CT Office of Planning and Management (OPM) prior to presentation to committees of the State Legislature which votes to approve and may request modifications.
Regular meetings occur between DMHAS and Department of Children and Families (DCF) as both agencies share MHBG funds.

Footnotes:

For statewide prevalence of adults with SMI, DMHAS used the 2017-2019 Behavioral Health Barometer for Connecticut which estimated 4.1% of Connecticut adults had SMI. Based on US Census Quick Facts from July 1, 2019, there were 2,837,968 persons 18+ in Connecticut so 4.1% of these would reflect 116,357 with SMI. For statewide incidence of adults with SMI, DMHAS used its Annual Statistical Report (FY20) which includes the number of adults diagnosed/treated with SMI (defined to include schizophrenia and related disorders, bipolar disorder, major depression and PTSD) in the state: 43,958. Children with Serious Emotional Disturbance are estimated at 10% of Connecticut's 727,319 children under age 18 or 72,732. And estimate that 67.9% of the 72,732 will equal the incidence rate or 49,385

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Women's Services staff conducts an on-site annual contract monitoring site visit which includes the following elements:
Leadership interview
Client Focus group Clinical Chart Review Policy Review
Facility and Program Tour and Evaluation

All programs are evaluated on each component and a comprehensive report is submitted to agency and program leadership. Based on the findings, agencies are given recommendations to improve service delivery. In the event that significant concerns are identified, programs may be placed on a Corrective Action Plan (CAP.) If on a CAP, a follow up visit is scheduled and a detailed remediation report is requested from the provider and reviewed by the department.

In addition, all programs participate in a bi-monthly learning collaborative which provides them with best practices, ongoing opportunities for learning, and training around new department initiatives and best practices.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — Yes / No
- **b)** 14-120 day performance requirement with provision of interim services — Yes / No
- **c)** Outreach activities — Yes / No
- **d)** Syringe services programs, if applicable — Yes / No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — Yes / No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — Yes / No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — Yes / No
- **c)** Use of peer recovery supports to maintain contact and support — Yes / No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? — Yes / No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — Yes / No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — Yes / No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — Yes / No
- **c)** Established co-located SUD professionals within FQHCs — Yes / No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? — Yes / No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas — Yes / No
- **b)** Establishment or expansion of tele-health and social media support services — Yes / No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — Yes / No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? — Yes / No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — Yes / No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ○ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — ( ) Yes (●) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ◉ Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ○ Yes ◉ No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ○ Yes ◉ No

c) Updating written procedures which regulate and control access to records — ○ Yes ◉ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ○ Yes ◉ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ○ Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ○ Yes ◉ No

b) Establishment of policies and procedures related to independent peer review — ○ Yes ◉ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ◉ Yes ○ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ○ Yes ◉ No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ◉ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.cga.ct.gov/current/pub/chap_319i.htm#sec_17a-450.
Licensing of substance use disorder programs is covered under a difference state agency: Department of Public Health.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ○ No

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

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

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

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

DCF as a trauma informed agency funds annual training through the Child Health and Development Institute to train all providers on being a trauma informed serve array. DCF has been addressing trauma informed practice through policies and practices for a number of years.
DMHAS has an annual contract with the CT Women's Consortium (CWC) to train providers on trauma-informed care and trauma-specific interventions. Thousands of state operated and PNP staff have received these trainings over the years. DMHAS, through CWC, has a Trauma & Gender Practice Improvement Collaborative for agencies. They attend bimonthly sessions to hear presentations, share lessons learned and learn from state agency staff. We've also published a trauma services directory for

clients, their families and other providers. Trauma services are embedded in all levels of care and not a level of care itself, so a directory was needed.

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

None

Footnotes:

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

The 21st century CARES Act - Opioid State Targeted Response (STR) grant provided funds to DMHAS, some of which will be used to support the Department of Correction (DOC), Court Support Services Division (CSSD), State's Attorney, and local police efforts. DOC, DMHAS, DPH and community providers are working together to maintain incarcerated clients on methadone. Efforts are underway to expand this to more prisons. Efforts are also underway to educate DOC employees about naloxone use and inmates and parolees are now being released with narcan kits.
"Second chance" is a Governor-led and legislatively supported initiative which helps to reduce prison populations and ensure nonviolent offenders are successfully reintegrated into society and become productive workers in Connecticut's economy, by emphasizing treatment and rehabilitation over punishment for nonviolent drug crimes.
Legislation also funds additional program expansion of vocational and job-based adult education, employment training, and school-based diversion initiatives (SBDI) to reduce suspensions, expulsions and school-based arrests; and supportive housing services for pregnant users or substances and individuals with mental health issues that cycle in and out of the corrections system. Reintegration units have been established for women, youth, and veterans for a focus on rehabilitation.

There are multiple jail diversion programs embedded in all arraignment courts in Connecticut:

Jail Diversion/Court Liaison Program (JD; statewide)
Clinicians in all 20 arraignment courts screen adult defendants with mental illness, most with SMI, many with COD, and can offer community treatment option in lieu of jail while case proceeds through court process. JD refers for services, monitors compliance, reports compliance to court.

Women's Jail Diversion (JDW; New Britain, Bristol, New Haven)
Offers full services to women with trauma sequelae, most with substance abuse, at risk of incarceration – mostly pretrial, some on parole/probation at risk of violation. Services include clinical, medication management, community support, limited temp housing, client supports.

Jail Diversion Veterans (JDVets; Norwich, New London, Middletown)
Targets veterans who have current criminal charges. Can offer community treatment option in lieu of jail while case proceeds through court process. Refer clients for clinical services and specialized veteran's services, monitor compliance, report compliance to court.

Jail Diversion Substance Abuse (JDSA; Hartford)
Targets adults with substance dependence who need immediate admission to residential detox and/or intensive residential treatment on day of arraignment or rapid admission to IOP. Includes intensive case management, sober house rent, other transitional housing options, client supports, monitor compliance, and report compliance to court.

Alternative Drug Intervention (ADI; New Haven)
Offers full services to pretrial defendants with substance dependence in New Haven court (mostly men; women go into the JD Women's program). Services include clinical, medication management, case management, client supports.

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

None

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

DMHAS has a large network of methadone providers and conducts on-site monitoring of all methadone clinics.
There is a learning collaborative conducted twice a year with all methadone clinics.
Given the ongoing opioid epidemic DMHAS has invested (with federal dollars) in many activities to increase and expand the use of MAT for OUD (e.g., enhanced clinics, mobile MAT, DATA waiver trainings).
Have collaborated extensively with DOC to assist in MAT expansion for their inmates and those re-entering DMHAS services.
Federal discretionary grants awarded will direct some of the funds to increase access to buprenorphine, naloxone and naltrexone.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

A mobile crisis team (MCT) learning collaborative of all state-funded team leaders meets monthly to discuss current and innovative practices, share information, etc. including a quarterly focus on CIT.
DMHAS received funding from SAMHSA through the National Association of State Mental Health Program Directors (NASMHPD) to establish a comprehensive psychiatric crisis bed registry system through the TTI initiative. The DMHAS mental health bed registry was implemented August 2020.
In August 2020 DMHAS also launched its first statewide crisis call center for adults. The vendor is the United Way of CT, which also staffs 211 and the National Suicide Prevention Lifeline (NSPL). This call center is called the ACTION Line (Adult Crisis Telephonic Interventions and Options Network) The ACTION connects callers to their mobile crisis team if needed.
For SED youth CT has a robust EMPS-Mobile Crisis response system that is available 24 hours a day, 365 days a year for all Connecticut youth in behavioral health crisis. Crisis clinicians are required to respond within 45 minutes of the call. Last year's statewide average was 30 minutes for a face to face crisis assessment.
DMHAS and DCF are co-leading the 9-8-8 Coalition and staffing the recent 988 Planning Grant, in preparation for 988 implementation July 2022.

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

NA

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Connecticut offers many components for peer support, coaching, education about alternative approaches to healing and recovery, as well as self-management for individuals served and family support, warm lines, supported employment, recovery centers, peer bridgers, Certified Recovery Support Specialists (mental health/co-occurring) and Certified Recovery Coaches (substance use/co-occurring). In 2014, DMHAS implemented a Commissioner's Policy Statement on supporting the creation of Advance Directives.
DMHAS launched the Hearing Voices Network in 2014. As part of this initiative, five international trainers in the Hearing Voices approach and the Maastricht Interview Technique were brought together with voice hearer, family members, professionals and the public. The centerpiece of the initiative has been the training of certified Hearing Voices Network support group facilitators and the creation of a network of peer-run community-based support groups for voice hearers.

Regional Behavioral Health Action Organizations (RBHAOs), which have strong representation of persons in recovery, provide evaluation and ongoing dialogue with DMHAS leadership through a variety of forums on service design and strategic planning. Satisfaction and other evaluative tools are used for ongoing quality improvement.

The manager at the Office of the Commissioner that is responsible for Recovery Community Affairs is a liaison to agency leadership providing ongoing input from grassroots advocacy organizations and programming.

DMHAS requires all state-operated and funded Assertive Community Teams (ACT) and Community Support Program (CSP) teams to employ at least one certified Recovery Support Specialist.

DMHAS accepts three trainings in the state for Recovery Support Specialists (i.e., Advocacy Unlimited, CCAR, Hartford Healthcare).

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

CCAR operates five recovery community centers (Bridgeport, Windham, Manchester, New Haven and Hartford) which offer a place to go and spend time with others in recovery from substance use, participate in 12-step meetings, and participate in other group activities. CCAR operates a Telephone Recovery Support program in which persons in recovery call others early in their recovery who are requesting the support. Assistance may also be provided in the form of transportation to self-help support meetings, information about available resources, etc. CCAR initiated a new program in March 2017 which involves hospital EDs contacting a CCAR- trained Recovery Coach when they have a patient present with a substance-related issue (such as an overdose). The Recovery Coach attempts to engage the patient and get them to take the next step toward recovery. This initiative now includes 23 hospital EDs.

Another recovery activity related to the current opioid epidemic is the "Gone But Not forgotten Quilt Project" which celebrated its first event in January 2017. Family members and significant others of persons who have died as a result of substance use are offered the opportunity to make a quilt square in memory of the loved one they lost to substances. The events were being held around the state and they provide an opportunity to raise awareness and reduce stigma.

5. Does the state have any activities that it would like to highlight?

No

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

None

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Although we are working towards a fully intergraded approach CT has eleven different state departments which share part of the role for the Behavioral Health System. CT has partially implements a “Care Management Entity (CME)” approach to allow for full integration of the Behavioral Health System. CT has hopes of implementing a more completed CME approach for improved, intergraded behavioral health care. CT has also applied for a sustainability grant.

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

DCF is committed to integration in infrastructure and development of the behavioral health system. To this end, through the federal System of Care CONNECT grant, seven work groups have been formed to facilitate this process. They include Fiscal Analysis and Mapping, Network of Care Analysis, Data Integration, Workforce Development, Communication, Family and Youth Engagement, and Implementation of the National CLAS Standards (and racial justice activities). CT has a sustainability plan that has allowed most of these activities to continue.

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

None

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The CT Suicide Prevention Plan 2025 (Plan 2025-www.preventsuicidect.org) was released September 2020 by the CT Suicide Advisory Board (CTSAB), the single state-level advisory board in CT that addresses suicide prevention, intervention and response across the lifespan. The CTSAB is co-chaired by the CT Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF), and the CT Chapter of the American Foundation for Suicide Prevention. The CTSAB leads the implementation of the state plan, advises all suicide-related federally funded initiatives directed by state departments (e.g., SAMHSA and CDC block grants; SAMHSA-Garrett Lee Smith Grants, CDC-CT Violent Death Reporting System, CDC-CT Suicide Prevention Initiative). Many subcommittees lead efforts to reduce suicides and attempts including: the CT Zero Suicide Learning Community and Committee on Clinical Workforce Development; Reducing Access to Lethal Means; Data TO Action; Intervention and Postvention Planning and Response; Lived Experience Advocacy; and Legislative Advocacy. Since 2015, the statewide suicide prevention, intervention and response infrastructure has been enhanced with the addition of five Regional Suicide Advisory Boards (RSABs), one in each DMHAS services region. These connect to local communities, across regions and up to the CTSAB to identify and address needs unique to their areas. This statewide infrastructure of the CTSAB and RSABs are comprised of diverse key stakeholders, partners representing hundreds of sectors, settings and populations. There are more than 1,000 members at present. Suicide prevention activities are prioritized and guided routinely by the CT Suicide Prevention Plan, data monitoring and CTSAB members. Examples of recent successes, in addition to the release of Plan 2025 and initiation of the RSABs include: the Aug '21 release of the updated state website; Hope and National Suicide Prevention Lifeline signage at data-driven sites where people have made attempts-bridges, overpasses, railway stations, parking areas; a lock box dissemination with counseling access to lethal means project with 20 health and behavioral healthcare sites; development of the Gizmo's Pawesome Guide to Mental Health© Read-Along Program and social media pledge campaign (www.gizmo4mentalhealth.org); partnership with the national American Foundation for Suicide Prevention to adopt Gizmo's Pawesome Guide to Mental Health© Read-Alongs and elementary curriculum for 3rd and 4th graders as 3rd party programs so their Chapters can fund local use; joint gatekeeper training with narcan training and kit dissemination to address the intersection of suicide and opioid use disorders; and the successful funding and implementation of two CDC grants (suicide and ACES prevention) and the 988 Planning Grant.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

The CT Department of Public Health (DPH) was awarded the CDC-funded CT Suicide Prevention grant (2020-2025) that focuses on youth age 10-17, young adults age 18-24, and non-Hispanic, White males age 35-64. DMHAS and DCF co-direct this grant with DPH. Also, The CT Office of Early Childhood was awarded the CDC-funded Preventing ACES grant (2020-2023) that focuses on young children up to age five. DMHAS and DCF are on various advisory committees for this grant. DMHAS was awarded the Vibrant Emotional Health 988 Planning grant (2/21-1/22). DCF co-directs this grant, and DPH is on the statewide planning coalition. This grant will help CT plan for 988 call/text/chat service implementation and expansion of crisis services across the lifespan. Gizmo's Pawesome Guide for Mental Health© Pledge and Read-Alongs for youth and their trusted adults.

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

We are in regular contact with the lead agencies of the national and federal initiatives, national Suicide Prevention Resource Center, Zero Suicide Institute, and the New England Mental Health Technology Transfer Center to plan strategies and activities, so we are currently receiving the assistance we need.

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

NA

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

None

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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

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

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

DMHAS (Department of Mental Health and Addiction Services) has been a single integrated department since 1995, servicing all behavioral health needs of adults. In 2012, the Mental Health Planning Council expanded its purview and membership to include substance use concerns and became the Behavioral Health Planning Council. Connecticut has been submitting combined mental health/substance abuse block grant applications since 2014/15. In 2018, Connecticut restructured its advocacy/evaluation/planning entities from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) into integrated Regional Behavioral Health Action Organizations (RBHAOs). The 5 RBHAOs cover the state via the 5 DMHAS regions for all behavioral health issues, including naloxone education and distribution. The RBHAOs are tasked with the annual review of the behavioral health service system and the priority setting process. Presentations for the Council are a mix of behavioral health concerns inclusive of substance use related topics.
The Children's Behavioral Health Advisory Council and the Adult Behavioral Health Planning Council were presented the 20/21 Block Grant Application at meetings in June and July and invited to comment and make recommendations. That information is included in the block grant application.

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

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

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

The Joint Behavioral Health Planning Council in Connecticut is comprised of the Adult Behavioral Health Planning Council coordinated by DMHAS and the Children's Behavioral Health Advisory Council, coordinated by DCF. Meetings are held separately for the adult and children's council and also jointly.
Duties of the Behavioral Health Planning Council include:
- to review the combined SABG/MHBG application/plan provided by DMHAS and to submit any recommendations for modifications of those plans
- to serve as advocates for adults with DMI and children with SED and their families, as well as others with behavioral health problems
- to monitor, review, and evaluate, at least annually, the allocation and adequacy of behavioral health services in Connecticut
Council membership includes representation from the RBHAOs, state agencies, other public and private entities concerned with

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Children’s Behavioral Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC)) to “promote and enhance the provision of behavioral health services for all children” in Connecticut. The CBHAC serves as the state’s Children’s Mental Health Planning Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state’s System of Care for children and families.

The 30 member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, five members appointed by the leadership of the General Assembly, as well as fifteen members appointed by the commissioner of DCF The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. “At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child.” In addition, a parent is to serve as co-chair of the CBHAC/CMHPC.

CBHAC meetings held throughout the year include time for review of the MHBG. Meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan

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

None

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]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

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Environmental Factors and Plan

Advisory Council Members

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

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

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Jennifer Abbatemarco	Youth/adolescent representative (or member from an organization serving young people)	DMHAS - YAS	1800 Silver Ave Middletown CT, 06457 PH: 860-262-6962 FX: 860-262-6962	jennifer.abbatemarco@ct.gov
Tiffanie Allain	Providers	PATH	277 South St. Brooklyn CT, 06234 PH: 860-412-0041	tallain@pathct.org
Nan Arnstein	Providers	Creative Arts for Developing Minds	141 Weston St. Hartford CT, 06142 PH: 860-834-3359	narnstein@creativeartsdm.org
Craig Burns	State Employees	Dept of Correction (DOC)	24 Wolcott Hill Rd Wethersfield CT, 06109 PH: 860-692-6262 FX: 860-730-8287	craig.burns@ct.gov
Erica Charles-Davey	Parents of children with SED/SUD		247 Collins St. Hartford CT, 06105 PH: 860-951-1830 FX: 860-310-2260	ericadevy@gmail.com
Joan Cretella	Family Members of Individuals in Recovery (to include family members of adults with SMI)		225 Beach St. West Haven CT, 06516 PH: 203-933-4272	
Michele Devine	Persons in recovery from or providing treatment for or advocating for SUD services	SERAC	228 West Town St. Norwich CT, 06360 PH: 860-848-2800 FX: 860-848-2801	serac.ed@sbcglobal.net
Steve DiLella	State Employees	Department of Housing	505 Hudson Street Hartford CT, 06106 PH: 860-270-8081	Steve.DiLella@ct.gov
Marcia DuFore	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Amplify	151 New Park Ave. Hartford CT, 06106 PH: 860-667-6388	mdufore@amplify.org
Ellen Econs	State Employees	Bureau of Rehabilitation Services	410 Capitol Ave. Hartford CT, 06134 PH: 860-308-4523 FX: 860-262-5852	ellen.econs@ct.gov

Antonia Edwards	Parents of children with SED/SUD			antonia.edwards@yahoo.com
Maria Feliciano	Providers	Disability Rights CT	846 Wethersfield Avenue 06114 Hartford CT, 06114 PH: 860-297-4300	Maria.Feliciano@DisRightsCT.org
Michaela Fissel	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Advocacy Unlimited	300 Russell Rd. Wethersfield CT, 06019 PH: 860-667-0460 FX: 860-666-2240	mfissel@advocacyunlimited.org
Kathy Flaherty	Others (Advocates who are not State employees or providers)	CT Legal Rights Project	CLRP, PO Box 351 Middletown CT, 06457 PH: 860-262-5033 FX: 860-262-5035	kflaherty@clrp.org
Allison Fulton	Persons in recovery from or providing treatment for or advocating for SUD services	Western CT Coalition	7 Old Sherman Turnpike Danbury CT, 06810 PH: 203-743-7741	afulton@wctcoalition.org
Ingrid Gillespie	Persons in recovery from or providing treatment for or advocating for SUD services	Liberation Programs	Liberation Programs Norwalk CT, 06850 PH: 855-542-7764	ingrid.gillespie@liberationprograms.org
Gabrielle Hall	Providers	Beacon Health Options	500 Enterprise Dr. Rocky Hill CT, 06067 PH: 860-707-1016	gabrielle.hall@beaconhealthoptions.com
William (Bill) Halsey	State Employees	Department of Social Services	25 Sigourney St. Hartford CT, 06106 PH: 860-424-5077 FX: 860-424-4812	william.halsey@ct.gov
Josephine Hawke	Parents of children with SED/SUD		65 Woodmere Rd. West Hartford CT, 06067 PH: 860-231-9856 FX: 860-563-3961	johawke@sbcglobal.net
Brenetta Henry	Parents of children with SED/SUD		73 Governor St. East Hartford CT, 06108	brenetta.henry@yahoo.com
Irene Herden	Others (Advocates who are not State employees or providers)		49 Bogue Ln East Haddam CT, 06423 PH: 860-873-1999 FX: 860-873-1999	evherd@comcast.net
MuiMui Hin-McCormick	Persons in recovery from or providing treatment for or advocating for SUD services	Rushford	1250 Silver St. Middletown CT, 06457 PH: 860-852-1021 FX: 860-343-1732	muimui.hin-mccormick@hhchealth.org
Lisa Jameson	Parents of children with SED/SUD		112 Bell-Aire Cir. Windsor CT, 06096 PH: 860-623-5790	lisajameson22@gmail.com
Tim Marshall	State Employees	Department of Children and Families	505 Hudson St. Hartford CT, 06105 PH: 860-550-6531 FX: 860-556-8022	tim.marshall@ct.gov

Mary Martinez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7 Mary Shepherd Pl. Hartford CT, 06120 PH: 860-719-5080	mryadvcomm35@gmail.com
Donna Maselli	State Employees	Department of Public Heatlh	410 Capitol Ave. Hartford CT, 06134 PH: 860-509-7505	donna.maselli@ct.gov
Pamela Mautte	Others (Advocates who are not State employees or providers)	Alliance for Prevention and Wellness	127 Washington Ave. North Haven CT, 06473 PH: 203-892-6418	pmautte@bhcare.org
Debbie McCusker	Parents of children with SED/SUD		35 Maywood St. Waterbury CT, 06704 PH: 203-757-7569	jamesmccusker@sbcglobal.net
George McDonald	Parents of children with SED/SUD		PO Box 2617 Hartford CT, 06146 PH: 860-794-6283	
Carol Meredith	State Employees	DMHAS - Prevention Division	410 Capitol Ave. Hartford CT, 06134 PH: 860-418-6826 FX: 860-418-6792	carol.meredith@ct.gov
Scott Newgass	State Employees	CT State Department of Education	450 Columbus Ave Hartford CT, 06106 PH: 860-807-2044 FX: 860-807-2127	scott.newgass@ct.gov
Daisy Olivo	Providers	FAVOR, Inc.	185 Silas Dean Hwy. Wethersfield CT, 06109 PH: 860-837-1436	dolivo@favor-ct.org
Maureen O'Neill-Davis	Parents of children with SED/SUD		Torrington CT, 06790 PH: 561-762-4747	maureenod65@gmail.com
Edwin Renaud	State Employees	CVH	PO Box 351 Middletown CT, 06457 PH: 860-262-5496 FX: 860-262-5895	edwin.renaud@ct.gov
Barbara Roberts	Family Members of Individuals in Recovery (to include family members of adults with SMI)		42 School St. Woodbury CT, 06798 PH: 203-263-3250	barbararoberts882@gmail.com
Heather Tartaglia	Providers	CREC	111 Charter oak Hartford CT, 06106 PH: 860-509-3732	heathertaglia@crec.org
Peter Tolisano	State Employees	DDS	460 Capitol Ave. Hartford CT, 06106 PH: 860-418-6086	peter.tolisano@ct.gov
John Torello	State Employees	Court Support Services Division (CSSD)	936 Silas Deane Highway Wethersfield CT, 06109 PH: 860-721-2157	john.torello@jud.ct.gov
Benita Toussaint	Parents of children with SED/SUD		45 Niles St. Hartford CT, 06105 PH: 860-249-4806	toussaintbenita@yahoo.com

Ofelia Velazquez	Parents of children with SED/SUD		55 Taylor Street Hartford CT, 06010 PH: 860-313-9130	ovy4252@yahoo.com
Doriana Vicedomini	Parents of children with SED/SUD		9 Kingfisher Ln. Suffield CT, 06078 PH: 504-259-4327	dmv35@aol.com
Laura Watson	State Employees	DOH	505 Hudson St. Hartford CT, 06106 PH: 860-270-8169 FX: 860-706-5741	laura.watson@ct.gov

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**41**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	11	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	4	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**23**	**56.10%**
State Employees	12	
Providers	6	
Vacancies	0	
Total State Employees & Providers	**18**	**43.90%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* 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?
The Planning Council is led by the Regional Behavioral Health Action Organizations (RBHAOs) who conduct Needs Assessments for each of their regions throughout the state. The RBHAOs are advocacy organization representing SMI and SUD populations and through their annual Priority Setting process, help to identify gaps in services and prioritize the needs in each region. That priority setting report is used to help inform the Needs Assessment in this Application. Additionally, this application will be posted on the DMHAS website and the corresponding link will be made available to the Planning Council. Any recommendations will be included in this section.

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ○ No

If yes, provide URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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Footnotes:

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**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[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 an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[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 and follow the steps below when requesting to direct FY 2021 funds to SSPs.

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

Future years are subject to authorizing language in appropriations bills.

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 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[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 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, 2018 (P.L. 115-141)

[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 an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

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

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

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

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

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

Footnotes:

2020 Connecticut SSP Data Summary

Ramon Rodriguez-Santana, MBA, MPH

CT DPH HIV Prevention Program-SSP Coordinator

In Loving Memory of

Pamela Renee' Foster

December 3, 1960 - April 29, 2021

Presentation Overview

- SSPs Data Notes
- SSPs Sites in Connecticut
- 2011 to 2020 Trend: Number of Clients who Visited SSPs
- SSP Clients (new vs previous)
- SSP Clients by Gender, Race/Ethnicity and Age Group
- SSP Clients Housing Status
- SSP Clients by Zip Code (Pareto Chart)
- SSP Clients Frequency Map
- SSP Clients by HEP C, HIV/AIDS, HEP B and HEP A Self-Reported Diagnosis
- SSP Clients HIV/HEP C tested within the las 12 months
- SSP Clients by Primary and Secondary Substance Used
- OD Prevention: Kits distributed, Trainings and Reversals
- Number of OD kits distributed (2016-2020)
- Number of fentanyl testing strips and crack kits distributed
- Pre and Post COVID-19 Impact on SSPs (2019 vs. 2020)
- SSPs Impact on HIV
- Conclusion: 2020 SSP data by the numbers
- Role of the DIS in Drug User Health?

2020 SSPs Data Notes

- All data is self-reported by the client, unless specified
- Data analyzed was for **2020** calendar year and reflects information obtained from the ***neo360 and e2CTPrevention*** data collection systems used by **13 SSPs**.

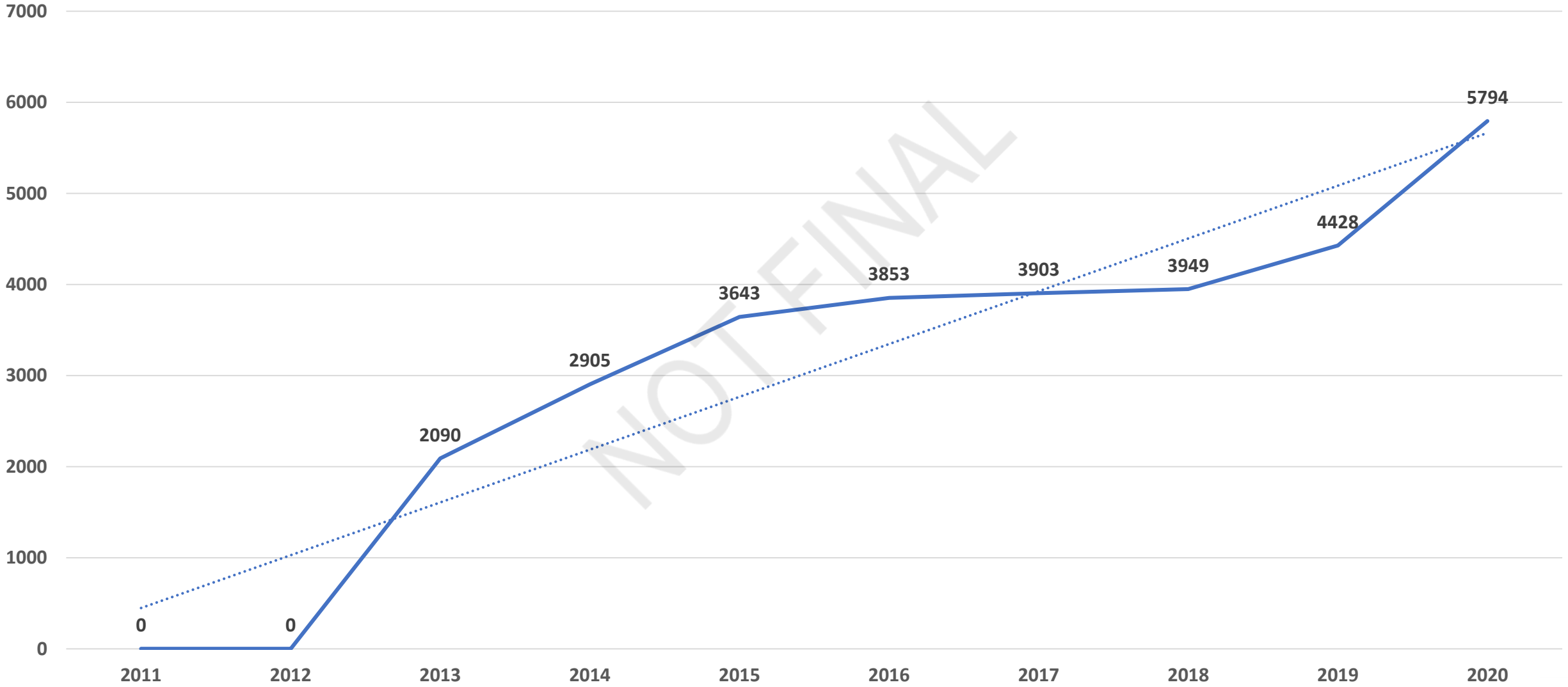
AIDS CT	**APEX**
Alliance for Living	**GBAPP**
GHHRC (w/ SWAN)	**Liberation Programs**
Perceptions Programs Inc. (w/ UNCAS Health District)	**Yale University CHCV**
Mid-Fairfield AIDS Proj.	**StamfordCARES**
Waterbury HD	

- **Data limitations:** Intentional reporting bias (e.g., the participant wants to be seen in a positive way), and/or unintentional reporting bias (e.g., the participant simply forgot that they had engaged in a risk behavior).
- Questions about the data can be emailed to: ramon.rodriguez-santana@ct.gov
- General questions about the SSPs can be emailed to: ramon.rodriguez-santana@ct.gov

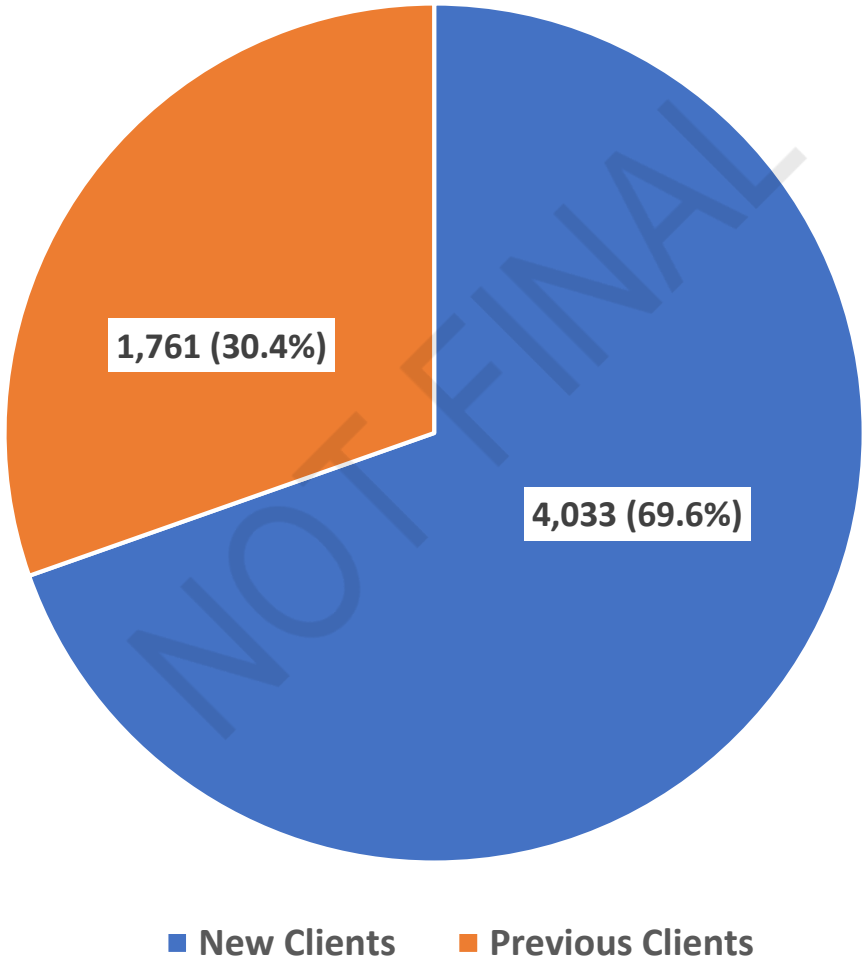
2020 SSPs Sites in Connecticut

SSP	Sites
AIDS CT	Hartford and Middletown
Alliance for Living	New London and Norwich
APEX	Danbury and Waterbury
GBAPP	Bridgeport
GHHRC (w/ SWAN)	Hartford, New Britain, Bristol, New Haven, Enfield and Torrington
Liberation Programs	Stamford, Norwalk, Bridgeport
Mid-Fairfield AIDS Project	Norwalk
Perceptions Programs Inc. (w/ UNCAS Health District)	Windham and Norwich
StamfordCARES	Stamford
Yale University CHCV	New Haven
Waterbury HD	Waterbury

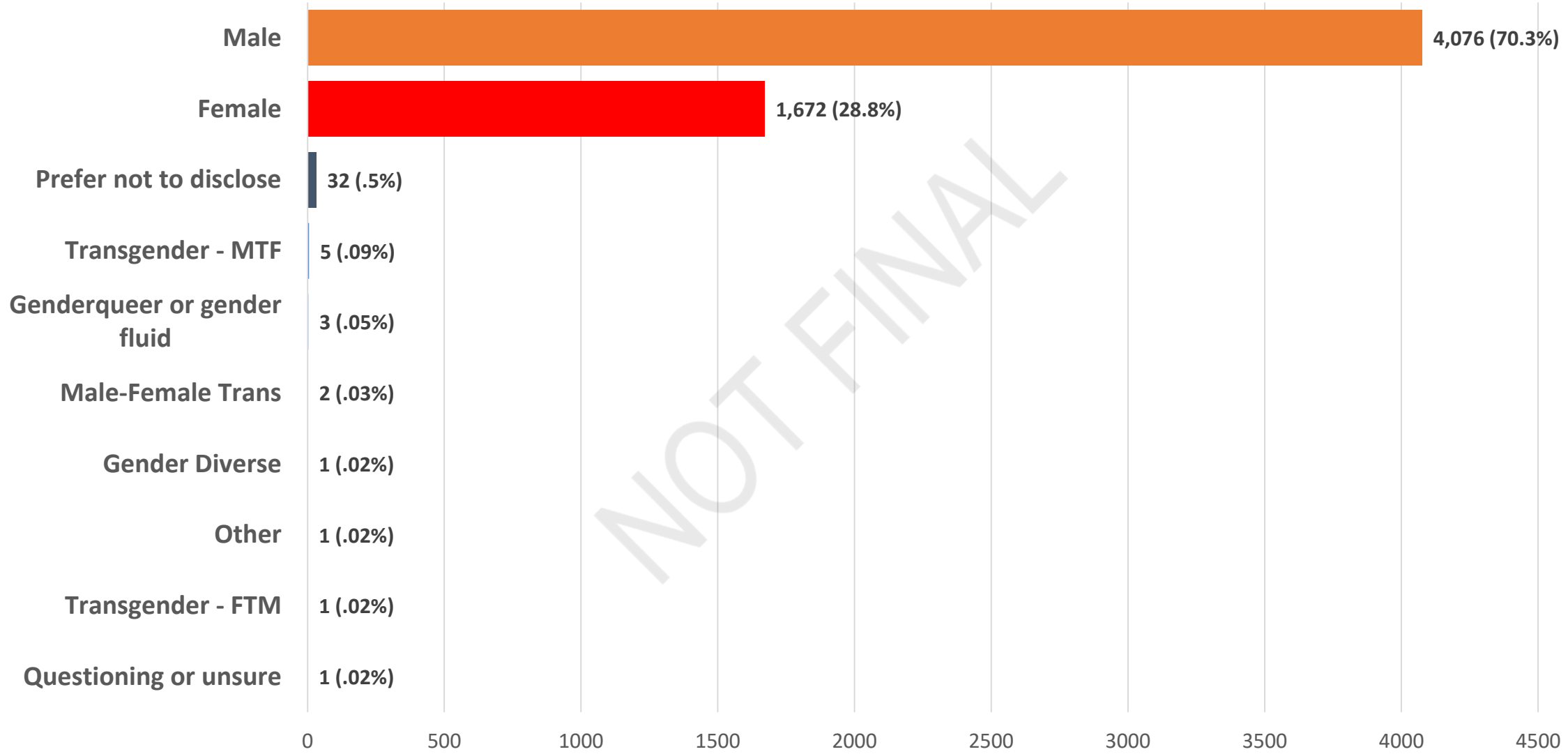
Trend of Total Number of Unique Clients who Visited SSPs, 2011 - 2020



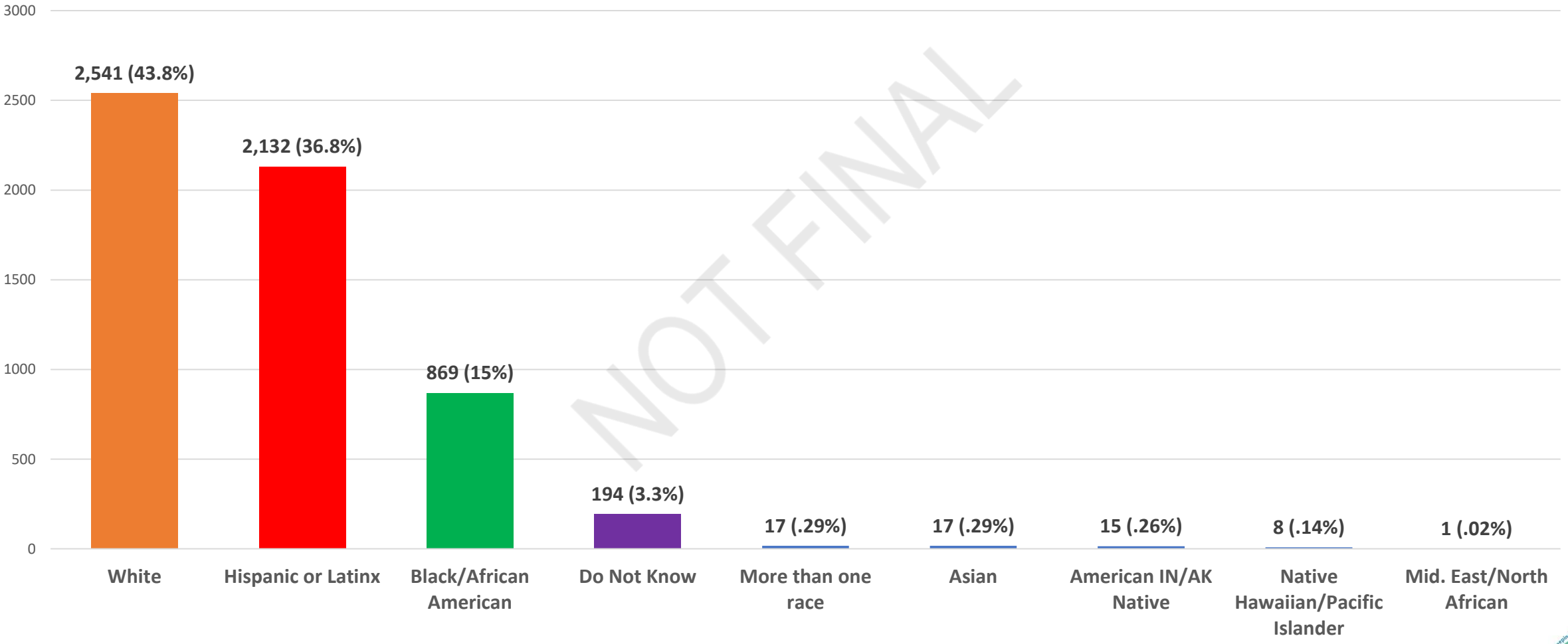
2020 SSP Clients, (N=5,794)



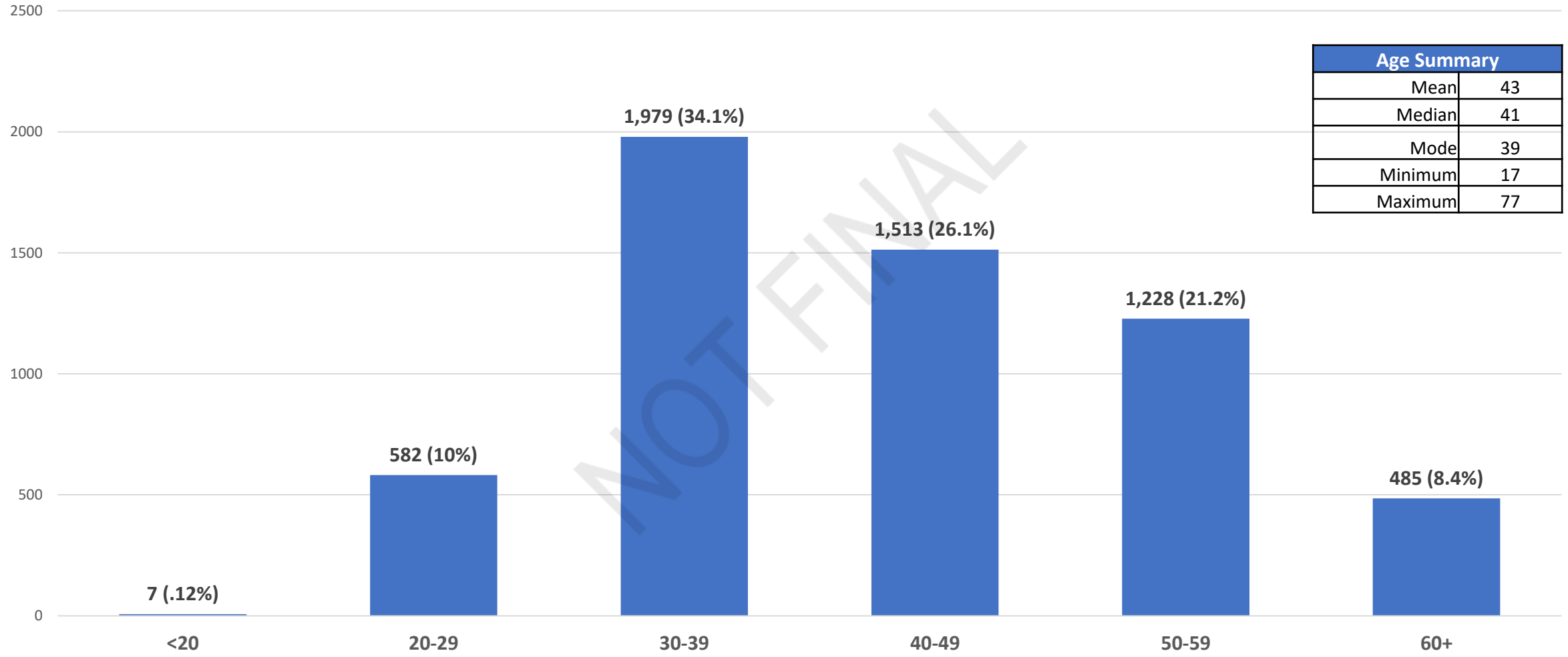
2020 SSP Clients Gender, Connecticut, (N=5,794)



2020 SSP Clients Race/Ethnicity, Connecticut, (N=5,794)

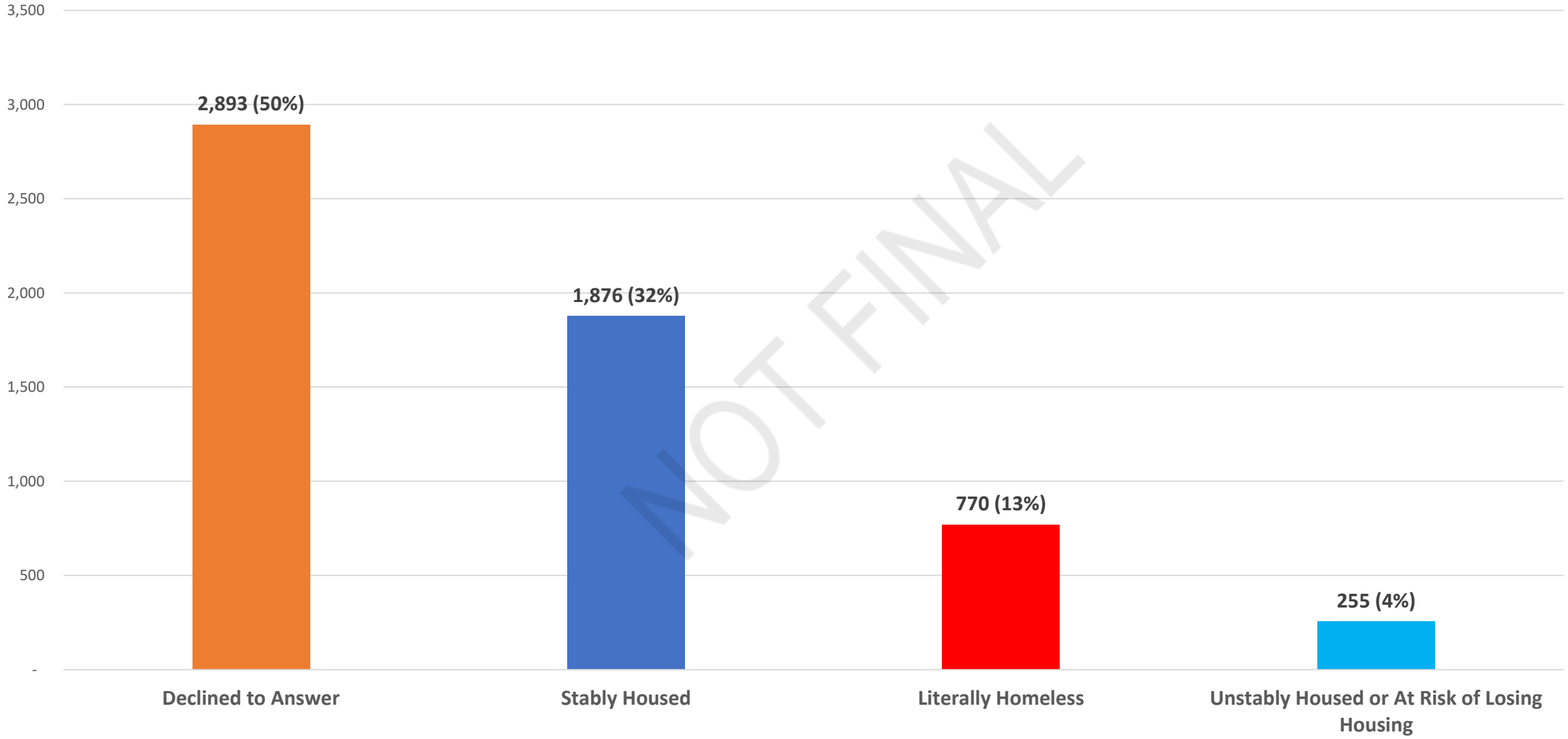


2020 SSP Clients Age Range, Connecticut, (N=5,794)

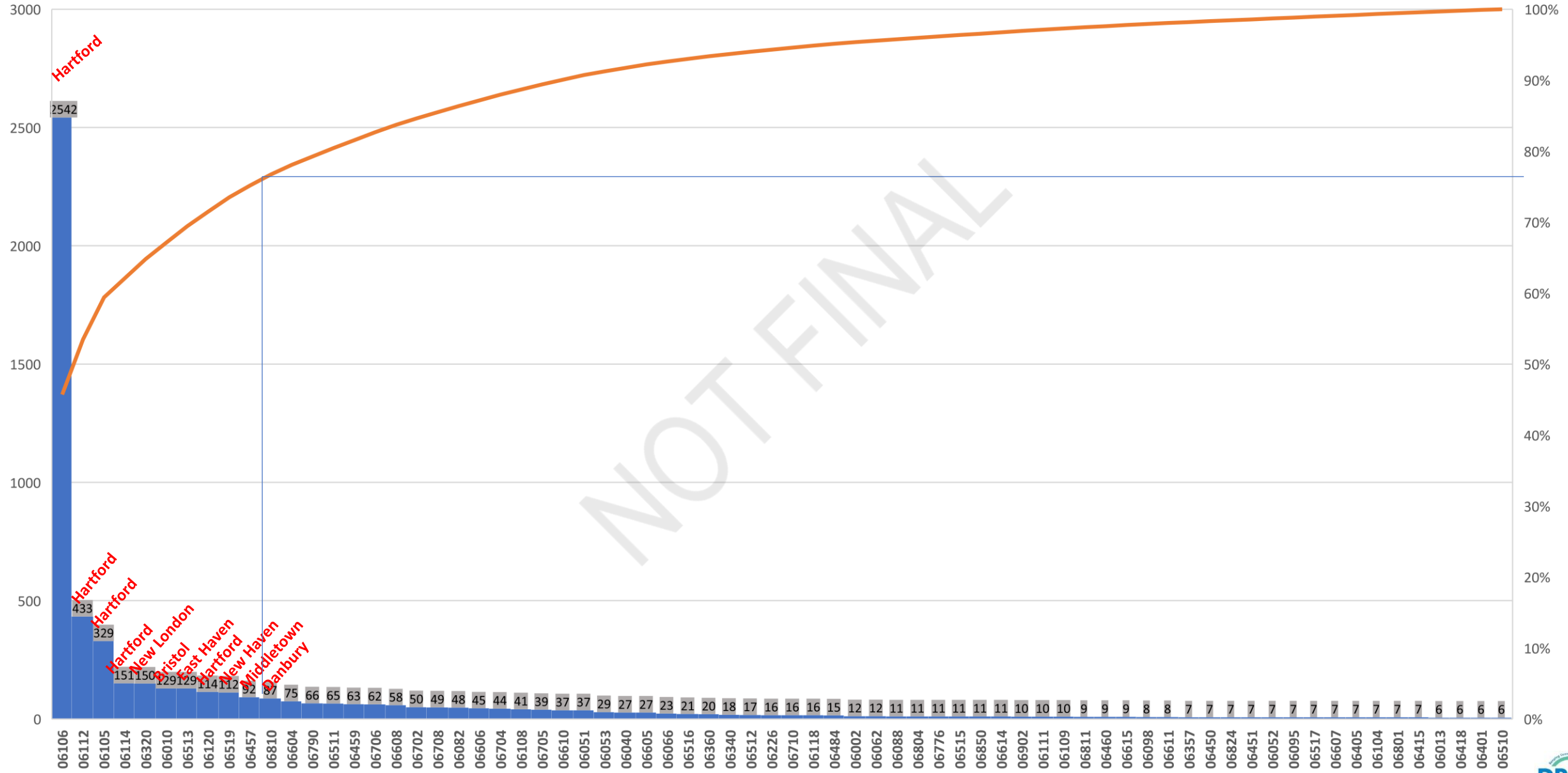


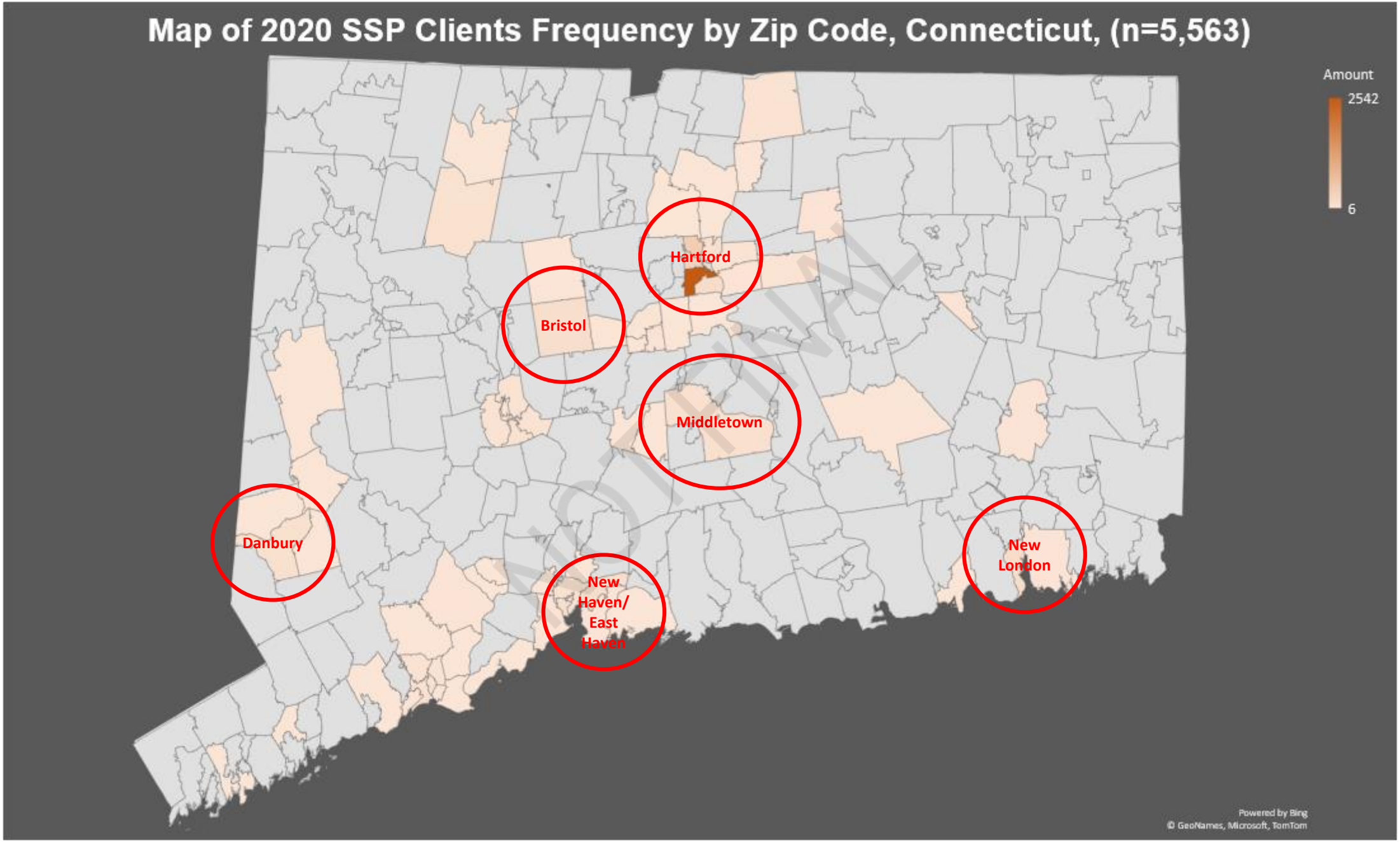
Age Summary	
Mean	43
Median	41
Mode	39
Minimum	17
Maximum	77

2020 SSP Clients Housing Status, Connecticut (N=5,794)

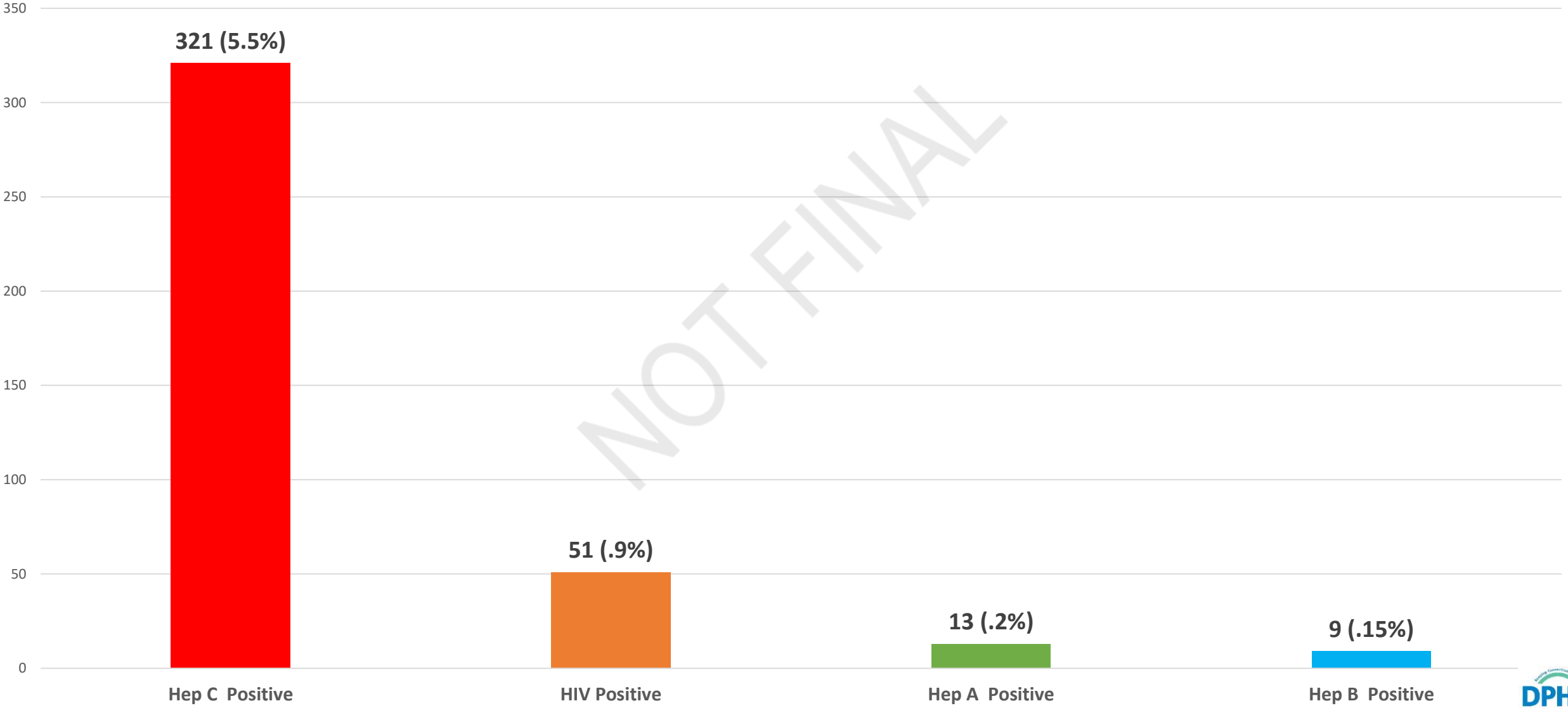


2020 SSP Clients Frequency by Zip Code, Connecticut, (n=5,563)

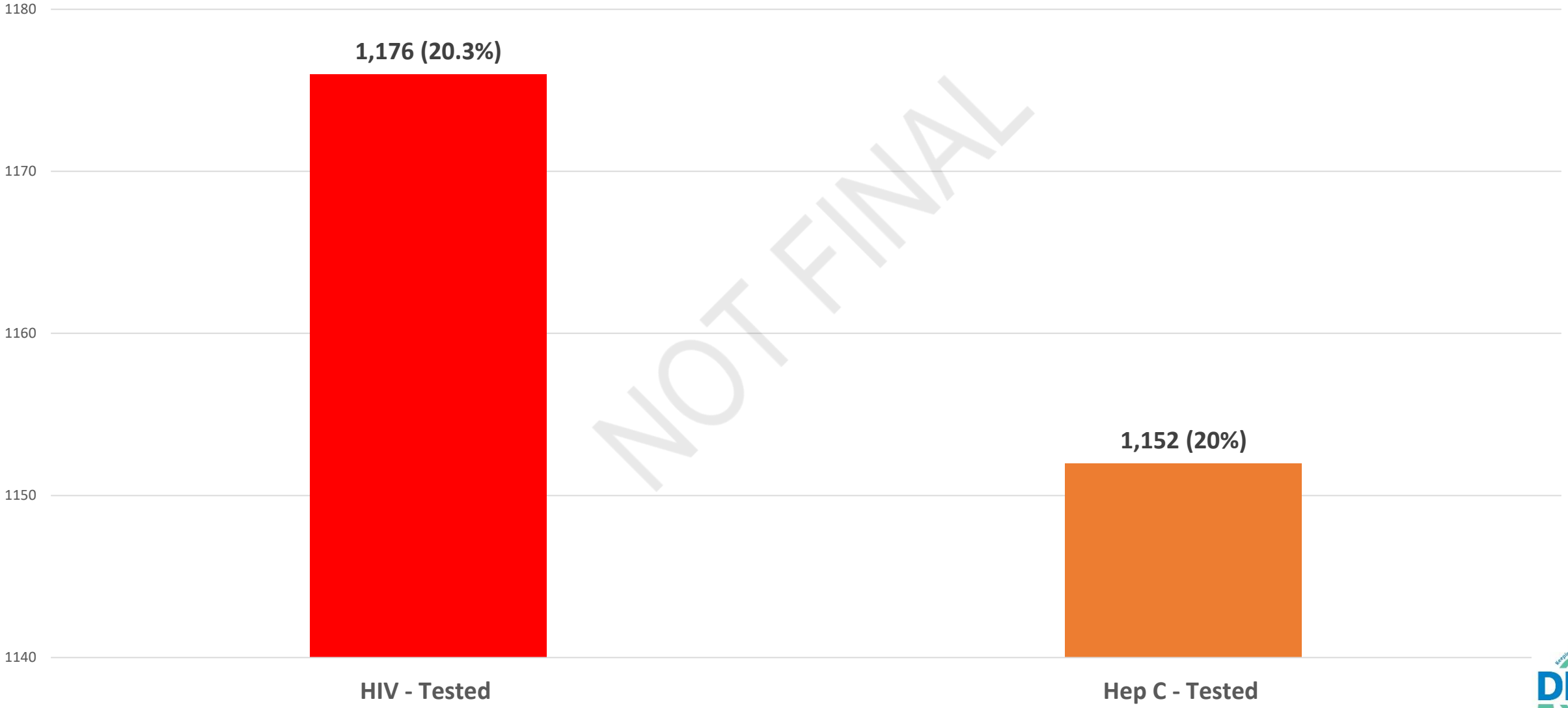



Map of 2020 SSP Clients Frequency by Zip Code, Connecticut, (n=5,563)
Amount
2542
6
Hartford
Bristol
Middletown
Danbury
New Haven/ East Haven
New London
NOT FINAL
Powered by Bing
© GeoNames, Microsoft, TomTom

2020 SSP Clients by HEP C, HIV/AIDS, Co-infection and TB Self-Reported Diagnosis, (N=5,794)



2020 SSP Clients HIV and Hep C Tested Within last 12 Months, Connecticut, (N = 5,794)

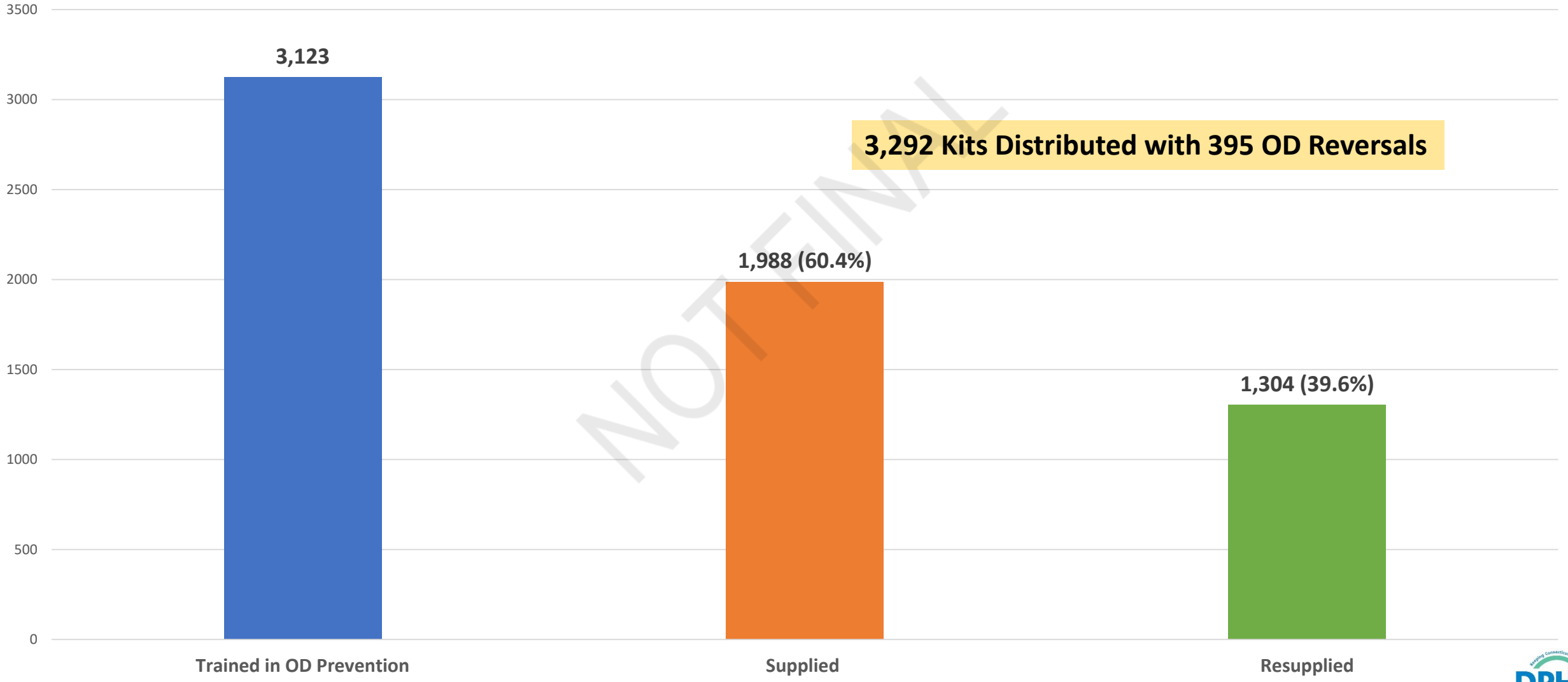


2020 SSP Clients Primary (n=3,256) and Secondary (n=981) Substance Used, Connecticut

Primary Substance Used		
Substance	**Injecting**	**Non-Injecting**
Heroin	2,021 (62.1%)	109 (3.3%)
Fentanyl	243 (7.5%)	17 (.5%)
Cocaine	139 (4.3%)	58 (1.8%)
Crack Cocaine	55 (1.7%)	555 (17%)
Methamphetamine	9 (.27%)	1 (.03%)
Steroids Anabolic	4 (.1%)	
Heroin Black Tar	2 (.06%)	
Prescription Opioids	2 (.06%)	2 (.06%)
Marijuana/Cannabis		26 (.8%)
Benzos		5 (.15%)
Oxy		1 (.03%)
Prescription Opioids		7 (.2%)

Secondary Substance Used		
Substance	**Injecting**	**Non-Injecting**
Cocaine	169 (17.2%)	47 (4.8%)
Heroin	109 (11%)	19 (2%)
Crack Cocaine	32 (3.3%)	534 (54.4%)
Fentanyl	30 (3%)	5 (.5%)
Methamphetamine	6 (.6%)	5 (.5%)
Benzos	1 (.1%)	3 (.3%)
Heroin Black Tar	1 (.1%)	
Oxy	1 (.1%)	
Marijuana/Cannabis		15 (1.5%)
Prescription Opioids		4 (.4%)

2020 SSP Clients Trained (n=3,123) in OD Prevention, Resupplied and Supplied with Naloxone Kit, Connecticut



Number of OD Kits Distributed (2016-2020)

SSP Clients

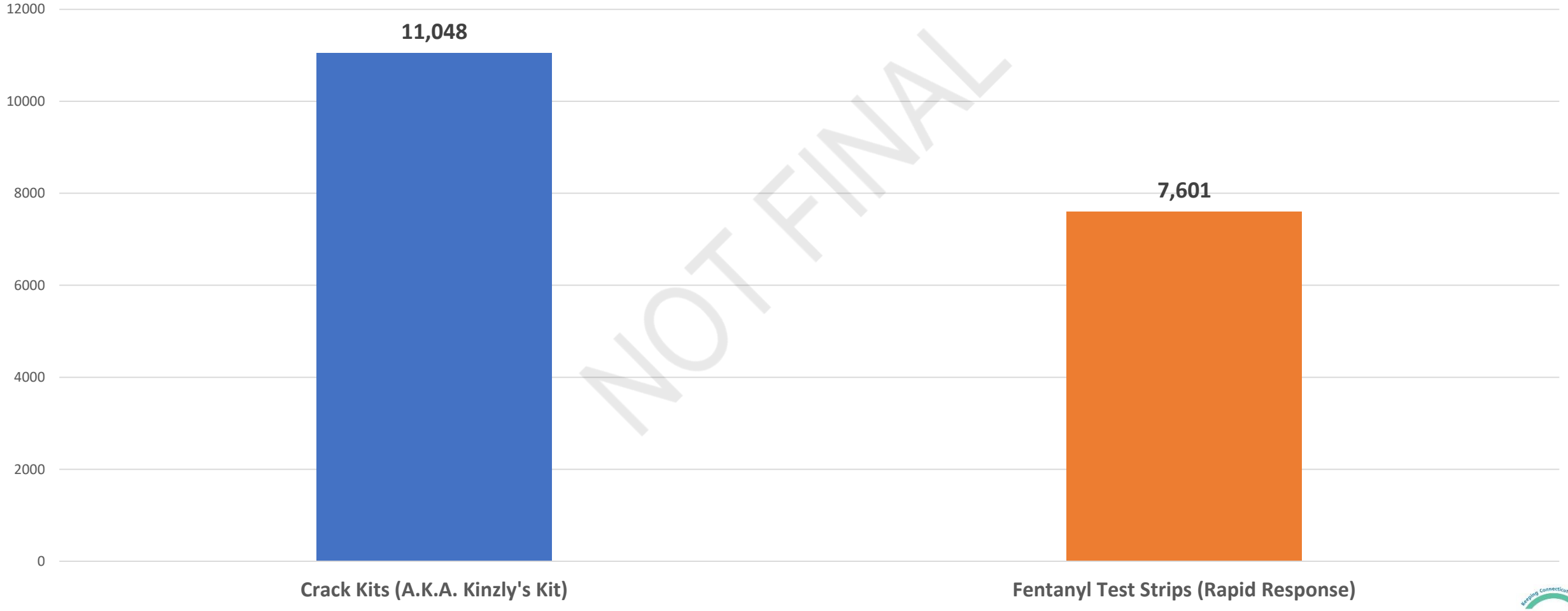
- YR 2016 - 1,301 Kits Distributed with 208 OD Reversals
- YR 2017 - 1,060 Kits Distributed with 158 OD Reversals
- YR 2018 - 515 Kits Distributed with 131 OD Reversals
- YR 2019 - 1,714 Kits Distributed with 274 OD Reversals
- YR 2020 - 3,292 Kits Distributed with 395 OD Reversals

Community Naloxone Distribution

- YR 2016 -3,210 Kits Distributed
- YR 2017 -2,122 Kits Distributed
- YR 2018 -408 Kits Distributed
- YR 2019 -2,602 Kits Distributed*
- YR 2020 -2,602 Kits Distributed*

* = DMHAS & DPH Community Naloxone Distribution Project, 2019 and 2020

2020 SSP Clients Fentanyl Test Strips (Rapid Response) and Crack Kits (A.K.A. Kinzly's Kit) Distributed, Connecticut, (N=5,794)



Pre and Post COVID-19 SSP Data

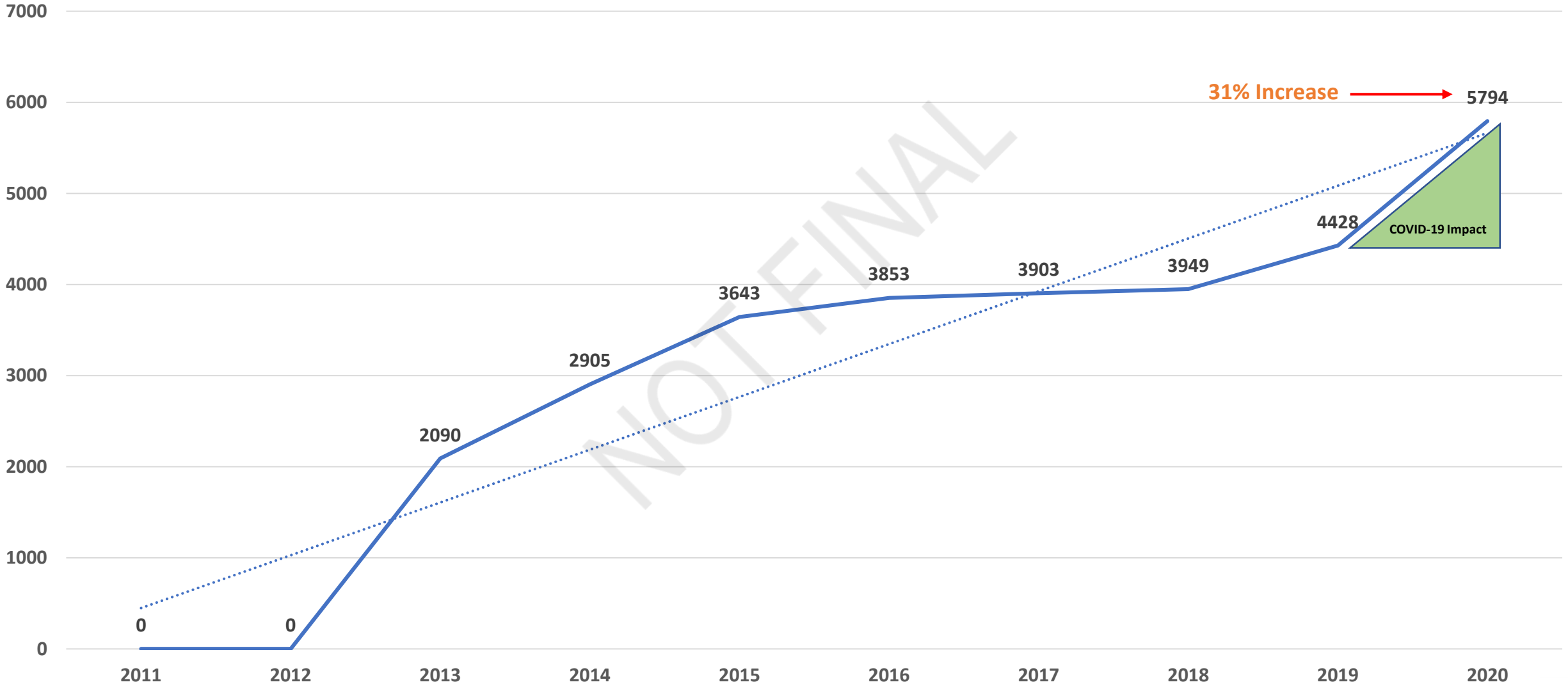
In 2019:

- **4,428** SSP Clients provided with harm reduction services
- **20,587** transactions by SSP clients
- **1,137,746** Syringes Dispensed
- **753,292** Syringes Collected
- **1,742** Narcan Kits Distributed (**Supply: 961**; **Resupply: 753**)

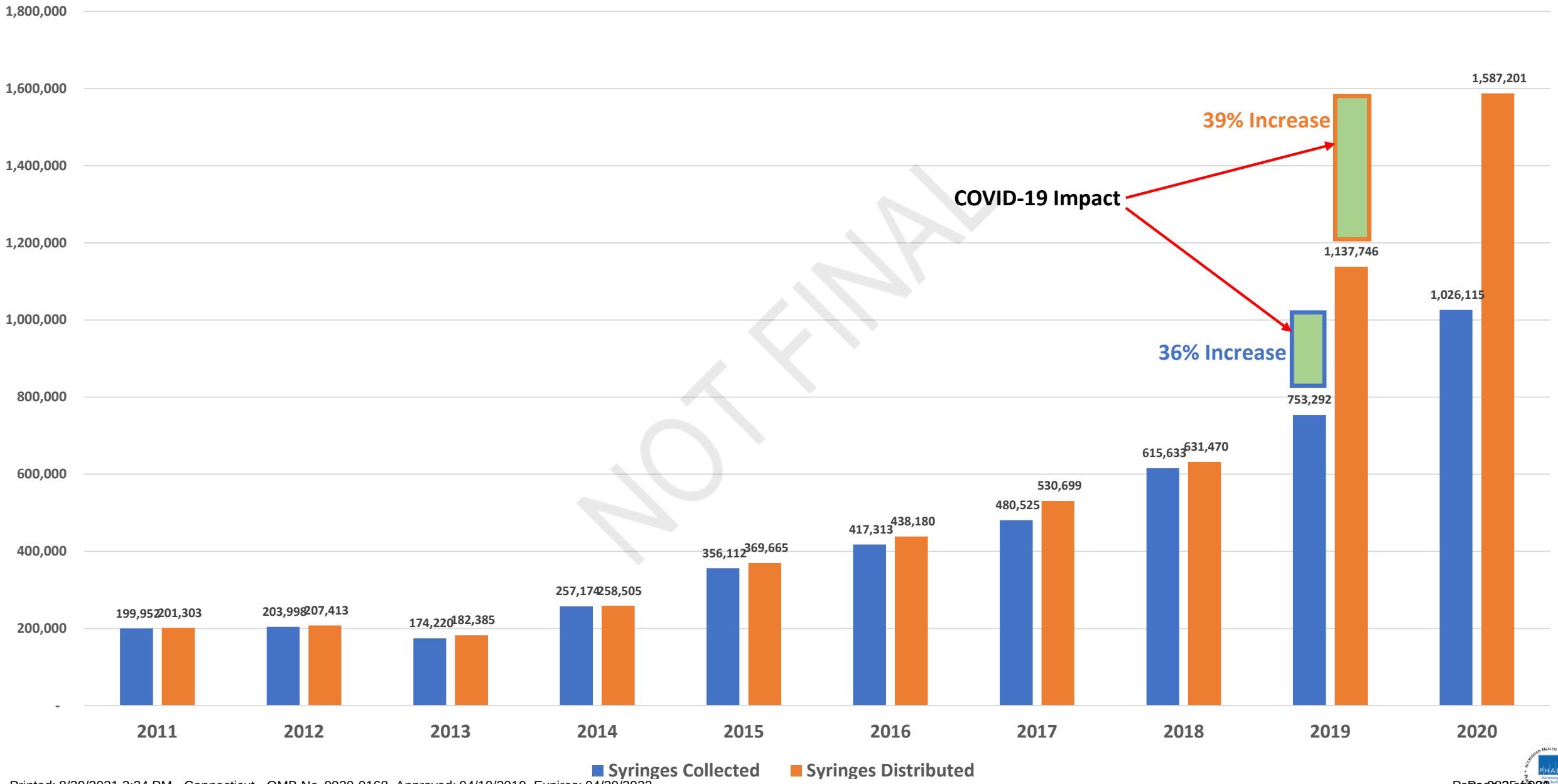
In 2020:

- **5,794** SSP Clients provided with harm reduction services ⬆
- **23,727** transactions by SSP clients ⬆
- **1,587,201** Syringes Dispensed ⬆
- **1,026,115** Syringes Collected ⬆
- **2,576** Narcan Kits Distributed (**Supply: 1,395**; **Resupply: 1,181**) ⬆

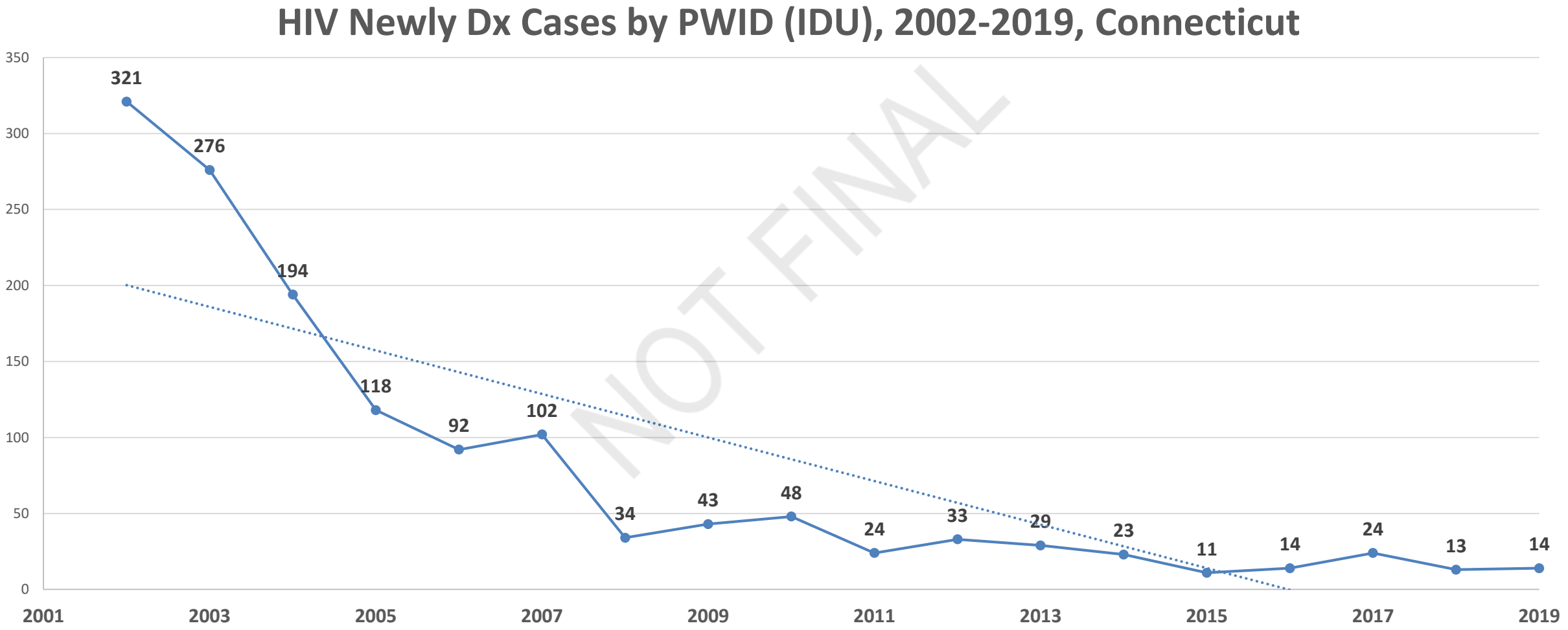
Trend of Total Number of Unique Clients who Visited SSPs, 2011 - 2020



Trend of SSPs' Syringes Collected vs Distributed, 2011 - 2020



SSPs Impact on HIV



In Conclusion: 2020 SSP Data by the Numbers

- **13 SSPs** providing drug user health services in Connecticut
- **5,794** SSP Clients provided with harm reduction services
- **1,587,201** Syringes Dispensed
- **1,026,115** Syringes Collected
- **23,727** transactions conducted by SSP clients
- **3,292** Narcan Kits Distributed
  (**Supply: 1,988**; **Resupply: 1,304; OD Kits Used: 395**)
- **11,048** Crack Kits distributed
- **7,601** Fentanyl Test Strips distributed
- **51** HIV positive clients provided SSP services
- **321** Hep C positive clients provided SSP services

Role of the DIS is in Drug User Health?

Suggested DIS Data Collection Variables for PWID, Crack Smoking Population and Sex Workers (A.K.A. Potential SSP Clients)

- Is client currently using an SSP (If not, next question)
- Last time a person used an SSP
- Name of SSP
- Town/location of SSP
- Was client referred to SSP
- Name of SSP client was referred to
- Town of SSP where client was referred to
- Date of the SSP referral

Sexual risk behaviors and STDs among persons who inject drugs: A national study

Kathryn A. Brookmeyer,* Laura T. Haderxhanaj, Matthew Hogben, and Jami Leichliter

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Abstract

Go to:

Opioid use and the rising case reports of STDs represent co-occurring epidemics; research indicates that persons who inject drugs (PWID) may be at increased risk for acquiring STDs. We use the National Survey of Family Growth (NSFG, 2011–2015) to examine the prevalence of risky sexual behaviors and STD diagnoses among PWID. We describe demographic characteristics, sexual behaviors, and self-reported STD diagnoses of sexually active women and men, separately, by whether they had ever engaged in injection-related behaviors (age 15–44; N = 9006 women, N = 7210 men). Results indicate that in 2011–15, 1.4% of women and 2.6% of men reported ever engaging in injection-related behaviors. Examining the full logistic regression models indicate that for women, sex with a PWID in the past 12 months (AOR = 5.8, 95% CI: 2.9, 11.7), exchanging money/drugs for sex in the past 12 months (AOR = 3.6, 95% CI: 1.2, 10.9), chlamydia and/or gonorrhea diagnosis in the past 12 months (AOR = 2.6, 95% CI: 1.2, 5.3), ever having a syphilis diagnosis (AOR = 8.5, 95% CI: 3.1, 23.4), and ever having a herpes diagnosis (AOR = 3.3, 95% CI: 1.0, 10.3) were associated with increased odds of engaging in injection-related behaviors. For men, sex with a PWID in the past 12 months (AOR = 10.9, 95% CI: 4.3, 27.7), ever being diagnosed with syphilis (AOR = 5.8, 95% CI: 1.8, 18.0), and ever being diagnosed with herpes (AOR = 2.7, 95% CI: 1.0, 7.1) were significantly associated with increased odds of engaging in injection-related behaviors. Future research may examine critical intervention points, including co-occurring factors in both STD acquisition and injection drug use.

Prev Med. Author manuscript; available in PMC 2019 Oct 28.
Published in final edited form as:

PMCID: PMC6816039
NIHMSID: NIHMS1055851

The End

Questions?

Thank you!

Special Thanks to all SSP staff!

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

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

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

Footnotes:

As of 2020 in Connecticut, there are 13 Syringe Services Programs (SSPs) in urban areas across the state. These SSPs are either funded (10) or supported with supplies (3) provided by the Connecticut Department of Public Health (DPH). In 2020, 1,587,201 syringes were distributed, and 1,026,115 syringes were collected. A total of 5,794 persons were served by SSPs, and approximately 7 out of 10 (69.6%) clients were new clients. New HIV cases in Connecticut continue to decline among PWIDs.
Given these circumstances, DMHAS is not proposing to use SABG funds for elements of SSPs.