Connecticut Department of Mental Health and Addiction Services

ANNUAL STATISTICAL REPORT

SFY 2020

Produced by the Evaluation, Quality Management, and Improvement Division

March 2021

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INTRODUCTION

The Evaluation, Quality Management and Improvement (EQMI) Division at the Department of Mental Health and Addiction Services (DMHAS) is pleased to publish its fifth Annual Statistical Report. The report provides information about the services the Department provides and the individuals served by our mental health and substance abuse system.

It is important to note that this report covers Fiscal Year 2020 (July 1, 2019 – June 30, 2020) and therefore a portion of the fiscal year does include the COVID-19 pandemic. Providers began making adjustments to their service delivery in March and April 2021 in order to be in compliance with public health safety recommendations. Thus, approximately three months of this fiscal year's data covers these pandemic-related business adjustments. We note that the Fiscal Year 2020 data does not indicate any significant changes in service utilization or delivery as a result of the pandemic. Largely, outpatient and community-based services were able to continue due to transitioning to telehealth service delivery platforms. Many congregate care settings needed to reduce their allowable capacities in order to observe social distancing in patient care areas, but because the pandemic accounts for just three months out of the twelve-month reporting period, annual data does not illustrate sharp declines in congregate care levels of care.

To develop this report, we used data taken from DMHAS' Enterprise Data Warehouse on November 23, 2020.

EQMI receives multiple requests for data from DMHAS staff, providers, legislative groups, researchers, and the media. This report makes key information more accessible to departmental stakeholders and the public; it includes data on clients served, demographic characteristics, types of services provided, residential and inpatient utilization, and substance use trends.

Special thanks to all of the EQMI staff and University of Connecticut School of Social Work contractors who assisted with this report. Karin Haberlin coordinated the development of the report, while Kristen Miller, Hsiu-Ju Lin, Jeff Johnson, and Xiulan Wu compiled, tested, and analyzed the data. Kristen Miller was responsible for writing the report.

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BACKGROUND

In this report, we summarize clients served and services provided by the Department of Mental Health and Addiction Services (DMHAS) during State Fiscal Year 2020. These data include clients served in DMHAS funded or DMHAS operated programs. The clients and the services are diverse, and the data is complex.

This report will, at different times, reflect numbers that refer to different subgroups or events that are based on *specific filtering of the data*. For instance, we frequently filter out programs that are not required to report treatment data when we present information from the Level of Care (LOC) perspective.

We also distinguish between clients and episodes. This distinction is important:

- **Client counts** are unduplicated counts in which each client is counted **once**.

- **Episode counts** represent an *episode of care* to a client – entailing admission, all services received, and discharge. Thus, an episode count is all activity that occurs within the context of an episode of care for a client at a particular program.

- Each client may have multiple episodes of care that occur within the fiscal year; thus, the client may be counted **multiple times** – once for each episode, if applicable.

- Thus, **Admissions and Discharges** are reported as **episode counts**, as many clients have multiple episodes.

- In addition, a client may be admitted to/enrolled in several programs simultaneously; therefore, *each* admission will be included in the overall Admission count below.

Figure 1 provides a visual representation of the different levels of analysis used in this report.

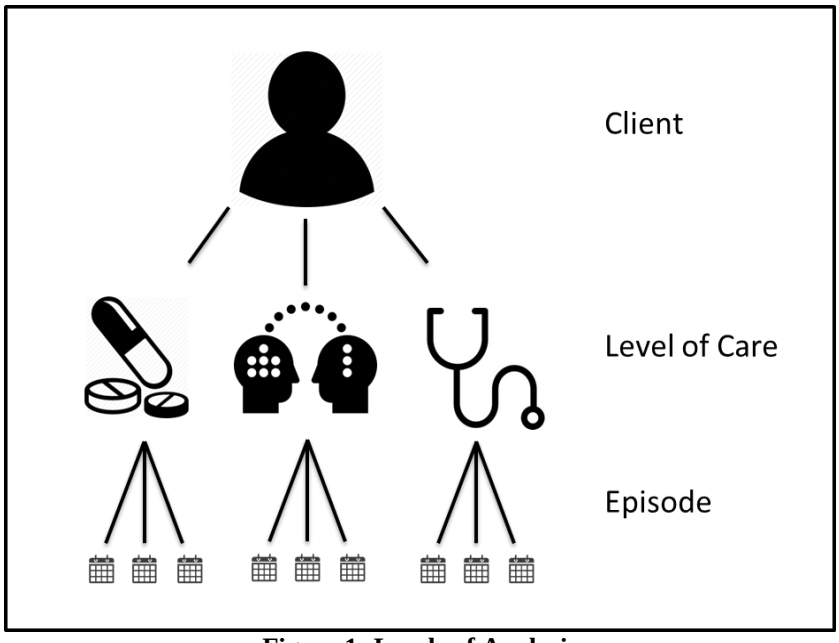


Figure 1: Levels of Analysis

In each section of the report, there is a brief description of what the counts represent.

The data contained in this report were taken from DMHAS' Enterprise Data Warehouse (EDW) on November 23, 2020. The data warehouse is a dynamic system, so reports or other analyses performed on different dates may produce slightly different results. **The numbers contained in this report are the official DMHAS data for SFY20.**

An Important Note Regarding SFY20 Data

We are frequently asked how the numbers presented in this report compare to reports generated by the Electronic Data Warehouse (EDW). Several levels of care (LOCs) are **not** included in these analyses, including Pre-Admit, Recovery Support and Other. These LOCs may be included in EDW reports, thus resulting in potential discrepancies when comparing numbers.

It is also important to note that this report only includes data from **DMHAS funded and operated programs**. EDW reports allow the user to included non-funded programs that are required to report per state statute.

DMHAS SFY20 Annual Statistical Data - Quick Facts

Program Type	Unduplicated Client Count
Mental Health Programs	52,078
Substance Abuse Programs	54,620
Total Unduplicated Count	99,715

Race	Unduplicated Client Count	%
White/Caucasian	61,109	61%
Black/African American	16,220	16%
Other	22,386	22%

Ethnicity	Unduplicated Client Count	%
Latino/Hispanic Identity	20,808	21%

Gender	Unduplicated Client Count	%
Male	58,584	59%
Female	40,641	41%
Transgender	21	0%
Unknown	469	0.5%

Level of Care	Unduplicated Client Count
MH Inpatient	979
MH Residential	1,983
MH Outpatient levels of care (see p. 13)	51,465
SA Inpatient (Detox)	1,954
SA Residential Rehab	9,192
SA Outpatient levels of care (see p. 16)	50,049

Primary Drug at MH or SA Admission – All SFY20 *Active*	N	%
Alcohol	28,724	36%
Heroin/Other Opioids	29,313	37%
Marijuana/Hashish/THC	10,463	13%

Primary Drug at MH or SA Admission – SFY20 *Admissions*	N	%
Alcohol	17,959	40%
Heroin/Other Opioids	15,797	35%

Major Diagnosis Categories	N	%
Serious Mental Illness (SMI) (includes PTSD)	43,958	59%
SA diagnosis	47,613	67%
Dual diagnosis (SMI + SA)	22,043	31%

Most Common MH Diagnosis Categories	N	%
Depressive Disorders	16,579	17%
Schizophrenia Spectrum and Other Psychotic Disorders	14,065	14%
Bipolar and Related Disorders	11,236	11%

DATA SUMMARIES

Clients

- During State Fiscal Year 2020 (July 1, 2019 – June 30, 2020), the Department of Mental Health and Addiction Services served **99,715** people.
    - **54,620** clients were treated in **Substance Abuse (SA)** programs
        - 47,637 in only SA programs,
        - 6,983 received a combination of SA and MH services
    - **52,078** clients were served in **Mental Health (MH)** programs
        - 45,095 in only MH programs
        - 6,983 received a combination of SA and MH services
    - **6,983** received services from **both MH and SA** programs during SFY20.[1]

Admissions

- There were **87,521 admissions** (each client may have a single or multiple admissions) to DMHAS operated or DMHAS funded programs.
- **68%** of clients had a **single SA program admission** during SFY20.
- **71%** of clients had a **single MH program admission** during SFY20.
- There were **17,279** more admissions to Substance Abuse programs than to Mental Health programs.

Discharges

During this same timeframe:

- There were **88,214** discharges from DMHAS operated or DMHAS funded programs. This does not necessarily mean that clients were discharged from the DMHAS system completely, but simply that an episode of treatment within a program ended.
- There were **15,354** more discharges from SA programs than from MH programs.

Open Episodes

- **51,668** episodes of care (covering **43,703** clients) were **open for the entire fiscal year** (admitted prior to SFY20 and not yet discharged by the end of SFY20).

[1] Note that receiving services from both program types does not imply that these clients have a dual diagnosis.

Table 1: SFY20 Episode Counts

Episode counts	SA	MH	Total
Admission	52,400	35,121	87,521
Discharge	51,784	36,430	88,214
Open*	19,536	32,132	51,668
Total	84,432	81,926	166,358

* Open-episode --started prior to FY20 and not yet discharged by 6/30/20

Table 2: Unduplicated Clients

Unduplicated Clients	SA	MH	Both	Total
Admissions	25,909	19,450	3,914	49,273
Discharges	26,734	21,788	3,896	52,418
Open	18,223	24,717	763	43,703
Unduplicated Clients	47,637	45,095	6,983	99,715

The tables below provide the same basic information as above, but have differentiated the data by DMHAS Human Services Agreement providers and State Operated facilities.

Table 3: DMHAS Human Services Agreement vs. State Operated – Episode Counts

Episode Counts	Funding source	SA	MH	Total
Admission	DMHAS Human Services Agreement	49,630	24,622	74,252
	DMHAS-operated	2,770	10,499	13,269
	Total	52,400	35,121	87,521
Discharge	DMHAS Human Services Agreement	48,865	25,175	74,040
	DMHAS-operated	2,919	11,255	14,174
	Total	51,784	36,430	88,214
Open	DMHAS Human Services Agreement	19,470	24,833	44,303
	DMHAS-operated	66	7,299	7,365
	Total	19,536	32,132	51,668

Table 4: DMHAS Human Services Agreement vs. State Operated - Unduplicated Clients

Unduplicated Clients	Funding source	SA	MH	Both	Total
Admissions	DMHAS Human Services Agreement	24,545	13,857	2,622	41,024
	DMHAS-operated	529	4,803	133	5,465
	Both	835	790	1,159	2,784
	Total	25,909	19,450	3,914	49,273
Discharge	DMHAS Human Services Agreement	25,236	15,215	2,596	43,047
	DMHAS-operated	682	5,689	96	6,467
	Both	816	884	1,204	2,904
	Total	26,734	21,788	3,896	52,418
Open	DMHAS Human Services Agreement	18,172	18,954	650	37,776
	DMHAS-operated	50	4,501	9	4,560
	Both	1	1,262	104	1,367
	Total	18,223	24,717	763	43,703
Total	DMHAS Human Services Agreement	46,203	33,617	4,993	84,813
	DMHAS-operated	573	8,492	131	9,196
	Both	861	2,986	1,859	5,706
	Total	47,637	45,095	6,983	99,715

DEMOGRAPHICS OF CLIENTS SERVED

The data presented in the Demographics section includes all clients served by DMHAS. The values represent unduplicated client counts (each client counted once) within program type (SA only, MH only or both SA & MH). The statewide total is a fully unduplicated client count. The narrative will generally discuss the results in terms of SA and MH programs; the counts under the "Both" category are added into the SA and MH counts to include everyone who received SA services or MH services.

Table 5: Gender

Gender	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
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%

- Statewide, more males received DMHAS services than females (59% vs 41%).
- In SA specific programs, there were twice as many male clients than female clients (31,530 (66%) and 15,675 (33%) respectively).

- Within MH specific programs, the ratio of men to women was almost equal (22,739 (50.4%) and 23,300 (49.5%) respectively).
- Additionally, clients who received both MH and SA services were more likely to be male (62% vs. 38% female). These patterns across program type have been observed since SFY13.

Table 6: Race

Race	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
American Indian/Native Alaskan	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/Other 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%
Multi-race	255	0.5%	214	0.5%	46	0.7%	515	0.5%
Missing/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%

- Of the total number of statewide clients served in FY 2020, 61% were White/Caucasian.
- With the addition of the next two largest groups, Black/African Americans and Other Race (at 16% and 15% respectively; this accounted for 92% of clients served.
- The distribution of clients by race was somewhat less consistent across SA and MH treatment programs, but follows the same pattern as in FY19. Within MH clients, White/Caucasian clients were the most represented in treatment, followed by Black/African American and Other. Within SA clients, the majority of clients are still White/Caucasian, but there were slightly more clients in the Other category than the Black/African American category.
- According to state population estimates on July 1, 2019, White/Caucasians represent 69.5% of Connecticut residents (reported as "White Alone, not Hispanic or Latino") and are thus underrepresented in the DMHAS population. Black/African Americans represent 12.2% of CT residents and thus are overrepresented in DMHAS data.[2]

[2] Data retrieved from https://www.census.gov/quickfacts/fact/table/CT/PST045216 on February 10, 2021.

Table 7: Ethnicity

Ethnicity	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
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%
Non-Hispanic	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%

- Of the total number of clients served by DMHAS, 21% were of Hispanic/Latino ethnicity; 16.9% of Connecticut residents are Hispanic or Latino, meaning that they are overrepresented in the DMHAS data.
- The largest group of Hispanic/Latino consumers was of Puerto Rican origin (12%).
- Statewide, 69% of clients receiving DMHAS services were not of Hispanic/Latino ethnicity. The distribution of ethnic origin across SA/MH programs was generally equivalent, with slightly more consumers in Substance Abuse programs (+2.2%) being of Hispanic/Latino origin.
- Non-Hispanic clients represented a slightly larger proportion (+7.6%) of mental health clients than substance abuse clients. These patterns have remained consistent for the past eight years.

Table 8: Age

Age	SA		MH		Both		Statewide Total	
	N	%	N	%	N	%	N	%
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%
missing/unknown/errors	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%

- Average age of DMHAS clients is 43.2 years (± 14.5)
- Average age of clients receiving MH services is 46.3 years (±15.7)
- Average age of clients receiving SA services is 40.3 years (±12.9)
- Average age of clients receiving both MH and SA services is 42.5 Years (±12.1)

- Younger clients (up to age 44) were more likely to receive Substance Abuse services, while older clients (45 and over) were more likely to receive Mental Health services.
- Among clients receiving mental health services, the largest age group was 55 to 64 years, while most frequent age group for Substance Abuse clients was the 26 to 34 age range.
- Of clients receiving treatment, few were 65 years or older with the majority of them in Mental Health services. As with other demographics, the age trend patterns have remained steady over the last eight years.

LEVEL OF CARE (LOC) DATA

The data presented in the Level of Care section include clients served by DMHAS funded and operated programs that are required to submit treatment data to DMHAS.

- The client counts represent unique (unduplicated) clients.
- The admission and discharge counts are based on episodes of care and represent duplicated client counts – each admission or discharge is counted once, but a client may have multiple admissions and/or discharges.
- To reduce the chance of confusion between unduplicated client count and admission/discharge counts (they all are counts based on clients), the number of clients admitted or discharged are referred to as 'admissions' or 'discharges' (versus 'clients admitted').

Substance Abuse Inpatient and Residential

Ten thousand two hundred sixty-eight (10,268) clients received Substance Abuse Inpatient and Residential services, which is 10% of all DMHAS clients served. Most (90%) of these clients were in the residential LOC. There were 18,149 admissions to SA inpatient or residential programs and 18,349 discharges during this timeframe.

Table 9: Substance Abuse Inpatient/Residential LOCs

11a. Active Clients		Total	%
Addiction	Inpatient Services	1,954	19%
	Residential Services	9,192	90%
Total SA		10,268	*

* Total SA represents an unduplicated client count and since a client may counted in multiple categories, it is not the sum of the subcategories

11b. Admissions		Total	%
Addiction	Inpatient Services	2,607	14%
	Residential Services	15,542	86%
Total SA		18,149	100%

11c. Discharges		Total	%
Addiction	Inpatient Services	2,726	15%
	Residential Services	15,623	85%
Total SA		18,349	100%

Substance Abuse Outpatient

For each LOC listed, we provide the unduplicated client count as well as the (fully unduplicated) total client count for all listed LOCs. Clients who received services from more than one LOC are counted in each relevant LOC.

Fifty thousand forty-nine (50,049) clients received SA Outpatient services in SFY20. This represents 50% of all DMHAS clients. Clients may be served in multiple LOCs:

- Outpatient SA programs (37%)
- Forensic SA community based (consisting of almost exclusively of Pre-Trial Intervention) (29%)
- Medication Assisted Treatment programs (29%)

There were 34,251 admissions to SA Outpatient LOCs during the Fiscal Year. This represents 39% of all admissions. Three-quarters of all of the admissions were to:

- Standard Outpatient (40%)
- Medication Assisted Treatment (18%)
- Forensic SA community based (Pre-Trial Intervention) services (16%)

There were also 33,435 discharges during SFY20. This represents 38% of total DMHAS discharges. Three-quarters of all of the discharges were from:

- Standard Outpatient (36%)
- Pre-Trial Intervention services (20%)
- Medication Assisted Treatment (18%)

Table 10: Substance Abuse Outpatient LOCs

12a. Active Clients		Total	%
Addiction	Case Management	4,303	9%
	Consultation	73	0%
	Employment Services	1,135	2%
	Intake	1,019	2%
	IOP	3,282	7%
	Medication Assisted Treatment	14,728	29%
	Outpatient	18,696	37%
	PHP	137	0%
Forensic SA	Case Management	531	1%
	Forensics Community-based	14,387	29%
Total SA		50,049	*

* Total SA represents an unduplicated client count and since a client may counted in multiple categories, it is not the sum of the subcategories

12b. Admissions		Total	%
Addiction	Case Management	2,885	8%
	Consultation	62	0%
	Employment Services	748	2%
	Intake	1,225	4%
	IOP	3,426	10%
	Medication Assisted Treatment	6,203	18%
	Outpatient	13,590	40%
	PHP	129	0%
Forensic SA	Case Management	466	1%
	Forensics Community-based	5,517	16%
Total SA		34,251	100%

12c. Discharges		Total	%
Addiction	Case Management	2,731	8%
	Consultation	36	0%
	Employment Services	674	2%
	Intake	1,225	4%
	IOP	3,661	11%
	Medication Assisted Treatment	5,867	18%
	Outpatient	12,043	36%
	PHP	140	0%
Forensic SA	Case Management	481	1%
	Forensics Community-based	6,577	20%
Total SA		33,435	100%

Mental Health Inpatient and Residential

DMHAS served 2,749 clients in mental health inpatient and residential programs, with 1,295 admissions and 1,355 discharges during SFY20. The majority (72%) of these clients were in residential LOCs.

Table 11: MH Inpatient/Residential LOCs

9a. Active Clients		Total	%
Forensic MH	Inpatient Services	388	14%
	Residential Services	35	1%
Mental Health	Inpatient Services	591	21%
	Residential Services	1,948	71%
Total MH		2,749	*

* Total MH represents an unduplicated client count and since a client may counted in multiple categories, it is not the sum of the subcategories

9b. Admissions		Total	%
Forensic MH	Inpatient Services	172	13%
	Residential Services	25	2%
Mental Health	Inpatient Services	355	27%
	Residential Services	743	57%
Total MH		1,295	100%

9c. Discharges		Total	%
Forensic MH	Inpatient Services	216	16%
	Residential Services	29	2%
Mental Health	Inpatient Services	369	27%
	Residential Services	741	55%
Total MH		1,355	100%

Mental Health Outpatient

- For each LOC listed, we provide the unduplicated client count as well as the (fully unduplicated) total client count for all listed LOCs.
- Clients who received services from more than one LOC are counted in each relevant LOC.

Fifty-one thousand four hundred and sixty-five (51,465) clients received services in outpatient levels of care, which is 52% of all DMHAS clients served.

- The majority of clients (61%) were served in a Standard Outpatient MH program, followed by
    - Case Management (13%)
    - Social Rehabilitation (12%)
    - Crisis (11%)
    - Community Support (11%)

There were 33,826 admissions to MH Outpatient LOCs during the Fiscal Year, which is 39% of all DMHAS admissions. Over half of all admissions were to two specific LOCs:

- Standard Outpatient (31%)
- Crisis Services (25%)

There were also 35,075 discharges during SFY20, which represents 40% of all DMHAS discharges. Over half of all discharges were from two specific LOCs:

- Standard Outpatient (34%)
- Crisis Services (24%)

Table 12: Mental Health Outpatient LOCs

10a. Active Clients		Total	%
Forensic MH	Case Management	48	0%
	Crisis Services	27	0%
	Forensics Community-based	3,762	7%
	Outpatient	501	1%
Mental Health	ACT	1,334	3%
	Case Management	6,635	13%
	Community Support	5,455	11%
	Consultation	743	1%
	Crisis Services	5,744	11%
	Education Support	248	1%
	Employment Services	3,460	7%
	Housing Services	392	1%
	Intake	3,633	7%
	IOP	179	0%
	Outpatient	31,636	61%
	Prevention	353	1%
	Social Rehabilitation	6,158	12%
Total MH		51,465	*

* Total MH represents an unduplicated client count and since a client may counted in multiple categories, it is not the sum of the subcategories

10b. Admissions		Total	
Forensic MH	Case Management	16	0%
	Crisis Services	25	1%
	Forensics Community-based	2,824	8%
	Outpatient	206	1%
Mental Health	ACT	353	1%
	Case Management	2,491	7%
	Community Support	1,682	5%
	Consultation	231	1%
	Crisis Services	8,294	25%
	Education Support	108	0%
	Employment Services	1,600	5%
	Housing Services	90	0%
	Intake	3,666	11%
	IOP	173	0%
	Outpatient	10,648	11%
	Social Rehabilitation	1,419	4%
Total MH		33,826	100%

10c. Discharges			Total
Forensic MH	Case Management	24	0%
	Crisis Services	21	0%
	Forensics Community-based	2,753	8%
	Outpatient	235	1%
Mental Health	ACT	390	1%
	Case Management	2,516	7%
	Community Support	1,707	5%
	Consultation	225	1%
	Crisis Services	8,258	24%
	Education Support	93	0%
	Employment Services	1,698	5%
	Housing Services	76	0%
	Intake	3,665	10%
	IOP	195	1%
	Outpatient	11,830	34%
	Prevention	33	0%
	Social Rehabilitation	1,356	4%
Total MH		35,075	100%

BED CAPACITY AND UTILIZATION

Data for this section were downloaded from the EDW on November 23, 2020. Bed Capacity represents the total number of DMHAS-operated and DMHAS-funded beds available within a Level of Care. Utilization is defined as the number of days each bed is in use during the SFY. Statewide utilization represents the total number of days each bed is used (sum # days used across all beds) divided by the total number of bed days (# beds * # days in FY)

- For each LOC, we provide the number of beds available statewide and the average utilization rate for those beds.
- For example, in Group Homes, there are 177 beds available, and they were in use 95% of the time
- Bed Utilization by Region data are located in Appendix A.

Table 13: Bed Capacity and Utilization

13a. MH Inpatient	Bed Capacity	State Avg. Utilization
Acute Psychiatric	328	90%
Acute Psychiatric - Intermediate	11	69%
Non-Certified Subacute	16	99%
Forensic MH Acute Psychiatric	232	94%

** Includes only State Operated programs*

13b. MH Residential	Bed Capacity	State Avg. Utilization
Group Home	177	95%
Intensive Residential	175	93%
Supervised Apartments	636	92%
Transitional	36	84%
13c. SA Inpatient	**Bed Capacity**	**State Avg. Utilization**
Intensive Res. Rehabilitation 3.8	111	94%
Medically Managed Detox 4.2	41	83%
13d. SA Residential	**Bed Capacity**	**State Avg. Utilization**
Intermediate/Long Term Res.Tx 3.5	500	94%
Long Term Care 3.3	50	95%
Medically Monitored Detox 3.7D	112	84%
SA Intensive Res. Rehabilitation 3.7	155	94%
SA Intensive Residential - Enhanced	59	91%
Transitional/Halfway House 3.1	84	87%

PRIMARY DRUG USE

The data in these tables represent the primary drug reported at admission to treatment related programs. Some clients do not report drug use (primarily MH programs), thus they are not included in the data analyses for this section of the report.

These counts do not represent unduplicated clients, as each client may have multiple admissions during the SFY.

- The admission totals in these tables are different from those in the previous section, because these data include *all LOCs* and the previous section pertained only to selected LOCs.
- Table 14 includes active clients – anyone *treated* during the fiscal year regardless of when they were admitted. Table 15 includes only those clients who had an admission during the fiscal year.

Across all active clients in DMHAS funded and operated treatment related (SA and MH) programs, **alcohol and heroin were the most frequently reported primary drug** (36% and 31% respectively) at the time of admission. If other opiates and synthetics are grouped with heroin, 37% of all primary drugs reported at admission involve an opioid. **Marijuana/hashish/THC** was the third most frequently reported drug at 13%; all other drugs were reported as primary at less than 8% of all admissions.

Among admissions to SA programs, **heroin** (40%) was the most frequently reported primary drug. **Alcohol** was reported as the primary drug in 32% of admissions. **Heroin and other opiates account for the primary drug reported at 48% of all SA admissions.** Note that Table 14 provides a description of the client population based on the drug that was reported as preferred *at the time of admission;* the admission may have occurred some time ago and thus Table 15 is provided on the next page to describe the drug of choice for admissions during the current FY.

During admission to MH programs, **alcohol** was reported as the primary drug for almost half of the admissions (47%). The second most frequently reported drug during admission to MH programs was **marijuana/hashish/THC** (23%).

Table 14: Primary Drug at Admission – All Active Clients Who Reported a Drug at Admission

	SA		MH		Total	
	# Admissions	%	# Admissions	%	# Admissions	%
Alcohol	17,921	31.6%	10,803	47.2%	28,724	36.1%
Heroin	22,880	40.4%	1,687	7.4%	24,567	30.9%
Marijuana, Hashish, THC	5,295	9.4%	5,168	22.6%	10,463	13.2%
Cocaine	3,769	6.7%	2,079	9.1%	5,848	7.4%
None	874	1.5%	430	1.9%	1,304	1.6%
Other Opiates and Synthetics	4,087	7.2%	659	2.9%	4,746	6.0%
Other Substances*	1,741	3.1%	1,324	5.8%	3,065	3.8%
Unknown	57	0.1%	730	3.2%	787	1.0%
Total	56,624	100%	22,880	100%	79,504	100%

*This category includes benzodiazepines, PCP, amphetamines, hallucinogens, non-prescription methadone, other sedatives or hypnotics, barbiturates, inhalants, methamphetamines, other stimulants, over the counter, tobacco, and tranquilizers.

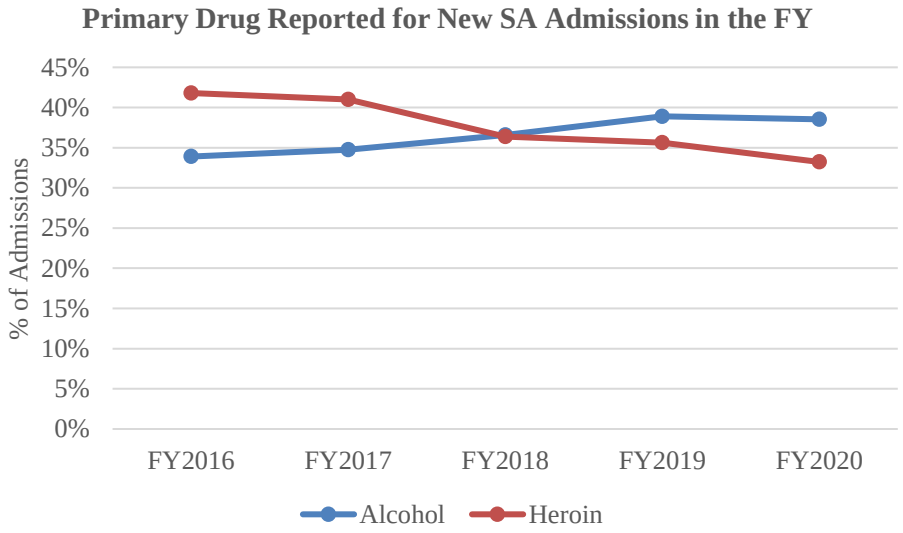
Table 15: Primary Drug at Admission - New Admissions with Drug Reported

	SA		MH		Total	
	# Admissions	%	# Admissions	%	# Admissions	%
Alcohol	14,370	38.5%	3,589	45.2%	17,959	39.7%
Heroin	12,386	33.2%	815	10.3%	13,201	29.2%
Marijuana, Hashish, THC	3,604	9.7%	2,004	25.2%	5,608	12.4%
Cocaine	2,896	7.8%	765	9.6%	3,661	8.1%
None	432	1.2%	122	1.5%	554	1.2%
Other Opiates and Synthetics	2,307	6.2%	289	3.6%	2,596	5.7%
Other Substances*	1,263	3.4%	354	4.5%	1,617	3.6%
Unknown	19	0.1%	27	0.2%	46	0.1%
Total	37,277	100%	7,965	100%	45,242	100%

*This category includes benzodiazepines, PCP, amphetamines, hallucinogens, non-prescription methadone, other sedatives or hypnotics, barbiturates, inhalants, methamphetamines, other stimulants, over the counter, tobacco, and tranquilizers.

When looking specifically at program admissions during SFY20 (Table 15 above), alcohol is the most frequent primary drug at admission (40%) with heroin reported by 29% of clients. In SFY16 alcohol and heroin were effectively tied (35% each) as the most frequent primary drug reported by clients admitted in that FY. Since SFY17, alcohol became and continues to be the most frequently reported primary drug at admission.

Overall, the trend in primary drug reported for all new admissions to SA programs has shifted over the past five years. In SFY16 and again in SFY17, new admissions reported heroin as the most frequently reported drug. In SFY18, alcohol and heroin were reported equally as often during new admissions. By SFY19, alcohol was the most frequently reported drug (39%), followed by heroin (37%). In FY20, the gap widened with alcohol as the most frequently reported drug (39%), followed by heroin (33%).



As reported in the last few years, more active clients in SA programs reported heroin and other opioids (48%) than did new admissions in SFY20 (39%). This is due to the number of clients who stayed in long-term methadone maintenance (Medication Assisted Treatment) programs.

DIAGNOSIS

Diagnosis data come from treatment related programs, and reflect the *most recent primary diagnosis* during the *most recent episode of care* that was open during the fiscal year.

These values represent *an unduplicated client count* within each diagnostic category.

Table 16: Primary Diagnostic Category for Treatment Related Programs[3]
Note: clients may have more than one primary diagnosis

Rank	Diagnosis	Frequency	%
1	Substance-Related and Addictive Disorders	39,116	39.5%
2	Depressive Disorders	16,579	16.8%
3	Schizophrenia Spectrum and Other Psychotic Disorders	14,065	14.2%
4	Bipolar and Related Disorders	11,236	11.4%
5	Trauma- and Stressor-Related Disorders	7,644	7.7%
6	Anxiety Disorders	4,860	4.9%
7	Neurodevelopmental Disorders	1,496	1.5%
8	Other Mental Disorders	810	0.8%
9	Disruptive, Impulse-Control, and Conduct Disorders	632	0.6%
10	Diagnosis Deferred On This Axis	590	0.6%
11	Obsessive-Compulsive and Related Disorders	576	0.6%
12	Other Conditions That May Be a Focus of Clinical Attention	462	0.5%
13	Personality Disorders	410	0.4%
14	Neurocognitive Disorders	231	0.2%
15	Feeding and Eating Disorders	43	0.0%
16	Somatic Symptom and Related Disorders	42	0.0%
17	Dissociative Disorders	35	0.0%
18	Paraphilic Disorders	35	0.0%
19	Sleep-Wake Disorders	28	0.0%
20	Gender Dysphoria	24	0.0%
21	Sexual Dysfunctions	4	0.0%
22	Elimination Disorders	1	0.0%
23	**Total**	**98,919**	**100%**

[3]Based on DSM V classification groups, using the most recent primary dx from the latest episode in SFY20, unduplicated cases with dx info, N=98,919

Table 17 presents the diagnosis data rolled up to SMI, SA, and Dual diagnoses. These are not unduplicated client counts and include both primary and non-primary diagnosis from the most recent treatment episode. Serious mental illness (SMI) includes the same diagnoses that qualify for Targeted Case Management (TCM) services.

Table 17: Serious Mental Illness (SMI) and SA Diagnosis Prevalence

17. Based on Primary and Non-Primary Diagnoses	FY20	
	N	%
SMI (includes PTSD)	43,958	62.0%
SA	47,613	67.1%
Dual diagnosis (SMI+SA)	23,679	33.4%

- Almost two-thirds (62%) of the clients qualify for an SMI (serious mental illness) diagnosis.
- Two out of three clients (67%) have a substance use/abuse disorder.
- One-third (33%) of clients qualify for a dual diagnosis, meaning that they have both an SMI diagnosis and a substance abuse diagnosis.

YOUNG ADULT SERVICES (YAS)

DMHAS YAS serves the most acute, high-risk cohort of young adults in the state of Connecticut between the ages of 18 and 25. Early intervention with young people experiencing behavioral health problems can reduce the likelihood of future disability, increase the potential for productive adulthood, and avoid life-long service costs and other adverse consequences. YAS continues to not only focus on meeting the needs of youth transitioning out of the Department of Children and Families (DCF) system into the DMHAS adult treatment system, but also accepts referrals from other community sources. These data represent unduplicated client counts. Clients are counted as YAS clients as long as they receive any YAS services.

In SFY20, **YAS** programs served **1,160** (10.8% of total 18-25 DMHAS population). To provide context, we present client numbers in different DMHAS subgroups below. Client counts are unduplicated within each subgroup, but not across subgroups.

Table 18: Young Adult Clients

ALL 18-25	SA 18-25	MH 18-25	Young Adult Services
10,750	5,599	5,644	1,160

- The majority of YAS clients (72%) live in a private residence.
- More than one-third (42.1%) of YAS clients were employed at program discharge. Employment data comes from the Outcomes at Discharge report produced by the UCONN School of Social Work.
- There were 292 clients discharged from YAS in FY20

Living Situation for YAS Clients Based on Periodic Assessment Data

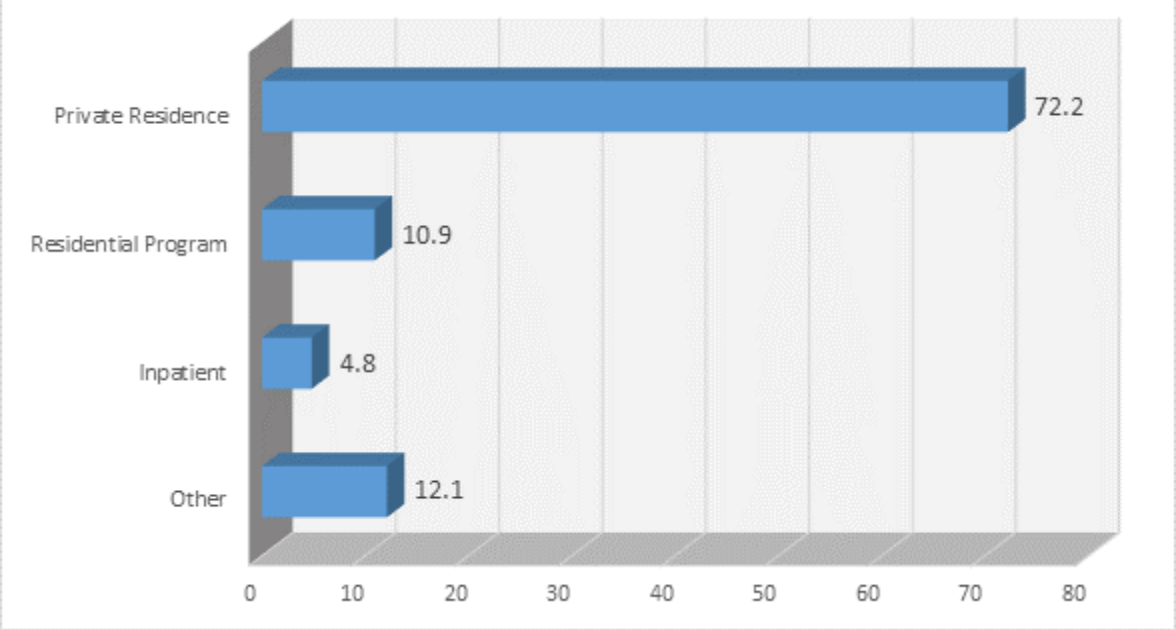


Figure 2: Living Situation for YAS Clients in SFY20

APPENDIX A. SFY20 Bed Capacity and Utilization by Region

Addiction		Region											
		1		2		3		4		5		Statewide	
LOC Type	LOC Mode	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%
Inpatient Services	Intensive Res. Rehabilitation 3.8	-	-	111	76%	-	-	-	-	-	-	111	76%
	Medically Managed Detox 4.2			41	64%	-	-	-	-	-	-	41	64%
Residential Services	AIDS Residential	15	96%	10	78%	-	-	9	65%	-	-	34	83%
	Intermediate/Long Term Res.Tx 3.5	63	105%	142	90%	148	82%	35	92%	82	115%	470	93%
	Long Term Care 3.3	-	-	-	-	-	-	-	-	50	96%	50	96%
	Medically Monitored Detox 3.7D	-	-	43	101%	20	75%	35	87%	14	103%	112	92%
	Recovery House	21	82%	37	84%	10	78%	58	68%	69	88%	195	80%
	SA Intensive Res. Rehabilitation 3.7	25	89%	34	122%	-	-	28	97%	40	95%	127	102%
	SA Intensive Residential - Enhanced	23	89%	-	-	16	82%	-	-	20	86%	59	86%
	Shelter	34	99%	90	85%	-	-	44	98%	-	-	168	91%
	Transitional/Halfway House 3.1	6	75%	-	-	34	87%	15	92%	14	98%	69	90%

(See next page for Mental Health)

Forensic MH		Region											
		1		2		3		4		5		Statewide	
LOC Type	LOC Mode	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%
Crisis Services	Respite Bed	3	83%	2	52%	-	-	-	-	4	66%	9	69%
	Acute Psychiatric	-	-	232	92%	-	-	-	-	-	-	232	92%
Residential Services	MH Intensive Res. Rehabilitation	-	-	6	58%	-	-	-	-	-	-	6	58%
	Transitional	-	-	11	79%	-	-	-	-	-	-	11	79%

Mental Health		Region											
		1		2		3		4		5		Statewide	
LOC Type	LOC Mode	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%	Cap	%
ACT	Assertive Community Treatment	-	-	10	81%	-	-	-	-	-	-	10	81%
Case Management	Supportive Housing – Dev	-	-	-	-	16	162%	-	-	-	-	16	162%
Crisis Services	Respite Bed	10	98%	35	71%	-	-	20	87%	26	34%	91	67%
Inpatient Services	Acute Psychiatric	62	99%	264	88%	2	32%	-	-	-	-	328	90%
	Acute Psychiatric - Intermediate	8	59%	-	-	3	14%	-	-	-	-	11	47%
	Non-Certified Subacute	-	-	-	-	-	-	16	99%	-	-	16	99%
Residential Services	Group Home	36	92%	55	97%	14	92%	42	89%	30	96%	177	94%
	MH Intensive Res. Rehabilitation	-	-	60	99%	6	97%	101	96%	17	90%	184	97%
	Other	-	-	-	-	15	57%	-	-	-	-	15	57%
	Residential Support	70	80%	40	90%	-	-	12	94%	145	78%	267	81%
	Sub-Acute	-	-	-	-	15	89%	-	-	-	-	15	89%
	Supervised Apartments	80	96%	150	94%	117	99%	151	85%	140	92%	638	93%
	Transitional	13	70%	-	-	9	92%	-	-	14	82%	36	80%

**Includes only State Operated programs*

APPENDIX B. DMHAS Clients by Town

Town of Client's Domicile	MH Only	SA Only	MH & SA	Total
Andover	22	31	8	61
Ansonia	468	401	59	928
Ashford	45	58	4	107
Avon	39	85	3	127
Barkhamsted	46	51	5	102
Beacon Falls	16	71	3	90
Berlin	85	217	15	317
Bethany	15	39	5	59
Bethel	77	199	9	285
Bethlehem	28	25	3	56
Bloomfield	310	197	26	533
Bolton	70	46	6	122
Bozrah	40	33	1	74
Branford	406	286	58	750
Bridgeport	2061	2818	425	5304
Bridgewater	4	17	1	22
Bristol	447	1543	128	2118
Brookfield	55	153	5	213
Brooklyn	154	117	11	282
Burlington	26	109	7	142
Canaan	61	77	3	141
Canterbury	42	57	1	100
Canton	46	76	3	125
Chaplin	31	46	9	86
Cheshire	102	167	16	285
Chester	22	29	5	56
Clinton	80	146	8	234
Colchester	95	159	13	267
Colebrook	23	20	1	44
Columbia	27	54	8	89
Cornwall	11	10	1	22
Coventry	129	142	29	300
Cromwell	79	171	9	259
Danbury	628	1250	111	1989
Darien	35	37	3	75
Deep River	26	57	6	89
Derby	208	251	24	483
Durham	22	56	3	81
East Granby	67	25	7	99
East Haddam	33	83	5	121

East Hampton	83	179	8	270
East Hartford	1486	622	178	2286
Town of Client's Domicile	**MH Only**	**SA Only**	**MH & SA**	**Total**
East Haven	457	472	93	1022
East Lyme	71	191	18	280
East Windsor	293	114	46	453
Eastford	10	17	2	29
Easton	15	37	1	53
Ellington	125	102	12	239
Enfield	1246	444	213	1903
Essex	45	38	2	85
Fairfield	150	282	24	456
Farmington	65	217	15	297
Franklin	16	16	1	33
Glastonbury	225	125	37	387
Goshen	34	25	3	62
Granby	111	54	17	182
Greenwich	163	192	8	363
Griswold	175	223	17	415
Groton	274	406	51	731
Guilford	163	131	27	321
Haddam	23	63	6	92
Hamden	628	418	76	1122
Hampton	26	33	4	63
Hartford	2913	3961	839	7713
Hartland	8	16	4	28
Harwinton	87	60	6	153
Hebron	65	65	8	138
Kent	35	38	2	75
Killingly	413	427	53	893
Killingworth	18	40	5	63
Lebanon	59	110	16	185
Ledyard	63	166	13	242
Lisbon	0	2	0	2
Litchfield	164	92	10	266
Lyme	0	1	0	1
Madison	76	132	14	222
Manchester	2039	578	181	2798
Mansfield	139	173	24	336
Marlborough	31	47	5	83
Meriden	1096	964	162	2222
Middlebury	16	50	1	67
Middlefield	24	41	2	67

Middletown	816	799	172	1787
Milford	649	554	87	1290
Town of Client's Domicile	**MH Only**	**SA Only**	**MH & SA**	**Total**
Monroe	24	133	6	163
Montville	188	244	24	456
Morris	33	30	1	64
Naugatuck	200	466	39	705
New Britain	1351	2038	295	3684
New Canaan	37	47	3	87
New Fairfield	21	112	5	138
New Hartford	73	92	5	170
New Haven	3204	2393	607	6204
New London	706	835	144	1685
New Milford	286	445	34	765
Newington	178	345	28	551
Newtown	70	252	9	331
Norfolk	33	24	4	61
North Branford	93	134	14	241
North Canaan	6	8	0	14
North Haven	211	180	24	415
North Stonington	18	45	5	68
Norwalk	1282	798	90	2170
Norwich	1075	821	157	2053
Old Lyme	31	92	9	132
Old Saybrook	49	86	6	141
Orange	81	89	11	181
Oxford	49	131	12	192
Plainfield	263	307	39	609
Plainville	104	409	27	540
Plymouth	67	268	10	345
Pomfret	30	33	1	64
Portland	74	120	18	212
Preston	34	46	5	85
Prospect	36	55	3	94
Putnam	171	189	28	388
Redding	16	37	0	53
Ridgefield	39	121	4	164
Rocky Hill	106	155	18	279
Roxbury	11	17	3	31
Salem	23	26	3	52
Salisbury	35	43	6	84
Scotland	4	16	0	20
Seymour	195	229	21	445

Sharon	15	26	6	47
Shelton	286	505	39	830
Town of Client's Domicile	**MH Only**	**SA Only**	**MH & SA**	**Total**
Sherman	15	29	1	45
Simsbury	106	108	14	228
Somers	142	69	19	230
South Windsor	258	101	18	377
Southbury	43	111	10	164
Southington	165	528	48	741
Sprague	29	36	2	67
Stafford	176	163	38	377
Stamford	1067	765	79	1911
Sterling	24	58	7	89
Stonington	122	218	11	351
Stratford	236	660	49	945
Suffield	166	70	25	261
Thomaston	80	103	12	195
Thompson	86	72	6	164
Tolland	90	81	11	182
Torrington	1609	926	186	2721
Trumbull	73	198	12	283
Vernon	600	281	85	966
Voluntown	18	26	3	47
Wallingford	281	420	38	739
Warren	15	13	1	29
Washington	32	36	2	70
Waterbury	2433	2548	268	5249
Waterford	119	223	16	358
Watertown	143	214	16	373
West Hartford	373	383	48	804
West Haven	796	656	118	1570
Westbrook	43	68	6	117
Weston	18	38	0	56
Westport	98	101	8	207
Wethersfield	163	240	22	425
Willington	60	59	7	126
Wilton	36	62	2	100
Winchester	374	297	34	705
Windham	709	1081	170	1960
Windsor	461	244	66	771
Windsor Locks	281	149	53	483
Wolcott	89	206	10	305
Woodbridge	22	52	5	79

Woodbury	38	64	2	104
Woodstock	50	56	7	113
Unknown	1772	1256	175	3203
Total	45095	47637	6983	99715

APPENDIX C. DESCRIPTIONS OF DMHAS LEVELS OF CARE (LOCs)

	LOC Type	LOC Mode	Definitions
MH	Inpatient Services	Acute Psychiatric	An acute psychiatric program provides short-term medically directed treatment of a psychiatric or co-occurring psychiatric and substance use disorder, where patient admission is the result of psychiatric decompensation that requires rapid stabilization of symptoms or a situation where it has been determined to be a danger to themselves or others. These services provide 24-hour medical and nursing supervision and include intensive evaluation, medication management, symptom stabilization and intensive brief treatment. Services may include those provided to individuals committed under a Physician's Emergency Certificate (PEC) pursuant to Sec.17a-502 of the Connecticut General Statutes. Services shall be targeted to non-forensic acute care, voluntary, involuntary, and civilly committed patients and ensure that such services shall be provided in a locked psychiatric inpatient unit.
MH	Sub-Acute	Sub-Acute	A sub-acute program provides intensive services in order to stabilize psychiatric symptoms, or behavioral and situational problems including substance use and, whenever possible, avert the need for acute hospitalization or to treat a deteriorating psychiatric disorder and reduce the risk of harm to self or others. Sub-acute beds may also be used to provide transitional care to individuals that are on leave, discharged from or transferred from other inpatient or residential facilities, but should not be used as transitional housing for people waiting for housing stock to become available. Sub-acute services can be provided in either a community or hospital setting.
MH	Inpatient Services (ABI)	Intensive Psychiatric Rehab	Intensive psychiatric rehabilitation is the medically and behaviorally directed treatment of a psychiatric or co-occurring psychiatric and substance use disorder where an individual's admission is the result of a serious, dangerous or persistent psychiatric or co-occurring disorder, or is the result of an Acquired Brain Injury that requires continued stabilization of symptoms. The program is utilized following the completion of an acute inpatient stay that does not result in stabilization of the psychiatric disorder, and when 24-hour medical and nursing supervision continue to be required to provide symptom stabilization. Services will include evaluation, medication management, and other intensive interventions of a therapeutic and rehabilitative nature, e.g., illness education, self-management and other skill-building as needed to achieve psychiatric stabilization. The program may provide services to individuals committed under a Physician's Emergency Certificate (PEC) pursuant to Sec. 17a-502 of the Connecticut General Statutes, and Probate Court Committed patients under Sec.17a-498 of the Connecticut General Statute.

	LOC Type	LOC Mode	Definitions
MH	Inpatient Services	Intermediate Psychiatric Rehab	Intermediate psychiatric rehabilitation is the medically and behaviorally directed treatment of a psychiatric or co-occurring psychiatric and substance use disorder where an acute and intensive psychiatric inpatient stay has not resulted in symptom stabilization. The program is utilized when 24-hour medical and nursing supervision are required to provide continued evaluation, medication management, and symptom stabilization. Other services include those of a rehabilitative nature such as illness education and self-management and other skill-building. Individuals receiving this service generally need a longer period of hospitalization to recover adequately for successful return to community services. The program may provide services to individuals committed under a Physician's Emergency Certificate (PEC) pursuant to Sec. 17a-502 of the Connecticut General Statutes, and Probate Court Committed patients under Sec.17a-498 of the Connecticut General Statute.
AS	Inpatient Services	Medically Managed Detox	Medically managed detoxification, provided in a private freestanding psychiatric hospital, general hospital or state-operated facility, is the medically directed treatment 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 medical withdrawal management. For individuals who have co-occurring mental health and substance use disorders, psychiatric assessment and management are available. The program may be provided to patients committed under a Physician's Emergency Certificate (PEC) Pursuant to Sec.17a-684 of the Connecticut General Statutes.
AS	Inpatient Services	Medically Monitored Detox	Medically monitored detox, provided in a state-operated facility or in a facility licensed by the Department of Public Health to offer residential detoxification and evaluation, involves treatment of substance use dependence when 24-hour medical and nursing supervision are required. Comprehensive evaluations and withdrawal management are provided as well as short-term counseling and referral to other supports. For individuals who have co-occurring mental health and substance use disorders, psychiatric assessment and management are available.
AS	Inpatient Services	Observation Bed	An observation bed is an inpatient service provided in a general hospital, private freestanding psychiatric hospital or state-operated or private-non-profit facility that involves medically necessary, supervised stabilization, clinical monitoring and laboratory testing as necessary to facilitate the formulation of an appropriate diagnosis and suitable treatment of an individual who is in urgent need of care and treatment for mental health or substance use disorders. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required.

	LOC Type	LOC Mode	Definitions
MH	ACT	Assertive Community Treatment	Assertive Community Treatment provides a range of activities to individuals with severe and persistent psychiatric and co-occurring psychiatric and substance use disorders. These individuals are typically difficult to engage in treatment, have been discharged from multiple or extended stays in hospitals, and have multiple, complex clinical and recovery support needs. Services are provided by multidisciplinary teams of mental health and addiction service workers, employment and peer specialists, clinical, nursing, and psychiatric staff. ACT teams will employ an outreach based, rehabilitation model that assists the individual in obtaining necessary clinical, medical, social, educational, rehabilitative, vocational and other services. These services are intended to support individuals in the community who would otherwise need hospitalization or could not use a range of community based programming. Services include intake and assessment, individual recovery planning and supports, counseling, medication monitoring and evaluation and transitioning to Community Support programming. Services are intensive and are frequently provided on a daily basis.
MH	CSP	Community Support Program	Community Support Programs include a comprehensive array of rehabilitation services, most of which are provided in non-office settings by a mobile staff utilizing a team approach. Services are focused on skill building to maximize self-management skills and independence and include intensive, rehabilitative community support, crisis intervention, individual, and group psycho-education and skill building for activities of daily living, peer support and self-management. Team services and interventions are highly individualized and focus on building and maintaining a therapeutic relationship with the individual while delivering rehabilitative, skill building interventions and activities, facilitating connections to the individual's community recovery supports, providing access to a Certified Peer Support Specialist who is specially trained and can provide effective self-help strategies and expertise through their lived experience, targeted case management (TCM) and emphasizing the individual's choices, goals and recovery path. Services include intake and assessment, individual recovery planning and supports, counseling, and medication monitoring.
MH AS	PHP	Partial Hospitalization Services	Partial Hospitalization services offer acute intensive treatment and interventions a minimum of four hours per day, five days per week. The program provides a range of therapeutic activities including evaluation, individual or group therapy, rehabilitative services and access to psychiatric, medical, and laboratory services when appropriate. The program is targeted to individuals who have been recently discharged from an inpatient or residential facility or whose admission to inpatient care might be prevented by treatment in a partial hospital program.

	LOC Type	LOC Mode	Definitions
AS	Residential Services	AS Intensive Residential Rehabilitation	Intensive Residential Treatment may be provided in a private freestanding psychiatric hospital, general hospital facility, or private-non-profit facility licensed by the Department of Public Health to offer intensive residential treatment to people with substance dependence, or co-occurring psychiatric and substance abuse disorders. These services are provided in a 24-hour setting to treat individuals who require an intensive rehabilitation program. Services in these settings 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. A minimum of thirty (30) hours per week of substance use disorders services in a structured recovery environment are provided to each individual.
AS	Residential Services	AS Intensive Residential ENHANCED	Intensive Residential Treatment ENHANCED provide intensive treatment to individuals with co-occurring psychiatric and substance use disorders, and is provided in a private-non-profit facility licensed by the Department of Public Health to offer intensive residential treatment. The program provides integrated treatment for both disorders and addresses the interactive nature and effects of both disorders. These services are provided in a 24-hour setting to treat individuals who require an intensive rehabilitation program. Services in these settings 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. A minimum of thirty (30) hours per week of substance use disorders services in a structured recovery environment are provided to each individual.
AS	Residential Services	AS Intermediate/Long Term Res. Tx	Intermediate or Long Term residential treatment is for people with substance use disorders, or co-occurring psychiatric and substance abuse disorders is a service provided in a private-non-profit facility licensed by the Department of Public Health to offer intermediate or long-term treatment. These residential services are recovery focused and provided in order to address significant problems with behavior and functioning in major life areas due to a substance use disorder with the goal of community re-integration. A minimum of twenty (20) hours per week of substance use disorders services in a structured recovery environment are provided to each individual.
AS	Residential Services	AS Long Term Care	Long Term Care is for people with substance use disorders, or co-occurring psychiatric and substance abuse disorders is a service provided in a private-non-profit facility licensed for care and rehabilitation by the Department of Public Health. These facilities shall provide recovery focused rehabilitation interventions to address relapse prevention barriers and facilitate community re-integration. A minimum of twenty (20) hours per week of substance use disorders services in a structured recovery environment are provided to each individual.

	LOC Type	LOC Mode	Definitions
AS	Residential Services	AS Transitional /Halfway House	Transitional and halfway house services is for people with substance use disorders, or co-occurring psychiatric and substance abuse disorders is provided in a private-non-profit facility licensed transitional or halfway-house services by the Department of Public Health. The facility shall provide four (4) hours per week of individual, group or family therapy;
MH	Residential Services	MH Intensive Res. Rehabilitation	Intensive Residential Treatment is for people with serious and persistent psychiatric, or co-occurring psychiatric and substance abuse disorders provides medically and behaviorally directed treatment of a psychiatric or dual-diagnosis condition where an individual's admission is the result of a serious, dangerous or persistent psychiatric condition, or is the result of an Acquired Brain Injury that requires continued stabilization of psychiatric symptoms. This service is defined as highly structured and rehabilitative providing 24-hour staff supervision, and a length of stay of six to twelve months. Admissions generally come directly from a hospital operated by DMHAS or through the Department's Medical Director or his designee.
MH	Residential Services	Mental Health Group Home	Mental Health Group Homes provide recovery oriented, rehabilitation, skill building services in a congregate, residential program licensed by the Department of Public Health that provides on-site staffing 24 hours a day, 7 days per week to multiple individuals with severe and persistent psychiatric disabilities, or co-occurring psychiatric and substance use disorders. Rehabilitative services are provided to address significant skill deficits in the areas of self-care and independent living in a structured recovery environment.
MH	Residential Services	Supervised Housing	Supervised Apartment programs provide staffing 24 hours a day, 7 days per week to supervise or support individuals residing in apartments in the community. Services focus on assisting individuals to live independently in community based living arrangements Activities include assistance in all areas of daily living, community integration, education assistance and counseling, individual management of personal financial resources and budgeting, referrals to all necessary services, meal preparation, improving communication skills, and use of leisure time. In addition, activities shall include case management services and, as needed, provide housing resource coordination to aid individuals in finding, obtaining and keeping safe, affordable housing.
MH	Residential Services	Transitional	Transitional residential services shall be provided in a congregate community residence with staff on site twenty-four (24) hours per day, seven (7) days per week. Participants may be transitioning from one level of services to another, from an inpatient setting to the community or awaiting a placement in a supportive housing program. The anticipated length of stay for all individuals utilizing transitional residential services shall not exceed thirty (30) days

	LOC Type	LOC Mode	Definitions
MH	Residential Services	Residential Support Supported Apartments	Residential Support services are provided to assist individuals with psychiatric disabilities, or co-occurring psychiatric and substance use disorders to live independently and successfully in community residences and fulfill tenant responsibilities. Staff are available Monday – Friday from 9:00 a.m. to 6:00 p.m. at a minimum to provide recovery oriented assistance in all areas of daily living, community integration, education assistance and counseling, individual management of personal financial resources and budgeting, referrals to all necessary services, meal preparation, improving communication skills, and use of leisure time. In addition, activities shall include case management services and, as needed, provide housing resource coordination to aid individuals in finding, obtaining and keeping safe, affordable housing. Staff are on-call on a 24-hour basis to individuals when there is a need for assistance or service outside the regular hours of operation.
MH	Housing Services	Supportive Housing – Development	Supportive Housing services are provided to people who hold their own leases (tenants) in apartments in a single site building or group of buildings. These case management services can be provided in their homes or in community settings of their choice. Case management provides coordination of services which are designed to offer the tenants support in community integration and living independently. Other support services that may be funded through the program include outreach and engagement, budgeting, peer mentoring and support, employment readiness and job retention supports.
MH	Housing Services	Supportive Housing – Scattered Site	Supportive Housing services are provided to people who hold their own leases (tenants) in apartments scattered throughout the community. These case management services can be provided in their homes or in community settings of their choice. Case management provides coordination of services which are designed to offer the tenants support in community integration and living independently. Other support services that may be funded through the program include outreach and engagement, budgeting, peer mentoring and support, employment readiness and job retention supports.
AS	Housing Services	Recovery House	Recovery House services are provided to individuals in recovery from substance use or co-occurring substance use and psychiatric disorders who would benefit from a clean and sober environment to support their recovery. These houses provide 24-hour temporary housing and supportive services for such persons who present without evidence of intoxication, withdrawal or psychiatric symptoms that would indicate clinical inappropriateness for participation in the recovery house program. The length of stay for residents of this program shall not exceed ninety days. The program does not provide direct treatment..

	LOC Type	LOC Mode	Definitions
AS	Housing Services	Sober House	Sober houses are for individuals in recovery from substance use or co-occurring substance use and psychiatric disorders who would benefit from a supportive 24-hour clean and sober residence to support their recovery. The program does not provide direct treatment.
MH	Crisis Services	Crisis Team	A crisis program is defined as mobile, i.e., occurs in community settings, accessible, rapid response services to individuals and families experiencing acute psychiatric crisis. It provides short term, concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce the risk of harm to self or others, stabilize psychiatric symptoms, or behavioral and situational problems, including substance abuse, and wherever possible to avert the need for hospitalization. Activities include assessment and evaluation, diagnosis, hospital prescreening, medication evaluation, and referral for continuing care if needed. When appropriate, brief clinical treatment may be provided in order to support the individual until he or she is transferred to other services or discharged. A CIT component can provide a collaborative crisis response with a CIT-trained police department. CIT crisis services may also include ongoing education, consultation and support to trained CIT officers.
MH	Crisis Services	Respite Services	Respite services provides support and interventions to people experiencing psychiatric distress or conflict in a current living situation of such intensity or duration to require temporary respite services. Services include temporary living quarters and staff support needed to stabilize psychiatric symptoms, or behavioral and situational problems including substance abuse and whenever possible to avert the need for acute hospitalization. An array of supportive services will be provided including mental status checks, medication monitoring, use of targeted interventions, assistance in all areas of daily living and use of skills for community living; use of coping strategies and recovery supports. Providers will facilitate the return of individuals to their homes.
MH AS	Case Management	Standard Case Management	This program provides a range of activities to assist individuals with severe and persistent psychiatric or co-occurring substance use and psychiatric disorders to live successfully in the community. Staff support people by providing assistance and acting as liaison for assuring the clinical, medical, social and rehabilitative needed for successful community participation and optimal quality of life. Services may include intake and assessment, individual recovery planning and supports, case management services, counseling, medication monitoring and evaluation. Services maybe episodically intensive, but are provided with less frequency and duration than an Intensive Case Management program.

	LOC Type	LOC Mode	Definitions
MH AS	Case Management	Outreach & Engagement	An outreach and engagement program provides staff to go into various community settings where people who are experiencing homelessness and may be diagnosed with a psychiatric disorder, or co-occurring psychiatric and substance disorder, may congregate or live. Staff use outreach and engagement strategies in an effort to connect with the person, and ultimately assist them in obtaining necessary clinical, medical, social, educational, rehabilitative, and vocational or other services, with the goal of engaging the person in establishing a life in recovery. Services may include intake and assessment, individual recovery planning and supports, case management services, counseling, and evaluation. Services maybe intensive and focus on the goal of engaging and referring the individuals in treatment and housing, services and supports needed to maintain life in recovery. These activities may focus on targeted populations.
MH AS	Case Management	Intensive Case Management	This program provides a range of activities to people with substance dependence, or co-occurring psychiatric and substance abuse disorders. The program employs community outreach strategies to engage and support the individual in recovery and prevent relapse. Staff may assist the individual in obtaining necessary clinical, medical, social, educational, rehabilitative, and vocational or other services in order to achieve optimal quality of life and community living. Services may include intake and assessment, individual recovery planning and supports, case management services, counseling, medication monitoring and evaluation. Intensive Case Management services are not rehabilitation/skill building oriented, do not provide clinical services, and are provided with less frequency than an ACT program.
MH	Case Management	Peer Bridger	This program provides services to individuals who have a psychiatric disorder, or co-occurring psychiatric and substance disorder who are currently involved with the criminal justice system or the Probate Court system or at risk of involvement with the criminal justice system or the Probate Court system. Peer Bridger staff are certified Recovery Support specialists who are self-identified as having a psychiatric diagnosis or co-occurring psychiatric and substance use disorder and a history of receiving behavioral health services, who are in recovery. Staff shall work in the community providing long-term, flexible, outreach and engagement activities, and peer supports and facilitate access to an array of recovery supports and needed services, including the development of Self Directed Life Coaching Plans and Wellness Recovery Action Plans. Services and supports shall be person centered, recovery oriented and linguistically accessible.
MH	Case Management	Specials	Trained peer individuals provide 1:1 recovery supports, observation, monitoring, and re-direction to individuals with pre-crisis level of behavioral health issues in a community setting to help stabilize their symptoms or behaviors and support community integration and participation.

	LOC Type	LOC Mode	Definitions
MH	Case Management	Life Coaching	This program provides one-to-one community based interventions and supports to individuals' psychiatric disorders, or co-occurring psychiatric and substance use disorders who experience social and emotional difficulties that create barriers to participating in and fully utilizing community services and supports. Eligible individuals will live in community locations. Individuals receiving Life Coaching must also be receiving services and supports through another DMHAS provider. Life Coaching will facilitate an individual's ability to manage activities of daily living and augment community participation in community services and supports. Life Coaching will include supervision and assistance necessary to maximize independence and an optimal quality of life, and provide oversight to minimize high risk behaviors.
MH	Community Support	CSP	This program provides a range of activities to individuals with psychiatric or co-occurring psychiatric and substance disorders. The activities are provided utilizing a Team model, which includes mental health workers, clinical staff, nursing, and psychiatric staff. The program employs community outreach to assist the individual in obtaining necessary clinical, medical, social, educational, rehabilitative, and vocational or other services in order to achieve optimal quality of life and community living. Services may include intake and assessment, individual recovery planning and supports, case management services, counseling, medication monitoring and evaluation. Community Support services must meet medical necessity requirements and be prescribed by a Core Provider. This Core Provider can either be within the agency, or an outside agency that has prescribed CSP treatment/recovery plan.
MH	Social Rehabilitation	Social Rehabilitation	This program offers consumer directed, long-term, supports and activities to assist individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder to develop and practice social skills necessary for successful integration and participation in community life. Programming is flexible, and the environment is structured through input from participants. The range of activities includes daily living skills, interpersonal skill building, life management skills, and pre-employment skills. Pre-employment activities may include temporary, transitional, or volunteer work assignments.
MH AS	Recovery Support	Transportation	Transportation programs provide transportation to individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder to support their access to treatment and recovery services.
AS	Recovery Support	Peer Based Mentoring	This program provides services to support individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder who have difficulty getting involved in activities outside their own homes, and may provide pre-employment job training for individuals who serve as peer companions/mentors. Mentors may accompany individuals on a one-to-one basis as often as daily, depending upon the needs of the individual. Mentors may be paid on a stipend basis but are not on the regular payroll of the agency.

	LOC Type	LOC Mode	Definitions
MH AS	Recovery Support	Peer Based Telephone Support	This consumer-operated program provides telephone support, advocacy, information and referral for non-crisis calls. Staff is available 24 hours per day, 7 days per week.
MH AS	Recovery Support	Advocacy	This program provides consultation and education services to assist individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder to become active participants in community issues that affect services in the DMHAS system.
MH	Employment Services	Employment Services	This program provides structured employment services directed at helping individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder to prepare for, obtain, and maintain employment activities. These activities will include services to functionally prepare the individual for being an employee, supportive activities to achieve or maintain the individual's employment status, and time-limited assessments and counseling for individuals so they may continue to pursue viable employment outcomes. Employment services may include the following: competitive employment, supported work placement, placement assistance, employment counseling and supervision, job coaching on-site, job development and employer consultation services, functional vocational training, and assisting in and obtaining job interviews for individuals.
MH	Education Support	Education Support	This program provides services to individuals with psychiatric or co-occurring psychiatric and addiction disorders to access and complete identified areas of education and study. Supported Education Services may include academic counseling, assistance with academic and financial applications, advocacy, facilitating tutoring, implementing study skills and career exploration. In addition, the contractor may also provide aptitude and achievement testing to assist in planning services and supports. The contractor shall provide supports for individuals pursuing Adult Basic Education, General Equivalency Diploma (GED), college, vocational education or training to enable individuals to become competitively employed.
AS	Medication Assisted Treatment	Ambulatory Detox	This outpatient program provides detoxification and evaluation services in a facility licensed by the Department of Public Health. The program provides substance dependence evaluation and withdrawal management. Individuals should not have significant, acute, or co-morbid conditions or risk factors for severe withdrawal.
AS	Medication Assisted Treatment	Methadone Maintenance	The program provides outpatient, medically directed substance dependence evaluation and withdrawal management through the primary use of methadone in a facility licensed by the Department of Public Health. Medical and nursing supervision are provided.
AS	Medication Assisted Treatment	Buprenorphine Maintenance	The program provides outpatient, medically directed substance dependence evaluation and withdrawal management through the primary use of buprenorphine. Medical and nursing supervision are provided.

	LOC Type	LOC Mode	Definitions
MH AS	Outpatient	Standard Outpatient	This program provides clinical evaluation, treatment and recovery services by appropriately licensed staff to individuals with psychiatric or substance use disorder, or co-occurring psychiatric and substance use disorders in a facility licensed by the Department of Public Health. Services are provided in regularly scheduled sessions and include individual, group, family therapy, and psychiatric evaluation and medication management to individuals with psychiatric or substance use disorders, or co-occurring psychiatric and substance disorder. Staffing includes clinicians, nurses, and psychiatrists. If the program focuses on the needs of seniors (those age 55 and over), information related to older adult services and substance abuse will be provided. These senior services will also be provided in homes, senior centers and nursing homes as necessary.
MH AS	Intensive Outpatient (IOP)	Standard IOP	This program offers acute intensive mental health or addiction outpatient services a minimum of three hours per day for up to four days per week in a facility licensed by the Department of Public Health. The program offers case management, individual and group therapy, therapeutic activities and a range of rehabilitative activities.
AS	Outpatient	Gambling	This outpatient program provides evaluation, treatment and recovery services to individuals who exhibit problematic or pathological gambling behavior in a facility licensed by the Department of Public Health. Services include individual, group, and family counseling and may include appropriate supportive services. These activities are provided in regularly scheduled sessions.
For	Forensics Inpatient	Acute	This specialized inpatient program provides medically and behaviorally directed treatment of forensic referrals or individuals committed with a serious psychiatric or psychiatric disorder, or co-occurring psychiatric and substance disorder diagnosis condition. The patient admission may be the result of a criminal commitment under Sec.54-56d of the Connecticut General Statutes for the purpose of restoration to competency to stand trial. The program is utilized when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication management, symptom stabilization and intensive brief treatment in order to determine whether the individual is able to be restored to competency to stand trial. The program may also provide services to patients committed under a Physician's Emergency Certificate (PEC) pursuant to Sec.17a-502 of the Connecticut General Statutes, Probate Court Committed patients under Sec.17a-498 of the Connecticut General Statutes patients referred by the criminal court for pre-sentence evaluation under Sec 17a-566 and patients transferred from correctional and other mental health facilities (DMHAS & private facilities).

	LOC Type	LOC Mode	Definitions
For	Forensics Inpatient	Rehabilitation	This specialized inpatient program provides medically directed diagnosis and assessment and ongoing treatment to offenders at all phases of the judicial process. The program is utilized when 24-hour medical and nursing supervision are required to provide intensive forensic evaluation, medication management, symptom stabilization and long term treatment. Patients may be committed to this level of care under a variety of legal and court dispositions found under the State of Connecticut statutes. These state statutes may include, but are not limited to, 'Not Guilty by Reason of mental disease or defect' and or subsequent placement under the jurisdiction of the Psychiatric Security Review Board (PSRB), Department of Corrections (DOC) Transfer for evaluation and treatment, and Restoration to Competency to Stand for Trial. DMHAS Voluntary, Civil, Probate patients may be treated in the maximum security setting of the Whiting Service or in the security enhanced setting of the Dutcher service. Patients in the security enhanced Dutcher service no longer require a maximum-security environment and may be in various stages of supervised community reintegration.
For	Forensics Community Based	Pretrial Intervention Programs	The pretrial diversionary intervention programs are only available for court ordered offenders referred in accordance with Sec. §54-56g or §54-56i. Services include evaluation, multiple levels of group interaction and possible referral for more intensive treatment.
For	Forensics Community Based	Court Liaison - Jail Diversion	Program provides evaluation, assessment, referral and consultation to improve access to community services for adults involved in the criminal justice system who have serious mental health and/or co-occurring mental health and substance abuse disorders, and are at risk for incarceration. These services may include, screening at the courthouse, treatment recommendation, referral to community services, interim clinical services, case management, monitor and report compliance with treatment, liaison to Department of Correction for individuals in jail. Additional services are provided for the Judicial Division including screening of defendants, consultation to court personnel, and coordination of emergency referral as needed. At the court's request, staff conduct evaluations related to firearm safety hearings and coordinate discharge planning.
For	Forensics Community Based	Re-Entry Programs	Program staff engages with inmates in correctional settings prior to release by offering individual and/or group programming and individual assessments that clinically drive individual treatment plans aimed at a successful transition from incarceration to community living. Services and supports are also post release.
For	Forensics Community Based	Office of Forensic Evaluations	This state-operated program provides specialized evaluations and expert testimony pursuant to CT General Statutes for individuals referred by the Court including but not limited to evaluations regarding Competency to Stand Trial and Substance Dependence.

	LOC Type	LOC Mode	Definitions
For	Forensic Community Based	Day Reporting	These site-based programs are intended to serve adults with significant psychiatric and/or co-occurring psychiatric and substance abuse disorders who are also involved with the criminal justice system. These programs provide intensive, targeted skill development in individual and group modalities, monitor and report compliance with treatment, case management services, direct and frequent monitoring of individual mental status, case consultation with mental health service providers and the arrangement of comprehensive aftercare services at discharge. Upon completion of the program, participants will have complied with the requirements of the criminal justice system, be engaged with local treatment providers and learned relapse prevention skills and strategies necessary to avoid future incarceration.
	Prevention	Prevention	Programs designed to promote the overall health and wellness of individuals and communities by preventing or delaying substance or tobacco use. Prevention services are comprised of six key strategies including information dissemination, education, alternative activities, strengthening communities, promoting positive values, and problem identification and referral to services.
	Other	Other	This level of care is for programs that are not part of the other levels of care and may represent contracts that provide fiduciary mechanisms for funding specific initiatives.
	Other	Integrated BH & Primary Care	This program provides integrated behavioral health and primary care that is high quality, accessible, and person-centered to individuals receiving Behavioral Health services from the Contractor, who have also been identified as frequent hospital inpatient and emergency department users. Services will be provided by licensed medical and wellness professionals and include health education, disease prevention education, preventive well care, sick care, chronic care and referrals to specialty care.
	Housing Coordination	Housing Coordination	This program provides service coordination to assist individuals to obtain safe, decent, affordable housing of their choice, and to prevent and address homelessness by providing housing opportunities and resources. Services are available to individuals who receive services from a designated Department Local Mental Health Authority (LMHA) and affiliate agencies. Housing Coordination may be a collaborative effort between identified agencies
	Residential	Community-Based Residence Program (CBRP)	This program provides service coordination to assist individuals who have acquired brain injuries or traumatic brain injuries (ABI/TBI). Contractor shall operate such services 24 hours a day/7days per week to provide access to comprehensive and coordinated physical, psychological, medical, vocational, and social services in a community-based living environment. Contractor shall develop and implement an individualized, person-centered service plan that delivers specialized services that are integrated into the department's statewide ABI/TBI system of care.