Connecticut

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/15/2025 11.51.53 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	R2J2V5BZNGY2

I. State Agency to be the SUPTRS BG 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 SUPTRS BG Grantee of the Block Grant

First Name	Kyle
Last Name	Barrette
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) 969-9617
Fax	
Email Address	kyle.barrette@ct.gov

State CMHS Unique Entity Identification

Unique Entity ID	R2J2V5BZNGY2

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	Kyle
Last Name	Barrette
Agency Name	Department of Mental Health and Addiction Services
Mailing Address	410 Capitol Avenue
City	Hartford
Zip Code	06134
Telephone	(860) 969-9617
Fax	
Email Address	kyle.barrette@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	Kyle
Last Name	Barrette
Telephone	(860) 969-9617
Fax	
Email Address	kyle.barrette@ct.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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		
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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, as applicable, with 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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: 05/28/2025 Expires: 01/31/2028

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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.
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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.).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
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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: 05/28/2025 Expires: 01/31/2028

Footnotes:

STATE OF CONNECTICUT

GOVERNOR NED LAMONT

July 23, 2025

Dr. Arthur Kleinschmidt, Ph.D.
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Kleinschmidt:

As the Governor of the State of Connecticut, for the duration of my tenure, I delegate authority to the current Commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS), or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) and Community Mental Health Services Block Grant (MHBG).

Sincerely,

Ned Lamont
Governor

210 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
TEL (860) 566-4840 • www.governor.ct.gov
Governor.Lamont@ct.gov

State Information

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

Fiscal Year 2026

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**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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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
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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.)
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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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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 19 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, as applicable, with 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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.

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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.

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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.

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THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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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.

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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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

STATE OF CONNECTICUT

GOVERNOR NED LAMONT

July 23, 2025

Dr. Arthur Kleinschmidt, Ph.D.
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Kleinschmidt:

As the Governor of the State of Connecticut, for the duration of my tenure, I delegate authority to the current Commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS), or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) and Community Mental Health Services Block Grant (MHBG).

Sincerely,

Ned Lamont
Governor

210 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
TEL (860) 566-4840 • www.governor.ct.gov
Governor.Lamont@ct.gov

Bipartisan Safer Communities ACT

Connecticut Proposal for MHBG Supplement

Background

In state fiscal year 2023, approximately 8,500 individuals in Connecticut were seen for a crisis evaluation by a mobile crisis clinician. Over 3,000 of these individuals (35%) were sent to the emergency department for further evaluation and 22% were referred back to their outpatient behavioral health provider. Evidence suggests that if an alternate level of care was available, many of these individuals could be diverted from the ED to a lower and more appropriate level of care and Connecticut could respond more effectively to mental health emergencies.

According to data from the Connecticut Department of Public Health from 2016 through 2020, approximately 10% of all emergency department visits were due to a primary behavioral health or substance use issue. Approximately 82% of these individuals were treated in the ED and discharged within 24 hours. It is suggested that an environment such as a Peer Respite center, would be a more recovery-oriented, effective and cost-efficient level of care to provide the needed services and supports as an alternative to the emergency department.

Until recently, Connecticut's continuum of crisis care and mental health emergency response consisted of mobile crisis teams (providing both in-person and telephonic support), a statewide crisis call line - 988 (providing telephonic support and warm handoff to a mobile crisis team/clinician if needed), crisis respite units, and assessment for referral to the system of care. Through analysis of behavioral health crisis data and dialogue with the state's recovery community it was identified that this previous crisis continuum did not provide options for a home-like, trauma-informed, stimulation-free environment that individuals may need. Therefore, individuals in crisis were often sent to the emergency department for further evaluation when no other level of care was available or appropriate. Connecticut recognized that our services could be augmented and expanded in a way that improved our ability to respond to mental health emergencies and provide more appropriate care for individuals in crisis.

Plan to Address Identified Needs

To address this need, and to respond to SAMHSA guidance recommending states utilize BSCA funding to strengthen and enhance mental health emergency preparedness and crisis response efforts, the Connecticut Department of Mental Health and Addiction Services (DMHAS) proposes to use the third allotment of BSCA MHBG funding to continue its implementation of a Peer Respite Center in Connecticut. While the Connecticut Department of Children and Families has established crisis stabilization units for children within the state, this level of care did not historically exist within the adult behavioral health system and was only recently implemented utilizing the state's first allocation of BSCA funding and other state funds. As such, Connecticut proposes to use BSCA funds to continue implementation of its Peer Respite Center for adults 18 and older.

Connecticut's adult Peer Respite Center offers an alternative to emergency department and psychiatric hospitalization admission by providing 24-hour crisis respite and observation in the community. The Peer Respite Center is designed to be more home-like than institutional. The center is staffed with a mix of clinical professionals and paraprofessionals, including peer staff. The setting of this model is a safe, home-like, low-stimulation environment that offers rapid assessment and stabilization, observation, and

reduction in crisis symptoms in a community-based setting. Staff assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a mental health disorder. Peer Respite services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing 24-hour observation and supervision for persons who do not require inpatient services. Services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.

The Peer Respite center serves an array of individuals experiencing a mental health crisis, often including those experiencing a psychotic-spectrum disorder and specifically, first-episode psychosis. As such, Connecticut plans to use ESMI/FEP set-aside funding from its third allotment of BSCA MHBG to continue implementation of the adult Peer Respite Center discussed above. Based on emergency department utilization data in Connecticut and existing literature, it is expected that individuals who are in the early stages (first two years) of psychosis make up over 10% of those admitted to the Peer Respite Center. The Peer Respite Center offers a safe and supportive alternative to Emergency Departments or more restrictive settings for individuals experiencing early or first-episode psychosis who do not require a higher level of care. ESMI/FEP set-aside funding will be used to support the continued implementation of the state's Peer Respite Center and ensure the availability of a non-restrictive crisis care setting for individuals experiencing early of first-episode psychosis that do not require a higher level of care.

While the establishment of Peer Respite will help to complete the continuum of crisis care and mental health emergency response in Connecticut, recently passed state legislation will require schools to include 988 information on student IDs for students in grade six and higher starting in the fall of 2023. This has resulted in an increase in 988 call volume from school age children and youth. To ensure the state's call center maintains its capacity to respond to crises and mental health emergencies, especially those occurring in school settings, DMHAS proposes to use a portion of BSCA MHBG funding to continue supporting child and youth focused staff within the statewide 988 call center. DMHAS currently contracts with the United Way to operate the statewide 988 call center. Connecticut proposes to use a portion of BSCA MHBG to continue funding child and youth focused contact specialists within the 988 call center who are specifically trained to answer calls related to children and youth. Specialized training will continue to be provided by United Way for these staff.

BSCA MHBG Funding Plan (4th Allotment)

Major Need/Set Aside	Activity	Total
ESMI/FEP	Peer Respite Center*	$74,292
Crisis Services	Peer Respite Center	$445,753
Crisis Services (Children and Youth)	Fund two contact specialists within statewide crisis call center that will be focused on responding to calls from youth	$222,877
		$742,922

*Based on ED utilization data in Connecticut and existing research findings, it is expected that individuals who are in the early stages (first two years) of psychosis will make up over 10% of those utilizing Peer Respite. Peer Respite centers offer a safe and supportive alternative to Emergency Departments or more restrictive settings for individuals experiencing psychosis who do not require a higher level of care. ESMI/FEP set-aside funding will be utilized to support Peer Respite to ensure the availability of a non-restrictive setting for individuals experiencing psychosis that do not require a higher level of care.

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: 05/28/2025 Expires: 01/31/2028

Footnotes:
Connecticut has no lobbying activities to disclose

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 prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system 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 mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

The CT Department of Mental Health and Addiction Services serves as the Single State Agency (SSA) for the SUPTRSBG and the State Mental Health Authority (SMHA) for the MHBG. DMHAS is responsible for providing a full range of behavioral health treatment services to adults age 18 and older, as well as primary prevention services over the lifespan. 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.

While DMHAS oversees adult behavioral health services in the state, the Connecticut Department of Children and Families (DCF) has statutory authority to provide for children's mental health services in the state and receives 30% of the mental health block grant annually, as directed by state statute. 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. While DCF does operate two Psychiatric Residential Treatment Facilities for children and youth with complex needs, DCF mainly contracts with community agencies to provide services within the children's mental health continuum. Through these contracts, DCF supports a wide range of over ninety clinical and non-traditional services, programs and rehabilitative supports across the state, including services to address trauma and co-occurring disorders.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

The Department of Mental Health and Addiction Services (DMHAS) serves as both the SMHA and SSA in Connecticut as noted in our response to question one. As a result, DMHAS is responsible for providing a full range of behavioral health treatment services to adults age 18 and older, as well as primary prevention services over the lifespan. DMHAS delivers and manages these services through a network of state operated and private non-profit Local Mental Health Authorities (LMHAs). These LMHA provide services directly within their own facilities, as well as through their network of affiliated community-based non-profit providers located in their region. The LMHAs oversee and manage services provided by these affiliates. The responsibilities and function of the LMHAs 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 the services provided through the LMHAs, various operational divisions within the Office of the Commissioner contract directly with community-based non-profits to deliver a range of specialized services that supplement the service array provided through the LMHAs and their affiliates. The operational divisions within the DMHAS Office of the Commissioner include the Community Services Division, the Statewide Services Division, the Managed Services Division, and the Prevention and Health Promotion Division. Each of these divisions include additional operational units which are focused on specific populations and services. These will be discussed in more detail in our response to question three.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Connecticut's adult behavioral health system is delineated into five distinct geographic service regions (see figure 1 in attached document). Each region is serviced by at least one Local Mental Health Authority which is responsible for providing comprehensive

behavioral health services within one of these defined service regions. LMHAs provide comprehensive services through their own facilities and through a network of affiliated community-based providers which they oversee. Together, the LMHAs and the affiliates play a critical role in the overall behavioral health system by providing system diversity, expanding the array of available services, enhancing local geographic access to underserved populations and contributing to a comprehensive network of care.

While services to the MHBG and SUPTRSBG priority populations are generally provided by the Local Mental Health Authorities (LMHAs) and their community-based provider affiliates, DMHAS has various divisions within its central office that have the responsibility of overseeing specific types of services and populations. The response sections below outline the organizational units responsible for overseeing services to each of the block grant priority populations. A description of the services that DMHAS supports and manages is included.

Pregnant Women and Women with Dependent Children (PWWDC)

DMHAS supports a range of specialized services for PWWDC and has a specific division which oversees these services. Women's Services (WS) is a unit within the Statewide Services Division of DMHAS and serves as the education and implementation division for women's health and wellness initiatives across Connecticut. WS staff are subject matter experts in a variety of topics related to PWWDC, including: trauma responsiveness, behavioral health treatment and recovery (including mental health, substance use and opioid use disorders), medication assisted treatment, gender specific best practices, inter-partner violence, reproductive health and sexual wellness, and prenatal and postpartum wellbeing. WS staff oversee a range of specialized services for PWWDC including: 15 Women's Residential programs (5 Pregnant and Parenting Women's Residential programs, 4 Women's specific residential treatment programs, 3 Pregnant and Parenting Women's Recovery Support Programs & 3 Women's Recovery Houses), 7 Outpatient programs, 6 Intensive Outpatient programs, and 5 Women's REACH programs which pair clients with a Recovery Navigator that provides recovery coaching and case management services. All program services are gender-specific and trauma-responsive.

Persons Who Inject Drugs (PWID), Persons with SUD at Risk for Tuberculosis (TB), Persons with SUD at Risk for HIV (EIS/HIV)

DMHAS supports a range of services for PWID and persons with SUD at risk of communicable disease. The Community Services Division (CSD) of DMHAS, and its regional managers oversee these services and help to ensure quality and fidelity to treatment expectations for these populations. The treatment and rehabilitation programs offered within the substance use service continuum include:
• Pre-Treatment: services and activities necessary for a client to become engaged in and/or enter treatment
• Withdrawal Management: medical management of the withdrawal from alcohol and drugs along with MOUD and case management linkages to treatment. Methadone protocols included.
• 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 (i.e., ASAM 3.7, 3.7E, 3.5, 3.5E, 3.5PPW, 3.3, 3.1)
• 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 MOUD (i.e., buprenorphine, naltrexone) and medications for alcohol use disorder (MAUD).
• 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 employment 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 also intended to serve the Substance Use Prevention, Treatment and Recovery Services Block Grant priority populations. The 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 MOUD 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.

Individuals with SMI/SUD Experiencing Homelessness

Recognizing the link between housing and behavioral health, and in an effort to decrease the number of homeless individuals with SMI and/or substance use disorders, DMHAS maintains a specialized unit focused on homeless services. The Housing and Homeless Services unit, housed within the Statewide Services Division, manages a range of programs and services which seek to address the behavioral health and housing related needs of individuals experiencing homelessness.

Projects for Assistance in Transition from Homelessness (PATH) - This unit continues 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.

Department of Housing and Urban Development (HUD) 2022 Special Notice of Funding Opportunity - DMHAS was awarded approximately $13 million in federal Housing and Urban Development (HUD) funding through the 2022 Special Notice of Funding Opportunity (SNOFO) to target, through outreach and supportive housing, the unsheltered homeless population. This funding is distributed throughout the Balance of State Continuum of Care (CTBOS CoC) which covers all of CT except for Fairfield County.

SSI/SSDI Outreach, Access, and Recovery (SOAR) - SOAR is a model used to help individuals complete the SSI/SSDI application to assist them in gaining access to the disability income benefit programs administered by the Social Security Administration (SSA). The SOAR model is used to support eligible adults who are experiencing homelessness or who are at risk of experiencing homelessness and have a serious mental illness and/or a co-occurring substance use disorder. These individuals often cycle in and out of emergency settings and institutions, and SSI/SSDI benefits are sought to help individuals maintain stable income and housing so that they can remain in the community. SOAR staff meet with individuals in the community to help them gather the necessary documentation and materials to complete their application for SSI/SSDI. Currently the state has SOAR staff placed in each service region of the state.

Outreach and Engagement - In addition to PATH and SOAR, DMHAS 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. Of the applications assisted using SOAR, 65% have been approved for SSI/SSDI upon initial application since SOAR began.

Transit Homeless Outreach Program - This unique partnership is a collaborative project between the Department of Mental Health and Addiction Services and the CT Department of Transportation. The Transit Homeless Outreach Program provides harm reduction and homeless outreach supports to individuals residing at and spending time in transit sites, including train stations and bus shelters. These individuals, who often have co-occurring mental health and substance use challenges in addition to housing challenges, are often particularly transient, and are often not engaged in any other homeless services. Activities are focused towards helping individuals access emergency shelter, housing supports, as well as medical, behavioral health, educational, and vocational supports. All outreach activities are conducted in later evening hours, with guidance from the Department of Transportation on locations that could benefit from additional support.

Supportive Housing - 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 can be offered long-term, if 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. Consumers in a Housing First model access housing faster and are more likely to remain stably housed.

Homeless to Housing (H2H) - DMHAS has developed a new collaborative service delivery program which creates service teams to support people experiencing unsheltered homelessness find and sustain stable, safe, permanent housing. The H2H program supports people experiencing unsheltered homelessness, find and sustain stable, safe, permanent housing by addressing the individualized needs of each consumer. The program conducts outreach to persons residing out of doors and in places not meant for human habitation to assist them in locating permanent housing; once housed the program continues to provide housing support services to ensure tenancy sustainability. Outcome goals include ensuring service staff are canvassing for people experiencing unsheltered homelessness, connecting them to the Coordinated Access Network (CAN), entering them on the statewide By Name List, to prioritize and advocate for subsidized housing opportunities, connecting to behavioral health services and increasing income through gaining employment or SSI/SSDI.

Persons in need of recovery support services for SUD (PRSUD)

At a statewide level, DMHAS has the Office of Recovery Community Affairs (ORCA) within the office of the Commissioner. This office and its director act as a liaison between DMHAS and the recovery community, including the state's peer led advocacy organizations. Through this office and its Director, DMHAS 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. The Office of Recovery Community Affairs has the responsibility for the development, support and expansion of community-based peer support in the state, including policy development, project coordination, as well as collaboration with grass roots peer organizations. The Office also coordinates

various events and initiatives related to peer and recovery services, such as the Hearing Voices Network.

Through the Office, DMHAS supports a range of recovery support services for people with SUD that are included within the substance use service continuum. These services include peer support, peer vocational services, recovery coaching, and case management. These services provide coaching, education about alternative approaches to healing and recovery, skill building for self-management, family support, as well as connection to resources and supports. Connecticut also has a number of Warm Lines operating throughout the state through which individuals can receive telephonic support services from people who have experience/expertise with mutual support. Recovery services and peer recovery staff are also integrated within various levels of care within the behavioral health system: Assertive Community Treatment, Community Support Program (CSP) teams and Supported Employment programs.

DMHAS also supports and contracts with Recovery Community Organizations (RCO) to provide peer recovery services. The Connecticut Community for Addiction Recovery (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 provide telephonic peer support to individuals who are early in their recovery and requesting support. Assistance may also be provided in the form of transportation to self-help support meetings, as well as information about available resources and supports in the community that are supportive of the individual's recovery. CCAR also operates an Emergency Department Recovery Coach program. Through this program, hospital emergency departments will contact an assigned and 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 program now provides this service to all 29 hospital emergency departments.
In addition to the recovery support services operated by CCAR, DMHAS funds MAT recovery coaches in each region of the state. These coaches engage with and support individuals who are receiving MAT, to help them continue their recovery.

These programs and services identified above are staffed with individuals holding one of three certifications as peers and recovery support specialists, and DMHAS is currently in the process of developing a centralized Peer Recovery Certification for Connecticut. The goal is to ensure that one standardized set of Peer Principles, Core Competencies and Code of Ethics are endorsed statewide and are in alignment with national best practice (SAMHSA, NCPRSS).
Individuals with a co-occurring mental health and SUD
DMHAS continues to enhance integrated treatment for people with co-occurring disorders through it's integrated care initiative, overseen by Evidence-Based Practices unit within DMHAS and supported by the statewide integrated care coordinator. Through this initiative, DMHAS has implemented specialized staff training for state operated facilities, consultation, and pilot treatment projects for persons with co-occurring disorders. In addition to pilot programs, DMHAS also implements case management programs which specifically target individuals with COD and seeks to support their engagement with treatment and services. The state's regional Local Mental Health Authorities (LMHAs) have implemented the Integrated Dual Disorders Treatment (IDDT) model and SUD treatment providers have used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index to guide integrated care for individuals with co-occurring disorders. DMHAS also contracted with Yale to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model. Through these efforts, co-occurring treatment has been integrated into many of the services that individuals can access through the LMHAs and the state currently funds four co-occurring enhanced residential treatment programs. As a result, individuals with COD have access to an expanded service array that meets their needs.

Individuals in Need of Primary Substance Use Prevention (PP)

The Prevention and Health Promotion Division within DMHAS is the operational arm of the department focusing on primary prevention. The Prevention & Health Promotion Division oversees and administers the prevention set-aside funds for the SUPTRS 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 SUPTRSBG–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.

State Educational Resource Center School-Based Center for Prevention, Education and Advocacy (SERC – Prevention Library) – is a K -12 statewide library and resource center for educators, students, families, organizations and communities' information on substance use and mental health disorders, prevention and health promotion, social-emotional learning, wellness and other related topics that is youth specific. The library contains supports, programs, practices, curriculums and interventions that is offered to school districts.

Direct service prevention 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 10 community-based programs/coalitions implement the 5-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 the Connecticut Healthy Campus Initiative (CHCI) also known as the 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.

Adults with SMI* including Older Adults

While DMHAS does not have a dedicated operational division focusing on the SMI population, the Evidence-Based Practices unit of DMHAS oversees specialized services that address the needs of this population including Community Support Program (CSP),

Assertive Community Treatment (ACT), as well as Illness Self-Management (ISM). In addition, Connecticut's network of Local Mental Health Authorities (LMHAs) offer a wide range of therapeutic programs and crisis intervention services which aim to enable individuals with SMI to remain in the community and function outside of inpatient or residential institutions. LMHAs serve as the central access point for individuals with SMI and support their connection to a wide array of services that can address their needs in the moment, as well as their recovery over the long term. The continuum of services offered through the LMHAs ranges from intensive services focused on acute or immediate needs, to longer term community-based services focusing on connection to ongoing supports and helping individuals to lead full lives in recovery. Many of the community-based programs that target individuals with SMI, such Assertive Community Treatment (ACT) and Community Support Program (CSP) include a specific focus on improving connection to supports, resources, and treatment. DMHAS has also developed and implemented a bed availability website which provides information on available beds within the DMHAS system for mental health treatment. The website is updated daily and provides bed availability for all pertinent levels of care for individuals with SMI, including inpatient, group home, supervised apartments, transitional, and respite.

Older adult services for individuals with SMI are oversee by the Adult Services Unit within DMHAS which oversees specialized services for this population. Specialized services include:
• Nursing Home Diversion and Transition Program – This program focuses on reducing inappropriate admissions of clients with SMI to nursing homes, and transitioning nursing home residents with a mental illness back to the community with support services.
• Senior Outreach and Engagement – This program provides assessment and case management services to older adults (55 and older) with SMI 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.

Individuals with SMI in rural areas

While DMHAS does not have an operational unit devoted to serving rural populations, access to the DMHAS behavioral health service array among rural populations is ensured through the regional administration and coordination of services in Connecticut. Connecticut is currently divided into five service regions, with the northwest (part of region 5) and northeast (part of region 4) sections representing the most rural areas of the state.

The regional administration and coordination of services in these regions takes into account their rural nature and low service density by focusing on access to treatment through transportation services, satellite offices, mobile services, and outreach programs that can reach people where they live in the community. To this end, DMHAS has recently increased staffing of mobile MOUD Teams and increased recovery supports among providers serving rural regions. Newly funded services include recovery coaches, located at 23 hospital EDs across the state, many of which serve patients from nearby rural towns. In addition, DMHAS has established the 24/7 Access Line to facilitate access to treatment for substance use disorders among populations with minimal access to transportation. Individuals from anywhere in Connecticut may call the Access line. For access to mental health services, DMHAS contracts with EdAdvance in the Northwest region and Reliance Health in the Northeast region, to provide transportation to mental treatment for individuals and families. As a note, these transportation services funded by DMHAS are in addition to transportation services that are available to Medicaid insured populations in Connecticut, to ensure that all insured and uninsured populations without transportation or proximity to service providers are able to access behavioral health services. increased capacity for MOUD services and recovery supports provided by agencies serving rural communities across the state.

In addition to ensuring physical access to treatment, DMHAS works to ensure that rural communities have behavioral health services that reflect their unique needs and preferences by contracting with local service providers that specifically serve rural regions of the state. Through the regional administration of behavioral health services, DMHAS outlines catchment areas for service providers in a way that allows them to focus on the needs of specific populations, regions, and communities. DMHAS contracts with Western Connecticut Mental Health Center to serve the northwest region of the state, and with United Services to serve the northeast region of the state. These providers have long histories of serving their respective rural communities and receive ongoing funds from DMHAS to obtain additional training and technical assistance related to serving rural populations.
Individuals who have an Early Serious Mental Illness (ESMI)
ESMI/FEP services are overseen and managed by the Evidence-Based Practices unit within DMHAS. While DMHAS directly funds and manages all CSC for FEP programs in the state, DMHAS collaborates with the Department of Children and Families (DCF) to ensure these programs service young adults under the age of 18. DMHAS funds FEP/ESMI services in two of Connecticut's largest metropolitan areas, the greater Hartford region and the greater New Haven region. In addition, DMHAS is currently working to expand the availability of FEP/ESMI services across Connecticut by providing training and consultation to clinical teams in community-based clinics in each service region of the state.
In the greater New Haven region FEP/ESMI services are contractually provided by The Yale STEP program, a nationally recognized FEP program that was developed through a public-academic partnership between Yale and DMHAS and housed within a community mental health clinic collaboratively administered by DMHAS and Yale. STEP is staffed by mental health providers in different fields – psychology, psychiatry, nursing, and social work. This "interdisciplinary" team seeks to provide comprehensive care for individuals 17-26 years' old who are early in the course of a psychotic illness in order to prevent symptoms from becoming disabling. Treatment at STEP starts with thorough assessment in order to gain the best understanding of what may be causing the person's difficulties. Based upon individual needs and preferences, treatment may include medication management,

community coaching (e.g. support in getting back to school or work), individual and group therapy, as well as support and education for family members and friends. Access to the program is available through referrals by healthcare providers, educational professionals, family members and individuals.
In the great Hartford region, FEP/ESMI services are contractually provided by the Potential program based in Hartford Healthcare's Institute for Living. The Potential Program is an early intervention model for patients 17-26 years' old who are currently presenting with psychotic symptoms that are currently interfering with daily functioning and are found to be distressing to the individual. Treatment is tailored to the individual's unique needs and can include group therapy, individual therapy, family therapy, medication management, cognitive remediation, educational support, support and education for family members, and community trips to help with rehabilitation.
Individuals in need of behavioral health crisis services (BHCS)

The Crisis Services Continuum is collaboratively managed by DMHAS and the Department of Children and Families (DCF). DMHAS funds and manages programs and services for adults, while DCF funds and manages programs and services for children and youth. On the adult side, the Evidence-Based Practices unit within DMHAS works to develop, enhance, and coordinate services within the continuum to ensure that Connecticut adults experiencing a crisis receives a timely and effective response. On the child side, the division of community mental health services within DCF provides funding and oversite of the crisis services system.

DMHAS and DCF both provide funding and oversite of the 988 Suicide and Crisis Lifeline, which is operated by the United Way of Connecticut. In terms of mobile response, DMHAS and DCF both provide funding and oversite of mobile crisis teams throughout the state. DMHAS funds 18 adult mobile crisis teams placed strategically throughout the state. DCF funds 14 mobile crisis teams throughout the state that respond to crises involving children and youth. Lastly, DMHAS and DCF both fund and oversee an array of programs and services that offer a safe alternative to the emergency department for all Connecticut residents experiencing a behavioral health crisis. For adults 18 and older, DMHAS funds a crisis stabilization unit, peer respite program, as well as 100 respite beds placed strategically across the state. For children and youth, DCF has established three community based Behavioral Health Urgent Crisis Assessment Centers across the state as well as one sub-acute crisis stabilization program which provides short-term care for those individuals who cannot be stabilized at a Behavioral Health Urgent care center.

Children with SED*

While DMHAS oversees adult behavioral health services in the state, the Connecticut Department of Children and Families (DCF) has statutory authority to provide for children's mental health services in the state and receives 30% of the mental health block grant annually, as directed by state statute. 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. While DCF does operate two Psychiatric Residential Treatment Facilities for children and youth with complex needs, DCF mainly contracts with community agencies to provide services to children with SED within the children's mental health continuum. Through these contracts, DCF supports a wide range of over ninety clinical and non-traditional services, programs and rehabilitative supports across the state, including services to address trauma and co-occurring disorders.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State of Connecticut
Combined MHBG/SUPTRS Block Grant Application
Federal Fiscal Year 2026 - 2027

The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) prepared the State of Connecticut FFY 2026-2027 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 which has purview over children's mental health services statewide. DCF prepares and submits documents specific to the children's mental health system for STEP one and two of the combined application. Both the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRSBG) 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.

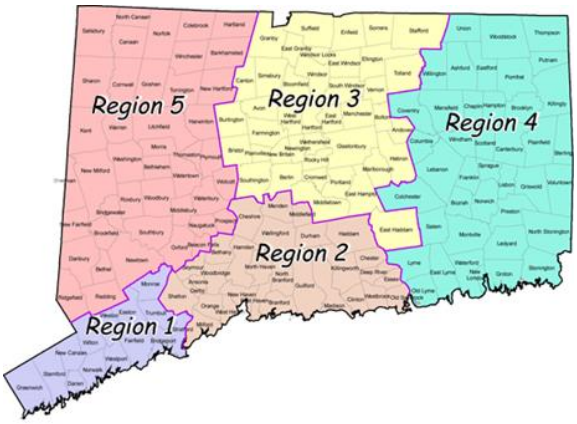
Table of Contents

Introduction: Connecticut Adult Behavioral Health System

The purpose of the Connecticut Department of Mental Health and Addiction Services (DMHAS) is to assist adults 18 and older 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 serves as the Single State Agency (SSA) for the SUPTRSBG and the State Mental Health Authority (SMHA) for the MHBG. 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 delivers and manages these services through a network of state operated and private non-profit Local Mental Health Authorities (LMHAs) and contracted community-based non-profit providers which deliver services at the community level. Connecticut's adult behavioral health system is delineated into five distinct geographic service regions (see figure 1) and each LMHA is responsible for providing comprehensive behavioral health services within one of these defined service regions (https://portal.ct.gov/DMHAS/Programs-and-Services/DMHAS-Directories/Local-Mental-Health-Authorities). LMHAs provide comprehensive services through their own facilities and through a network of affiliate providers which they oversee. Together, the LMHAs and the affiliates play a critical role in the overall behavioral health system by providing system diversity, expanding the array of available services, enhancing local geographic access to underserved populations and contributing to a comprehensive network of care.

Figure 1. DMHAS Service Regions



While DMHAS delivers and manages comprehensive behavioral health services through the LMHAs, the department supports system planning and improvement through its partnership with the state's statutorily defined planning entities, the Regional Behavioral Health Action Organizations (RBHAOs). Each of the five RBHAOs covers a distinct service region of the state and is responsible for a range of planning, education, prevention, and advocacy activities. These activities include regional needs assessment, mental health promotion, substance use prevention and suicide prevention, as well as coordination with advocacy agencies, families, consumers/persons in recovery, and other state agencies to maximize behavioral health resources and improve service delivery.

During state fiscal year (SFY) 2022, DMHAS delivered behavioral health services to over 95,000 individuals through the regional service system outlined above. The sections below provide an overview of the full behavioral health service array funded or delivered by DMHAS, including operational structures in place for oversite and management of the service system.

Operational Structure for Community-based Treatment Services

The department's **Community Services Division (CSD)** has direct responsibility for overseeing most DMHAS contracted services, which include behavioral health services provided through the Local Mental Health Authorities (LMHAs) and substance use services provided by community nonprofit providers. CSD activities are listed below.

- Monitoring the contracted private nonprofit providers that make up the DMHAS system of behavioral health, including private nonprofit substance use treatment providers and LMHAs, 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

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 Chief of State-Operated Services, CSD Regional Supervisors 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 and substance use providers not funded by DMHAS
- Department of Corrections (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

Patient Confidentiality and Privacy

DMHAS works to ensure privacy and confidentiality for all clients receiving behavioral health services within DMHAS funded and operated facilities. Each DMHAS operated and funded facility has a designated compliance and privacy officer and facility oversight committee. These officers report up to the DMHAS Compliance and Privacy Officer. The DMHAS Compliance and Privacy Officer, appointed by the Commissioner, reports regularly to the department's Executive Compliance Steering Committee regarding the compliance status of facilities. The Executive Compliance Steering Committee is comprised of members of the Commissioner's Executive Group and other key department staff. The Compliance and Privacy Officers for individual facilities conduct a range of activities to ensure client privacy and confidentiality including:

- 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 facility 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.

Continuum of Mental Health Services

988

DMHAS partners with the United Way of Connecticut to administer the state's 988 crisis line and the CT-specific Adult Telephone Intervention and Options Network (ACTION) Line for individuals in the state who in the midst of a psychiatric or emotional crisis for which an immediate response may be required. Call center staff are trained to offer an array of supports and options to individuals in distress, including: telephonic support, referrals and information about community resources and services; warm-transfer to the Mobile Crisis Team (MCT) of their area; and when necessary, direct connection to 911.

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 Authorities (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. DMHAS has been working diligently with the adult mobile crisis providers to expand these services to be 24/7. More than half of the teams in the state are currently providing mobile crisis services 24/7 with plans for all teams to be operating 24/7 by the end of 2024.

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 aged 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.

Other Residential Programs

Transitional Residential Services

Transitional residential services are for individuals age eighteen (18) or older who have serious and persistent psychiatric disorders, or co-occurring serious and persistent psychiatric disorders and substance use disorders. Transitional residential services are 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 is approximately thirty (30) days.

Supervised Apartments

Supervised apartments provide long-term independent housing for individuals age eighteen (18) or older who have serious and persistent psychiatric disorders who do not require the intensive supports provided within more acute residential settings. Individuals residing in supervised apartments have access to staff 24/7 who provide a range of support services for residents to help them manage their symptoms and functioning in the community.

Inpatient

DMHAS operates two state hospitals and several other smaller inpatient units throughout the state (Hartford, Bridgeport, New Haven).

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. DMHAS currently funds or operates approximately 35 CSP programs throughout the state. CSP utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, individual, and group psycho-education and skill building for activities of daily living, peer support and self-management.

CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile staff. Services are focused on skill building with a goal of maximizing self-management skills and independence. Community-based treatment enables the team to become intimately familiar with the individual's surroundings, strengths and challenges, and to assist the individual in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Mental Health Bed Registry

DMHAS launched a real-time bed availability website for all DMHAS operated and funded mental health beds in 2020. The website includes over 1700 beds across 45 agencies, including Inpatient, Intensive, Group Home, Supervised, Transitional, and Respite beds. Bed availability is updated at-least weekly by providers, with a departmental push towards real-time updates. CSD maintains this website in partnership 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

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 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

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

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.

Continuum of Substance Use Services

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 for Opioid Use Disorder and Ambulatory Withdrawal Management:** medication for opioid use disorder (MOUD), counseling and management of withdrawal for alcohol, heroin and other opioids in a non-residential setting
- **Withdrawal Management:** medical management of the withdrawal from alcohol and drugs along with, MOUD, 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 (ASAM 3.7, 3.5, 3.3, 3.1)
- **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 MOUD (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 Use Prevention, Treatment and Recovery Services 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 MOUD 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.

Withdrawal Management 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 substance use outpatient services for veterans. . 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 use is provided. These senior services are delivered in homes, senior centers, and nursing homes as necessary.

Medication for Opioid Use Disorder

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 Withdrawal Management

Ambulatory withdrawal management 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 (https://www.ctaddictionservices.com/). 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

The Evidence-Based Practices and Grants division within DMHAS works to promote the adoption of evidence-based practices throughout the system of care. The division takes the lead in writing and submitting applications for SAMHSA discretionary grants which are often the vehicle for incorporating EBPs into the system. Division staff also work to support implementation and fidelity monitoring of EBPs to ensure the highest quality of services. EBPs are embedded within the mental health and substance use services continuum and are made available to their targeted populations. The EBP Division maintains a webpage on the DMHAS website which provides an overview of the different EBPs available within the behavioral health system. The webpage includes information and resources to support implementation among providers, as well as information for consumers and families (https://portal.ct.gov/DMHAS/Initiatives/Evidence-Based/EvidenceBased--Best-Practices).

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 has continued this work through contracts with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model for a couple of years. DMHAS is currently re-invigorating this work and has convened a system-wide workgroup for the state operated programs that is advancing new emphasis in this area.

Supported Employment

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.

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 to monitor and continually improve these programs and services.

Latino Outreach

The intent of Latino Outreach services is to reduce the stigma that surrounds substance use in the Latino community, to identify Latinos who have a substance use disorder for which they are not seeking treatment and help connect them with treatment, to help decrease the numbers of Latinos discharged from treatment programs against medical advice or for non-compliance, and to raise awareness of substance use programs about the cultural needs of Latinos as well as the services the Latino Outreach Programs provide.

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.

Dialectical Behavior Therapy (DBT)

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

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).

Recovery Services

Connecticut offers a range of recovery support services for people with SMI/SED that are included within the mental health and substance use service continuum. These services include peer support, peer vocational services, community-based peer bridging services, parenting support and parenting rights education for parents with psychiatric disabilities, as well as supported education and employment. These services provide coaching, education about alternative approaches to healing and recovery, skill building for self-management, family support, as well as connection to resources and supports. Connecticut also has a number of Warm Lines operating throughout the state through which individuals can receive telephonic support services from people who have experience/expertise with mutual support. Recovery services and peer recovery staff are also integrated within various levels of care within the behavioral health system: Assertive Community Treatment, Community Support Program (CSP) teams and Supported Employment programs.

DMHAS also supports and contracts with Recovery Community Organizations (RCO) to provide peer recovery services. The Connecticut Community for Addiction Recovery (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 provide telephonic peer support to individuals who are early in their recovery and requesting support. Assistance may also be provided in the form of transportation to self-help support meetings, as well as information about available resources and supports in the community that are supportive of the individual's recovery. CCAR also operates an Emergency Department Recovery Coach program. Through this program, hospital emergency departments will contact an assigned and 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 program now provides this service to all 29hospital emergency departments.
In addition to the recovery support services operated by CCAR, DMHAS funds MOUD recovery coaches in each region of the state. These coaches engage with and support individuals who are receiving MOUD, to help them continue their recovery. DMHAS also contracts with Advocacy Unlimited, a peer run agency that provides a variety of mental health supports. DMHAS contracts with a new Black-led Recovery Center in New Britain to provide training for a variety of stakeholders.

These programs and services identified above are staffed with individuals holding one of three certifications as peers and recovery support specialists, and DMHAS is currently in the process of developing a centralized Peer Recovery Certification for Connecticut. The goal is to ensure that one standardized set of Peer Principles, Core Competencies and Code of Ethics are endorsed statewide and are in alignment with national best practice (SAMHSA, NCPRSS).

At a statewide level, DMHAS has the Office of Recovery Community Affairs within the office of the Commissioner. This office and its director act as a liaison between DMHAS and the recovery community, including the state's peer led advocacy organizations. Through this office and its Director, DMHAS 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. The Office of Recovery Community Affairs has the responsibility for the development, support and expansion of community-based peer support in the state, including policy development, project coordination, as well as collaboration with grass roots peer

organizations. The Office also coordinates various events and initiatives related to peer and recovery services, such as the Hearing Voices Network. As part of this initiative, five international trainers in the Hearing Voices approach and the Maastricht Interview Technique were brought together with voice hearers, 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.

Targeted Services and Populations

First Episode Psychosis/Early Serious Mental Illness

Currently, DMHAS funds FEP/ESMI services in two of Connecticut's largest metropolitan areas, the greater Hartford region and the greater New Haven region. In addition, DMHAS is currently working to expand the availability of FEP/ESMI services across Connecticut by providing training and consultation to clinical teams in community-based clinics in each service region of the state.

In the greater New Haven region FEP/ESMI services are contractually provided by The Yale STEP program, a nationally recognized FEP program that was developed through a public-academic partnership between Yale and DMHAS and housed within a community mental health clinic collaboratively administered by DMHAS and Yale. STEP is staffed by mental health providers in different fields – psychology, psychiatry, nursing, and social work. This "interdisciplinary" team seeks to provide comprehensive care for individuals 17-26 years' old who are early in the course of a psychotic illness in order to prevent symptoms from becoming disabling. Treatment at STEP starts with thorough assessment in order to gain the best understanding of what may be causing the person's difficulties. Based upon individual needs and preferences, treatment may include medication management, community coaching (e.g. support in getting back to school or work), individual and group therapy, as well as support and education for family members and friends. Access to the program is available through referrals by healthcare providers, educational professionals, family members and individuals.

In the great Hartford region, FEP/ESMI services are contractually provided by the Potential program based in Hartford Healthcare's Institute for Living. The Potential Program is an early intervention model for patients 17-26 years' old who are currently presenting with psychotic symptoms that are currently interfering with daily functioning and are found to be distressing to the individual. Treatment is tailored to the individual's unique needs and can include group therapy, individual therapy, family therapy, medication management, cognitive remediation, educational support, support and education for family members, and community trips to help with rehabilitation.

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 holds a bimonthly meeting that 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

Women's Services (WS), as part of DMHAS Statewide Services Division, is the education and implementation division for women's health and wellness initiatives across Connecticut for DMHAS. The department currently consists of a Program Director and 3 Program Managers. All staff are master's level professionals including one Master of Public Health and three licensed clinicians who use their clinical expertise to enhance the work.

WS staff are subject matter experts in a variety of topics related to women's health, including: trauma responsiveness, behavioral health treatment and recovery (including mental health, substance use and opioid use disorders), medication assisted treatment, gender specific best practices, LGBTQIA+, inter-partner violence, reproductive health and sexual wellness, and prenatal and postpartum wellbeing. Additionally, WS staff have extensive experience in prevention, advocacy, policy development, contract compliance and program operations.

WS furthers DMHAS' mission in a number of ways through our daily operations. These activities include:

- WS staff organize and/or are contributing members of numerous workgroups, councils and learning collaboratives, aimed at improving the lives of women, birthing persons, and children in CT.
- Internal to DMHAS, WS staff works collaboratively with other units including Evidenced Based Practices and Grants Division (EBP), Evaluation, Quality Management and Improvement Division (EQMI), Fiscal Services Division, Community Services Division (CSD), and the Office of Multicultural Health Equity. Internal collaboration includes data collection and sharing, grant identification and submission, contract development and oversight, and SUD program performance improvement.
- WS oversees contracts for numerous women-specific SUD treatment programs statewide across the DMHAS continuum of care. On-going activities include site visits (annual and follow up as needed), technical support, staff trainings, and review of critical incidents and client cases.
- In FY 2020, WS began managing the DMHAS contract with the CT Women's Consortium (CWC). Per this contract, the CWC provides space, technology, and expertise to organize and execute numerous meetings and trainings for the DMHAS continuum of care throughout the year.
- WS developed new or continued existing partnerships to enhance services, knowledge, and treatment for women across the state.

Overview of Women Specific Programs

Women's Services currently oversees a variety of programs including: 7 Women's Residential programs (5 Pregnant and Parenting Women's Residential programs, 2 Pregnant and Parenting Women's Recovery Support Program ,) 5 Outpatient programs, 2 Intensive Outpatient programs, 5 Women's REACH and program. All program services are gender-specific and trauma-responsive.

In addition, DMHAS WS oversees a number of special projects related to SAMHSA grants and COVID relief funding, including: PROUD (Parents Recovering from Opioid Use Disorder,) expansion of doula services throughout the system of care, expansion of the REACH program, expansion of LGBTQ+ training, expansion of Hoarding training, enhancement of Intimate Partner Violence (IPV) services in collaboration with the Connecticut Coalition Against Domestic Violence (CCADV), and technology and training enhancement for the 6 PPW residential programs and 1 Women's Recovery Support Program.

All programs participate in annual program visits that include a review of selected client treatment and service records, a review of program staff supervision and training history, and an examination of policies and procedures. Additionally, a client focus group is facilitated by WS staff to ensure that the client experience is captured. Technical assistance and opportunities for staff training are provided to programs on an on-going basis. Historically, all site visits have occurred on site within programs; however, a change in policy and procedure was updated to conduct visits virtually in response to the COVID19 pandemic.

Women's Residential SUD Services (101 beds Statewide)

All services are gender-responsive and trauma-informed, and are tailored to meet the specific needs of women with co-occurring disorders. Harm reduction practices and overdose risk reduction education are a component of all programs. Treatment incorporates evidence-based practices and evolves to meet the needs of women in care. Priority admission is given to women with an opioid use disorder.

Additionally, the programs provide and/or refer women to the following services:

- Individual and/or Group Therapy
- Medication Assisted Treatment/Medications for Opioid Use Disorder
- Peer Support/Recovery Coaching

- Reproductive Health Education
- Mental Health Evaluations
- Parenting Skill Development
- Case Management Services
- Employment Readiness Skills

The Women's Residential SUD programs are:

- Community Health Resources – Milestone Program (Putnam)
- McCall Center for Behavioral Health – Hanson House (Torrington)
- Perception Programs – Perception House (Willimantic)
- MCCA—Trinity Glen Women's Program (Kent)
- SCADD – Coit Street Women's Program (New London)
- Mercy Housing and Shelter Corp.— Recovery House (Hartford)
- Recovery Network of Programs – Tina Klem Serenity House (Bridgeport)

Pregnant and Parenting Women (PPW) Residential SUD Services (48 beds Statewide)

Provide specialized state-funded substance use residential treatment to pregnant women and women with dependent children. Pregnant women are granted priority access. Program applicants must be connected to residential treatment within 48 hours of their request. If a bed is not available at that time, applicants must be offered interim services that include, at a minimum, a referral for prenatal care, the REACH program, and PHP or IOP treatment. Program services include: substance use and mental health assessments, medication management, overdose risk reduction education, on-site case management, connection to recovery resources, individual, group and family therapy, reproductive health education, CAPTA education and assistance with development of Plans of Safe Care, and linkages to Medication Assisted Treatment/Medications for Opioid Use Disorder. Women receive 20 hours of treatment per week that includes activities around:

- Relapse Prevention and Overdose Risk reduction
- Reproductive Health and family planning
- Recovery Planning & support network development
- Parenting & Attachment Education and skill building
- Trauma and Co-Occurring Disorders

The PPW residential programs are:

- Apt Foundation— Amethyst House (New Haven)
- Community Health Resources— New Life Center (Putnam)
- InterCommunity, Inc. – Coventry House (Hartford)
- Wellmore – Women & Children's Program (Waterbury)
- Liberation Programs – Families in Recovery Program (Norwalk)

Women's Recovery Support Program

The Women's Recovery Support Programs (WRSP) are step-down program where pregnant and/or parenting women participate in community treatment while living in a safe and structured environment. Clients meet with their case manager on a weekly basis and attend daily psychoeducational groups related to parenting skills, recovery promotion, women's wellness, overdose prevention, discharge planning and more.

Prior to transitioning into WRSP, a discharge meeting is held with the referring provider, client, Women's Recovery Support Specialist (if applicable) and the WRSP team to review future scheduled appointments with established providers (Behavioral health treatment, OBGYN, Psychiatric, MAT/MOUD, Recovery Supports, etc.), the client's treatment plan goals, and program operations.

The WRSP programs are:

- The Connection, Inc. – Hallie House (Middletown)
- The Connection, Inc. – Coley House (Middletown)

Women Specific Intensive Outpatient (IOP) and Outpatient (OP) Services

Provide outpatient services to women age eighteen (18) or older who have severe and persistent substance use or co-occurring disorders. IOP is defined as non-residential treatment for a minimum of three (3) hours per day, ranging from 9 to 20 hours of structured programming per week. OP treatment activity hours are variable and based on client need and/or preference. Women specific IOP and OP services are gender-specific and trauma-responsive. Additionally, in an effort to reduce barriers to accessing and participating in treatment, all women's service OP and IOP offer on-site childcare.

During the COVID pandemic, the need arose for the IOP/OP service providers to develop virtual telehealth modalities (audio/visual) for clients to continue to engage in group and individual treatment, without having to physically come into an actual building and be in spaces where social distancing could be difficult. This flexibility has allowed for countless clients to continue to receive care and have access to their recovery supports, clinicians and medication prescribers without taking on additional risk. While all women's specific IOP/OP programs have returned to some level of in person treatment, telehealth treatment remains as an option in all programs to some degree and is utilized based on the individual needs of a client.

Intensive Outpatient Services:

- Family & Children's Agency – Project Reward (Norwalk)
- Wheeler Clinic – Lifeline (New Britain)

Outpatient Services:

- CASA, Inc. – Project Courage (Bridgeport)
- Wheeler Clinic – Lifeline (New Britain)
- MCCA – Women & Children's Program (Danbury)
- The Connection – Counseling Center (Groton)
- APT Foundation – Access Center (New Haven)
- Wellmore – Behavioral Health (Shelton and Waterbury)

Women's REACH (Recovery, Engagement, Access, Coaching & Healing) Program

WS oversees the DMHAS REACH contracts with five community based agencies (Chemical Abuse Services Agency (CASA), McCall Center for Behavioral Health, Advanced Behavioral Health (ABH), The Village for Children and Families, and The Connection Inc.). Each of the five REACH programs provides outreach and engagement services to one DMHAS geographic region. The five regionally based Women's REACH programs provide access to three female Recovery Navigators, who offer pregnant and parenting women comprehensive case management and recovery coaching services. Recovery Navigators are women with lived experience who are in recovery from their own substance use or co-occurring disorders; they use their personal journey to help support others. WS staff facilitate monthly meetings with the recovery navigators and supervisory staff, provide ongoing technical assistance and

training, and offer an annual retreat for all recovery navigators. COVID specific funding has allowed for expansion of the scope of individuals able to access the REACH program; effective September 1, 2021 each program added a "Family Recovery Navigator." This family recovery navigator helps support families impacted by substance use disorders including partners, single fathers, LGBTQ+ families, grandparents and/or relatives acting in the primary caregiver role.

PROUD: Parents Recovering from Opioid Use Disorders Program

WS 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. This includes the urban and suburban communities in and around: Hartford, Manchester, Enfield, Windham, Middletown, Meriden, Waterbury, Bristol and New Britain.

Intercommunity and Wheeler Clinic are the direct service providers of the PROUD initiative; DMHAS oversees these contracts, and provides ongoing technical assistance, programmatic oversight, and monitoring to ensure compliance with contract and grant specific expectations. Each site team 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. Special attention was paid when developing the PROUD service model to address traditional barriers PPW encounter when trying to access or remain in treatment. In response to this, 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. Telehealth services are also offered to clients and have been a popular format for receiving services when there are COVID related concerns. Additionally, Wheeler Clinic and Intercommunity provide wrap-around services to PPW and their family members/partners to support whole-person health, including: behavioral health, primary care, MAT/MOUD, and pediatric care. The PROUD site teams also engage in extensive community outreach and engagement activities, including ongoing collaboration with the birthing hospitals in their geographic catchment area. 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 funding has being utilized to support the creation and dissemination of marking materials by the O'Donnell Group.

DMHAS WS meets with all contractors on a monthly basis and as needed to support contract and grant-specific compliance, plan for upcoming activities, and promote collaboration and professional development.

Access Mental Health for Moms

Connecticut ACCESS Mental Health for Moms is a consultative psychiatry service to be made available to all of Connecticut's perinatal practitioners (Obstetricians, Gynecologists, Midwives, Primary Care Providers, MH/SUD Treatment Providers) working with pregnant and post-partum women presenting with mental health and substance use concerns irrespective of insurance coverage.

The purpose of ACCESS Mental Health for Moms program is to improve access to treatment for perinatal women with mental health and/or substance use concerns. By providing real-time access to a team of behavioral health experts, the program is designed to increase the competencies of front-line medical providers to identify and treat behavioral health disorders in perinatal women and to increase their knowledge/awareness of local resources designed to serve the needs of perinatal women with these disorders and their families.

The service is to be delivered primarily through telephonic communication by members of the ACCESS Mental Health for Moms consulting team (Hub). When warranted, circumstances may require face-to-face consultation with the perinatal practitioner or in-person behavioral health assessment of the pregnant or post-partum woman for whom the practitioner is seeking consultative support.

Individuals with SMI/SUD Experiencing Homelessness

Recognizing the link between housing and behavioral health, and in an effort to decrease the number of homeless individuals with SMI and/or substance use disorders, DMHAS maintains a specialized unit focused on homeless services. The Housing and Homeless Services unit manages a range of programs and services which seek to address the behavioral health and housing related needs of individuals experiencing homelessness.

Projects for Assistance in Transition from Homelessness (PATH)

This unit continues 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.

Department of Housing and Urban Development (HUD) 2022 Special Notice of Funding Opportunity

DMHAS was awarded approximately $13 million in federal Housing and Urban Development (HUD) funding through the 2022 Special Notice of Funding Opportunity (SNOFO) to target, through outreach and supportive housing, the unsheltered homeless population. This funding will be distributed throughout the Balance of State Continuum of Care (CTBOS CoC) which covers all of CT except for Fairfield County.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

SOAR is a model used to help individuals complete the SSI/SSDI application to assist them in gaining access to the disability income benefit programs administered by the Social Security Administration (SSA). The SOAR model is used to support eligible adults who are experiencing homelessness or who are at risk of experiencing homelessness and have a serious mental illness and/or a co-occurring substance use disorder. These individuals often cycle in and out of emergency settings and institutions, and SSI/SSDI benefits are sought to help individuals maintain stable income and housing so that they can remain in the community. SOAR staff meet with individuals in the community to help them gather the necessary documentation and materials to complete their application for SSI/SSDI. Currently the state has SOAR staff placed in each service region of the state.

Outreach and Engagement

In addition to PATH and SOAR, DMHAS 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.

Supportive Housing

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.

Homeless to Housing (H2H)

DMHAS has developed a new collaborative service delivery program which creates service teams to support people experiencing unsheltered homelessness find and sustain stable, safe, permanent housing. The H2H program will support people experiencing unsheltered homelessness, find and sustain stable, safe, permanent housing by addressing the individualized needs of each consumer. The program will conduct outreach to persons residing out of doors and in places not meant for human habitation to assist them in locating permanent housing; once housed the program will continue to provide housing support services to ensure tenancy sustainability. Outcome goals include ensuring service staff are canvassing for people experiencing unsheltered homelessness, connecting them to the Coordinated Access Network (CAN), entering them on the statewide *By Name List,* to prioritize and advocate for subsidized housing opportunities, connecting to behavioral health services and increasing income through gaining employment or SSI/SSDI.

Older Adult Services

DMHAS coordinates and oversees behavioral health services to older adults through its Long Term Services and Supports (LTSS) unit. This unit continuously expands its statewide partnerships to coordinate and improve care to older adults. The LTSS Clinical Director has an active role in the CT Office of Policy and Managements' Long Term Care Planning Committee, Medicaid Long Term Services and Rebalancing Committee and the Connecticut 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.

With regards to direct services to older adults, DMHAS LTSS manages the Senior Outreach and Engagement Program that serves older adults with SUDs and mental health needs. Five private nonprofit agencies in Connecticut, representing each of the 5 DMHAS regions, focus on outreach and engagement with 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 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 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. The program expanded in 2023 with the addition of one full time staff in each region, doubling the capacity of the program statewide.

Senior Outreach and Engagement Provider	**Locations Served**
Family and Children's Agency	Region 1 (Bridgeport, Norwalk & Stamford)
Bridges	Region 2 (Middletown, Meriden & New Haven)
United Services	Region 3 (Norwich, New London & Willimantic)
Wheeler Clinic	Region 4 (Hartford, New Britain & Manchester)
McCall Foundation	Region 5 (Danbury, Waterbury & Torrington)

The Senior Outreach and Engagement Program complements and collaborates with existing DMHAS programs, such as the Nursing Home Diversion and Transition Program (NHDTP), which focuses on diverting older adults with behavioral health needs from long term care and developing home and community-based services to assist older adults with aging in place. 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 older adults and assist them with aging in place. The program expanded in 2022 with the addition of two (2) nurses and a case manager to address the growing need for ongoing education and training to Residential Care Homes and LTSS providers across the state. Training topics include boundaries and power struggles, crisis de-escalations, healthy communications and mental illness 101 and have been well received.

DMHAS LTSS also collaborates with the CT Department of Social Services' Money Follows the Person Demonstration Project and the Mental Health Waiver Program. These programs also seek to maintain individuals in the least restrictive setting by offering any array of intensive community-based services to adults and older adults with SMI, to help them remain in the community. DMHAS and the Department of Social Services (DSS) completed the application for renewal of waiver services for the next 5 year waiver period and were approved, through the Centers for Medicare and Medicaid Services (CMS), to continue waiver services for the period April 1, 2022 through March 31, 2027. For the current waiver period, that began April 1, 2022, the waiver added two (2) new waiver services, Mental Health Counseling and Interpreting services to better meet the changing needs of the participants served. The program also added two (2) new waiver clinicians to meet the increase in program referrals and ensure clients were assessed in a timely manner.

Forensic Services

The DMHAS Division of Forensic Services was established to implement and coordinate specially-skilled evaluation and treatment services for individuals with serious mental illness and/or substance use disorders who become involved in the criminal justice system, and to serve the courts and other components of the criminal justice system. Division efforts are intended to promote recovery and prevent or limit criminal justice system involvement to the extent possible, to promote public safety and to coordinate activities with other state and private agencies. Services within the Division span the continuum of the criminal justice system from pre-booking to end of sentence after incarceration and return to the community.

The five major components of the Division of Forensic Services provide clinical programming, specialized consultation and evaluation services, specific intervention programs to divert people from the criminal justice system and into treatment where possible, programs to help people re-enter community living successfully after a period of incarceration, and training and consultation to the criminal justice system. In all these efforts, one of our overarching goals is the decriminalization of mental illness. These components are as follows:

Whiting Forensic Hospital

Whiting Forensic Hospital provides high quality, comprehensive, and individualized treatment and evaluation services for patients with mental health conditions who are involved in the criminal justice system or are not yet ready to be safely treated in less restrictive settings. The hospital consists of 91 maximum security beds and 138 enhanced security beds.

Consulting Forensic Psychiatry Services

Consulting Forensic Psychiatry Services provide risk management consultations to hospital and community providers to assure safe and viable treatment plans for DMHAS clients that are attentive to relevant risk factors for the individuals.

Office of Forensic Evaluations

The Office of Forensic Evaluations (OFE) provides a host of evaluations pursuant to state statute, including competence to stand trial, substance dependency, restoration of competency, and reports to the Psychiatric Security Review Board. OFE employs full-time licensed clinical social workers with specialized forensic training, as well as consulting forensic psychologists and psychiatrists. OFE has four offices, which are located in Bridgeport, Hartford, New Haven, and Norwich, with central administration in Middletown on the campus of Connecticut Valley Hospital (CVH). OFE completes nearly 2000 evaluations per year.

Community Forensic Services

Community Forensics Services (CFS) implements an array of court-based and community base services that support individuals with a serious mental illness and/or substance use disorder who are justice involved or at-risk of justice involvement. These programs include:

Jail Diversion/Court Liaison Program

Jail Diversion/Court Liaison programs provide court-based services to persons with psychiatric disorders, substance use disorders and co-occurring (mental health and substance use) disorders who are arrested on minor offenses. The primary function of the program is to facilitate access to appropriate treatment services by providing assessment, referral, and linkage to community mental health services. Diversion staffs work to maintain individuals in community treatment services, inform court personnel of treatment compliance, and facilitate access to mental health services through contacts within the Department of Correction when an individual is incarcerated.

Women's Jail Diversion (JDW)

JDW serves women at risk of incarceration in New Britain, and New Haven courts. Comprehensive treatment and support services promote recovery among women with histories of trauma through immediate access to a trauma informed and comprehensive system of care. Services include treatment for trauma, mental illness, and substance use as well community support services and limited transitional housing. In addition to referrals from court, JDW accepts referrals from Probation and Parole. The program achieves significant reduction in incarceration and in future arrests.

Alternative Drug Intervention (ADI)

ADI provides intensive outpatient substance use treatment to 100 to 120 New Haven residents per year. It is the successor to the New Haven Drug Court, providing intensive case management, basic needs, employment, education and linkage to 12-Step groups. Eighty-five percent of participants successfully complete the 6 month treatment program without re-arrest.

Office of Pretrial Interventions

The Office of Pretrial Interventions operates two programs under CT General Statutes to serve people referred by the court. The Pretrial Alcohol Education Program and Pretrial Drug Education Program are provided to help individuals avoid convictions for drug and/or alcohol related arrests by offering educational programming aimed at increasing awareness of risks associated with drug and/or alcohol use and available resources.

Community Recovery Engagement Support and Treatment Center (CREST)

CREST is an intensive day reporting program which provides daily monitoring and structured skill building and recovery support services for participants. The program serves up to 30 participants who would not otherwise be diverted from or released from incarceration if not accepted into the program. Services are provided in collaboration with clinical services at the DMHAS-operated Connecticut Mental Health Center to ensure comprehensive, individualized treatment.
Advanced Supervision and Intervention Support Team (ASIST)

<u>Enhanced Forensic Respite Bed (PILOT)</u>

This program provides residential mental health treatment as well as transition planning to persons who otherwise would be incarcerated or hospitalized while awaiting competency evaluation and restoration for a misdemeanor charge. The program will also provide counseling/clinical case management for similar individuals who do not need residential treatment.

Recovery Coaches

Recovery Coaches will be added to support Jail Diversion teams in 3 areas of the state that have high concentrations of opioid overdoses, Hartford, Waterbury and Bridgeport. The Recovery Coaches will be hired through Connecticut Community for Addiction Recovery (CCAR) and serve individuals with SUD living in the community who are justice-involved and who are at-risk of being incarcerated. The Recovery Coaches will provide temporary support and stabilization services to a population that was significantly impacted by the pandemic to assist with linkage to long-term services.

Transitional Services

Criminal Justice Interagency Program

The Criminal Justice Interagency Program promotes recovery and re-integration for people with severe psychiatric disabilities, who are transitioning from state correctional facilities to the community, through a comprehensive referral program. Individuals are referred to the program 3-6 months prior to their release from the DOC and meet with a representative from the appropriate Local Mental Health Authority to arrange for services in the community. This program also facilitates communication among DMHAS, DOC, the Court Support Services Division of the Judicial Branch, Probation, and Parole to resolve system issues and coordinate care.

Connecticut Offender Re-entry Program (CORP)

CORP provides services for offenders with mental illness, returning to the Hartford, Bridgeport, New Haven, Norwich/New London, Waterbury, and New Britain/Bristol communities after an extended period of incarceration. CORP serves men and women with severe psychiatric disabilities with or without a co-occurring substance use disorder. The emphasis is on developing skill and structure needed for successful reentry and also on reducing recidivism by identifying and intervening in those areas most in need. The CORP program extends culturally appropriate intensive case management, integrated mental health and substance use treatment services, and linkages for men and women to their community.

Transitional Case Management

DMHAS, in partnership with DOC, established the transitional case management program forinmates with significant histories of substance use who are discharging to Hartford, Norwich/New London, New Britain/Bristol and Waterbury. The program includes: pre-release development of a recovery-oriented reentry plan by the community case manager, DOC counselor, and the individual; and transitional case management by the community case manager to implement the plan; and post-release substance use treatment, community support/encouragement, transitional housing and employment

Conditional Release Service Unit (CRSU)

CRSU provides oversight, consultation, and training to community agencies that provide temporary leave and conditional release services to individuals committed to the jurisdiction of the Psychiatric Security Review Board (PSRB). Additionally, the unit serves as a link between DMHAS, Local Mental

Health Authorities, state funded agencies and the PSRB to enhance the coordination of services, the monitoring of persons on conditional release, and reporting to the PSRB.

Young Adult Services

The Department of Mental Health and Addiction Services (DMHAS) statewide Young Adult Services (YAS) program was established to facilitate the successful transition of young adults from the Department of Children & Families (DCF) to the adult mental health system and facilitate acquisition of the necessary skills for adulthood. DMHAS YAS currently has MOAs with the Department of Children and Families (DCF), Beacon Health Options, and Court Support Services Division (CSSD) to facilitate early engagement, referral, assessment, and transition planning for youth and young adults as early as age 16. Other referral sources include Department of Corrections (DOC), school systems, hospitals, community providers, and self-referrals through the DMHAS Local Mental Health Authorities (LMHAs). The current population served by YAS includes the most acute, high-risk cohort of young adults in the state between the ages of 18 and 25.

The YAS service system consists of 18 community-based age-specific programs at state-operated and private non-profit LMHAs across the state of Connecticut which provide intensive, individualized wraparound interventions within an array of milieus. Services include treatment in community based specialized residential programs, supervised apartments, and supported housing, as well as outpatient and recovery support services such as behavioral planning, case management, psychiatric and clinical services, medication management, educational and vocational support, coaching, peer support, and perinatal support services for pregnant and parenting young adults. YAS also funds a 17-bed inpatient unit at CVH. In addition, there are out-of-state contracted private non-profit residential sites providing specialized services not available in CT.

All aspects of YAS services are trauma-informed, built upon the principles of trauma treatment, predicated upon a client's individualized needs, and are voluntary, strength-based, person-centered, and recovery oriented. The focus of services is on:

- Providing clinical and behavioral interventions to mitigate risk to the community or injury to self or others
- Assisting clients to develop viable and durable recovery and social support systems
- Fostering school success and vocational readiness with a significant emphasis on assisting clients in the early phases of employment
- Fostering adaptive, pro-social behaviors
- Teaching independent living skills and social skills
- Fostering supportive relationships using both traditional clinical supports, positive behavioral supports, case management, wraparound, and nontraditional supports, including peer support
- Providing services *in vivo*; focusing on activities, developing coping skills to deal with the impact of trauma and affect dysregulation, and emphasizing stabilization through supports, rather than relying predominantly on office-based psychotherapy
- Teaching symptom management skills
- Reinforcing substance use prevention and treatment
- Utilizing planned, structured step-downs to less intensive levels of support commensurate with clients' progress

<u>Current YAS Initiatives</u>

YAS ACE Study

Previous research conducted on the YAS cohort confirmed high-rates of childhood trauma exposure as measured by the Adverse Child Events Scale (ACE). More recently, YAS developed an enhanced instrument that adds additional measures of childhood adversities along with onset risk behaviors. In collaboration with the EQMI Division, itemized scores are entered directly into a centralized database that captures adversity data on every individual referred through the Office of the Commissioner YAS Division. Data analysis on these cases continues with the goal of informing YAS' efforts to better understand and mediate the effects of early childhood trauma on behavioral challenges in young adulthood.

Attachment, Self-Regulation and Competency (ARC)

YAS has been training direct care and clinical staff in the trauma-based ARC framework. The ARC Model builds staff competencies required to assist young adults with ameliorating the debilitating physiological, behavioral and psychological effects of their traumatic experiences. ARC is strongly grounded in the theoretical and research literature, drawing in particular from the fields of trauma, attachment, and child development, and anchored in the research on resilience.

Trauma Treatment

In an effort to provide a wider array of treatment models to YAS clients with developmental trauma, an initiative to train and supervise YAS clinicians in an evidence-based trauma model called ***Cognitive Restructuring for PTSD*** was completed this year. The model was presented by a nationally recognized trauma expert in a day-long intensive training followed by group and peer supervision for six consecutive months. Despite COVID-related challenges to in-person treatment, the initiative accomplished the goal of training 10 YAS clinicians statewide. YAS plans to train a second cohort of clinicians in the next year. YAS also offers EMDR Consultation and Trauma Informed Stabilization Treatment Peer Supervision to clinicians trained in these approaches.

Collaborative Support Model

The YAS OOC Clinical Assessment and Consultation team offers training and consultation to local agencies statewide in the use of the Collaborative Support Model (CSM). The Collaborative Support Model provides a systematic approach to address emotional dysregulation and challenging behaviors within residential settings. This model is based upon Dartmouth's Integrative Dual Diagnosis Treatment (IDDT) residential programming and has been modified to meet the needs of the young adult population.

YAS Substance Use Treatment Trainings

A five module training program was developed for YAS staff that focuses on increasing skills and knowledge of trauma, harm reduction and motivational interviewing in the context of young adult development. Presenters include staff from the Office of the Commissioner along with partners from local YAS programs who participated in the development of this curriculum.

YAS Perinatal Support Program

Providing supports to pregnant and newly parenting YAS clients increases the likelihood of healthy birth, healthy attachment between mother and baby, parenting sense of competency and an interruption in generational cycles of trauma and system involvement for these children. DMHAS YAS has collaborated with Birth Support, Education & Beyond, LLC (BSEB) around the development and implementation of a comprehensive Perinatal Support Program that provides services including home-visiting prenatal maternal and childbirth education, labor, birth & postpartum doula services and in-home parenting support and education services for all pregnant and parenting active YAS clients statewide.

Child Trafficking

YAS continues to collaborate with the DCF to facilitate the Introduction to Child Trafficking (formerly Domestic Minor Sex Trafficking DMST) in CT for statewide DMHAS YAS staff. In addition, four DMHAS staff have been certified as Trainers in the DCF Introduction to Child Trafficking Curriculum and have offered this training to statewide staff/providers. In 2022, this group of trainers began to meet to establish a DMHAS Human Trafficking Initiative/Committee with a Steering Committee and various workgroups to include: Training, Diversity/Equity/Inclusion, Prevention, Intervention, Policy and Practice, Medical, Housing, Legal, and Survivors/People with lived experience to increase awareness of human trafficking and integrate screening, assessment and survivor informed intervention into care.

Data Informed Program Monitoring

YAS OOC uses dashboard reports developed in collaboration with and generated by UConn School of Social Work that provide data related to discharge outcomes highlighting education/employment, housing stability and achievement of program goals at discharge. YAS also continues to collaborate with the Department's EQMI Division to create and enhance data reports related to the YAS Fidelity Scale developed to monitor statewide program standards and expectations.

Employment/Education Outcomes

YAS teams offer support to young adults through employment readiness training, and provide linkages to training, school and work. YAS incorporates IPS principles, with modification and added supports including coaching tailored to meet the developmental needs of young adults. Quarterly meetings with employment/education specialists are held to educate, share, review employment outcomes, strategize and validate successes. Since January 2021, YAS Employment/Education has facilitated a new Quarterly report tool that has provided enhanced data and outcomes around the engagement of young adults in employment and education opportunities.

DLA-20

In collaboration with the EQMI Division, YAS has successfully trained all state-operated and private non-profit programs to utilize the DLA-20 tool to measure outcomes of skill-based services. YAS is also collaborating with researchers at the University of Connecticut School of Social Work to measure skill improvements in the YAS client cohort using this tool. DLA-20 scores have also been integrated into quarterly Utilization Management (UM) discussions as a benchmark for program success and clients progress in statewide YAS transitional apartment programs and community based specialized residential programs.

UM – Transitional Apartments

YAS OOC provides funding and oversight to 16 transitional apartment programs across the state with 104 apartments beds in total. YAS continues to implement a UM Tool developed to ensure effective utilization of those beds with an emphasis on skill building, community integration of clients and intensive clinical supports to address high-risk behaviors. Recent data analysis suggests that transitional apartments are effective in decreasing high- risk behaviors, and that program alumni demonstrate housing stability at the one-year post completion mark. This tool has been modified for implementation across all YAS residential levels of care effective FY 23.

CT Stay Strong Grant

In 2020, five-year federal grant was awarded to Connecticut DMHAS und YAS Division to develop and implement an early intervention program for young people between the ages of 16 and 25 operated by the New Britain and East Hartford LMHAs. Stay Strong provides outreach, engagement, coordination of care and treatment support to youth and young adults who are considered to be at-risk for developing serious mental health disorders.

Young Adult Voice Initiative

The goal of this initiative is to increase young adult participation in all aspects and phases of service delivery by creating a practice that includes young adults as partners and decision makers serving on committees that determine policy, procedures, and program services, such as the statewide YAS Advisory Board and YAS Advisory Boards at each LMHA.

YAS Peer Support Services

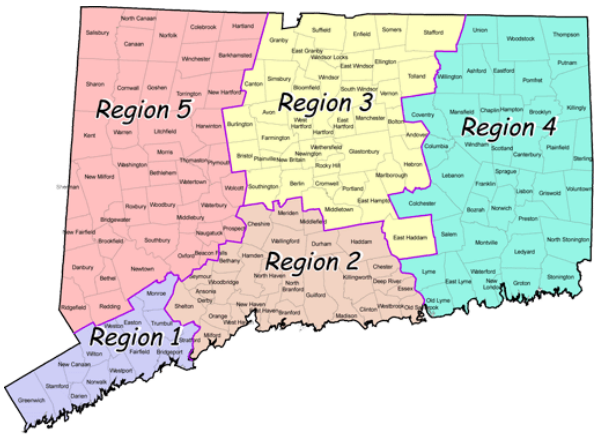
TurningPointCT.org, a website created by young adults for young adults, offers an online peer support community and uses technology to strengthen young adult engagement in mental health and substance use recovery by providing resources, developmentally relevant information, and social support. Enhancements to the TurningPointCT.org website have enabled youth and young adults to access live/real time online RSS peer support, coaching, training and other resources. YAS has also allocated funding to add RSS positions to many YAS state-operated and private nonprofit community teams to enhance local peer support services to young adults served in YAS.

Esports Pilot Project

YAS is collaborating with Affinity Esports, a community-based organization founded in 2021, in a pilot to offer social programming for young adults in YAS. Affinity Esports will provide social groups for young adults who enjoy gaming, but require additional prosocial experiences. Facilitated by gamers, the project models moderation, balance, health, and wellness in their gaming activities. It promotes the development of experiential learning through gaming, encourages safe spaces for personal expression, fosters teamwork, encourages in-person socialization among participants, and builds healthy habits that promote mental health and wellbeing. YAS plans to expand this pilot with Affinity Esports to offer additional age and developmentally appropriate exposure opportunities in areas such as graphic design and coding for young adults.

Rural Populations

While DMHAS does not have a standing division devoted to serving rural populations, access to the DMHAS behavioral health service array among rural populations is ensured through the regional administration and coordination of services in Connecticut. Connecticut is currently divided into five service regions, with the northwest (part of region 5) and northeast (part of region 4) sections representing the most rural areas of the state.



The regional administration and coordination of services in these regions takes into account their rural nature and low service density by focusing on access to treatment through transportation services, satellite offices, mobile services, and outreach programs that can reach people where they live in the community. To this end, DMHAS has recently increased staffing of mobile MOUD Teams and increased recovery supports among providers serving rural regions. Newly funded services include recovery coaches, located at 23 hospital EDs across the state, many of which serve patients from nearby rural towns. In addition, DMHAS has established the 24/7 Access Line to facilitate access to treatment for substance use disorders among populations with minimal access to transportation. Individuals from anywhere in Connecticut may call the Access line. For access to mental health services, DMHAS contracts with EdAdvance in the Northwest region and Reliance Health in the Northeast region, to provide transportation to mental treatment for individuals and families. As a note, these transportation services funded by DMHAS are in addition to transportation services that are available to Medicaid insured populations in Connecticut, to ensure that all insured and uninsured populations without transportation or proximity to service providers are able to access behavioral health services. increased capacity for MOUD services and recovery supports provided by agencies serving rural communities across the state.

In addition to ensuring physical access to treatment, DMHAS works to ensure that rural communities have behavioral health services that reflect their unique needs and preferences by contracting with local service providers that specifically serve rural regions of the state. Through the regional administration of behavioral health services, DMHAS outlines catchment areas for service providers in a way that allows them to focus on the needs of specific populations, regions, and communities. DMHAS contracts with Western Connecticut Mental Health Center to serve the northwest region of the state, and with United Services to serve the northeast region of the state. These providers have long histories of serving their respective rural communities and receive ongoing funds from DMHAS to obtain additional training and technical assistance related to serving rural populations.

Prevention and Health Promotion Services

Prevention and Health Promotion 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 SUPTRSBG–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.

State Educational Resource Center School-Based Center for Prevention, Education and Advocacy (SERC – Prevention Library) – is a K-12 statewide library and resource center for educators, students, families, organizations and communities' information on substance use and mental health disorders, prevention and health promotion, social-emotional learning, wellness and other related topics that is youth specific. The library contains supports, programs, practices, curriculums and interventions that is offered to school districts.

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 10 community-based programs/coalitions implement the 5-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, the **Connecticut Healthy Campus Initiative** (CHCI) also known as the ***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.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

DMHAS collaborates with and funds the University of Connecticut Center for Prevention Evaluation and Statistics (CPES) to develop a statewide needs assessment that serves as the epidemiological basis for identification of strengths, gaps, needs, and priorities within the state's behavioral health system, as well as the state's planning process for the Mental Health Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant. The needs assessment incorporates analysis and synthesis of quantitative data from an array of state and national sources. It also includes a distillation of findings from the state's biennial regional priority setting process, which compiles qualitative and quantitative information from local and regional stakeholders regarding the behavioral health needs, emerging issues and priorities within the state. Lastly, needs assessment includes a survey of the state's Behavioral Health Planning Council regarding their understanding of the gaps, needs, and emerging issues within the behavioral health system.

Using state and national sources, the needs assessment compares Connecticut data to that of the region and the nation, to identify potential emerging needs and service gaps in the state. The national data sources utilized within the needs assessment include: the Substance Abuse and Mental Health Service Administration (SAMHSA) 2022-2023 National Survey on Drug Use and Health (NSDUH); the Center for Disease Control and Prevention (CDC) 2023 Behavioral Risk Factor Surveillance System (BRFSS); the CDC 2023 Youth Risk Behavior Surveillance System (YRBSS); the United Way 2024 National 211 Impact Survey; Trevor Project; the United Health Foundation America's Health Rankings 2025 Senior Comprehensive Report; and US Census population estimates data. State data sources include: the Department of Mental Health and Addiction Services (DMHAS) SFY 2024 Annual Statistical Report; Department of Public Health 2023 Connecticut School Health Survey (CSHS - Connecticut's YRBS); DataHaven 2024

Community Wellbeing Survey (DCWS); Connecticut Statewide Opioid Response Directive (SWORD); Connecticut LGBTQ+ Needs Assessment; Connecticut Office of the Chief Medical Examiner (OCME) ; Connecticut Department of Public Health (DPH); the Connecticut Office of Rural Health; and the Connecticut Department of Children and Families.

DMHAS also funds and collaborates with Connecticut's State Epidemiological Outcomes Workgroup (SEOW) to support the Connecticut Behavioral Health Needs Assessment process. The SEOW, co-chaired by UConn Health and DMHAS and supported by CPES, operates through a DMHAS contract with the UConn Health Department of Public Health Sciences.

The SEOW is a collaborative of state partners focused on identifying and sharing data resources and encouraging more widespread use of these resources to improve substance use prevention, mental health promotion, and general behavioral health. SEOW partner organizations include: the 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 Corrections (DOC); Office of Policy and Management (OPM); State Department of Education (SDE); Regional Behavioral Health Action Organizations (RBHAOs); Board of Pardons and Parole; Connecticut Data Collaborative (CTData); the Office of the Child Advocate; the UConn Center for Public Health and Health Policy; and UConn Health Department of Public Health Sciences. The SEOW and CPES conduct an array of activities to support the identification of and response to behavioral health risks and needs throughout Connecticut, including:

• Identifying, collecting and analyzing data related to behavioral health issues;
• Assessing data quality and utility;
• Identifying indicators of risk and protective factors for substance use and related problems;
• Reviewing available data to assess and address health disparities in Connecticut;
• Identifying and tracking emerging substances and patterns;
• Supporting a statewide needs assessment that measures the prevalence and distribution of substance use and mental health-related problems;
• Promoting the use of data within the behavioral health prevention and treatment community and its partners through dissemination of data through the SEOW Prevention Data Portal and its products;
• Interfacing with Connecticut's Alcohol and Drug Policy Council (ADPC) and its Prevention Subcommittee;
• Promoting data-driven decision-making to improve planning, evaluation, and more effective and efficient targeting of prevention resources.

Connecticut also conducts additional assessment and recommendations for the children's behavioral health system through state's comprehensive Behavioral Health Plan for Children. This plan, originally developed in 2014 and continually updated, serves to guide the efforts of multiple stakeholders in creating a children's behavioral health system that builds on existing strengths and addresses the challenges faced by children with SED. The Behavioral Health Plan for Children was informed by input from many diverse families, service providers, and stakeholders at open forums, facilitated discussions, and community conversations held across the state. The implementation of the plan is overseen by the Behavioral Health Plan Implementation Advisory Board, appointed by DCF, and led by three tri-chairs. Workgroups are established to address specific needs identified by the board and their recommendations are reviewed by the Advisory Board to inform its annual progress reports to the Connecticut General Assembly. In FFY 24, this Advisory Board held 6 open forums across the state, facilitating input from parents, mental health experts, and community members; held 5 meetings of the advisory committee focused on the Plan's development; facilitated 12 discussions on aspects of the children's behavioral health system; and held 22 community conversations across the state specifically to gather input from families and youth regarding the children's behavioral health system and network of care in Connecticut.

Connecticut also has a legislatively established body, the Children's Behavioral Health Advisory Committee (CBHAC), which serves in an advisory capacity for system of care issues. Beginning in 2018, families were consulted over five years with the Statewide Family Advocacy Agency in collaboration with Yale University. The Family Advocacy Agency facilitated Community Conversations across the state. Beginning in August 2021, these conversations moved from formal facilitated conversations to informal discussions that were had by Peer Specialists. The current, more informal, community conversations continue to be facilitated by the Family Systems Managers from FAVOR.

The data and stakeholder feedback gathered from the Behavioral Health Plan for Children and CBHAC, is analyzed and used to identify and prioritize the current challenges within the children's behavioral health system.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

The statewide behavioral health needs assessment discussed in our response to question one identifies service needs and critical caps across a number of populations. Our response to this question will focus at a high level on the identified needs of the MHBG and SUPTRSBG priority populations. However, a full analysis of gaps and needs across all populations is included in the full report attached to this application section.

Pregnant Women and Women with Dependent Children (PWWDC)

Between 2023 to 2024, Connecticut experienced a reduction in the number of individuals admitted to substance use treatment programs who identified as pregnant at admission. In 2023, 293 (1%) of clients admitted to a substance use treatment facility identified as pregnant compared to 132 in 2024. The 2023 number was a slight increase from the 257 admitted in 2022. While the number and percentage has fluctuated, pregnant individuals have historically accounted for 1% or less of those admitted to

substance use treatment programs in Connecticut. While this data points to stability in the number on parenting individuals as a subpopulation, it is recognized that parenting individuals experience behavioral health issues associated with parenting stressors, including those related to their children's behavioral health, and benefit from programming the helps them manage these stressors while they are receiving treatment and working towards recovery. This points to the need for case management and recovery services for PWWDC that can address the needs of the family as a whole, while targeting the recovery of PWWDC.

While there is limited direct data focused on PPWDC, the state continues to capture data on the risk of substance exposure among infants. According to state CAPTA data for 2022, Marijuana remains by far the most commonly identified infant substance exposure, occurring in four out of five (80%) notifications. Infant exposure to Methadone (8.8%) and/or Buprenorphine (5.2%) was combined into an "MOUD" category revealing that 1 in 7 notifications involved infant exposure to one or both medications. The "Non-MAT Opioids" category (9%) includes both non-prescribed and prescribed opiates other than MOUD. Infant exposures are not mutually exclusive. Reports of infants exposed to multiple substances (i.e., Polysubstance) occurred in about 16% of notifications. These data point to the need for ongoing education for PWWDC as well as their service providers, regarding safe storage of medication and plans for safe use.

Persons Who Inject Drugs (PWID)
Client level admissions data over the past three state fiscal years show a continued decline of intravenous injection as the preferred route of administration for substances in Connecticut. The number of clients receiving services within the statewide behavioral health system who identified intravenous substance use declined from 8,522 in SFY22 (17%), to 7,931 (15%) in SFY24. Additionally, the statewide stakeholder survey and the Planning Council did not identify specific service gaps or needs for PWID. However, given the high risk associated with intravenous substance use there remains an ongoing need for quick and responsive access to treatment for this population, as well as education and support to help PWID mitigate the health risks associated with this route of administration.

Additionally, although intravenous substance use is on the decline overall within the state, certain populations have been identified to have higher rates of intravenous use compared to others. The Latino population in Connecticut was identified as having higher rates of intravenous drug use compared to other ethnic groups in the state, identifying a need for support services that target this population.

Persons in need of recovery support services for SUD (PRSUD)
While state and national survey data identified adequate levels of recovery support services for PRSUD, Planning Council members frequently identified case management services and peer/recovery supports as treatment levels that are unavailable or inadequately provided in the substance use services system for PRSUD. Additionally, workforce development and training were identified as needs within the Recovery Support workforce. These findings point to the need to increase awareness of existing peer/recovery supports and to improve workforce development within the recovery support workforce.

Individuals with a co-occurring mental health and SUD
According to the most recent NSDUH data for Connecticut, prevalence estimates of co-occurring substance use disorder and any mental illness (AMI) for adults in Connecticut showed that nearly 1 in 10 adults (9%) and nearly 2 in 10 (17%) young adults had these conditions co-occurring. Prevalence was higher for both young adults and adults in Connecticut than in the Northeast US and the nation. In addition, The Planning Council determined that co-occurring mental health and substance use disorders was an emerging issue within the state behavioral health system that required additional attention.

Persons experiencing homelessness
According to the most recent NSDUH data (2022-2023), 36% of homeless individuals in Connecticut had a serious mental illness (SMI) in 2024 and 22% had a substance use disorder (SUD). These percentages have been and remain much higher among the unsheltered homeless population compared to the sheltered population in Connecticut. As of 2024, the percentage of unsheltered individuals with serious mental illness was nearly twice that of the sheltered homeless population (30% vs. 16%). Similarly, the percentage of unsheltered individuals with a substance use disorder was 19% compared to 9.7% of the sheltered population. Rates of SMI and SUD within the general population in Connecticut were 5% and 20%, respectively, highlighting higher rates of SMI and SUD within the homeless population and identifying the need for targeted behavioral health services for this population.

Homelessness among individuals admitted to any behavioral health service increased by 10%, between state fiscal year 2022 to SFY 2023 but were unchanged from SFY 2023 to SFY 2024. Homeless individuals accounted for 5.2% of those admitted across all treatment programs (substance use and mental health) in SFY 2024.

Statewide stakeholder survey data, as well as Planning Council members, identified homeless individuals and families as populations underserved by the substance use service system and discussed the need for community based supports, such as case management.

Persons with SUD at Risk for Tuberculosis (TB) and HIV (EIS/HIV)
Officials from the Connecticut Department of Public Health (DPH) have identified that tuberculosis (TB) cases in Connecticut have been declining since 2022 despite increases in case rates nationally. Similarly, rates of TB among individuals with SUD receiving services within our behavioral health system have remained stable between 2022 to 2024. However, non-declining rates of TB

among the general population and those that use substances point to the need for continued education and support services to ensure individuals are aware of the risks for TB, especially those who ingest substances intravenously.

Connecticut is not currently a designated state for HIV. According to the most recent data, Connecticut's HIV case rate was 6.1 per 100,000 people. Despite this, there remains a need for continued education and support services for individuals who use substance to ensure they are aware of their risk for infectious diseases, including HIV, especially those who ingest substances intravenously.

Individuals in Need of Primary Substance Use Prevention (PP)
According to the most recent NSDUH data (2022-2023), Connecticut's prevalence of alcohol use and binge alcohol use (defined as 4 or more drinks on one occasion for women and 5 or more drinks for men) among the general population increased slightly compared to previous years and were higher in compared to both the nation and Northeast US. The NSDUH data also show that past year prevalence of Alcohol Use Disorder is slightly higher among Connecticut's youth 12-17 and young adults 18-25 compared to their peers in the Northeast US and the nation. As with alcohol use in general, prevalence of AUD is highest among Connecticut's young adults 18-25. Results of the 2023 Connecticut School Health Survey (CT YRBS) and the corresponding national CDC Youth Risk Behavior Survey data from 2023 align with the 2022-2023 NSDUH data. Connecticut data shows an increase in the percentage of Connecticut high school students reporting past 30-day alcohol use and binge alcohol use from 2021 to 2023. Among students reporting alcohol use, females were more likely to report alcohol use in the past 30 days compared to males (24.5% compared to 17.6%). These data point to the pressing need for primary prevention services focused on alcohol and targeted to youth and young adults.

According to the most recent NSDUH data (2022-2023), Connecticut residents' use of tobacco products decreased compared to previous years, specifically among youth (12-17) and young adults (18-25). In addition, past month cigarette use decreased among all age groups, with the lowest prevalence among youth 12-17 (slightly under 1%). However, a newly added indicator in the 2022-23 NSDUH shows that while cigarette use remains low, nicotine vaping is increasingly prevalent among Connecticut's young adults 18-25 and is higher than any other age bracket in the state. Additionally, past month prevalence of nicotine vaping was higher among young adults in Connecticut compared to their peers in the Northeast US and Nationally. While data from the 2021 Youth Risk Behavior Survey points to a significant decrease in use of ENDS, the most recent NSDUH data seem to highlight a shift towards increased use of nicotine vaping products and identify a clear need for continued education and primary prevention services focused specifically on tobacco and tobacco products (ENDS) targeted to youth and young adults.

Adults with SMI* including Older Adults
Based on 2022-23 NSDUH data, estimated prevalence of serious mental illness (SMI) among adults in Connecticut has remained steady over the past four years at roughly 5.4%, which is slightly lower than rates found in the Northeast and nationally. For the state's treatment population, data from the DMHAS SFY 2024 Annual Statistical Report documented that more than half of the individuals (58%) receiving clinical treatment services during SFY 2024 met criteria for an SMI diagnosis, which is an increase from SFY2022, during which 44% of individuals receiving clinical treatment met criteria for SMI. Alongside this increase in SMI among the state's treatment population, data from the statewide stakeholder survey and feedback from the Planning Council identified the need for appropriate community-based supports that can help individiuals with SMI remain in the community.

Regarding older adults in Connecticut, this is a population of concern due to increased physical and behavioral healthcare needs, and because older adults are a growing population in the state. The median age in Connecticut is 41.1 as compared to a nationwide median age of 38.8, according to the 2024 Connecticut State Plan on Aging. Social isolation and access issues are important challenges for this population. According to data from America's Health Rankings Annual Report, rates of mental illness among individuals ages 65 and older in Connecticut are similar to national rates. In 2023, 14.2% of adults 65 and older in Connecticut reported having a depressive disorder compared to 14.7% of adults 65 and older nationally. During this same time period, 7.0% of adults 65 and older in Connecticut reported frequent mental distress compared to 8.7% of adults 65 and older nationally. In Connecticut, the suicide rate among adults 65 and older in 2023 was 12.8 per 100,000 population compared to 17.7 nationally. While these rates of mental health issues among older adults were lower in Connecticut compared to national data, statewide stakeholder survey data identified the need for mobile community-based services for older adults that could reach this population in their homes due to the physical challenges and limited mobility.

Individuals with SMI or SED in rural areas and among those experiencing
homelessness, as applicable*
One of the principal challenges facing residents of rural communities in Connecticut is the distance to various health care facilities and services, such as hospitals. While Connecticut is a geographically small state, limited access to facilities can lead to individuals not seeking services, missing appointments, and facing potentially long drives to obtain treatment. According to the 2024 DataHaven Community Wellbeing Survey (DCWS), 26% of the respondents living in rural communities missed a visit to a health care provider because they had no access to reliable transportation, and more than 33% of respondents living in rural towns noted they felt depressed for more than several days in the past week. These data points combine to point to the need for additional services that provide mobile outreach and/or transportation to help meet the mental health needs of individuals residing in rural areas of the state.
While rates of homelessness are higher within urban areas, homeless individuals residing in rural areas can be harder to serve within the behavioral health system. According to the most recent NSDUH data (2022-2023), 36% of homeless individuals in Connecticut had a serious mental illness (SMI) in 2024 and was even higher among the unsheltered homeless population which

often resides in rural areas. The rate of SMI within the general population in Connecticut was only 5%, highlighting drastically higher rates of SMI within the state's homeless population and identifying the need for targeted behavioral health services for this population that include a mobile outreach element to reach unsheltered individuals residing in rural areas.

Individuals who have an Early Serious Mental Illness (ESMI) * (10 percent MHBG set aside)

While rates of Schizophrenia Spectrum disorders among individuals served within the Connecticut behavioral health system fell slightly between SFY2022 (15%) and SFY 2024 (12%), the estimated prevalence of these disorders among the statewide population remains high. Based on national epidemiologic estimates and the age structure of Connecticut, it is estimated that about 500 new cases of psychosis will eventually be diagnosed with a schizophrenia spectrum or non-affective psychotic disorder (i.e., FEP) each year. It is expected that at least 3 times that number will experience a new onset psychosis, but this larger number will include individuals with substance-induced psychosis or affective psychotic disorders. These data point to a need to expand early identification and support services for individuals with new onset psychosis in Connecticut, and ensure that these individuals are able to be connect to appropriate care as quickly as possible.

Individuals in need of behavioral health crisis services (BHCS) * (5 percent MHBG set aside)

Based on statewide treatment data, roughly 16% of all clients receiving mental health services in SFY24 received crisis services. Additionally, 29% of all admissions to mental health services in SFY24 were admissions for a crisis service. These data highlight the significant prevalence of individuals in need of behavioral health crisis services within our system. When surveyed about needs within the mental health system, over half of the members of the Planning Council identified crisis response as a service that is most needed to assist individuals with mental health issues. These findings do not directly reflect those from the statewide stakeholder survey, but both respondent pools frequently identified community support services as needed within the crisis services system, pointing to the need to sustain and expand community-based crisis services within the behavioral health system in Connecticut.

Children with Serious Emotional Disturbance (SED)

Children with Serious Emotional Disturbance require access to quality behavioral health care in a timely manner. Based on the results of the above-mentioned needs assessments, DCF has identified Workforce Development as a critical area for improving treatment for children with SED. Connecticut, like many other States, faces two challenges: rising behavioral healthcare needs among children with SED and significant behavioral health workforce shortages, which hinder the provision of necessary treatment. Workforce staffing shortages result in longer wait times for families, during which children's acuity may increase, resulting in a need for higher levels of care. These shortages have resulted in reduced access to and quality of services for children with SED. A recent survey of Connecticut non-profit providers found more than one in five positions were vacant, and there was a 39% rate of staff turnover in the last year.

Connecticut is committed to the ongoing development of the workforce treating children with SED. While Connecticut has some strong workforce training programs, gaps in training and access to training remain. The following are examples of training needs that were identified as of high priority across the workforce treating children with SED:

- Expansion of child, youth and family-focused evidence-based treatments (EBTs)
- Serving youth with complex needs especially children with intellectual or developmental disabilities
- Supervisory skills and strategies to support staff wellness
- Identification of behavioral health needs and effective prevention and early intervention strategies for the broader child-serving workforce

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Pregnant Women and Women with Dependent Children (PWWDC)

To address the identified needs for PWWDC, DMHAS will continue its funding and support for the Women's REACH (Recovery, Engagement, Access, Coaching & Healing) program, which provides statewide integration of 15 Recovery Navigators positioned throughout each of the five DMHAS regions. The Recovery Navigators are women who are in a position to use their own personal recovery journey to help others. Guided by the goals of the individual, these women use recovery coaching techniques and case management services to support women and individuals in their community by connecting them to the resources they need to support their recovery and manage stressors associated with parenting.

To address the needs of PWWDC and their children, DMHAS will provide support to the substance exposed pregnancy initiative in Connecticut (SEPI-CT) to expand education and safety protocols and reduce accidental ingestion of MOUD and other substances by infants and children. This will support expanded training for medical providers that encounter substance exposed pregnancies, as well PPW treatment providers, with the aim of helping them develop plans for safe use with and safety measures with their PWWDC clients that will help reduce infant and child substance exposure.

Persons Who Inject Drugs (PWID)

To address the identified needs for PWID, DMHAS will support the statewide 24/7 Access Line (hotline), which facilitates access to

Substance Use services for Connecticut residents. Access Line staff use a recovery-oriented approach to ask screening questions, and provide callers with education, support, hope and tangible assistance to individuals having difficulty living with substance use issues. Minimally, resource education is provided to each caller on various available treatment options; medications for addiction (e.g., methadone, buprenorphine, naltrexone, naloxone); and various other community programs. The Access Line is able to provide same day assessment and induction for PWID considering medically managed withdrawal services, MOUD services, as well as an array of other treatment options provided within the state. Additionally, DMHAs will support the road to recovery program which provides PWID and other treatment seeking individuals with same day transport to treatment. This helps to ensure that individuals taking the first steps towards recovery are able to attain immediate support and treatment. Additionally, DMHAS will support the array of treatment options for PWID that the Access Line is able help individuals access, including medically managed withdrawal, intensive residential treatment, and intensive outpatient treatment.

To address the identified need for specific services within the Latino population, DMHAS will support the Latino Outreach program which provides regional community outreach services designed to reduce the stigma that surrounds substance use in the Latino community and to identify Latinos who have a substance use disorder for which they are not seeking treatment, or who are at risk of having a substance use disorder for which they are not likely to seek treatment. Latino Outreach workers provide informational sessions and training in traditional settings such as social service agencies as well as non-traditional settings within the Latino community to raise awareness on overdose prevention and substance use programs. Latino Outreach workers establish linkages with organizations offering services to Latinos in order to facilitate referral to such services and develop approaches that will result in greater access for the Latino population.

Persons in need of recovery support services for SUD (PRSUD)
To address identified needs for PRSUD, DMHAS will support a full array of recovery services including case management, Recovery Centers, employment supports, and telephonic support services which provide peer recovery support. To improve services for PRSUD and address PRSUD workforce needs, DMHAS will support a new training and certification process that will ensure all Peer Recovery Support professionals have the requisite skills, knowledge and professional development to provide the best possible care for PRSUD. This effort will provide training and professional development to all eligible individuals within the peer recovery workforce.

Individuals with a co-occurring mental health and SUD
To address the identified needs for individuals with co-occurring mental health and SUD, DMHAS will continue to enhance existing mental health and SUD services to provide integrated treatment for people with co-occurring disorders. Specialized staff training, consultation, and a pilot project for persons with co-occurring disorders will be put in place to address the treatment needs of individuals with co-occurring disorders. The pilot project will include the development of a reporting system for Local Mental Health Authorities to identify all individuals with co-occurring disorders that are active in their system, to allow for better care coordination and tracking of this population at a facility level.

In addition, the state's regional Local Mental Health Authorities (LMHAs) will implement the Integrated Dual Disorders Treatment (IDDT) model and SUD treatment providers will use the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index to guide integrated care for individuals with co-occurring disorders. DMHAS will also contract with Yale University staff to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model. Lastly, DMHAS will fund four co-occurring enhanced residential treatment programs. As a result, individuals with COD have access to an expanded service array that meets their needs.

Persons experiencing homelessness
To address the identified needs for individuals experiencing homelessness DMHAS will support two case management and outreach and engagement programs which focus on reaching individuals in hard-to-reach areas of the state. The first program will focus on reaching individuals with SMI and/or a co-occurring substance use disorder living near train and bus stations throughout the state. Program staff will conduct mobile outreach to engage with these individuals and help them connect to support services and treatment. The second program will seek to engage unsheltered individuals with SMI and/or a co-occurring substance use disorder throughout the state and provide specific support to help these individuals apply for and receive entitlements that will support their recovery, including housing, income supports, and medical insurance.

Persons with SUD at Risk for Tuberculosis (TB) and HIV (EIS/HIV)
To address the identified needs for individuals with SUD at Risk for TB and HIV, DMHAS will support training and technical assistance to nurses that are placed in SUPTRSBG funded treatment programs. This training and technical assistance will help nurses to improve identification, education, and prevention related to infectious diseases. Trainings to nurses will focus on recent trends in infectious diseases, high-risk populations, prevention strategies, and best practices.

Individuals in Need of Primary Substance Use Prevention (PP)
To address the identified need for primary prevention services focused specifically on tobacco products and alcohol targeted to youth and young adults, DMHAS will continue to support established prevention infrastructure targeting these substances and age groups.
DMHAS will continue to support the Connecticut Clearinghouse which serves as a resource center for information on substance use prevention and health promotion. The clearinghouse is instrumental in providing educational materials for the tobacco merchant education program which discourages the selling of tobacco products to minors. It also hosts the online tobacco

training for retailers. Effective October 2024, all retailers must complete this online course as part of the ENDS licensing process.

DMHAS will also continue to support Local Prevention Councils (LPCs) throughout the state which provide mini grants to 169 cities/towns throughout Connecticut 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 support activities that address ATOD concerns specific to their communities.

DMHAS will also continue to support 10 Prevention in CT Communities (PCCs) across the state that serves as community-based programs/coalitions implementing the 5-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. Through the SPF process, the PCC grantees have identified tobacco and underage alcohol use as priority areas to address in their communities.

Lastly, DMHAS is developing an online alcohol education module for both on-premise and off premise license holders that aims to reduce the illegal sale of alcohol to underage youth and young adults.

Adults with SMI* including Older Adults
To address the identified needs for adults with SMI, DMHAS will continue to support the new Crisis Respite and Peer Respite programs within the state which provide a safe, community-based alternatives to the emergency department for adults with SMI experiencing a crisis and/or in need of respite services. DMHAS will seek to improve awareness of these programs within the state's referral network, to improve utilization of these programs among adults with SMI.

To address the needs identified for older adults with SMI, DMHAS will continue to support the Senior Outreach and Engagement program which provides assessment and case management services to at-risk older adults (55 and older) 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 focus of this service is diverting older adults with SMI from long term care and developing home and community-based services to assist older adults with "aging in place."

Individuals with SMI or SED in rural areas and among those experiencing
homelessness, as applicable*
To meet the identified needs for individuals with SMI in rural areas and among those experiencing homelessness, DMHAS will support two case management and outreach and engagement programs which focus on reaching individuals in hard-to-reach areas of the state. The first program will focus on reaching individuals with SMI living near train and bus stations throughout the state. Program staff will conduct mobile outreach to engage with these individuals and help them connect to support services and treatment. The second program will seek to engage unsheltered individuals with SMI throughout the state and provide specific support to help them access medical and behavioral healthcare specific to their diagnosis. The program will also help these individuals apply for and receive entitlements that will support their recovery, including housing, income supports, and medical insurance.

Individuals who have an Early Serious Mental Illness (ESMI) * (10 percent MHBG
set aside)
To address the needs identified for ESMI/FEP, DMHAS will continue to support and strengthen the state's two Coordinated Specialty Care programs. Additionally, the DMHAS will support and strengthen it's current statewide initiative to reduce the duration of untreated psychosis. Research has shown that reducing the duration of untreated psychosis by quickly connecting individuals to appropriate care improves individual level outcomes in the short and long term. To work towards this goal, DMHAS will fund and support regional early detection and assessment specialists (EDACs) that will proactively engage with community stakeholders (schools, police, hospitals, family groups, etc.) to identify individuals that may be in the early stages of psychosis, assess their condition, and help connect them to appropriate services so they can begin receiving treatment as soon as possible. In addition to the EDACs, DMHAS will engage the state's lead CSC program to provide training and technical assistance to the state's Local Mental Health Authorities. This effort will focus on helping the LMHAs to establish intake and care coordination processes that direct individuals with FEP into care as quickly as possible and help ensure necessary follow-up to keep them engaged in care.

Individuals in need of behavioral health crisis services (BHCS) * (5 percent MHBG
set aside)
To address the needs identified for BHCS, Connecticut will continue to support and strengthen the crisis services continuum in Connecticut which includes the statewide crisis line, 18 adult and mobile crisis teams and 14 child/youth mobile crisis teams, one crisis stabilization unit, three behavioral health urgent care centers for children/youth, a new Peer operated respite program, as well as 100 respite beds across the state. Specifically, DMHAS will expand the hours of chat and text options for 988. Currently the state responds to chat and text during the first shift of the work day. However, DMHAS will support the expansion of this service

and respond to chat and text during the second and third shift as well, to ensure that individuals in crisis have someone to speak with at any time during the day. Lastly, the Department of Children and Families will provide specific support for mobile crisis services for children and youth with SED and seek to increase the number of children and youth served by this service.

Children with Serious Emotional Disturbance (SED)
To address the identified needs for children with SED, DCF will focus on workforce development within the children's behavioral health system. Areas of focus in the next two years will include development and offering of specific trainings. Trainings will focus on both clinical and non-clinical staff, and will seek to improve the ability of the workforce to manage increasing acuity and complexity among children with SED, as well as to help increase retention within the children's behavioral health workforce. Trainings will focus on: Serving youth with complex needs especially children with intellectual or developmental disabilities; Supervisory skills and strategies to support staff wellness; and Identification of behavioral health needs and effective prevention and early intervention strategies for the broader child-serving workforce.

DCF will also focus on expanding the availability of evidence-based treatments (EBT) for children with SED and their families. DCF will work towards this expansion by engaging with EBT developers and expert trainers to offer free EBT trainings and consultation to children's behavioral health providers that commit to offering the model of treatment. Providers will be expected to develop and maintain teams of clinical staff that will implement the identified EBT and work to improve care for the identified populations. Some of the EBTs trainings that will be provided as part of this initiative include Trauma Focused Cognitive Behavior Therapy (TF-CBT); Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH - ADTC); Cognitive Behavioral Intervention for Trauma in Schools; Bounce Back.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Connecticut Adult Behavioral Health Needs Assessment

Introduction

The Connecticut Behavioral Health Needs Assessment serves as the epidemiological basis for identification of strengths, gaps, needs, and priorities within the state's behavioral health system, as well as the state's planning process for the Mental Health Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant. The needs assessment incorporates analysis and synthesis of quantitative data from an array of state and national sources. It also includes a distillation of findings from the state's biennial regional priority setting process, which compiles qualitative and quantitative information from local and regional stakeholders and sources regarding the behavioral health needs, emerging issues and priorities within the state.

The national data sources utilized within the needs assessment include: the Substance Abuse and Mental Health Service Administration (SAMHSA) 2022-2023 National Survey on Drug Use and Health (NSDUH)[1]; the Center for Disease Control and Prevention (CDC) 2023 Behavioral Risk Factor Surveillance System (BRFSS)[2]; the CDC 2023 Youth Risk Behavior Surveillance System (YRBSS)[3]; the United Way 2024 National 211 Impact Survey[4]; Trevor Project[5]; the United Health Foundation America's Health Rankings 2025 Senior Comprehensive Report[6]; and US Census population estimates data.[7]

State data sources include: the Department of Mental Health and Addiction Services (DMHAS) SFY 2024 Annual Statistical Report[8]; Department of Public Health 2023 Connecticut School Health Survey (CSHS -Connecticut's YRBS)[9]; DataHaven 2024 Community Wellbeing Survey (DCWS) and Equity Profiles[10,11]; Connecticut Statewide Opioid Response Directive (SWORD)[12]; Connecticut LGBTQ+ Needs Assessment[13]; Connecticut Office of the Chief Medical Examiner (OCME)[14]; Connecticut Department of Public Health (DPH)[15]; the Connecticut Office of Rural Health[16]; and the Connecticut Department of Children and Families.[17]

DMHAS funds and collaborates with Connecticut's **State Epidemiological Outcomes Workgroup (SEOW)** and the Center for Prevention Evaluation and Statistics (CPES) at the UConn Health Department of Public Health Sciences (DPHS) to support the Connecticut Behavioral Health Needs Assessment process**.** The SEOW, co-chaired by UConn Health and DMHAS and supported by CPES, operates through a DMHAS contract with the UConn Health Department of Public Health Sciences.

The SEOW is a collaborative of state partners focused on identifying and sharing data resources and encouraging more widespread use of these resources to improve substance use prevention, mental health promotion, and general behavioral health. SEOW partner organizations include: the 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 Corrections (DOC); Office of Policy and Management (OPM); State Department of Education (SDE); Regional Behavioral Health Action Organizations (RBHAOs); Board of Pardons and Parole; Connecticut Data Collaborative (CTData); the Office of the Child Advocate; the UConn Center for Public Health and Health Policy; and UConn Health Department of Public Health Sciences. The SEOW and CPES conduct an array of activities to support the identification of and response to behavioral health risks and needs throughout Connecticut, including:

- Identifying, collecting and analyzing data related to behavioral health issues;
- Assessing data quality and utility;
- Identifying indicators of risk and protective factors for substance use and related problems;
- Reviewing available data to assess and address health disparities in Connecticut;
- Identifying and tracking emerging substances and patterns;
- Supporting a statewide needs assessment that measures the prevalence and distribution of substance use and mental health-related problems;
- Promoting the use of data within the behavioral health prevention and treatment community and its partners through dissemination of data through the SEOW Prevention Data Portal and its products;
- Interfacing with Connecticut's Alcohol and Drug Policy Council (ADPC) and its Prevention Subcommittee;
- Promoting data-driven decision-making to improve planning, evaluation, and more effective and efficient targeting of prevention resources.

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Persons Served in Connecticut's Behavioral Health Programs

One key element of Connecticut's behavioral health infrastructure is its service system, ranging from residential to community-based treatment for substance use and mental health issues. During SFY 2024, a total of 94,397 unique individuals received mental health and/or substance use services in Connecticut. Of this total, 40,028 individuals were treated within substance use programs and 47,992 were treated within mental health programs. These totals include 6,377 co-occurring clients who both mental health and substance use services. 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 (58%), followed by Black/African American (17%), and Other Race (13%). Twenty-one percent of DMHAS clients were of Hispanic/Latino ethnicity, primarily of Puerto Rican origin (11%). Younger clients were more likely to receive substance use services while older clients were more likely to receive mental health services.

The most utilized level of care was community-based treatment, with 95% of mental health clients and 81% of substance use clients receiving these services. For mental health clients, community-based treatment services include standard outpatient (59%), Case Management (13%), Crisis Services (16%), and Social Rehabilitation (10%). For substance use clients, community-based treatment services include Standard Outpatient (35%), Medication Assisted Treatment (33%), and Case Management (12%). Among inpatient and residential services, inpatient services were the next most utilized by mental health clients (17%), and residential services by substance use clients (91%). Inpatient care was received by 2% of mental health clients and 4% of substance use clients.

Substance-related and addictive disorders were the most frequently diagnosed condition among those receiving any services within the behavioral health system at 40%. The largest mental health category diagnosed outside of substances was Depressive Disorders (12%), followed by Schizophrenia Spectrum and Other Psychotic Disorders (7%) and Trauma and Stressor Related Disorders (7%).

Prevalence and Treated Prevalence: Mental Health

Any Mental Illness (AMI)

Utilizing the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-4) definition for any mental illness (AMI), which is "a diagnosable mental, behavioral, or emotional disorder other than a developmental or substance use disorder," the 2022-23 National Survey on Drug Use and Health (NSDUH) data highlights that Connecticut's reported prevalence of past year mental illness among both young adults (18-25) and adults (26 and older) has risen slightly above both the Northeast US region and the nation as a whole since 2021-22, with young adults having the highest reported prevalence of mental illness in both data collection periods.

Any Mental Illness in the Past Year (NSDUH 2022-2023)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	22.95%	35.02%	21.09%
Northeast	22.63%	34.77%	20.83%
Connecticut	**24.13%**	**36.43%**	**22.23%**

Serious Mental Illness (SMI)

The National Survey of Drug Use and Health (NSDUH) defines Serious Mental Illness (SMI) as a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder that resulted in serious functional impairment.

Based on 2022-23 NSDUH data, estimated prevalence of serious mental illness (SMI) among adults in Connecticut (5.3%) remained steady since 2021-22 (5.4%), slightly lower than US and Northeast US prevalence, and highest for young adults (10.6%) versus other age groups.

Serious Mental Illness (SMI) in the Past Year (NSDUH 2022-2023)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	5.83%	10.97%	5.04%
Northeast	5.45%	10.76%	4.66%
Connecticut	**5.32%**	**10.62%**	**4.50%**

For the state's treatment population, data from the DMHAS SFY 2024 Annual Statistical Report documented that more than half of the individuals (58%) receiving clinical treatment services during SFY 2024 met criteria for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, major depression, anxiety disorder, and trauma-and-stressor related disorder (including PTSD), which is an increase from SFY2022, during which 44% of individuals receiving clinical treatment met criteria for SMI.

Depression

NSDUH 2022-23 data estimated Connecticut's prevalence of a past year major depressive episode increased from 2021-22 for Connecticut's adult population as well as nationally. Connecticut's estimated prevalence was slightly higher for youth 12-17 and young adults 18-25 than for those age groups in the Northeast US region and the larger US.

Major Depressive Episode in the Past Year (NSDUH 2022-2023)

	Age 12 - 17	Ages 18 - 25	Ages 18 +
U.S.	18.82%	18.81%	7.06%
Northeast	18.34%	19.36%	6.69%
Connecticut	**19.66%**	**21.59%**	**6.67%**

Connecticut's BRFSS data showed depressive disorder is more prevalent among non-Hispanic White adults compared to Hispanic and Black adults.

Diagnosed with A Depressive Disorder* (CT BRFSS 2023)

	White	Hispanic	Black
Connecticut	20.4%	16.5%	14.8%

*including depression, major depression, dysthymia, or minor depression

During SFY 2024, 16% of individuals receiving clinical treatment services in Connecticut had a depressive disorder as their primary diagnosis, a 2% decrease from SFY 2022.

Bipolar Disorder

The rate for bipolar disorder as primary diagnosis among the treatment population sustained its SFY 2022 (7%) decrease from SFY 2021 (12%), remaining steady at SFY 2024 (8%).

Schizophrenia Spectrum and Other Psychotic Disorders (including First-Episode Psychosis)

Rates of Schizophrenia Spectrum disorders as primary diagnosis among individuals served within the Connecticut behavioral health system increased again in SFY 2024 to 12% from the SFY 2022 rate of 7% that was a marked decrease from SFY 2021 (15%).

Based on national epidemiologic estimates and the age structure of Connecticut, it is estimated that about 500 new cases of psychosis will eventually be diagnosed with a schizophrenia spectrum or non-affective psychotic disorder (i.e., FEP) each year. It is expected that at least 3 times that number will experience a new onset psychosis, but this larger number will include individuals with substance-induced psychosis or affective psychotic disorders.[18,19]

During SFY 2024, there were a total of 87 admissions to the state's two coordinated specialty care programs for individuals with first-episode psychosis. This points to a continued need for additional FEP specific services to address the gap between the current capacity of the state's FEP programs and the estimated incidence of FEP within the state.

Suicidal Thoughts and Suicide

Connecticut's estimated past year prevalence of serious suicidal thoughts increased slightly from 2021-22 across age groups. Connecticut's prevalence rates among Connecticut's adults (18+) and youth 12-17 remain slightly lower than their US regional and national peers. As in 2022-23, young adults (18-25) report slightly higher prevalence of past year suicidal thoughts than the Northeast region and the US.

Serious Thoughts of Suicide in the Past Year (NSDUH 2022-2023)

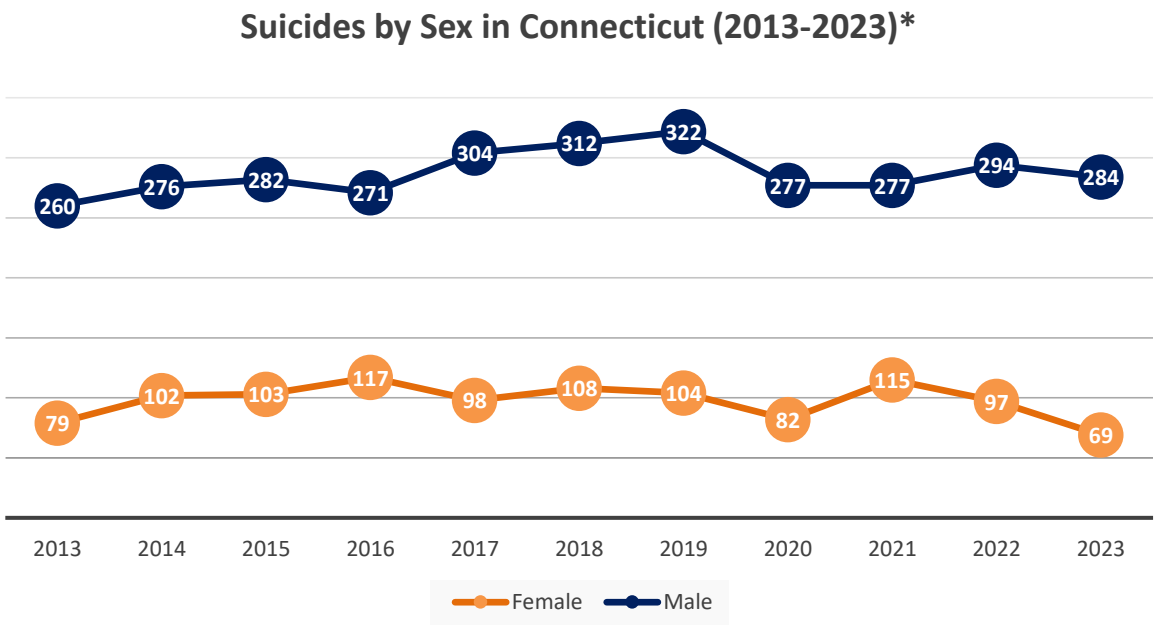
	Age 18+	Ages 12 - 17	Ages 18 - 25	Age 26+
U.S.	5.06%	12.87%	12.95%	3.84%
Northeast	5.14%	12.43%	12.51%	4.04%
Connecticut	**4.86%**	**11.87%**	**13.08%**	**3.60%**

Attempted Suicide in the Past Year (NSDUH 2022-2023)

	Age 18+	Ages 12 - 17	Ages 18 - 25	Age 26+
U.S.	0.60%	3.52%	2.04%	0.38%
Northeast	0.57%	3.18%	2.00%	0.35%
Connecticut	**0.54%**	**2.99%**	**1.87%**	**0.33%**

NSDUH 2022-23 estimates of past year suicide attempts remain steady or show a slight decrease from 2021-22 estimates, with Connecticut estimates remaining below northeast region and US estimates across age groups. While rates remain low, youth 12-17 and young adults 18-25 remain populations of concern due to their consistently higher prevalence than adults 26 and older.

Data from the Connecticut Office of the Chief Medical Examiner on deaths by suicide indicates that the total number of suicides decreased from 2022 (391) to 2023 (353). Connecticut's 2023 rate of suicide deaths per 100,000 population (9.76) is lower than that of the US (14.1), in line with recent years, placing Connecticut in the lowest 10% of states for suicide deaths. Historically, more males died by suicide than females. That trend continued in 2022 (75% of suicide decedents were male) and 2023 (80% male), but there was a decrease in suicide deaths among both females and males between 2022 and 2023, with a greater decrease among females (a 29% decrease from 97 to 69) than males (a 3.4% decrease from 294 to 284).



Source: Connecticut Office of the Chief Medical Examiner. https://portal.ct.gov/OCME/Statistics

Mental Health Treatment

Received Mental Health Services in the Past Year (NSDUH 2022-2023)

	Age 18+	Ages 12 - 17	Ages 18 - 25	Age 26+
U.S.	22.38%	30.84%	27.04%	21.66%
Northeast	23.44%	32.57%	29.43%	22.54%
Connecticut	**24.32%**	**33.72%**	**30.98%**	**23.29%**

While the 2022-23 NSDUH estimated the prevalence of certain mental health conditions to be higher in Connecticut compared to the Northeast region and nation, it also showed that a slightly higher proportion of individuals reported receipt of mental health services in Connecticut compared the region and nation.

According to DMHAS treatment data for SFY 2024, there were 54,369 admissions to mental health programs in Connecticut and 47,992 unique individuals served in mental health programs during this time frame. Among those served, depressive disorders were the most common diagnosis, followed by schizophrenia spectrum and other psychotic disorders, and trauma and stressor-related disorders. Of the individuals served within a mental health program in SFY 2024, slightly more than half were male (51%). Among clients served, 257 (<1%) identified as transgender/other. More than half of individuals were White/Caucasian (58%), followed by Black/African American (19%) and “Other” (12%). Two in 10 (20%) individuals served were of Hispanic/Latino origin and 8.9% identified specifically as Puerto Rican.

Comparing the percentages of individuals receiving mental health services in SFY 2024 to the most recent census statistics, White/Caucasian individuals were underrepresented among the population receiving mental health services, comprising 78% of the general population but only 59% of the population receiving services. Black/African American individuals were overrepresented among the population receiving mental health services, comprising 13% of the general population and 18% of the population receiving services. Individuals served within a mental health program were relatively distributed across age groups, with a mean age of 46.3 (± 16.3).[20]

Prevalence and Treated Prevalence: Substance Use

Alcohol

According to the most recent NSDUH data (2022-2023), Connecticut's prevalence of alcohol use and binge alcohol use (defined as 4 or more drinks on one occasion for women and 5 or more drinks for men) among the general population have slightly increased compared to previous years. Reported prevalence of alcohol use and binge alcohol use among all age groups were higher in Connecticut compared to both the nation and Northeast US.

Alcohol Use in the Past Month (NSDUH 2022-2023)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	6.88%	49.91%	52.28%
Northeast	6.98%	54.40%	55.58%
Connecticut	**7.19%**	**58.60%**	**57.64%**

Binge Alcohol Use in the Past Month (NSDUH 2022-2023)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	3.58%	29.10%	23.50%
Northeast	3.83%	31.90%	24.37%
Connecticut	**4.37%**	**37.29%**	**25.30%**

Underage (12 - 20) Alcohol Use and Binge Use in the Past Month (NSDUH 2022-2023)

	Alcohol Use in the Past Month	Binge Alcohol Use in Past Month
U.S.	14.88%	8.39%
Northeast	16.72%	9.36%
Connecticut	**18.14%**	**10.67%**

According to Connecticut's 2023 BRFSS, White adults have higher past 30-day alcohol use compared to Hispanic and Black adults. On the other hand, both White adults and Hispanic adults have slightly higher prevalence of past 30-day binge alcohol use than Black adults.

Alcohol Use in the Past Month (CT BRFSS 2023)

	White	Hispanic	Black
Connecticut	64.0%	44.3%	48.1%

Binge Alcohol Use in the Past Month (CT BRFSS 2023)

	White	Hispanic	Black
Connecticut	15.2%	15.6%	10.9%

Alcohol Use Disorder (AUD)

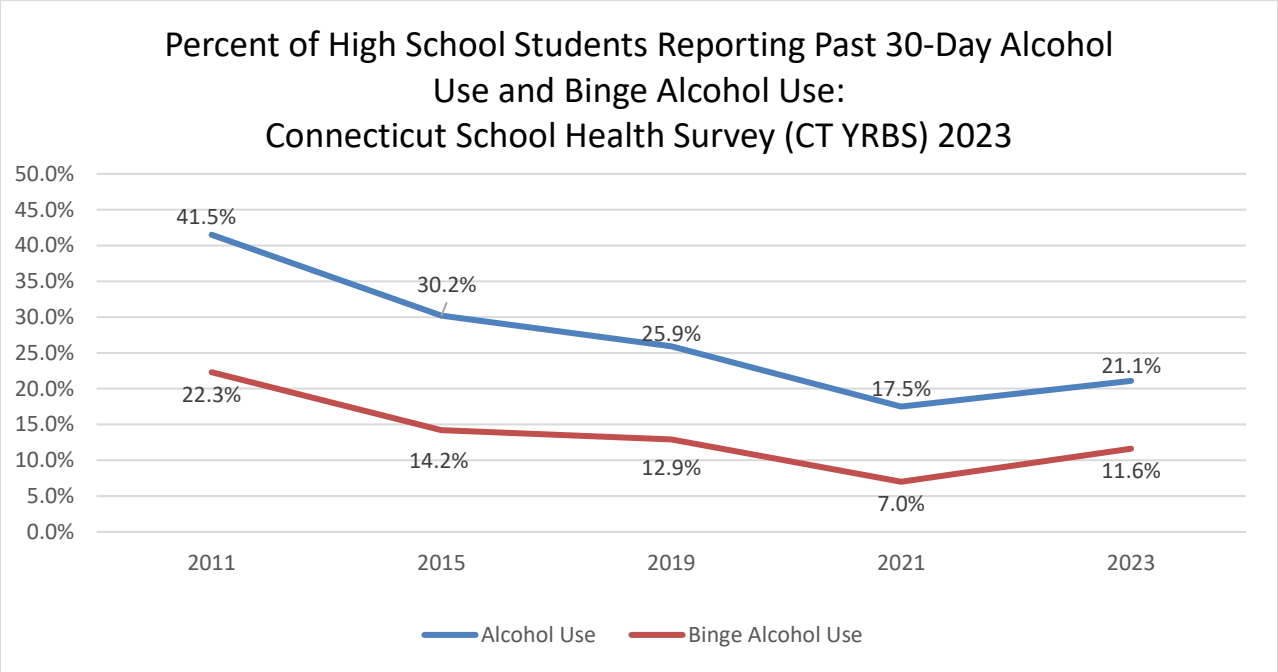
Alcohol remains the primary drug of choice among individuals served within the Connecticut behavioral health system. During SFY 2024, 44.3% of all admissions to a behavioral health program in Connecticut identified alcohol as their primary drug of choice, mirroring the rate from SFY 2023 (44.3%).

The NSDUH data show that the past year prevalence of Alcohol Use Disorder is slightly higher among Connecticut's youth 12-17 and adults 18 and older than for their peers in the Northeast US and the nation, and higher for Connecticut's young adults 18-25. As with alcohol use, prevalence of AUD is highest among Connecticut's young adults.

Alcohol Use Disorder in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	2.92%	15.71%	11.07%
Northeast	2.85%	16.54%	11.21%
Connecticut	**3.70%**	**20.26%**	**12.76%**

Results of the 2023 Connecticut School Health Survey (CT YRBS) and the corresponding national CDC Youth Risk Behavior Survey data from 2023 align with the 2022-2023 NSDUH data. Connecticut data shows an increase in the percentage of Connecticut high school students reporting past 30-day alcohol use and binge alcohol use from 2021 to 2023. Among students reporting alcohol use, females were more likely to report alcohol use in the past 30 days compared to males (24.5% compared to 17.6%).



Cigarettes and Tobacco

Connecticut residents' use of tobacco products shows a decrease mainly among youth (12-17) and young adults (18-25) compared to previous years. Past month cigarette use is highest among Connecticut adults (13.7%) and lowest among youth (slightly under 1%), but prevalence for youth is lower than their peers in the Northeast US and US.

Cigarette Use in the Past Month (NSDUH 2022-2023)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	1.28%	10.67%	15.39%
Northeast	1.26%	10.18%	13.85%
Connecticut	**0.98%**	**10.73%**	**13.73%**

Tobacco Product Use in the Past Month (NSDUH 2022-2023)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	1.91%	15.56%	19.43%
Northeast	1.75%	15.03%	17.55%
Connecticut	**1.79%**	**16.08%**	**16.98%**

According to Connecticut 2023 BRFSS data, Hispanic and Black adults were more likely to identify as a current smoker than White adults.

Current Smoker (CT BRFSS 2023)

	White	Hispanic	Black
Connecticut	7.8%	9.8%	9.9%

E-cigarettes/Electronic Nicotine Delivery Systems (ENDS)

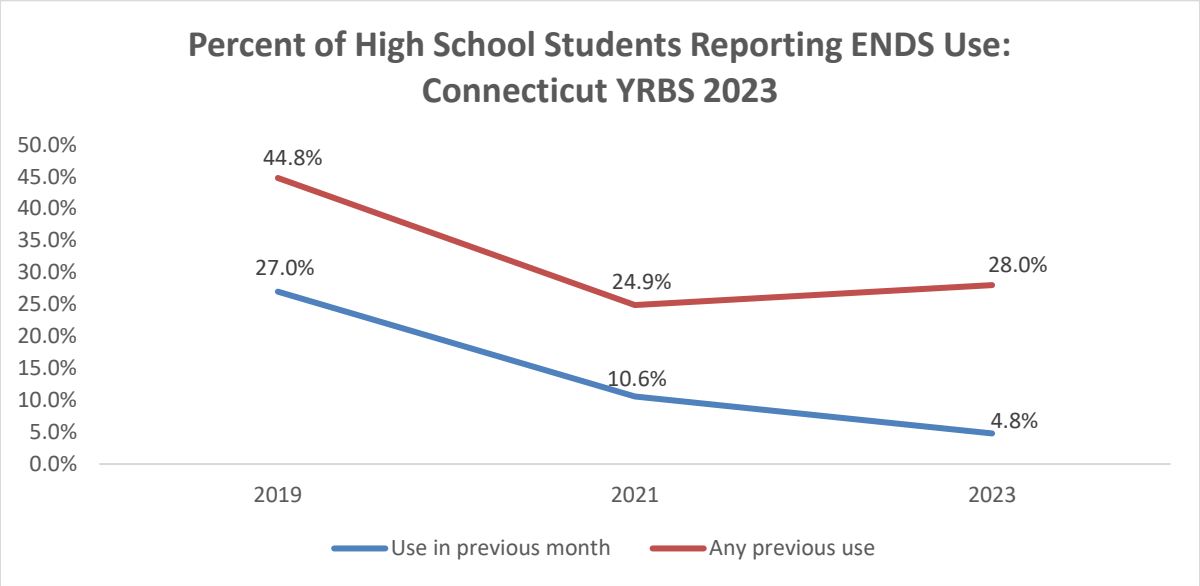
A newly added indicator in the 2022-23 NSDUH shows that nicotine vaping is more prevalent among Connecticut's young adults 18-25 than either youth or adults in the state. Past month prevalence of nicotine vaping is higher for young adults than for their peers in the Northeast US and US. Past month nicotine vaping is slightly lower among Connecticut's youth aged 12-17 than the Northeast US but almost identical with the US.

Nicotine Vaping in the Past Month (NSDUH 2022-2023)

	Age 12- 17	Ages 18 - 25	Ages 26 +
U.S.	6.82%	24.04%	6.75%
Northeast	7.06%	23.68%	5.79%
Connecticut	**6.87%**	**26.91%**	**6.16%**

While previous year reductions in the use of traditional tobacco products among Connecticut residents have been offset by increases in the use of e-cigarettes or electronic nicotine delivery

systems (ENDS), especially among youth and young adults, data from the 2021 Youth Risk Behavior Survey points to a significant decrease in use of ENDS. While a major decrease was reported in 2021 and considered a possible artifact of the COVID pandemic, this decrease has continued as evidenced by the 2023 data. Connecticut has taken legislative action to curb the dramatic rise in the use of e-cigarettes/ENDS and these data seem to provide evidence for the impact of this legislation.



Illicit Substances

Illicit substances include marijuana, misuse of prescription medications, heroin, cocaine, etc. According to historical NSDUH data, illicit drug use rates for Connecticut decreased between 2019 and 2021 for young adults ages 18 to 25 (-3%) but increased among all adults 18 and older (+1.5%). However, the prevalence of illicit substance use among youth and young adults have exceeded both region and nation in the 2022-23. Overall, adults ages 18 and older reported higher prevalence compared to the region and nation. The 2022-23 NSDUH data has shown an increase in illicit substance use among young adults 18-25 (+3.4%) and adults (+4%) compared to 2021-22 data, which were 30.44% for young adults and 17.09% for adults in general.

Illicit Drug Use in the Past Month (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	7.26%	26.71%	17.62%
Northeast	7.43%	29.76%	18.95%
Connecticut	**8.51%**	**33.88%**	**21.00%**

Given the array of substances included within the illicit drug category, narrowing this category to remove marijuana clarifies rates of use related to “hard” drugs and those associated with more severe health consequences. Using a narrower definition of illicit drug use to preclude

marijuana shows that prevalence of illicit drug use among Connecticut youth ages 12-17 is slightly higher than the prevalence in the Northeast region and the nation, with use among young adults ages 18-25 being highest. Prevalence among young adults and all adults continues to be in line with regional and national rates.

Illicit Drug Use Other than Marijuana in the Past Month (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	1.63%	4.22%	3.49%
Northeast	1.47%	4.70%	3.63%
Connecticut	**1.74%**	**4.74%**	**3.61%**

In line with the NSDUH prevalence estimates for illicit drug use, NSDUH 2022-2023 data show that Connecticut youth, young adults and adults have higher prevalence of Drug Use Disorder than their peers in the country, with young adults having the highest of the three age groups at all geographic levels.

Drug Use Disorder in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	6.96	18.30%	9.88%
Northeast	6.72	18.94%	9.87%
Connecticut	**7.18**	**23.17%**	**10.49%**

Marijuana

Marijuana continues to be the primary illicit drug used in the state among the general population. With neighboring states and now Connecticut legalizing recreational marijuana use, near-term use is expected to increase as perception of risk associated with smoking marijuana initially declines. However, we expect targeted prevention and health promotion activities within the state to have a balancing effect on legalization that stabilize or reduce rates of marijuana use moving forward. According to historical NSDUH data, rates of monthly marijuana use in Connecticut increased between 2019 and 2021 (from 12.34% to 14.89%), with similar increases across the region and nation. However, the 2022-2023 data show the prevalence of monthly marijuana use in Connecticut surpassed both the regional and national rates across all age groups. Compared to the 2021-2022 NSDUH data, marijuana use increased among young adults (+2.8%) and adults (+3.2%).

Marijuana Use in the Past Month (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	6.22%	25.54%	16.11%
Northeast	6.56%	28.80%	17.26%
Connecticut	**7.39%**	**32.62%**	**18.81%**

According to the Connecticut's BRFSS, the prevalence of past 30-day marijuana use is higher in White and Black adults than Hispanic adults.

Marijuana Use in the Past Month (CT BRFSS 2023)

	White	Hispanic	Black
Connecticut	15.3%	11.1%	14.0%

Rates of perceived risk from smoking marijuana were lower across all age groups in Connecticut compared to the region and nation, which corresponds with Connecticut's higher use rates across age groups.

Perception of Great Risk from Smoking Marijuana Once a Month (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	20.54%	10.88%	20.38%
Northeast	20.33%	10.49%	19.53%
Connecticut	**15.18%**	**8.12%**	**16.41%**

While marijuana continues to be the primary drug of choice among the general population, it was identified as the primary drug of choice in only 9.2% of behavioral health admissions in SFY 2024. This was a reduction from SFY 2022, during which time 10.5% of all admission identified marijuana as the primary drug of choice.

Heroin and Fentanyl

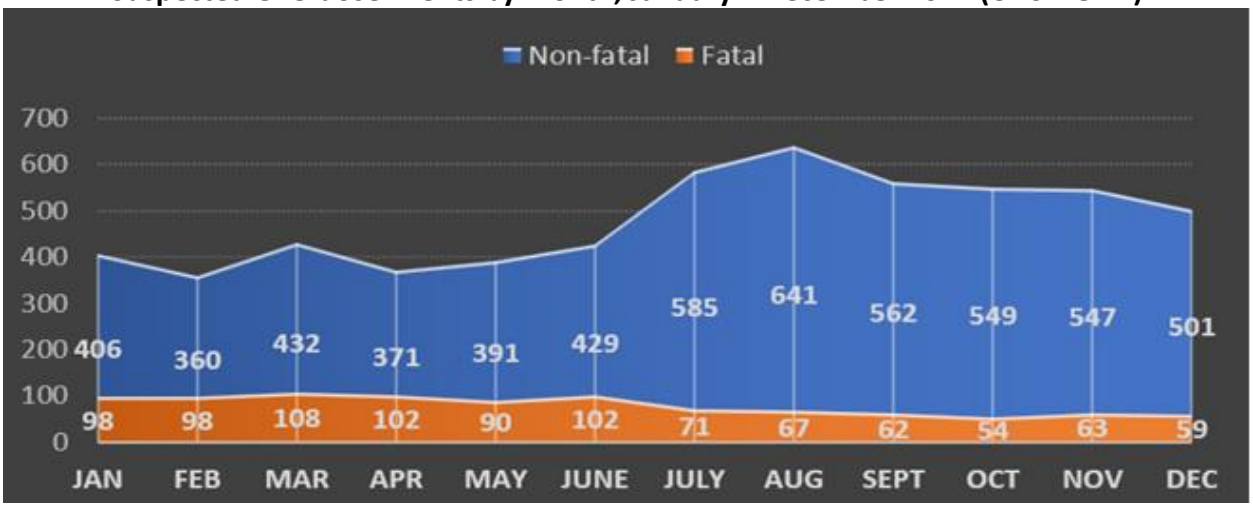
The opioid crisis has and continues to take a significant toll on Connecticut and the Northeast region. Reported prevalence of use of heroin in Connecticut was similar to both the Northeast region and the US among adults ages 18 and older, but Connecticut's use estimate was higher among young adults ages 18-25. Stakeholders have noted the limitations of reported heroin use as an indicator of illicit opioid treatment need due to heroin use being supplanted by other synthetic Opioids such as fentanyl. Currently population-level prevalence data are limited for these synthetic opioids and fentanyl specifically. For Connecticut, DMHAS collects data on "other opiates and synthetic opiates" as a separate drug category than "Heroin" to assess the prevalence of non-heroin opioid use among the treatment population.

Heroin Use in the Past Year (NSDUH 2022-2023)

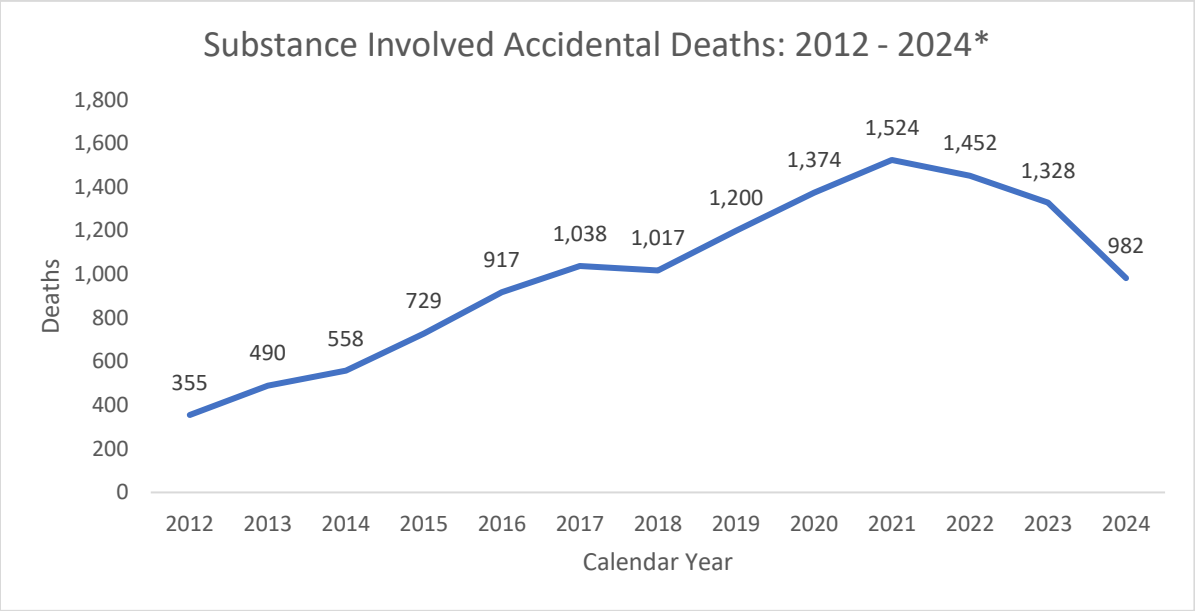
	Ages 18 - 25	Age 18+
U.S.	0.12%	0.33%
Northeast	0.13%	0.41%
Connecticut	**0.17%**	**0.42%**

Given this limitation, stakeholders have looked to data on overdose reversals and overdose deaths as a means for identifying prevalence of opioid use. While systematic collection of data on overdose reversals is a work in progress, some data is currently available on suspected overdose events (fatal, non-fatal, and reversed) through the Statewide Opioid Reporting Directive and its data resource, ODMap. These data, compiled statewide from the Office of Emergency Medical Services (OEMS) from information provided by first responders at the scene of each overdose event, indicate that while overdose events fluctuated throughout the year, 974 non-fatal overdoses were reported in 2024, an average of 80 per month, with non-fatal overdoses trending downward in the second half of the year.

Suspected Overdose Events by Month, January – December 2024 (CT SWORD)



Data on overdose deaths continues to be collected, improved, and utilized.[21] In calendar year 2024, Connecticut's Office of the Chief Medical Examiner (OCME) reported a total of 982 accidental deaths involving substances, 86% of which involved opioids. This represents a continued reduction from 1,339 deaths in calendar year 2022 and 1,216 deaths in calendar year 2023, and the third year-over-year reduction since 2018. There was a decline in death rates across all age groups in 2023 except for adults 65 and older, with mortality rates rising from 11.4 in 2021 to 18.5 in 2023. In 2023, males (56.3 per 100,000 population) had higher mortality rates when compared to females (17.9 per 100,000 population). The non-Hispanic Black population had highest mortality rate (67.9) followed by the Hispanic (all races included) population (38.0), both of which have higher concentrations in Connecticut's urban core and urban periphery communities. While the number of deaths remains historically high, this trend of reduction represents a significant achievement for the state and the treatment and recovery community.



*Based on data from the Connecticut Office of the Chief Medical Examiner. https://portal.ct.gov/OCME/Statistics

Prescription Pain Reliever Misuse

Although accidental overdose death data do not provide a full picture regarding opioid use prevalence and treatment need, rates of prescription pain reliever misuse provide additional information and point to a possible reduction in opioid use between 2019 and 2021. According to historical NSDUH data, rates of reported prescription pain reliever misuse in Connecticut reduced across all age groups during this time period, with the biggest reduction among young adults ages 18 to 25 (-2.2%). Rates in 2022-2023 were similar across the state, region, and nation, with a slightly lower rate among young adults 18-25 and adults 18 and older in Connecticut compared to other geographies. Compared to 2021–2022, misuse of prescription pain relievers declined by 1.2% among young adults, while rates among youth remained unchanged.

Prescription Pain Reliever Misuse in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	1.89%	2.82%	3.13%
Northeast	1.62%	2.23%	2.58%
Connecticut	**1.72%**	**1.88%**	**2.32%**

While the NSDUH data above provide a picture of opioid use among the general population, state treatment data provide an understanding of needs among the treatment seeking population. Heroin was identified as the primary drug of choice in 16.7% of all admissions to a substance use treatment program during SFY 2024, a reduction from 28.5% compared to SFY 2022. However, people identifying other opiates and synthetic opiates as their primary drug increased during this time period, with 13.9% of admissions reporting other/synthetic opiates

as their primary drug in SFY 2022 compared to 17.9% in SFY 2024. Combining figures for heroin and other/synthetic opiates reveals that the percentage of admissions to a substance use treatment program that identified any opiate as their primary drug of choice was lower in SFY 2024 (34.6%) compared to SFY 2022 (42.4%).

Stimulants

In Connecticut, cocaine was identified as the primary drug of choice in 10.7% of behavioral health admissions in SFY 2024, reflecting an increase from 4.3% of admissions in SFY 2022. Among the general population, rates of cocaine use in Connecticut are higher across all age groups compared to national rates and regional rates.

Cocaine Use in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.20%	3.40%	1.98%
Northeast	0.19%	3.88%	2.15%
Connecticut	**0.24%**	**4.29%**	**2.28%**

Methamphetamine use has and continues to be low among both the general population and those receiving behavioral health services in Connecticut. During SFY 2024, only 0.2% of behavioral health admissions identified methamphetamine as their primary drug of choice, which was the same percentage as SFY 2022. Among the general population, methamphetamine use is lower in Connecticut compared to national and regional rates among young adults ages 18-25 and adults ages 18 and older.

Methamphetamine Use in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.11%	0.39%	1.03%
Northeast	0.11%	0.27%	0.65%
Connecticut	**0.12%**	**0.17%**	**0.54%**

Substance Use Disorder (SUD)

The NSDUH defines Substance Use Disorder (SUD) as meeting the DSM-4 criteria for alcohol or drug use disorder. Connecticut's estimated prevalence of SUD in 2022-23 was higher than the Northeast region of the US and the nation for youth (12-17), young adults (18-25), and adults (18+), with highest prevalence among young adults at nearly 34%.

Substance Use Disorder in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	8.56%	27.46%	18.05%
Northeast	8.43%	28.40%	18.34%
Connecticut	**9.72%**	**33.76%**	**20.00%**

Connecticut's estimated prevalence of those needing but not receiving treatment for substance use was also higher than the Northeast US and the nation for 12-17-year-olds at over 70% reporting unmet treatment need, but slightly lower than those counterparts for adults 18 and over. Unmet treatment need continues to be highest among young adults ages 18 to 25, at nearly 85%, which is in line with the Northeast US and the country.

Needing but Not Receiving Substance Use Treatment in the Past Year (NSDUH 2022-2023)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	60.52%	83.51%	77.06%
Northeast	64.72%	83.96%	77.15%
Connecticut	**70.98%**	**83.85%**	**75.74%**

Substance Use Treatment

In SFY 2024, there were 46,405 admissions to substance use programs in Connecticut and 40,028 unique individuals were served within a substance use program during this time. The top three substances identified as the primary drug of choice among admissions to substance use treatment programs in SFY 2024 were alcohol (44.5%), heroin (16.7%), and other/synthetic opioids (17.9%). Of the individuals served within a substance use program in SFY 2024, 66% were male and 34% were female. 257 clients identified as transgender/other. Most individuals were White/Caucasian (59%), followed by Black/African American (14%) and "Other" (15%). Twenty-two percent of clients served by DMHAS substance use programs were of Hispanic/Latino origin, with 12% identifying as Puerto Rican. Comparing these percentages to state census data, non-Hispanic White/Caucasian clients were underrepresented (comprising 63% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 13% and 19% of the state population, respectively). Individuals served within a substance use program were clustered in the age groups of 26-34 (23.2%) and 35-44 (28.3%), with a mean age of 42years (+ 15), highlighting a slightly younger population of individuals receiving substance use services compared to the population receiving mental health services.

Needs Among Identified Populations

Individuals with Co-Occurring Mental Health and Substance Use

In 2022-2023, prevalence estimates of co-occurring substance use disorder and any mental illness (AMI) for adults in Connecticut showed that nearly 1 in 10 adults (9%) and nearly 2 in 10 (17%) young adults had these conditions co-occurring. Prevalence was higher for both young adults and adults in Connecticut than for their peers in the Northeast US and the nation.

Co-Occurring SUD and Any Mental Illness in the Past Year (NSDUH 2022-2023)

	Ages 18+	Ages 18 - 25	Age 26+
U.S.	8.17%	14.62%	7.17%
Northeast	8.00%	14.72%	7.00%
Connecticut	**9.11%**	**17.22%**	**7.86 %**

Roughly one-third (28%) of the persons treated by DMHAS in SFY 2024 had both a mental health (SMI) and a substance use diagnosis, a 16% increase from SFY 2022 (24%). Over 6,000 (6,377) individuals received services from both mental health and substance use programs during SFY 2024, reflecting an 8% increase from the 5,904 clients served during SFY 2022. As in SFY 2022, these clients were more male (64%) than female (36%), and over half (59%) were White/Caucasian, while 20% were Black/African American and 14% were classified as “Other.” Among the 21% of those who identified as Hispanic/Latino, 13% of Hispanic-Puerto Rican, 9.3% of Hispanic-Other, 0.4% of Hispanic-Mexican, and 0.2% of Hispanic-Cuban were admitted for co-occurring mental health and substance use treatment. Based on these demographics, co-occurring clients do not appear to be significantly different demographically from substance use only or mental health only clients.

Pregnant and Parenting Persons

Between 2023 to 2024, Connecticut experienced a reduction in the number of individuals admitted to substance use treatment programs who identified as pregnant at admission. In 2023, 293 (1%) of clients admitted to a substance use treatment facility identified as pregnant compared to 132 in 2024. The 2023 number was a slight increase from the 257 admitted in 2022. While the number and percentage has fluctuated, pregnant individuals have historically accounted for 1% or less of those admitted to substance use treatment programs in Connecticut.

According to state CAPTA data for 2022, Marijuana remains by far the most commonly identified infant substance exposure occurring in four out of five (80%) notifications.[22] Infant exposure to Methadone (8.8%) and/or Buprenorphine (5.2%) was combined into an “MOUD” category revealing that 1 in 7 notifications involved infant exposure to one or both medications. The “Non-MAT Opioids” category (9%) includes both non-prescribed and prescribed opiates

other than MOUD. Infant exposures are not mutually exclusive. Reports of infants exposed to multiple substances (i.e., Polysubstance) occurred in about 16% of notifications. The overall pattern of the rate of detected drugs has held constant over time, but more recent data are not currently available for this report.

While there is little direct data on parenting individuals as a subpopulation, it is recognized that parenting individuals experience behavioral health issues associated with parenting stressors, including those related to their children's behavioral health. Additionally, substance use and mental health issues among parents are recognized as Adverse Childhood Experiences (ACES) that detrimentally impact the wellbeing of children and have long term effects on into adulthood.[23] In its ACE module, the 2023 CSHS (CT YRBSS) asks high school students about these experiences. Nearly one in four (23.3%) Connecticut students reported having lived with a parent or guardian who had problems with alcohol or drug use. Similarly, about a quarter (24.9%) indicated they had lived with a parent or guardian who suffered from severe depression, anxiety, another mental illness, or had suicidal tendencies. Youth reporting these issues of their parents or guardians were more likely to be female, White and Latino/Hispanic.[9] Connecticut's Mobile Crisis Services (211, 988) reported 11,346 episodes of care in SFY 24, serving 8,428 unique youth.[8]

Older Adults

Connecticut's population is aging. The median age in Connecticut is 41.1 as compared to a nationwide median age of 38.8, according to the 2024 Connecticut State Plan on Aging. Older adults are a population of concern due to increased physical and behavioral healthcare needs. Social isolation and access issues are important challenges for this population, and the COVID pandemic exacerbated gaps and needs in these areas. According to data from America's Health Rankings Annual Report,[24] rates of mental health and substance use issues among individuals ages 65 and older in Connecticut are similar to national rates. In 2023, 14.2% of adults 65 and older in Connecticut reported having a depressive disorder compared to 14.7% of adults 65 and older nationally. During this same time period, 7.0% of adults 65 and older in Connecticut reported frequent mental distress compared to 8.7% of adults 65 and older nationally. Adults 65 and older in Connecticut had a lower rate of suicide compared to the nation. In Connecticut, the suicide rate among adults 65 and older in 2023 was 12.8 per 100,000 population compared to 17.7 nationally.[25] The rate of excessive drinking among older adults in Connecticut was also lower than the national rate (5.8 per 100,000 population vs 6.9 nationally) and excessive drinking among older adults was significantly lower than the general adult population in Connecticut (5.8 per 100,000 population vs. 6.2). The only behavioral health area where Connecticut's rate among older adults exceeded the national rate was drug related deaths, which aligns with Connecticut's higher rates among the population as a whole (40.9 per 100,000 in Connecticut vs. 32.4 for the nation). In 2023, the drug related death rate among individuals 65 and older was higher in Connecticut (17.7 per 100,000) than in the US (13.3 per 100,000), and that age group was the only group to experience a rise in mortality rate (11.4 in

2021 to 18.5 in 2023). Older adults still account for a smaller percentage of drug-related deaths (10% or less) than any other adults.[26]

Homeless Population

According to the multi-year point-in-time count data for Connecticut, there was a downward trend in homelessness in Connecticut from 2016 through 2021, but more recent data shows a slightly different picture.[27,28] There was a modest increase (3%) from 2,930 in 2022 to 3,015 in 2023, and a greater increase (13%) to 3,410 in 2024. Similarly, the number of unsheltered homeless (homeless individuals living in a place not meant for human habitation) in Connecticut increased by nearly 15%, from 501 in 2023 to 574 in 2024. Among Connecticut's homeless population statewide, those who identify as Black, Indigenous and/or People of Color (BIPOC) make up the majority (68%) of persons experiencing homelessness, with White individuals accounting for 32% of the homeless population.

Within the overall homeless population, 36% had a serious mental illness in 2024, compared to an estimated 5% in the general population (NSDUH 2022-2023) and 22% had a substance use disorder. These percentages have been and remain much higher among the unsheltered homeless population compared to the sheltered population in Connecticut. As of 2024, the percentage of unsheltered individuals with serious mental illness was nearly twice that of the sheltered homeless population (30% vs. 16%). Similarly, the percentage of unsheltered individuals with a substance use disorder was 19% compared to 9.7% of the sheltered population.[29]

Homelessness among individuals being admitted to behavioral health services in Connecticut has been relatively static. Homelessness among individuals admitted to any behavioral health service increased by 10%, however, between state fiscal year 2022 to SFY 2023, remaining unchanged from SFY 2023 to SFY 2024. Homeless individuals accounted for 5.2% of those admitted across all treatment programs (substance use and mental health) in SFY 2024.

Homelessness Among Behavioral Health Admissions in Connecticut[8]

	SFY 2022	SFY 2023	SFY 2024
All admissions (SU and MH)	12.8%	14.2%	14.1%

Rural Population

One of the principal challenges facing residents of rural communities in Connecticut is the distance to various health care facilities and services, such as hospitals. While Connecticut is a geographically small state, limited access to facilities can lead to individuals not seeking services, missing appointments, and facing potentially long drives to obtain treatment. According to the 2024 DataHaven Community Wellbeing Survey (DCWS), 26% of the

respondents living in rural communities stayed at home from a doctor's appointment or a visit to a health care provider because they had no access to reliable transportation.[10] This can serve as a critical barrier to addressing mental health needs among the rural populations, considering that more than one-third of DCWS respondents living in rural towns felt depressed for more than several days. Additionally, rural residents have been personally impacted by opioid addiction in ways that are not captured in prevalence and incidence data. Results from the 2024 DCWS highlight that a higher percentage (36%) of rural residents report having a close friend, family member, or acquaintance affected by opioid addiction in the last 3 years than any other community type and the state as a whole (30%).

LGBTQ+ Population

Rates of self-reported mental health challenges and substance use among the LGBTQ+ population remain higher than the general population, including the heterosexual population, particularly for youth. According to 2023 CSHS/YRBS data for Connecticut, the percentage of high school students identifying as Lesbian, Gay, or Bi-Sexual (LBG) who reported their mental health was not good was 51.6% compared to 21.2% of high school students who identified as heterosexual. These differences are supported by more recent state-specific survey data from the 2024 National Survey on LGBTQ Youth Mental Health which showed that 26% of LBGTQ Youth in Connecticut reported seriously considering suicide -including 36% of transgender and nonbinary youth- within the past year and 39% reported experiencing symptoms of depression. Rates of self-reported substance use mirror mental health rates and point to higher substance use among LGB identifying high-school students compared to heterosexual identifying students. According to YRBS (2023) data, 24.8% of LGB identifying students reported current alcohol use compared to 21.0% of heterosexual students. Similar disparities were documented across all substance use related questions on the YRBS and were significantly disparate in terms of self-reported cannabis/marijuana use, EVP use, and misuse of prescription pain medication.

Data on the LGBTQ+ population in Connecticut is limited, and even more limited are data collected directly from LGBTQ+ individuals themselves. The Connecticut LGBTQ+ Community Survey,[30] a needs assessment survey of LGBTQ+ individuals conducted by the legislatively created LGBTQ+ Health and Human Services Network in 2021, found that only one-third (35%) of respondents agreed that the needs of the LGBTQ+ population were represented across various government programs and services offered in Connecticut, and less than half (40%) of respondents felt that there was at least one community organization in their city or town that advocates for LGBTQ+ specific issues. Slightly over half (55%) of respondents had concerns about accessing mental health, addiction, and/or substance use services including affordability (22%), competence of providers to meet LGBTQ+ community member needs (18%) and concerns that services will not be LGBTQ+ friendly (17%). About 1 in 7 respondents believed they had been refused mental health, addiction, and/or substance use services because of their LGBTQ+ identity. Top mental healthcare needs reported by LGBTQ+ respondents included: a psychologist/counselor (31%); a psychiatrist (13%); and peer support groups to navigate mental health needs or substance use challenges (10%). Respondents also highlighted LGBTQ+ youth as

a specific subpopulation of need. Many of these responses varied significantly by race/ethnicity (see **Black, Indigenous, and People of Color** section below), highlighting intersectional needs and considerations for this population. These findings highlight the need for more supportive/affirming healthcare services, including behavioral health, and community supports to facilitate access to these services, with consideration of intersectional needs in strengthening these resources and access points.

Black, Indigenous, and People of Color (BIPOC)

Racial/ethnic disparities in substance use have been well-documented in the realm of substance use, risk factors, and social determinants for these issues. The mortality rate of overdose deaths was highest for individuals of color. According to OCME data, the rate of fatal overdose per 100,000 population in 2024 was almost twice as high in the Black population than the white population and had grown significantly in proceeding years. The non-Hispanic Black population had the highest mortality rate (67.9) followed by the Hispanic (all races included) population (38.0), both of which are more concentrated in the state's lowest resourced urban core and periphery communities.

Based on a comparison with state census data, persons of color were also overrepresented in Connecticut's SFY 2024 substance use treatment data, with Black/African American individuals comprising 13% (vs. 14% of treatment population) and persons of Hispanic/Latino origin comprising 19% of the state population but 22% of the treatment population. Black/African American individuals were also overrepresented in mental health treatment for the same period (18% of the population receiving services vs. 13% of CT population).

Connecticut's BIPOC population is also overrepresented in other high need populations of focus. For example, those identified as BIPOC make up the majority (68%) of persons experiencing homelessness in the state.

Additionally, race/ethnicity has a collective impact on the experience of LGBTQ+ individuals. The Connecticut LGBTQ+ Community Survey highlights that when asked about mental health and substance use treatment, Black, Hispanic/Latinx, and Multiracial respondents were significantly less likely to agree their behavioral health needs were met all or most of the time compared to White respondents. Additionally, Black and Hispanic/Latinx respondents were significantly less likely than White respondents to agree their provider(s) considered their LGBTQ+ identity when talking to them about their service needs, suggesting that racial/ethnic identity for individuals of color in other subpopulations may compound challenges in behavioral health care settings.

Young Adults

Data presented throughout this report highlight ways that young adults in Connecticut are a population of concern for behavioral health, as they report higher prevalence of mental health and substance use issues than other age groups, and young adults exceed the prevalence of their peers in the region and the US in multiple areas, making them a vulnerable, at-risk group for behavioral health consequences. In the area of mental health, young adults are also a population of concern in Connecticut, with young adults' reported prevalence of co-occurring substance use and mental health issues, depression, and suicidal thoughts/attempts greater than for young adults in the Northeast US and the nation. Additionally, young adults in-state had higher prevalence of reported past year mental illness and serious mental illness (SMI) and suicidal thoughts and attempts than any other age group. Regarding substance use, survey data show that Connecticut's young adults report the highest prevalence of alcohol and illicit drug use, as well as Alcohol and Substance Use Disorder, of any age group. Cannabis use in the state has increased among this population in recent years. Moreover, prevalence rates of nicotine vaping, illicit drug use, alcohol and substance use disorder, and unmet treatment need for Connecticut young adults rise above their peers in the Northeast US and the nation. DMHAS Young Adult Services (YAS) serves the most acute, high-risk cohort of young adults 18-25 in Connecticut. In SFY 24, YAS programs served 1,252 individuals, representing 12.2% of the total DMHAS population of 18-25-year-olds.

Statewide Priority Setting Process

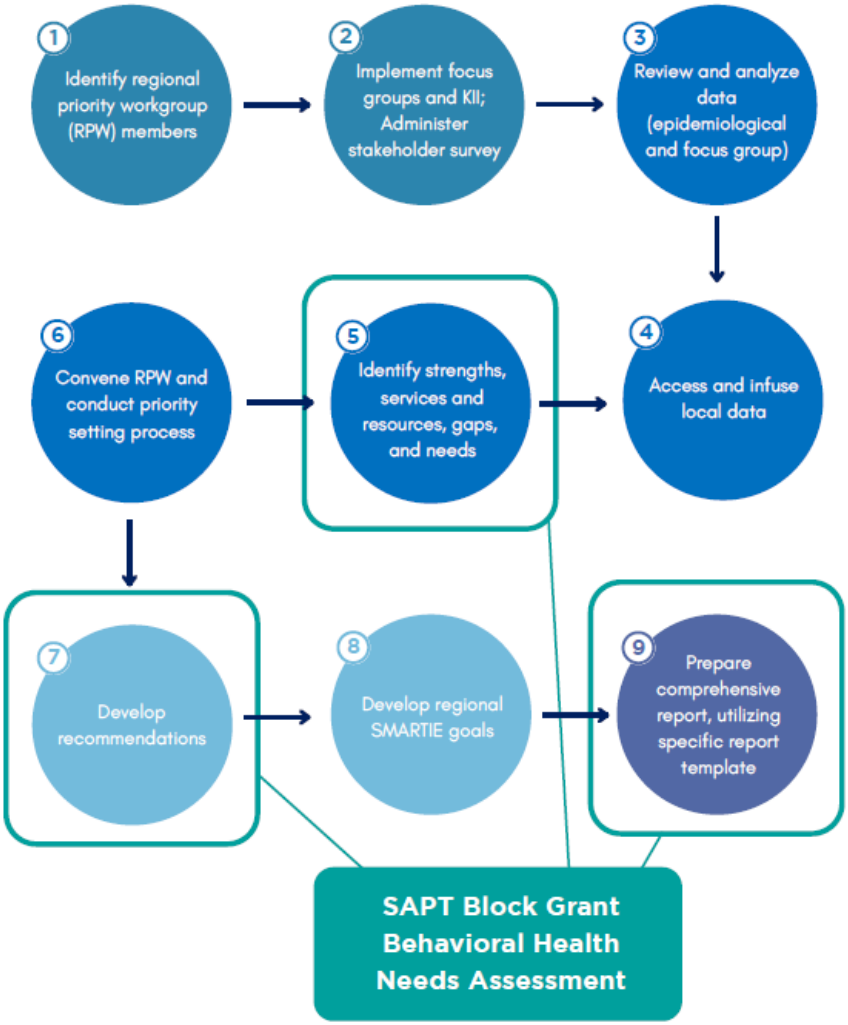
DMHAS supports comprehensive and unified planning across its state-operated and funded mental health and substance use services, utilizing a data-driven regional prioritization process to facilitate such planning at the local, regional, and state levels. The regional priority setting process provides an ongoing method to: 1) assess 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 more informed decision making, service delivery, and policy development. This comprehensive, collaborative process provides important data that can be aggregated and analyzed to assess behavioral health needs statewide.

Background

The biennial priority setting process is conducted by the state's Regional Behavioral Health Action Organizations (RBHAOs) with support from the DMHAS Prevention Unit and Block Grant State Planner, and ongoing guidance and technical assistance from the DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health. Standardized processes are organized into a unified activity comprehensively assessing the entire DMHAS behavioral health service system. The regional priority setting process has been re-envisioned and revamped since 2023, informed by RBHAO and DMHAS input, to increase efficiency, responsiveness, and precision, and to improve the quality and acuity of results and recommendations resulting from this process. While focus areas and core elements have not changed, the process itself has evolved, and the outputs and reporting elements based on this process have also been re-envisioned, focusing on foundational questions. The basic steps in the 2025 regional priority setting process are:

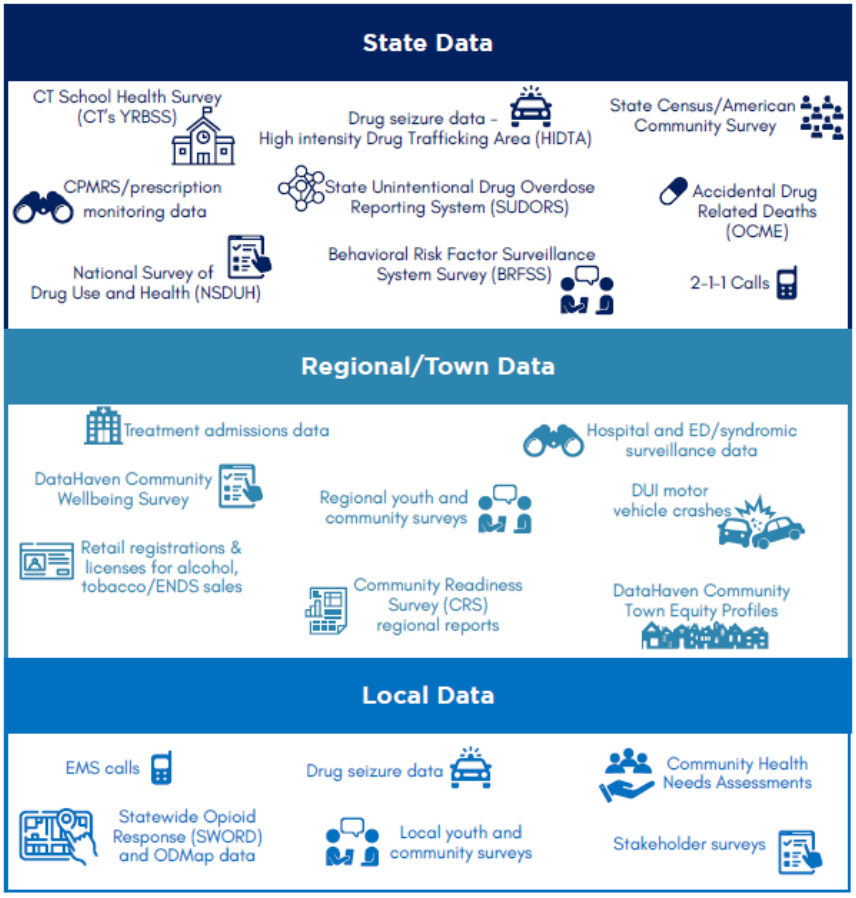
- Compilation and examination of quantitative (epidemiological and administrative/systems) data from a wide array of local, state, and national surveys and assessments;
- Strategic outreach resulting in key informant participation in a standardized statewide Stakeholder Survey assessing issues of concern, emerging issues, subpopulations, and resource gaps and needs;
- Qualitative data collection from multiple stakeholders (consumers, families, town officials, law enforcement, providers, etc.) via focus groups, key informant interviews, community conversations, and discussions at routine meetings, community events, etc.;
- Consideration of other targeted regional needs assessment results and funded initiatives;
- Workgroup synthesis of data across sources and types to develop regional priorities and recommendations;
- Creation of a regional profile to describe the characteristics of their catchment areas;

- Development of regional reports inclusive of all the elements above in a standardized format along with emerging issues, populations of focus, strengths, identified needs/gaps/barriers, recommendations, and regional SMART goals.
- Distillation of regional report content into a statewide summary report;
- Share results with Connecticut's state planning organizations to inform prevention and treatment planning and implementation.



The process of prioritization and report development was data driven, with RBHAOs utilizing both quantitative and qualitative data at the state, regional, and town/local levels. Data were used in a variety of ways. With the support of CPES, RBHAOs compiled and analyzed data to share with stakeholders within each RBHAOs identified Regional Priority Workgroups (RPW) to inform a systematic prioritization of substance misuse and mental health issues to address within the region. Data at the state, regional and local level spanned state agencies and organizations, including but not limited to: Centers for Disease Control (CDC); Substance Abuse and Mental Health Services Association (SAMHSA); CT Department of Public Health; Office of

the Chief Medical Examiner (OCME); Department of Consumer Protection (DCP); Department of Mental Health and Addictions Services (DMHAS); DMHAS Problem Gambling Services (DMHAS PGS); the United Way; DataHaven; CT Hospital Association; Department of Transportation/UConn; UConn Health/CT Emergency Medical Services (EMS); CT State Department of Education (SDE); CT Clearinghouse; CT Data Collaborative; Child Health Development Institute (CHDI); High Intensity Drug Trafficking Area (HIDTA); Drug Enforcement Agency (DEA); Carelon and the CT Behavioral Health Partnership. RBHAOs supplemented these data with local (town and health district) data from local health districts/departments (LHD), local law enforcement, Local Prevention Councils, and treatment providers.



RPWs also relied on local qualitative data from key informants and stakeholders, in the form of focus groups, key informant interviews, and discussions with their Catchment Area Councils, Regional Suicide Advisory Boards, Gambling Awareness Teams, Local Prevention Councils, Community Care Teams, the recovery and faith communities, youth serving providers, consumers, and others.

To provide standardized stakeholder data for the regional priority setting process across regions, CPES developed an online statewide Stakeholder Survey for which the RBHAOs conducted outreach to a strategic sample of key informants across sectors. The survey was new

to the priority setting process and gathered data on behavioral health issues of concern, emerging issues, and service gaps and needs. Results from this survey are described below.

Stakeholder Survey: Substance Use and Mental Health Issues of Concern

Stakeholder Survey respondents were asked to rank ten issues from 1 (issue of greatest concern) to 10 (issue of least concern) for five distinct age groups (infants & young children; youth; young adults; adults; older adults). These issues included:

- Alcohol
- Tobacco/cigarettes/vaping nicotine
- Marijuana/cannabis/hashish/THC/ vaping marijuana
- Cocaine/crack
- Heroin/fentanyl
- Prescription drug misuse
- Anxiety
- Depression
- Trauma
- Suicide

On average, anxiety and depression ranked in the top three across all age groups. Alcohol had the highest mean rank for both adults and young adults, and the second highest for older adults. For all age groups, heroin/fentanyl and cocaine/crack ranked as the issue of lowest concern on average. Issues of focus shared across age groups include anxiety, depression, and alcohol.

Top Three Issues of Ranked Concern* For Age Groups in Connecticut

Age Group	Issue 1 (mean rank)	Issue 2 (mean rank)	Issue 3 (mean rank)
Infants and Young Children (<11)	**Anxiety** (2.58)	**Trauma** (3.23)	**Depression** (3.32)
Youth (12-17)	**Anxiety** (2.91)	**Depression** (3.51)	**Tobacco Use** (4.28)
Young Adults (18-25)	**Alcohol Use** (3.47)	**Anxiety** (3.65)	**Depression** (3.95)
Adults (26-64)	**Alcohol Use** (2.87)	**Depression** (3.92)	**Anxiety** (4.16)
Older Adults (65+)	**Depression** (2.45)	**Alcohol Use** (3.00)	**Anxiety** (4.01)

*Ranked by stakeholder key informants, range 1 to 10, 1 being of highest concern

For suicide prevention, survey respondents most frequently selected either youth (44.5%) or young adults (31.9%) as the age group of greatest concern.

Stakeholder Survey: Service System Gaps and Needs

Shared gaps and needs between substance use and mental health service systems included: outpatient therapy; intensive outpatient treatment; community support services (including case management); care coordination; and housing with support services (including sober housing).

Substance Use Services

Inpatient rehabilitation (short/long term), outpatient therapy, and intensive outpatient were most frequently identified as unavailable or inadequately provided treatment levels/types of care for substance use. About half of key informants identified community support services (including case management) as a support service needed for individuals with substance use issues. Many survey respondents also identified housing with support services (including sober housing) and care coordination as needed support services.

Respondents to the Stakeholder Survey identified young adults (18-25) and homeless individuals and families as populations underserved by the substance use service system which reflects the priority populations identified earlier in this report. In addition, respondents frequently identified youth (12-17) and non-English speaking individuals as groups who are inadequately served by this service system.

Mental Health Services

Outpatient therapy, intensive outpatient, and emergency/crisis—followed closely by inpatient rehabilitation (short/long term)—were most frequently identified as unavailable or inadequately provided treatment levels/types of care for mental health. Nearly half of survey respondents identified community support services (including case management) as a needed support service for individuals with mental health issues. Many key informants also identified care coordination and housing with support services as needed services.

Similar to findings about the substance use service system, Stakeholder Survey respondents identified youth, young adults, homeless individuals and families, and non-English speaking individuals as groups who are underserved by the mental health service system. In addition, respondents identified youth, young adults, LGBTQ+ individuals, homeless individuals and families, and veterans and service members as populations who are not adequately served by suicide prevention services. These findings mostly align with the priority populations previously discussed in this report.

Planning Council Survey

The regional Stakeholder Survey and its results were used to develop an abbreviated survey that was administered to the Adult Behavioral Health Planning Council (*n* = 14). This survey gathered data on emerging issues in substance use and mental health, as well as service gaps and needs.

Emerging Issues

Over half of Planning Council members identified counterfeit or contaminated substances as an emerging substance use issue. In addition, council members identified oral nicotine pouch use, benzodiazepines (including designer benzodiazepines), and kratom as emerging issues. Other emerging substance use issues reported by Planning Council members included: access to cannabis through unlicensed retailers; increasing cannabis use among teens; poly substance use; and use of THC and ETOH among young adults.

For mental health, nearly three-quarters of members identified anxiety as an issue of concern. The Planning Council also determined that co-occurring mental health and substance use disorders, depression, and trauma were emerging issues in mental health. Other emerging mental health issues reported by members included eating disorders and community health.

Emerging Substance Use Issue	Count of Members	Percent of Members (%) *n* = 14
Counterfeit or contaminated substances	9	64.3
Other substance reported	6	42.9
Benzodiazepines or designer benzodiazepines	5	35.7
Oral nicotine pouch use	5	35.7
Kratom	4	28.6
Sedatives	2	14.3
Nitrous oxide	1	7.1
Pink cocaine	1	7.1
Emerging Mental Health Issue	**Count of Members**	**Percent of Members (%) *n* = 14**
Anxiety	10	71.4
Co-occurring mental health and substance use disorders	8	57.1
Depression	5	35.7
Trauma	5	35.7
Suicide	3	21.4
Social isolation or loneliness	3	21.4
Other mental health issue reported	3	21.4
Psychosis or first-episode psychosis	2	14.3

Substance Use Service System

Similar to the Stakeholder Survey results, Planning Council members frequently identified outpatient therapy as a treatment level that is currently unavailable in the substance use service system. In addition, the Planning Council deemed that intensive wrap-around services, inpatient services, and peer/recovery supports were treatment levels that are unavailable or inadequately provided in this system.

Members of the Planning Council identified the following as needed support services in the substance use system: peer/recovery supports; housing with support services (including sober housing); community support services (including case management); prevention services; and screening diagnosis and risk assessment. These findings do not directly reflect those from the Stakeholder Survey, but the two respondent pools agree that housing and community support services are needed.

Homeless individuals and families as well as LGBTQ+ individuals were the two groups most frequently identified by Planning Council members as underserved by the substance use service system. These results align with the priority populations identified in this report.

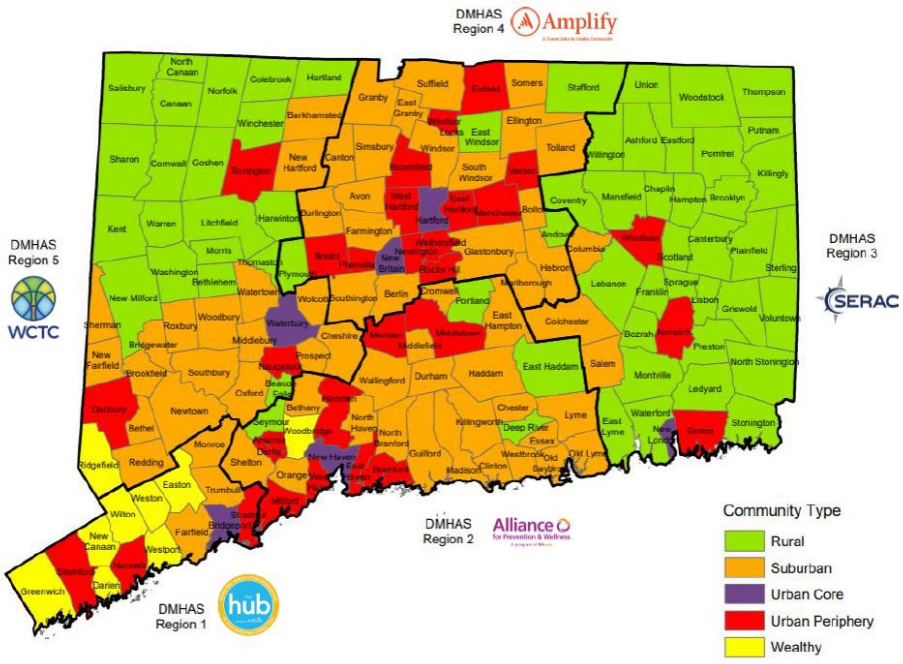
Mental Health Service System

Half of Planning Council members identified outpatient therapy as a treatment level that is unavailable or inadequately provided in the mental health service system. This finding reflects that of the regional Stakeholder Survey. Other treatment levels identified as inadequate by council members included intensive wrap-around services, emergency/crisis care, and peer/recovery supports.

Over half of the members identified crisis response as a service that is most needed to assist individuals with mental health issues. In addition, the Planning Council determined that community support services (including case management), peer/recovery supports, and screening diagnosis and risk assessment were needed in the mental health service system. These findings do not directly reflect those from the Stakeholder Survey, but both respondent pools frequently identified community support services as needed within this system.

The population that council members most frequently identified as underserved by mental health services was LGBTQ+ individuals, which reflects findings about the substance use service system. In addition, the Planning Council identified non-English speaking individuals and youth as groups who are inadequately served by the mental health service system. This finding aligns with results from the regional Stakeholder Survey.

Distilled Results from the 2025 Regional Prioritization Process



Regional Priority Issues

Regions used various processes to prioritize issues and arrive at regional substance use and mental health priorities, but all regional teams considered magnitude/severity of the issue, impact on the community, populations at risk, and changeability in determining regional priority issues, in addition to the results of other issue-specific needs assessments over the past two years, and consideration of existing funded efforts in the region. Roughly in line with Stakeholder Survey results, anxiety was a top priority across regions, with depression, alcohol, and illicit opioids identified as top in three of five regions, followed by vaping/ENDS, and cannabis. Unlike the Stakeholder Survey, RPW prioritization was not done by age group. Instead, regions were asked to identify populations of focus (at-risk, underserved, overrepresented in the problem area) for each priority they identified.

For anxiety and depression, youth and young adults, LGBTQIA+ individuals, and older adults were identified as populations of focus, as well as BIPOC and non-English speaking individuals in one region for mental health in general. For suicide/suicide prevention, youth and LGBTQIA+ individuals were identified across regions, as well as adult men in 3 regions, and Latino youth and older adults in one region, respectively.

Regional priorities and populations for substance use were slightly more diverse by region. For alcohol, adults in general were the primary population, with specific focus on males, BIPOC, and lower income individuals. Youth were also identified.

For illicit opioids, young adults and adults were identified, with a focus on Black individuals, individuals in urban centers, homeless individuals and those with co-occurring disorders.

For vaping/ENDS and cannabis, youth in general and LGBTQIA+ youth were populations of focus, with a geographic focus in suburban areas. Young adults and parents were also identified, both as users and possibly a population of concern as a point of access for youth.

Emerging Issues

Emerging issues identified through this process spanned both new issues and issues already on the state's radar, but possibly applied to new or other populations or geographies.

"Zynning," a term for use of oral nicotine pouches colloquially referred to as "Zyn" (one brand name of several) was again identified as an emerging issue for youth and young adults in regions 2, 4 and 5, and more specifically athletes in region 2, and males in region 5.

Impaired driving was identified in regions 2 and 4, for younger adults and males in region 2. For region 4, wrong way driving and driving under the influence of cannabis were highlighted.

Alcohol use, long existing in the state, was identified as an emerging issue in regions 1 and 4, due to under-addressed alcohol use disorder among males in an urban community in region 1, and due to high intensity drinking among young adults and alcohol attributable to cancer in region 4.

In the areas of cannabis and polysubstance use and overdose deaths, which was identified in regions 1, 3, 4, and 5, various substances and populations were identified as emerging. The involvement of multiple substances and specifically stimulants in substance-involved deaths was an issue of concern. Additionally, the constant flow of new additives, contaminants and synthetics into the illicit drug supply, including Medetomidine, a veterinary drug, and Nitazenes and Carfentanil as synthetics, remains an area of focus. Designer benzodiazepines, including Bromazolam, were also identified.

In the realm of cannabis and vaping, normalization among youth in middle and high school, illegal access to high potency products, including tinctures, the rising number of vape retailers, and cannabis use psychosis were all identified.

This information is summarized in the table below.

Substance Issue	Regions	Emerging Populations/ Areas of Concern

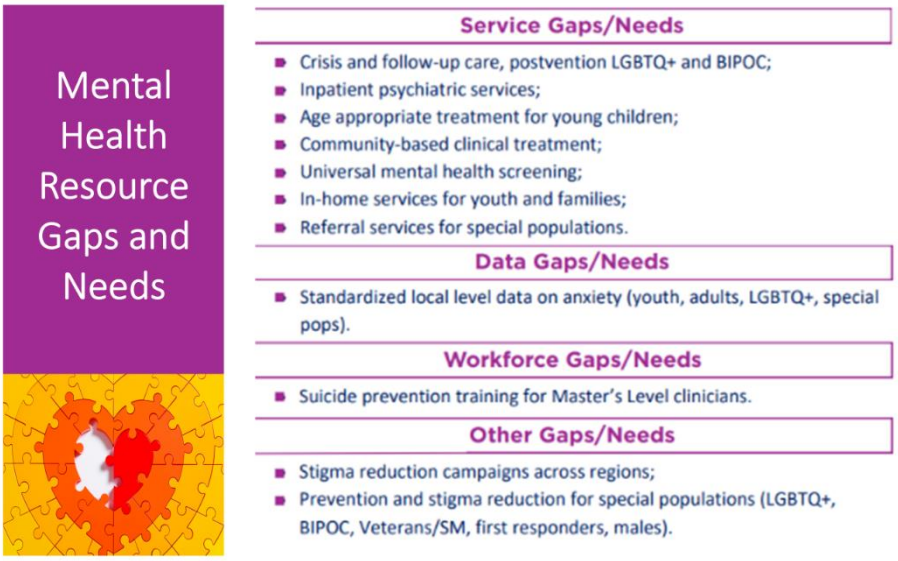
Cannabis and Vaping	**1, 3, 4, 5**	**•Normalization among MS, HS students (R1) •Youth, Young Adults, Adults (R3) •Illegal access to high potency products (R1, R4) •Cannabis use psychosis (R4) •Rising number of vape retailers (R5)**
Poly-substance/ Overdose Deaths	**1, 3, 4, 5**	**•Deaths involving stimulants (R1, R3, R5) •Prescription drug misuse among older adults (R3) •Synthetic opioids (e.g., Nitazenes, Carfentanil) (R4, R5) •Designer benzodiazepines (e.g., Bromazolam) (R4, R5) •Medetomidine (R5) •Tainted (additives in) cocaine (R5)**

For mental health, emerging issues were more nuanced. The table below outlines mental health emerging issues across regions.

Mental Health Issue	Emerging Populations/ Areas of Concern
Increase in ADD/ADHD prescriptions	Youth, young adults (R5)
Surge in Loneliness and Mental Health Decline	Youth, Seniors, and Working Adults (R1)
Provider Burnout and Systemic Fatigue	Behavioral health providers and case workers (R1)
Culture shift: Adults seeking to taper off medications and change prescribers after 20+ years (innovations, etc.)	Adults and older adults (R5)

Resource Gaps and Needs

Mental health service system gaps and needs fell into the categories of services, data, workforce, and other gaps/needs. Crisis and other services for special populations was a theme across regions, as was the need for better standardized data on anxiety prevalence for the population as a whole. Other gaps/needs focused on reducing stigma, especially for special populations. These are detailed in the graphic below.



Substance system gaps/needs identified by regions focused on the need for funding, as well as workforce strengthening, including staff supports and a focus on recovery. Service coordination was another key area of focus. Service needs focused largely on youth, although culturally responsive opioid use treatment, intensive outpatient, and cannabis-focused treatment and recovery were all highlighted. Data was also a need identified through the regional process, one key focus being the need for comprehensive naloxone administration data beyond what EMS provides through the Statewide Opioid Response Directive (SWORD). The graphics below detail service gaps and needs.

Funding Gaps/Needs

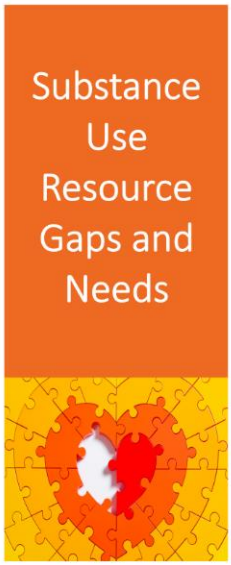
- Flexible, sustainable funding for local prevention efforts (LPCs);
- Funding for recover organizations (CCAR)

Workforce Gaps/Needs

- Bi-lingual and culturally competent providers;
- Provider/staff supports;
- Living wage for peer recovery coaches

Service Gaps/Needs

- Behavioral supports in schools;
- Long term residential treatment for youth;
- Intensive outpatient services;
- Culturally responsive OUD treatment;
- In-home services for youth and families;
- Cannabis-focused treatment and recovery services



Service Coordination and Access Gaps/Needs

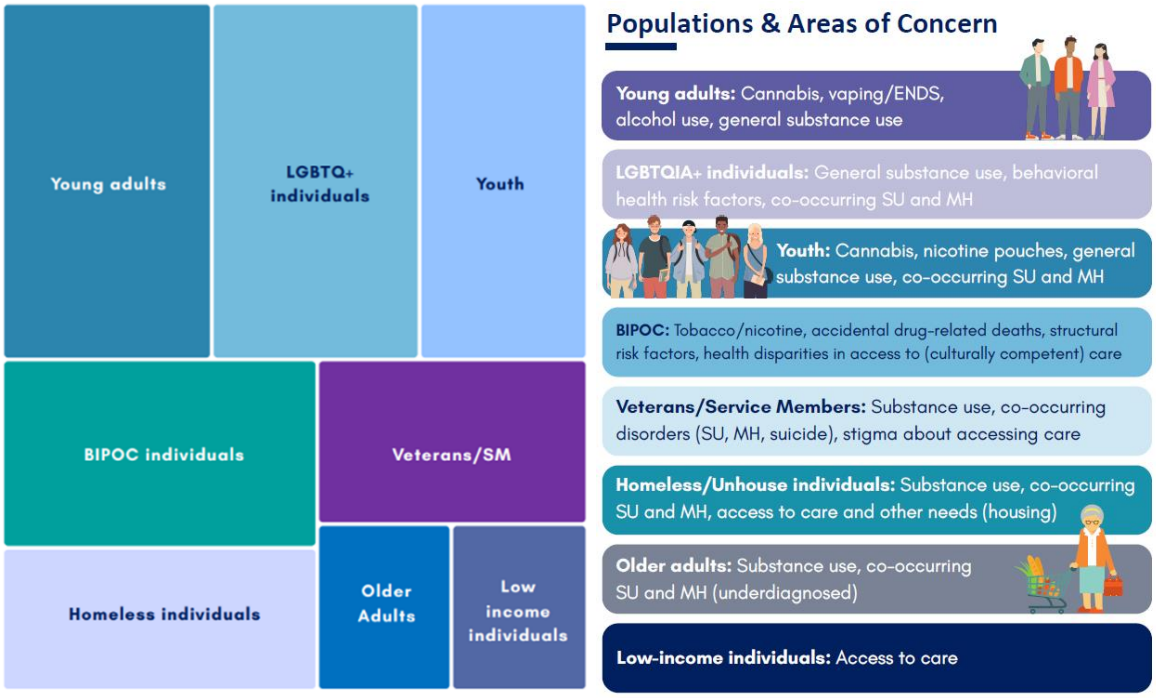
- Additional care coordination (case management):
- Access to care for:
  - Homeless individuals
  - Women
  - Uninsured/under-insured
  - Undocumented individuals
  - Non-English speaking
  - Individuals in urban communities
- Transportation Support

Data Gaps/Needs

- Young adult Behavioral Health data;
- Stimulant use data;
- Buprenorphine prescribing/use (youth, adults);
- More accurate/complete OD event data;
- Standardized naloxone administration data (beyond EMS);
- Regional/local data (across focus areas), including youth and adult alcohol use survey (R4)

Underserved Populations

Underserved populations, also identified as populations of concern, were identified by RPWs as those with increased risk, burden, or representation in the behavioral health data, emerging issues, and service gaps and needs. These populations align largely with the Block Grant priority populations, and are represented below.



The areas of concern for these populations ranged from general substance use and co-occurring mental health disorders to specific substance-related use and behaviors, detailed above.

Regional Recommendations: Substance Use

Regional recommendations addressed many of the gaps and needs identified through the process.

Regional recommendations for substance use prevention focused in the areas of funding, enforcement, workforce development/strengthening, social marketing, and data and technology. These are detailed below.

Substance Use/Misuse Prevention

Substance Use/Misuse Prevention

Funding

- **Expand funding** opportunities for LPCs to be flexible and sustainable. (R2)
- **Flexibility of funding** for vaping campaign materials targeting youth and young adults under 21. (R3)

Enforcement

- **Stricter policies** and **enforcement** of retailers. (R1)
- Prioritize investment in modernized **enforcement policies** to enhance public safety and support prevention goals by reducing cannabis-related harm on roadways. (R4)
- Create a formal task force as part of the WCTC vape/cannabis workgroup and mobilize R5 communities to adopt **density laws** for ENDS/vape shops. (R5)

Workforce Development

- Partner with universities to advertise **career paths** in prevention. (R2)

Social Marketing

- Implement **region-wide campaigns**. (R2)

Data and Technology

- Review and discuss available impaired driving **fatality/crash data** with key partners (DOT, DMV) with a focus on incidents that involve alcohol and other substances. (R4)
- Prioritize investment in **reliable roadside testing technologies** to enhance public safety and support prevention goals by reducing cannabis-related harm on roadways. (R4)

Regional recommendations for substance use treatment and recovery focused in the areas of improving treatment access, addressing material support needs for those with treatment need, strengthening recovery services and support for the general population and specific populations of focus, harm reduction, expansion of education efforts and social marketing. Specific recommendations are detailed in the graphic below.

Substance Use Treatment/Recovery

Substance Use Treatment/Rcovery

Treatment/Access

- **Cessation programs** for youth and young-adult cannabis and nicotine use. (R2)
- Require **warm hand-offs** between behavioral health providers. (R2)
- **Create a toolkit** for physicians on men's co-occurring disorders. (R3)
- Expand capacity of **tobacco treatment specialists** (TTS) and access to youth focused cessation programs. (R4)

Recovery Services & Support

- Insurance coverage for **peer support/recovery** people. (R1)
- Implement **women-focused recovery services** and **sober community events** and increase **peer-led community outreach** in hot spots and employment sites. (R2)
- Build **regional networks** of substance use **recovery support** utilizing specific guidelines, toolkits, and other planning instruments. (R5)

Public Education/Social Marketing

- Promote **public education efforts** that emphasize the link between nicotine use and mental health challenges with a focus on parents/trusted adult. (R4)
- Develop a **living resource document for websites** to share RFC, RFW, sober-related news and events throughout the year. (R5)

Material Supports

- Provide **affordable housing**. (R1)
- Expand emergency and permanent **housing options**. (R2)

Harm Reduction

- Increase **harm reduction education and practices**. (R1)
- Increase accessibility to **reliable drug testing tools**. (R1)

Regional Recommendations: Mental Health

Mental health promotion, treatment and recovery recommendations also addressed gaps and needs within the regions, again with a focus on treatment access and special populations, public education, workforce development, and data. Specific recommendations are detailed below.

Mental Health Promotion, Treatment & Recovery

Mental Health Promotion

- Integrate mental health promotion within primary substance use
- prevention initiatives (R2);
- Promote alternatives to therapy (R2);
- Develop a statewide educational model for youth to address resiliency skill building and anxiety (R3);
- Fund regular, sustainable programs and events that offer social engagement and experiential learning (R5).

Public Education/Social Marketing

- Develop a statewide mental health stigma reduction campaign (R4);
- Develop a "Trusted Adults for Healthy Futures campaign" (R1, R2).

Data

- Comprehensive look at youth anxiety including a statewide survey (R1).

Treatment Services and Access

- Expand outpatient care and support for recovery support services to reduce waitlists, increase continuity of care and prevent the need for emergent/urgent types of care (R3.

Special Populations

- Identify and/or develop more resources and spaces recognizing specific risk and protective factors of the LGBTQIA+ community youth and emerging adults (R5).

Workforce Development

- Develop clinical series on trauma for providers to enhance expertise regionally (R2).

Suicide prevention recommendations focused on protection and sustainment of funding for 988 and the state's Regional Suicide Advisory Boards (RSABS), and expansion of crisis centers throughout the state.

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Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: First-Episode Psychosis

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Improve pathways to care for individuals experiencing First-Episode Psychosis in Connecticut

Strategies to attain the goal:

Deploy regional early detection assessment coordinators (EDACs) to each service region of the state. EDACs will conduct early detection activities in their region to identify potential new cases of First Episode Psychosis (FEP). EDACs will help to improve pathways to care for these individuals and collect data on the quality, delay (Duration of Untreated Psychosis) and engagement with services. EDACs will work directly with the Local Mental Health Authority in their assigned region to help connect the individual to services, and to specialty care if a CSC program or FEP team exists in the region.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Median wait time for individuals with FEP seeking care within a Local Mental Health Authority (LMHA). Target is 7 days or less.

Baseline measurement (Initial data collected prior to and during 2026): Two LMHAs currently have a median wait time less than 7 days

First-year target/outcome measurement (Progress to the end of 2026): Median wait time less than 7 days across at least 5 LMHAs

Second-year target/outcome measurement (Final to the end of 2027): Median wait time less than 7 days across at least 9 LMHAs

Data Source:

Yale STEP clinic database; LMHA database

Description of Data:

Client level data is captured by Yale when completing all outreach, engagement, and assessment activities with individuals identified within the community as possibly having FEP. Client level admission and treatment data is collected by the respective LMHAs.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Percent of clients with FEP engaging in treatment after initial referral (engagement rate) to Local Mental Health Authority. Target is 80%.

Baseline measurement (Initial data collected prior to and during 2026): Three LMHAs currently have at least 80% of clients with FEP engaging in treatment after initial referral.

First-year target/outcome measurement (Progress to the end of 2026): At least 5 LMHAs will have client engagement rate of 80% or higher

Second-year target/outcome measurement (Final to the end of 2027): At least 9 LMHAs will have client engagement rate of 80% or higher

Data Source:

Yale STEP clinic database; LMHA database

Description of Data:

Client level data is captured by Yale when completing all outreach, engagement, and assessment activities with individuals identified within the community as possibly having FEP. Client level admission and treatment data is collected by the respective LMHAs.

Data issues/caveats that affect outcome measures:

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

Priority #: 2

Priority Area: Crisis Services Continuum

Priority Type: BHCS

Population(s): SED, BHCS

Goal of the priority area:

All Connecticut residents experiencing a behavioral health crisis receive a timely response and the care they need

Strategies to attain the goal:

Extend hours for chat and text options for 988. Connecticut currently staffs chat and text for 988 during first shift but National backup center is currently responding to text and chat for second and third shift. State will provide staffing for second and third shift.

All child/youth mobile crisis providers will conduct a minimum of 10 outreaches per quarter to increase community awareness; DCF will collaborate with the CT State Department of Education to provide education and information to school districts to increase utilization of services; DCF will partner with local emergency departments on creative strategies to increase referrals to child/youth mobile crisis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: State answer rate for 988 chat and text

Baseline measurement (Initial data collected prior to and during 2026): 38% (state responds to 39% of chat and text, national backup responds to 61%)

First-year target/outcome measurement (Progress to the end of 2026): 60% (state responds to 60% of chat and text, national backup responds to 40%)

Second-year target/outcome measurement (Final to the end of 2027): 90% (state responds to 90% of chat and text, national backup responds to 10%)

Data Source:

Vibrant database

Description of Data:

Vibrant collects various data related to 988, including call volume, wait time, and chat and text.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of children/youth receiving a crisis evaluation from a mobile crisis clinician

Baseline measurement (Initial data collected prior to and during 2026): 8,428 (SFY24)

First-year target/outcome measurement (Progress to the end of 2026): 8,600

Second-year target/outcome measurement (Final to 8,700

the end of 2027):

Data Source:

Statewide Database, Performance Information Exchange

Description of Data:

Total number of episodes and unique individuals served

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Community based services for SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Individuals with SMI

Strategies to attain the goal:

Improve awareness and utilization of community-based programs and services for individuals with SMI, including Crisis Respite and Peer Respite programs. Coordinate transportation to ensure individuals from all parts of the state can utilize these services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Utilization rate for Crisis Respite and Peer Respite programs

Baseline measurement (Initial data collected prior to and during 2026): 56%

First-year target/outcome measurement (Progress to the end of 2026): 70%

Second-year target/outcome measurement (Final to the end of 2027): 85%

Data Source:

Enterprise Data Warehouse (EDW)

Description of Data:

The EDW captures client level data for DMHAS funded and operated programs. Client data, including admissions and lengths of stay, will be utilized to identify the utilization rate for the program based on the number of available beds.

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: Access to substance use services

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Improve access to treatment for PWID

Strategies to attain the goal:

Increase capacity of Access Line call center to respond to additional calls. The Access Line facilitates access to Substance Use services for Connecticut residents by providing rapid assessment, referral, and connection to transportation providers who can transport the individual to a treatment facility.

Increase staffing for Access Line transportation providers to be able to provide additional transports to treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Median wait time for callers to the Access Line call center

Baseline measurement (Initial data collected prior to and during 2026): 40 seconds (CY24)

First-year target/outcome measurement (Progress to the end of 2026): 38 seconds (CY25)

Second-year target/outcome measurement (Final to the end of 2027): 36 second (CY26)

Data Source:

Monthly reports from call center

Description of Data:

Monthly reports from call center identify the median wait time for callers. Monthly data will be aggregated to identify annual median wait time.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of transports to a substance use treatment facility

Baseline measurement (Initial data collected prior to and during 2026): 3967 (CY24)

First-year target/outcome measurement (Progress to the end of 2026): 4000 (CY25)

Second-year target/outcome measurement (Final to the end of 2027): 4100 (CY26)

Data Source:

Monthly reports from transportation providers

Description of Data:

Monthly reports from transportation providers identify the total monthly transports to a substance use treatment facility. Monthly data will be aggregated to identify annual transports.

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Women who use substances during and after their pregnancy

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Support PWWDC and their children to live safe and healthy lives

Strategies to attain the goal:

Provide training and consultation to healthcare entities, and other pertinent community partners, on overdose prevention strategies including secure storage practices, to increase ability to educate women and birthing individuals who use substances.

Distribute secure storage lock boxes to programs serving PWWDC to ensure widespread distribution to all discharging women.

Improve awareness and utilization of Women's REACH program which provides case management and recovery coaching services with the goal of supporting PWWDC and family members impacted by substance use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of women who have documented overdose prevention education, including confirmation of secure storage lock box receipt, as part of their clinical discharge summary.

Baseline measurement (Initial data collected prior to and during 2026): 0%

First-year target/outcome measurement (Progress to the end of 2026): 50 % of woman discharging from the PWWDC programs will have documented overdose prevention education.

Second-year target/outcome measurement (Final to the end of 2027): 100 % of woman discharging from the PWWDC programs will have documented overdose prevention education.

Data Source:

Client discharge summary stored in clinical record.

Description of Data:

DMHAS staff will conduct clinical chart reviews to review discharge summary of clients discharged from PWWDC programs.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Clients served by Women's REACH program

Baseline measurement (Initial data collected prior to and during 2026): 208 clients (SFY25)

First-year target/outcome measurement (Progress to the end of 2026): 375 clients (SFY26)

Second-year target/outcome measurement (Final to the end of 2027): 500 clients (SFY27)

Data Source:

Client admission, treatment, and discharge data stored in Enterprise Data Warehouse (EDW).

Description of Data:

Client admission, treatment and discharge data will allow DMHAS to track the number of unique clients served within all Women's REACH programs

Data issues/caveats that affect outcome measures:

None

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 Development Sustainability 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 to date.
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: Indicator: Maintain the number of faculty trained in the curriculum

Baseline measurement (Initial data collected prior to and during 2026): 278 professionals received Current Trends certificate of course

First-year target/outcome measurement (Progress to the end of 2026): An additional 100 professionals will receive Current Trends certificate of course; an additional 25 guest presentations and 5 family guest presentations will be Annual Performance Indicators to measure goal success 3,700 (SFY2025) Printed: 3/25/2025 10:51 AM - Connecticut Page 8 of 10 completed

Second-year target/outcome measurement (Final to the end of 2027): An additional 100 professionals will receive Current Trends certificate of course; an additional 25 guest presentations and 5 family guest presentations will be completed

Data Source:

Wheeler Clinic provider report

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: TRAUMA INFORMED TREATMENT

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.

Strategies to attain the goal:

Partner with a Performance Improvement Center to implement EBP's in CT through systems development and staff training.
Identify specific EBPs and train clinical staff in outpatient clinics and schools in EBPs such as MATCH model, CBITS and TF-CBT.
EBP dissemination will be facilitated through a Learning Collaborative (LC) implementation model

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of clinical staff trained to deliver EBPs

Baseline measurement (Initial data collected prior to and during 2026): In FY 24, A total of 667 children received MATCH- ADTC 49 new clinical staff were trained to deliver MATCH- ADTC 22 agencies were trained

First-year target/outcome measurement (Progress to the end of 2026): 20 new clinical staff will be trained, 20 agencies will receive ongoing training and 2 new agencies will join

Second-year target/outcome measurement (Final to the end of 2027): An additional 20 new clinical staff will be trained, 20 agencies will receive ongoing training and 2 new agencies will join

Data Source:

Performance Improvement Center tracking

Description of Data:

The PIC will provide DCF with the total number of clinicians/agencies trained.

Data issues/caveats that affect outcome measures:

NONE

Priority #: 8

Priority Area: Recovery Support

Priority Type: SUR

Population(s): PRSUD

Goal of the priority area:

PRSUD receive the support they need to sustain recovery

Strategies to attain the goal:

Implement new training and certification process for the peer recovery workforce. Training and certification will help ensure peer recovery staff have the requisite skills, knowledge and professional development to provide the best possible care for PRSUD.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of certified peer recovery staff within state

Baseline measurement (Initial data collected prior to and during 2026): 0

First-year target/outcome measurement (Progress to the end of 2026): 50 certified peer recovery staff

Second-year target/outcome measurement (Final to the end of 2027): 100 certified peer recovery staff

Data Source:

Certification data

Description of Data:

Certification data will allow DMHAS to identify the total number of staff actively certified across the state

Data issues/caveats that affect outcome measures:

Priority #: 9

Priority Area: Infection control

Priority Type: SUT

Population(s): EIS/HIV, TB

Goal of the priority area:

Individuals with SUD are aware of and work to mitigate their risk for infectious disease

Strategies to attain the goal:

Provide training (2) and technical assistance (ongoing) to nurses that are placed in SUPTRSBG funded treatment programs. Training and technical assistance will help nurses to improve identification, education, and prevention related to infectious diseases. Trainings to nurses will focus on recent trends in infectious diseases, high-risk populations, prevention strategies, and best practices.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Training attendance

Baseline measurement (Initial data collected prior to and during 2026): None

First-year target/outcome measurement (Progress to the end of 2026): 50% of statewide nurses trained

Second-year target/outcome measurement (Final to the end of 2027): 100% of statewide nurses trained

Data Source:

Training attendance sheets

Description of Data:

The attendance sign-in sheets will be used to identify total percentage of nurses trained

Data issues/caveats that affect outcome measures:

Turnover among nursing staff

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$13,752,591.00		$18,944,764.00	$159,342,166.00	$0.00	$0.00	$5,264,176.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$2,873,459.00		$307,864.00	$10,229,136.00			$200,000.00	
b. All Other	$10,879,132.00		$18,636,900.00	$149,113,030.00			$5,064,176.00	
2. Recovery Support Services[c]	$16,043,020.00		$18,565,656.00	$24,200,498.00			$5,872,000.00	
3. Primary Prevention[d]	$11,098,143.00		$16,820,242.00	$15,450,046.00			$17,482,434.00	
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$25,000.00							
13. Administration[g]			$2,202,154.00	$20,255,251.00			$1,435,592.00	
14. Total	**$54,671,345.00**		**$75,477,580.00**	**$378,590,127.00**	**$0.00**	**$0.00**	**$35,318,378.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data 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 SUPTRS BG 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

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: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$2,282,440.00			$710,804.00			$74,292.00
7. State Hospital			$158,675,434.00	$188,816.00	$519,994,464.00		$10,515,408.00	
8. Other Psychiatric Inpatient Care				$3,659,342.00				
9. Other 24-Hour Care (Residential Care)		$1,172,848.00	$153,967,884.00	$130,192,278.00	$215,175,352.00		$412,834.00	
10. Ambulatory/Community Non-24 Hour Care		$10,864,463.00		$15,466,448.00	$974,562,599.00		$11,555,460.00	
11. Crisis Services (5 percent Set-Aside)[c]		$6,028,015.00			$37,237,486.00		$210,126.00	$668,630.00
12. Other Capacity Building/Systems Development								
13. Administration				$10,721,384.00	$96,057,609.00		$6,989,304.00	
14. Total		**$20,347,766.00**	**$312,643,318.00**	**$160,228,268.00**	**$1,843,738,314.00**	**$0.00**	**$29,683,132.00**	**$742,922.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:
Connecticut recently received its fourth and final allotment under BSCA for $742,922. To date, Connecticut has received a total of $2,956,798 in BSCA funds.

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	7774	380
Women with Dependent Children	23561	5312
Individuals with a co-occurring M/SUD	334799	46759
Persons who inject drugs	67621	9465
Persons experiencing homelessness	712	6688

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

1. Pregnant Women: The estimated population percentage of Connecticut between the ages of 18-44 (adults in the fertility range) is 17.3% of the total population of Connecticut (America's Health Rankings, 2025). With an estimated population of 3,675,069 (Connecticut Department of Public Health, 2024), the number of adult females in the fertility range is 635,787. The General Fertility Rate (GFR) in the US is 53.8 births per 1,000 women aged 15-44, or 5.38% (Martin, et al., 2025). This would indicate there were 34,205 women who gave birth in 2024. 165 fetal deaths were reported, as noted in the 2023 Provisional Connecticut Registration Report (Connecticut Department of Public Health, n.d.), though it is acknowledged that this is likely underreported. The total estimated pregnancies is calculated to be 34,370. According to the NSDUH state estimates in Table 31(SAMHSA, 2023), Connecticut's estimated need for substance use treatment is 22.62% for those 18 and over. This would indicate 7,774 pregnant individuals in Connecticut were estimated in need of SUD treatment. America's Health Rankings. (2025). *Population – Women – Ages 18–44 in Connecticut*. United Health Foundation. https://www.americashealthrankings.org/explore/measures/pct_female_18-44/CT Connecticut Department of Public Health. (2024). *Estimated populations in Connecticut as of July 1, 2024*. https://portal.ct.gov/-/media/departments-and-agencies/dph/population/town-pop/pop_towns2024pdf.pdf Connecticut Department of Public Health. (n.d.) 2023 PROVISIONAL Report tables. Retrieved August 7, 2025, from: https://portal.ct.gov/dph/health-information-systems--reporting/hisrhome/vital-statistics-registration-reports Martin, J. A., Hamilton, B. E., & Osterman, M. J. K. (2025, July). *Births in the United States, 2024* (NCHS Data Brief No. 535). National Center for Health Statistics, Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db535.htm Substance Abuse and Mental Health Services Administration. (2023). *2023 NSDUH state estimates: Percentages*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.xlsx 2. Women with Dependent Children: According to the U.S. Census Bureau (n.d.), there are an estimated 178,967 female householders with no spouse present and 58.2% of those households have one or more people under 18 years old, or 104,158. The Connecticut state estimate from NSDUH in Table 31(SAMHSA, 2023) indicates an estimated 22.62% of those 18 and over need substance use treatment. Therefore the estimate is that 23,561 females with dependent children need substance use treatment in Connecticut. U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Households and Families. American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1101. Retrieved August 7, 2025, from https://data.census.gov/table/ACSST5Y2023.S1101?q=female+households&t=Families+and+Living+Arrangements&g=040XX00US09. 3. Individuals with a Co-Occurring M/SUD: Using the NSDUH state estimates (SAMHSA, 2023), Table 35, it is estimated that 9.11% of Connecticut's population has a co-occurring substance use disorder and any mental illness. With the population of Connecticut (Connecticut Department of Public Health, 2024) estimated to be 3,675,069, 9.11% incidence rate would indicate 334,799 individuals are estimated to have co-occurring SUD/MH diagnoses. Connecticut Department of Public Health. (2024). *Estimated populations in Connecticut as of July 1, 2024*. https://portal.ct.gov/-/media/departments-and-agencies/dph/population/town-pop/pop_towns2024pdf.pdf Substance Abuse and Mental Health Services Administration. (2023). *2023 NSDUH state estimates: Percentages*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.xlsx 4. Persons who inject drugs: Using the estimated Northeast incidence rate of 1.84% for Adult Persons who Inject Drugs (PWID) from Table 2 in the article by Bradley, et al. (2023), the population of Connecticut (CT DPH, 2024) is estimated to be 3,675,069. The estimated number of PWID in CT was then estimated to be 1.84% of 3,675,069, or 67,621. Bradley, H., Hall, E. W., Asher, A., Furukawa, N. W., Jones, C. M., Shealey, J., Buchacz, K., Handanagic, S., Crepaz, N., & Rosenberg, E. S. (2023). Estimated number of people who inject drugs in the United States. *Clinical Infectious Diseases, 76*(1), 1–7. https://www.natap.org/2023/HCV/ciac543.pdf Connecticut Department of Public Health. (2024). *Estimated populations in Connecticut as of July 1, 2024*. https://portal.ct.gov/-/media/departments-and-agencies/dph/population/town-pop/pop_towns2024pdf.pdf 5. Persons experiencing homelessness: According to Connecticut Balance of State Continuum of Care (2024, pp. 25-26), there were 3,147 individuals aged 18+ experiencing homelessness during the Point in Time (PIT) survey on January 23, 2024. Using the By Name List it is estimated that there were over over 3,700 individuals aged 18 and over who were homeless from 2023 into 2024. Per the NSDUH state estimates in Table 31(SAMHSA, 2023), Connecticut's estimated need for substance use treatment

is 22.62% for those 18 and over. Using the PIT survey data, the number of individuals in Connecticut experiencing homelessness and needing SUD treatment is 712. Connecticut Balance of State Continuum of Care. (2024). Nutmeg final report: Point-in-time count 2024. Retrieved August 7, 2025, from https://www.ctbos.org/wp-content/uploads/PIT-2024-Nutmeg-Final-Report_2024.07.30.pdf Connecticut Department of Housing. (2024). Statewide Data Fact Sheet Substance Abuse and Mental Health Services Administration. (2023). *2023 NSDUH state estimates: Percentages*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.xlsx

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Footnotes:

Due to the limited availability of public health data and challenges of estimating treatment need for the specific populations listed in this table, we believe the estimates we were able to establish in column A represent a over-estimation of the treatment need for the identified populations.

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$6,290,022.00
2 . Recovery Support Services[b]	$8,918,116.00
3 . Substance Use Primary Prevention[c]	$5,226,239.00
4 . Early Intervention Services for HIV[d]	
5 . Tuberculosis Services	
6 . Other Capacity Building/Systems Development[e]	$25,000.00
7 . Administration[f]	
8. Total	$20,459,377.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data 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 SUPTRS BG 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.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	3062930.00
1b. Crisis Services for Adults	4678015.00
1c. CSC/ESMI program for Adults	1672007.00
1d. Other outpatient/ambulatory services for Adults	1754395.00
1e. *Other Direct Services for Adults	2652183.00
2. Subtotal of Services for Adults	13819530.00
3. Services for Children	
3a. EBPs for Children	341000.00
3b. Crisis Services for Children	600000.00
3c. CSC/ESMI program for Children	610443.00
3d. Other outpatient/ambulatory services for Children	225000.00
3e. *Other Direct Services for Children	2331887.00
4. Subtotal of Services for Children	4108330.00
5. Other Capacity Building/Systems Development[a]	2419906.00
6. Administrative Costs[b]	0.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**20347766.00**

Please provide brief explanation for services with an asterisk* below:

Programs and services listed under “Other Direct Services for Adults” include outreach and engagement and case management services for individuals with SMI who are homeless or unstably housed, as well as residential programs which provide 24/7 supervised care within a home-based environment for individuals with a serious mental illness. Programs and services listed under “Other Direct Services for Children” include funding for the state’s Regional Suicide Advisory Boards which coordinate and implement suicide prevention, intervention, and postvention activities, including grief support and recovery activities, in each of the five service regions of the state. This funding also includes a statewide family advocacy and peer support program for families with children who have SED. The statewide family advocacy and peer support program helps families and providers work together to improve outcomes for children with SED by offering guidance, education, and empowering families to effectively advocate for their children. Support is typically provided by individuals who have personal experience as parents or caregivers of children with SED. These peer advocates understand the challenges families face and work alongside them to ensure the most appropriate services are accessed and delivered.

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$292,196
	Selective	$6,151
	Indicated	$9,227
	Unspecified	
	Total	**$307,574**
2. Education	Universal	$1,607,076
	Selective	$33,833
	Indicated	$50,750
	Unspecified	
	Total	**$1,691,659**
3. Alternatives	Universal	$48,699
	Selective	$1,025
	Indicated	$1,538
	Unspecified	
	Total	**$51,262**
4. Problem Identification and Referral	Universal	$48,699
	Selective	$1,025
	Indicated	$1,538
	Unspecified	
	Total	**$51,262**
	Universal	$2,045,369
	Selective	$43,060

5. Community-Based Processes	Indicated	$64,591
	Unspecified	
	Total	**$2,153,020**
6. Environmental	Universal	$292,196
	Selective	$6,151
	Indicated	$9,227
	Unspecified	
	Total	**$307,574**
7. Section 1926 (Synar)-Tobacco	Universal	$100,000
	Selective	
	Indicated	
	Unspecified	
	Total	**$100,000**
8. Other	Universal	$535,692
	Selective	$11,278
	Indicated	$16,918
	Unspecified	
	Total	**$563,888**
Total Prevention Budget		**$5,226,239**
Total Award [a]		**$0**
Planned Primary Prevention Percentage		

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$3,397,055
2. Universal Indirect	$1,567,872
3. Selective	$104,525
4. Indicated	$156,787
5. Column Total	**$5,226,239**
6. Total SUPTRS Award[a]	**$20,459,377**
7. Primary Prevention Percentage	**25.54%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☐
Prescription Medications	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Fentanyl or Other Synthetic Opioids	☑
Other	☑
Priority Populations	
Students in College	☑
Military Families	☐
American Indian/Alaska Native	☐
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☑
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$25,000.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$25,000.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$0.00**	**$25,000.00**	**$0.00**

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$100,000.00	
2. Infrastructure Support	$745,000.00	
3. Partnerships, Community Outreach, and Needs Assessment	$398,906.00	
4. Planning Council Activities	$50,000.00	
5. Quality Assurance and Improvement	$455,000.00	
6. Research and Evaluation	$0.00	
7. Training and Education	$671,000.00	
8. Total	**$2,419,906.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

a) Adults with serious mental illness

For Adults with SMI, Connecticut's network of Local Mental Health Authorities (LMHAs) offer a wide range of therapeutic programs and crisis intervention services which aim to enable individuals with SMI to remain in the community and function outside of inpatient or residential institutions. LMHAs serve as a central access point for individuals with SMI and support their connection to a wide array of services that can address their needs in the moment, as well as their recovery over the long term. The continuum of services offered through the LMHAs ranges from intensive services focused on acute or immediate needs, to longer term community-based services focusing on connection to ongoing supports and helping individuals to lead full lives in recovery. Many of the community-based programs that target individuals with SMI, such Assertive Community Treatment (ACT) and Community Support Program (CSP) include a specific focus on improving connection to supports, resources, and treatment. DMHAS has also developed and implemented a bed availability website which provides information on available beds within the DMHAS system for mental health treatment. The website is updated daily. Bed availability information is available all pertinent levels of care including inpatient, group home, supervised apartments, transitional, and respite.

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

DMHAS partners with our sister agency, the Department of Developmental Services (DDS), to collaborate and communicate regarding individuals with SMI and I/DD. DMHAS and DDS hold quarterly meetings where the needs of this population are discussed and where barriers to care for this population can be identified and addressed. Through these meetings, the departments are able to work together and coordinate each of their service offerings to meet the unique needs of individuals with SMI and I/DD.

c) Pregnant women with substance use disorders; Women with substance use disorders who have dependent children

In recognition of the unique experiences and challenges faced by women seeking treatment for substance use disorders, DMHAS funds specialized and comprehensive programs for women and their children. These include residential treatment, outpatient treatment, and specialized care management for women transitioning from a residential setting to community-based recovery services. While programs are located statewide in many communities to allow a woman to remain "local", she may also attend programs outside her immediate area, based on availability. The treatment programs are located in both urban and rural settings, to increase access for individuals residing in diverse areas of the state.

As a way to engage women in the community and help increase access to resources and supports, DMHAS launched its Women's Recovery Engagement Access Coaching and Healing (REACH) program. The REACH program 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.

Another program which seeks to engage women in the community and improve access to recovery resources is the Parents Recovering from Opioid Use Disorder (PROUD) program. PROUD is a SAMHSA-funded program for pregnant and postpartum women with substance use disorders living in the Greater Hartford and New Britain communities. This is program, community non-profit partners provide clinical, case management, and recovery coaching services to eligible women and their family members. To improve systems level access issues and increase awareness of the specific treatment and recovery needs of parenting women, a portion of PROUD 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.

To address systems level barriers to treatment and improve access to services for pregnant women, 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. These collaborations include the SEI/FASD Initiative, CT Women and Opioids Workgroup (CT-WOW), Women's Services Practice Improvement Collaborative (WSPIC), and the Trauma and Gender Practice Improvement Collaborative (TAG).

d) Persons who inject drugs; Persons with substance use disorders who have, or are at risk for, HIV or TB

DMHAS has worked at the systems level and programmatic level to increase access to treatment services for persons with opioid use disorders who inject drugs. At the systems level, DMHAS has worked to implement a bed registry system which identifies statewide bed availability within various levels of care including withdrawal management, residential treatment, recovery houses, and sober homes. At a systems level, DMHAS has also worked to expand the hours of MOUD programs in specific areas of the state and to move towards 24/7 operations so that individuals can access induction services at any point during the day or

evening. DMHAS also funds a 24/7 access line for persons with a substance use disorder who are interested in accessing treatment. Through the access line, individuals can access initial screening, referral, and direct transportation to treatment options across the state, with the goal of connecting persons with Opioid Use Disorders (OUDs) and other SUDs rapidly to treatment. This service, which was previously only available to one region of the state, has been expanded statewide in response to the opioid crisis. Through this service, individuals can access the most appropriate services regardless of their location and their access to a vehicle or public transportation.

At the programmatic level, DMHAS has worked to improve access to services for these populations through the implementation of mobile services. DMHAS has funded mobile MOUD units in each service region of the state. These units provide information, education, and referral, in addition to medication. These units serve as mobile hubs for OUD treatment and services, and help to increase access by meeting people where they are in the community. The mobile units spend time in various locations within the community including shelter parking lots, public parks, and other areas identified outreach staff. The mobile units include outreach staff and medical staff who help engage individuals in services and provide health education about transmissible diseases and ways to reduce health risks. In addition to mobile units, DMHAS funds outreach and engagement programs in each service region of the state which seek to help connect homeless individuals with SUD to appropriate care and services. Outreach activities are 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. Lastly, services for individuals with TB and HIV/AIDS are integrated into many levels of care throughout the SUD service system. Services available for persons with TB and HIV/AIDS including screening, counseling, treatment and referrals for care.

e) Persons with substance use disorders in the justice system

DMHAS collaborates directly with the Department of Corrections and Department of Public Health to address the treatment needs of individuals with SUD in the justice system. Through this collaboration the state is able to provide MOUD and SUD treatment to incarcerated clients, and to train prison and probation staff on the use of Narcan to reduce overdoses. In addition, DMHAS implements targeted jail diversion programs and re-entry programs through its Forensic Services division. These programs aim to address the needs of individuals with SUD who are at risk of entering the justice system or who returning to the community. DMHAS has an array of diversion programs which target the general justice involved population, as well as target populations such as women, veterans, and individuals who are dependent on substances. Services within diversion programs include clinical treatment, medication management, community support, temporary housing, and basic needs resources. For individuals who present with substance dependence on the day of their arraignment, program staff work to facilitate immediate admission to residential withdrawal management and/or intensive residential or IOP.

f) Persons using substances who are at risk for overdose or suicide

DMHAS has worked to improve access to rapid treatment services for individuals who are at risk for overdose, and to improve access to crisis services for individuals with SUD. DMHAS funds a 24/7 access line which facilitates immediate access to screening, referral, and direct transportation to treatment options across the state, including withdrawal management and residential treatment, with the goal of rapidly connecting the individual to treatment. DMHAS has also funded mobile MOUD units in each service region of the state, with the intention of meeting individuals at-risk for overdose where they are in the community. Mobile units spend time in overdose “hot-spots” and areas identified by community stakeholders as areas of high use. Mobile unit staff seek to engage individuals at risk for overdose and provide harm reduction education and materials, and connection to treatment if the individual is interested. In addition to the aforementioned initiatives, DMHAS has also worked to shape the crisis service system to respond to individuals who use substances that are at-risk for overdose or suicide. DMHAS utilized federal funding received during the pandemic to add an SUD focused staff member to each of the regional mobile crisis teams that acts as a resource and support for any SUD related crises that the team responds to. In addition, 988 call center staff are trained in responding to both mental health and substance use related crises. Call center staff are trained to include substance misuse in their suicide risk assessment and to provide information regarding the use of Naloxone to respond to Opioid related overdoses.

g) Other adults with substance use disorders

DMHAS coordinates and oversees behavioral health services to older adults through its Long Term Services and Supports (LTSS) unit. At a systems level, this unit continuously expands its statewide partnerships to coordinate and improve access to care for older adults, including older adults with SUD. The LTSS Clinical Director has an active role in the CT 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 towards many goals for the older adult population, including improving access to behavioral health services. At a programmatic level, DMHAS seeks to improve access to behavioral health services for older adults through the Senior Outreach and Engagement Program which serves older adults with SUDs and mental health needs. Five private nonprofit agencies in Connecticut, representing each of the 5 DMHAS regions, focus on outreach and engagement with 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 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.

h) Children and youth with serious emotional disturbances or substance use disorders
Connecticut continues its efforts to improve access to children and youth with serious emotional disturbances and co-occurring disorders. Included in these efforts is our focus to expand access to crisis services. As a result, we expanded access to child-serving Mobile Crisis services by increasing the availability of services to 24 hours per day/7 days per week/365 days per year. We have created Behavioral Health Urgent Care Centers (youth/children ages 6–17 years) which offers a short-term, bidirectional crisis stabilization program to avoid unnecessary emergency department stays and improve throughput for children on inpatient levels of care. Additionally, we have also created a 12-bed Sub-Acute Crisis center which offers up to a 14-day stay for intensive treatment and crisis stabilization. The ACCESS Mental Health program was also expanded to enable comprehensive, local integration of primary care medical and behavioral health integration.

i) Children and youth with SED and I/DD
The Department of Children and Families (DCF) has prioritized efforts to improve access to care for children with Serious Emotional Disturbance (SED) and co-occurring Intellectual or Developmental Disabilities (I/DD). To support cross-system coordination, DCF and the Department of Developmental Services (DSS) meet regularly to collaboratively review and plan for complex cases involving children with co-occurring needs. These meetings help ensure appropriate service planning, reduce fragmentation, and promote timely, effective responses. Additionally, to further equip children's mental health providers in meeting the needs of this population, DCF secured a TTI Grant to enhance training across the system. As part of this initiative, an asynchronous training course was developed to provide a comprehensive introduction to the field of developmental disabilities for children's mental health providers, including exploring various conditions, their characteristics, and the impact on individuals and families. Through this course, clinicians have gained a deeper understanding of the challenges faced by individuals with developmental disabilities and the importance of supportive interventions. This course is available to all Mobile Crisis Intervention Services staff and will become available to an array of service providers in the coming year.

j) Individuals with co-occurring mental and substance use disorders
DMHAS knows that a large number of individuals served by the department have both a mental health and a substance use disorder (COD). DMHAS continues to enhance the mental health and SUD services 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 to address the treatment needs of individuals with co-occurring disorders. In addition to pilot programs, DMHAS also implements case management programs which specifically target individuals with COD and seeks to support their engagement with treatment and services. The state's regional Local Mental Health Authorities (LMHAs) have implemented the Integrated Dual Disorders Treatment (IDDT) model and SUD treatment providers have used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index to guide integrated care for individuals with co-occurring disorders. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model. Through these efforts, co-occurring treatment has been integrated into many of the services that individuals can access through the LMHAs and the state currently funds four co-occurring enhanced residential treatment programs. As a result, individuals with COD have access to an expanded service array that meets their needs.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

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 shared between the Department of Mental Health and Addiction Services (DMHAS), Department of Social Services (Medicaid Authority) and the Department of Children and Families (DCF) through 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.
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.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

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 1995 when the Department became DMHAS, combining mental health and substance use services. There is a Commissioner's policy on integrated treatment: Chapter64pdf.pdf (ct.gov) Mental health and SUD treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders.
Also, in 2009 DMHAS implemented co-occurring screening that was required at admission for all individuals receiving treatment for mental health and/or substance use. We have since stopped the collection of these individual level data but continue to support and emphasize the importance of integrated mental health and substance use screening measures. We support programs using a number of screening tools; we do not want them to be limited to just the four we had selected 14 years ago, so we changed the data collection component.

In 2022 DMHAS launched the Integrative Care Collaborative to highlight best practices in providing services to individuals with a holistic approach. With the support of Yale University staff, the initiative is providing education and support for providing comprehensive care with individuals with co-occurring disorders. These activities include:

1. Case Consultations focused on co-occurring disorders provided to the state operated LMHAs and hospitals
2. Monthly lunch-and-learn webinars on integrated care topics;
3. Distribution of curricula and workbooks for individual and group sessions
4. Analysis of DMHAS client-level data relative to co-occurring disorders and development of reports for agency use.

a. Please describe how this system differs for youth and adults.

In regard to children and youth, Connecticut has several levels of public services to help children, youth, and their families identify, treat and support recovery from mental health and substance use disorders. These services can be provided in the home or in your community. They often prevent the need for more intensive and out-of-home care such as inpatient hospital, residential, or group home services. The adolescent substance use service array is available to all families in the community. DCF also supports the Voluntary Care Management Program that provides, on a voluntary basis, casework, community referrals and treatment services to children who are not committed to the Department and do not require protective service intervention, but who may require, due to emotional or behavioral difficulties, any of the services offered, administered by, under contract with or otherwise available to the Department.
The recovery-oriented system of care is designed to prevent the negative impact of addiction; promote health, wellness and resiliency for our children, families, and community at large; intervene and support children and caregivers who need services to recover from addiction related problems; and sustain recovery for children, adults and families by providing recovery supports, recognition that recovery is possible, and the elimination of stigma in our communities. There are many different types of help available for teens and their families. Help is available through assessment, treatment, support groups for teens and their families, and positive activities for teens that replace substance use. Some state-funded services are available through 2-1-1 Info Line, a free and confidential phone service that helps people across Connecticut find the local resources they need. It is available 24 hours a day and 7 days a week. Also, Mobile Crisis Intervention Services is a mobile intervention service for children and adolescents in crisis that can be accessed through 2-1-1 as well as 988. The Mobile Crisis program comprises a team of nearly 150 trained mental health professionals across the state that can respond immediately face to face or by phone when a child is experiencing an emotional or behavioral crisis, including a co-occurring disorder.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

The state's 13 Local Mental Health Authorities implement the Integrated Dual Disorders Treatment (IDDT) model and other community 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 has continued this work through contracts with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model for a couple of years. DMHAS is currently re-invigorating this work and has convened a system-wide workgroup for the state operated programs that is advancing new emphasis in this area. The Integrated Care Workgroup continues to meet on a weekly basis since March of 2021. The workgroup has facilitated multiple learning opportunities for state operated facility staff to enhance their skills in providing integrated care to those they serve.

c. How many IT-COD teams do you have? Please explain.

13. All of the state's 13 Local Mental Health Authorities provide services for individuals with COD.

d. Do you monitor fidelity for IT-COD? Please explain.

DMHAS is in the process of training designated staff from the quality departments of each Local Mental Health Authority to be able to monitor fidelity and provide quality assurance/quality improvement for the COD programs within their Local Mental Health Authority. This monitoring and oversite is expected to begin in 2026.

e. Do you have a statewide COD coordinator? (●) Yes ( ) No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

DMHAS has actively worked to integrate behavioral health and primary health care through the establishment of Behavioral Health Homes (BHHs) in 14 agencies across the state, including all the state's Local Mental Health Authorities (LMHAs) and one other private agency. A Behavioral Health Home is a healthcare service delivery model focused on the integration of primary care, mental health services, and social services and supports for adults and children diagnosed with mental illness. The Behavioral Health Home model of care uses a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. The 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. BHH core services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community support services. 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.
To facilitate access to the BHH service array for those who need it most, individuals with SMI who are Medicaid eligible and meet a certain claims threshold are automatically enrolled in the program. As a result of enrollment efforts DMHAS serves approximately 10,000 individuals with BHH 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) in 2023 which is allowing Connecticut to further expand our integration efforts.
The state's 13 Local Mental Health Authorities implement the Integrated Dual Disorders Treatment (IDDT) model and other community 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 has continued this work through contracts with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model for a couple of years. DMHAS is currently re-invigorating this work and has convened a system-wide workgroup for the state operated programs that is advancing new emphasis in this area. The Integrated Care Workgroup continues to meet on a weekly basis since March of 2021. The workgroup has facilitated multiple learning opportunities for state operated facility staff to enhance their skills in providing integrated care to those they serve.
The Department of Mental Health and Addiction Services has intensified its adoption of integrated care as a central part of its mission. To expand the integrated care knowledge base statewide DMHAS, since 2022 has sponsored multiple integrated care conferences and monthly learning seminars to discuss such various topics related to integrated care practices.
To implement integrated care for children and youth, Connecticut Department of Children and Families (DCF) utilizes the CareHub model, which is designed to enhance collaboration and coordination in the existing infrastructure and service system for youth that will result in reduced behavioral health visits to EDs, utilization of PRTFs, inpatient hospitalizations, and reduced suicide among youth/young adults. DCF has established goals and objectives designed to expand and sustain the necessary infrastructure and access to services in Connecticut to further advance integration of our statewide system of care to equally and effectively meet the needs of all our children, youth, and families. We aim to increase access to CT's service array for youth with SED through enhanced collaboration and communication between schools, Primary Care Providers, behavioral health agencies and families through the development/sustainment of 6 CareHubs per year within all 6 Network of Care regions. As a result of the CareHubs, schools and PCPs are set to increase referrals to Mobile Crisis, care coordination and outpatient care. The State has developed an FEP Learning Collaborative and a CHR-P Learning Collaborative that will expand over 6 agencies. Efforts to promote health and decrease/prevent suicide among youth age 21 and under will be demonstrated by training 150 people annually in Question, Persuade, Refer (QPR) curriculum, and the distribution of at least 1000 suicide prevention materials annually. Ongoing quarterly technical assistance, coaching, and mentoring support from National System of Care leaders targeted toward sustaining CT's integrated service system is aimed at sustaining the system of care.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Adults with serious mental illness
Care coordination services are provided across a variety of levels of care within the DMHAS system. For individuals with severe and

persistent mental illness who have significant service utilization and are on Medicaid, the state provides care coordination through a Behavioral Health Home Model which has been implemented at 14 sites and serves approximately 10,000 individuals. The Behavioral Health Home model of care uses a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. Services provided within this model include (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care; (5) individual and family support; and (6) referral to community and support services. Connecticut supports the health homes to meet their goals on increasing access to and utilization of routine and preventative health care services, improved health outcomes, providing higher quality of treatment, improving consumer experience with care; and improving cost effectiveness through declines in the use of hospitals, emergency departments, and other costly inpatient care. DMHAS works with providers to implement specific interventions within the behavioral health homes that incorporate care coordination activities, like implementation of a treatment and recovery plan in collaboration with the individual that include linkages to community supports, appropriate referrals, coordination and follow-up to needed services and supports, and ensuring access to medical, behavioral health, pharmacological and recovery support services. Medicaid members with SMI or SUD that have high service utilization can also receive intensive case management and care coordination through the state's Medicaid administrative service organization.

For individuals with SMI that may not have Medicaid or high services utilization but are connected to care at one of the state's Local Mental Health Authorities (LMHA), care coordination and case management services are provided 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.

• Persons with mental health conditions and/or substance use disorders living in permanent supportive housing (PSH) receive Housing First case management that assists them with in-home services that address factors that may have contributed to their homelessness. The services help to support individuals through the process of finding and retaining housing and decreasing the potential for a return to homelessness. Case management services are provided in the community and a person's home in a "wrap around" format to address integrated care needs. For persons experiencing homelessness with Serious Mental Illness (SMI) and/or substance use conditions, outreach and case management services are provided in order to facilitate connection to comprehensive services and stable housing.

• Older adults with SMI and/or substance use disorder are provided with care coordination services through the Senior Outreach and Engagement Program (SOEP). This program provides care coordination and case management services to at-risk older adults aged 55 and older in a person-centered, strengths-based, and culturally sensitive manner that reduces substance misuse, stabilizes behavioral health symptoms, and improves quality of life while assisting older adults to remain integrated in the community in the least restrictive setting possible. Staff 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.

• Women with substance use disorder are provided with care coordination services through the Women's REACH (Recovery, Engagement, Access, Coaching & Healing) program. Women receive case management, care coordination and recovery support through the program. Services are prioritized for pregnant or parenting women with substance use or co-occurring disorders. Based on an outreach and engagement model, REACH staff develop collaborative relationships with local community-based programs and providers within the medical and behavioral health community including birthing hospitals, recovery-based programs and other state partners including DCF and OEC. The staff work within their respective communities to engage women needing access to care to increase real time engagement with treatment and support the development of an individualized recovery support network. These staff have a key role in the development and support of individualized plans of safe care, in line with state and federal CAPTA legislation.

• Individuals with SMI and/or SUD receiving services within a residential treatment program are provided with care coordination and case management as part of this level of care.

• Targeted case management has also been integrated into several community-based mental health and SUD levels of care (Assertive Community Treatment, Community Support Program, etc.) to provide intensive case management services for individuals with SMI and/or SUD needing care coordination.

Adults with Substance Use Disorder

The state has also increased implementation of care coordination for individuals with SUD through a recent demonstration waiver. In April 2022, The State of Connecticut Department of Social Services, working in collaboration with the Department of Mental Health and Addiction Services and the Department of Children and Families, was approved by the Centers for Medicare and Medicaid Services for a five-year demonstration waiver under Section 1115 of the Social Security Act for substance use disorder (SUD) treatment for adults and children. Under Connecticut's 1115 SUD Demonstration increased fee-for-service payment rates were developed within Connecticut's Medical Assistance Program for substance use treatment. Care coordination is a central feature of Connecticut's approach to this Demonstration. The goals of Connecticut's SUD Demonstration are to (1) increase rates of identification, initiation and engagement in treatment for OUD and other SUDs; (2) increase adherence to and retention in treatment for OUD and other SUDs; (3) reduce overdose deaths, particularly those due to opioids; (4) reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; (5) experience fewer admissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs; and (6) improve access to care for physical health conditions among beneficiaries with OUD and other SUDs. To achieve these goals, Connecticut has included the milestone of improved care coordination and transitions between levels of care. Care coordination expectations

under this milestone are assessed during monitoring visits to providers conducted by DMHAS and their administrative service organization Advanced Behavioral Health Options. Care coordination payments are built into the daily service rate under the Demonstration.

In December 2024, The State of Connecticut Department of Social Services, working in collaboration with DMHAS and Department of Children and Families, was approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) for a Certified Community Behavioral Health Center (CCBHC) planning grant. Care coordination is a core component of the CCBHC model and requires clinics to "coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs" (Substance Abuse and Mental Health Services Administration, 2023, p. 16). The State partner agencies will provide technical assistance and care coordination support to the clinics identified to participate in the state's CCBHC project.

Adults with SMI and I/DD

DMHAS partners with our sister agency, the Department of Developmental Services (DDS), to coordinate care for individuals with SMI and I/DD. The departments meet on a quarterly basis to case conference for individuals with SMI and I/DD that are being discharged from an inpatient or other intensive treatment setting, or who are transitioning between departments. Each department also has a designated liaison that coordinates care for individuals with SMI and I/DD. These liaisons work directly with one another and identify the most appropriate programs and services that are available for the individual, based on their identified needs, and collaboratively work with the individual to ensure they stay connected to care.

Children and youth with serious emotional disturbances or substance use disorders

The child and youth Care Coordination program is funded by DCF and is free to families. The Wraparound process is designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision. A Wraparound facilitator, called a Care Coordinator, helps families build a team of natural, informal, and formal supports using the Wraparound process. This is called the Child and Family Team (CFT). The family learns how to use the strength-based empowerment model to help their child improve functioning in home, school, and community. The team helps guide the family toward meeting their needs and ultimately achieving their shared Family Vision through help, healing and hope.

The program serves children and youth through age 18 (or still attending school) who require coordination of multiple services/supports to meet the needs of the child/youth and their family. The length of service for each child and family is generally up to 6 months. However, based on the seriousness and complexity of child/youth's behavioral health needs, an extension will be offered.

An additional program, Intensive Care Coordination, was developed to work with children/youth who are risk for inpatient care and other placements separating them from their homes and communities. ICC addresses these challenges with intensive care coordination and the wraparound practice model. Families do not need to have Medicaid coverage or be DCF-involved to receive ICC services. This program is directly aimed to assist youth who are in need of discharge planning support; at risk of out of home placement; those frequently in need of emergency services and psychiatric inpatient care; and those in need of ongoing care to remain in their homes and communities.

Children and youth with SED and I/DD

The Department of Children and Families (DCF) has prioritized efforts to improve access to care for children with Serious Emotional Disturbance (SED) and co-occurring Intellectual or Developmental Disabilities (I/DD). To support cross-system coordination, DCF and the Department of Developmental Services (DSS) meet regularly to collaboratively review and plan for complex cases involving children with co-occurring needs. These meetings help ensure appropriate service planning, reduce fragmentation, and promote timely, effective responses. Additionally, to further equip children's mental health providers in meeting the needs of this population, DCF secured a TTI Grant to enhance training across the system. As part of this initiative, an asynchronous training course was developed to provide a comprehensive introduction to the field of developmental disabilities for children's mental health providers, including exploring various conditions, their characteristics, and the impact on individuals and families. Through this course, clinicians have gained a deeper understanding of the challenges faced by individuals with developmental disabilities and the importance of supportive interventions. This course is available to all Mobile Crisis Intervention Services staff and will become available to an array of service providers in the coming year.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

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 1995 when the Department became DMHAS, combining mental health and substance use services. There is a Commissioner's policy on integrated treatment: Chapter64pdf.pdf (ct.gov) Mental health and SUD treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders.

The state's 13 Local Mental Health Authorities implement the Integrated Dual Disorders Treatment (IDDT) model and other community 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 has continued this work through contracts with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and SUD treatment agencies on a combined Co-Occurring and Supervision model for a couple of years. DMHAS is currently re-invigorating this work and has

convened a system-wide workgroup for the state operated programs that is advancing new emphasis in this area. The Integrated Care Workgroup continues to meet on a weekly basis since March of 2021. The workgroup has facilitated multiple learning opportunities for state operated facility staff to enhance their skills in providing integrated care to those they serve.
DMHAS also implements an Integrative Care Collaborative to highlight best practices in providing services to individuals with co-occurring disorders using a holistic approach. With the support of Yale University staff, the initiative is providing education and support for providing comprehensive care with individuals with co-occurring disorders. These activities include:
1. Case Consultations focused on co-occurring disorders provided to the state operated LMHAs and hospitals
2. Monthly lunch-and-learn webinars on integrated care topics;
3. Distribution of curricula and workbooks for individual and group sessions
4. Analysis of DMHAS client-level data relative to co-occurring disorders and development of reports for agency use.
In regard to children and youth, Connecticut has several levels of public services to help children, youth, and their families identify, treat and support recovery from mental health and substance use disorders. These services can be provided in the home or in your community. They often prevent the need for more intensive and out-of-home care such as inpatient hospital, residential, or group home services. The adolescent substance use service array is available to all families in the community. DCF also supports the Voluntary Care Management Program that provides, on a voluntary basis, casework, community referrals and treatment services to children who are not committed to the Department and do not require protective service intervention, but who may require, due to emotional or behavioral difficulties, any of the services offered, administered by, under contract with or otherwise available to the Department.
The recovery-oriented system of care is designed to prevent the negative impact of addiction; promote health, wellness and resiliency for our children, families, and community at large; intervene and support children and caregivers who need services to recover from addiction related problems; and sustain recovery for children, adults and families by providing recovery supports, recognition that recovery is possible, and the elimination of stigma in our communities. There are many different types of help available for teens and their families. Help is available through assessment, treatment, support groups for teens and their families, and positive activities for teens that replace substance use. Some state-funded services are available through 2-1-1 Info Line, a free and confidential phone service that helps people across Connecticut find the local resources they need. It is available 24 hours a day and 7 days a week. Also, Mobile Crisis Intervention Services is a mobile intervention service for children and adolescents in crisis that can be accessed through 2-1-1 as well as 988. The Mobile Crisis program comprises a team of nearly 150 trained mental health professionals across the state that can respond immediately face to face or by phone when a child is experiencing an emotional or behavioral crisis, including a co-occurring disorder.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

For adults, DMHAS partners with our sister agency, the Department of Developmental Services (DDS), to coordinate care for individuals with SMI and I/DD. The departments meet on a quarterly basis to case conference for individuals with SMI and I/DD that are being discharged from an inpatient or other intensive treatment setting, or who are transitioning between departments. Each department also has a designated liaison that coordinates care for individuals with SMI and I/DD. These liaisons work directly with one another and identify the most appropriate programs and services that are available for the individual, based on their identified needs, and collaboratively work with the individual to ensure they stay connected to care. While the departments collaborate closely to best serve individuals with SMI and I/DD, the state does not currently have specific integrated programming for this co-occurring population.

For children and youth, the Department of Children and Families (DCF) has prioritized efforts to improve access to care for children with Serious Emotional Disturbance (SED) and co-occurring Intellectual or Developmental Disabilities (I/DD). To support cross-system coordination, DCF and the Department of Developmental Services (DSS) meet regularly to collaboratively review and plan for complex cases involving children with co-occurring needs. These meetings help ensure appropriate service planning, reduce fragmentation, and promote timely, effective responses. Additionally, to further equip children's mental health providers in meeting the needs of this population, DCF secured a TTI Grant to enhance training across the system. As part of this initiative, an asynchronous training course was developed to provide a comprehensive introduction to the field of developmental disabilities for children's mental health providers, including exploring various conditions, their characteristics, and the impact on individuals and families. Through this course, clinicians have gained a deeper understanding of the challenges faced by individuals with developmental disabilities and the importance of supportive interventions. This course is available to all Mobile Crisis Intervention Services staff and will become available to an array of service providers in the coming year.

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

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
CSC	2.00
	0.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,141,220.00	1,141,220.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Connecticut's CSC programs are currently grant funded and the state does not have a state plan amendment in place to allow CSC programs to bill Medicaid for their services. CSC programs may seek reimbursement for individual services provided as part of the CSC program, such as individual and group therapy, medication management, etc. but many components are currently unbillable and are supported through the grant funding that the programs receive from the state (DMHAS).

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Currently, DMHAS makes formal FEP/ESMI services available in two of Connecticut's largest metropolitan areas, the greater Hartford region and the greater New Haven region. In addition, DMHAS is currently working to expand the availability of FEP/ESMI services across Connecticut by providing training and consultation to clinical teams in community-based clinics in each service region of the state.
In the greater New Haven region FEP/ESMI services are contractually provided by The STEP program, a nationally recognized FEP program that was developed through a public-academic partnership between Yale and DMHAS and housed within a community mental health clinic collaboratively administered by DMHAS and Yale. STEP is staffed by mental health providers in different fields – psychology, psychiatry, nursing, and social work. This "interdisciplinary" team seeks to provide comprehensive care for individuals 16-35 years' old who are early in the course of a psychotic illness in order to prevent symptoms from becoming disabling. Treatment at STEP starts with thorough assessment in order to gain the best understanding of what may be causing the person's difficulties. Based upon individual needs and preferences, treatment may include medication management, community coaching (e.g. support in getting back to school or work), individual and group therapy, as well as support and education for family members and friends. Access to the program is available through referrals by healthcare providers, educational professionals, family members and individuals.
In the great Hartford region, FEP/ESMI services are contractually provided by the Potential program based in Hartford Healthcare's Institute for Living. The Potential Program is an early intervention model for patients 17-26 years' old who are currently presenting with psychotic symptoms that are currently interfering with daily functioning and are found to be distressing to the individual. Treatment is tailored to the individual's unique needs and can include group therapy, individual therapy, family therapy, medication management, cognitive remediation, educational support, support and education for family members, and community trips to help with rehabilitation.
In addition to providing the ESMI/FEP services outlined above, the state also contracts with the Yale University STEP program to provide training, technical assistance, and clinical consultation to child and adult treatment providers throughout the state to improve their capacity to treat individuals with ESMI/FEP. Training opportunities are available Statewide and are available to both child and adult behavioral health providers. Technical assistance and clinical consultation are provided through a statewide call line where treatment providers can request assistance and case consultation. Consultation is provided by treatment and medical staff from the Yale department of Psychiatry and STEP program.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

The STEP Program utilizes a diversity of early detection strategies (ED) to increase awareness of and access to their specialty services at the earliest possible point during the onset of psychosis. These strategies include media campaigns, public and community outreach, and targeted social media campaigns. These strategies have been evaluated and were shown to halve the duration of untreated Psychosis (DUP) across STEP's catchment area in Greater New Haven. Once an individual is admitted to the STEP Clinic, treatment starts with thorough assessment in order to gain the best understanding of what may be causing the person's difficulties. Based upon individual needs and preferences, treatment may include medication management, community coaching (e.g. support in getting back to school or work), individual and group therapy, as well as support and education for family members and friends.
The Potential Program based in Hartford Healthcare's Institute of Living accepts patients with or without insurance. The diverse care team includes clinicians, recovery support specialists, and peer support staff who help patients access and secure ancillary services and resources so that treatment and recovery can be the primary focus. The Potential Program assists patients in securing health insurance, cash assistance, disability, job and educational training, legal assistance, housing, and other resources, such as clothing, cell phones and means of transportation (bus passes and bicycles). The program also has a van which can be used to link patients to services and community support.

The outreach and engagement program conducted by the state's care management entity (CME) requires that 100% of youth and young adult clients ages 12 – 26 with a First Episode Psychosis will receive appropriate FEP-ICM services for the purposes of improving the opportunities for recovery; 100% of all those identified and engaged will be referred to appropriate services; 100% of those who refuse services will be informed of the benefits available to them.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Connecticut has developed a new statewide initiative in collaboration with the STEP Clinic at Yale University, focused on reducing the duration of untreated psychosis through early identification and engagement, and improving treatment outcomes for individuals experiencing first-episode psychosis. To improve outcomes for individuals experiencing FEP, the state is taking a multi-pronged approach to expand and improve FEP services that includes targeted collaboration with each of the state's local mental health authorities (LMHA). The LMHAs serve the most acute individuals within the mental health system who are unable to be served by our community non-profit providers. This collaboration will include development of a streamlined intake and referral system for individuals identified with early psychosis to receive timely treatment and reduce the duration of untreated psychosis. To improve early identification and engagement with individuals experiencing FEP in the community, the state is deploying regional Early Detection and Engagement Specialists (EDACs) to service each region of the state. EDACs will receive all calls for assistance from families or individuals that may be experiencing first-episode psychosis. EDACs will help to improve pathways to care for these individuals and collect data on the quality, delay (Duration of Untreated Psychosis) and engagement with services. EDACs will work directly with the LMHAs in their assigned region to help connect the individual to services, and to specialty care if a CSC program or FEP team exists in the region. EDACs will also outreach to community partners and providers that are likely to encounter individuals experiencing FEP, such as school systems, hospitals, primary care providers, and others. The EDAC will seek to increase awareness of first-episode psychosis among these stakeholders to improve identification of individuals in the community who are in the earliest stages of a psychotic illness, and to improve their pathway to care. This engagement with community partners and stakeholders will be enabled by regional early detection and assessments coordinators (EDACs) that will operate in each of the state's five service regions.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

All primary psychotic illnesses in the schizophrenia spectrum (psychosis NOS, schizophreniform disorder, schizophrenia, schizoaffective disorder, delusional disorder, acute and intermittent psychotic disorders)

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

Based on international epidemiologic estimates and the age structure of Connecticut, we estimate about 500 new cases of psychosis who will eventually be diagnosed with a schizophrenia spectrum or non-affective psychotic disorder (i.e.FEP). We expect at least 3 times that number with new onset psychosis, but this larger number will include individual with substance-induced psychosis or affective psychotic disorders.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

While Connecticut's two CSC programs have historically engaged with community partners and stakeholders in their region to increase awareness of first-episode psychosis and enroll more individuals in their programs, Connecticut has begun a statewide initiative focused on reducing the duration of untreated psychosis and improving outcomes for individuals experiencing a first-episode psychosis. A central component of this project includes engagement with community partners, including primary care providers, hospitals, schools, and other pertinent stakeholders in each region of the state. This engagement seeks to increase awareness of first-episode psychosis, improve identification of individuals in the community who are in the earliest stages of a psychotic illness, and improve care pathways for these individuals so they can be seamlessly connected to care within a CSC program or to care teams that have been trained in evidence-based practices for FEP treatment.
This engagement with community partners and stakeholders will be enabled by regional early detection and assessments coordinators (EDACs) that will operate in each of the state's five service regions. Each region will have an assigned EDAC who will receive all calls for assistance from families or current or prospective patients of early psychosis services. EDACs will learn about and help to improve pathways to care and collect data on the quality, delay (Duration of Untreated Psychosis) and engagement with CSC or other services. EDACs will also coordinate outreach to community partners and providers that are likely to encounter individuals experiencing FEP, such as school systems, hospitals, primary care providers, and others. The outreach will integrate a complementary set of offerings, including specific webinars for clinicians and community stakeholders, workforce development for that provide training and consultation services.

12. Please indicate area of technical assistance needs related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Since 2014, staff within all the state's Local Mental Health Authorities receive training and technical assistance to implement person-centered planning. DMHAS resources and tools for Person Centered Planning that are used within the behavioral health system can be found on the following webpage: https://portal.ct.gov/DMHAS/Publications/Publications/Person-Centered-Planning.

Staff engage consumers and their caregivers in making health care decisions through the development of an individual person-centered recovery plan (IRP) that identifies a person's Life Goals, includes stage-based objectives or the small steps the individual wishes to take to achieve his or her Life Goal, and the interventions or action steps each person on the individual's recovery team, including the individual, will take to reach the identified objectives. Life Goals drive the IRP as opposed to problem areas or issues. Staff engage consumers and their families in developing Life Goals that reflect what they want to achieve in their life and not what someone else wants for them.

Through the development of the IRP and Life Goals, DMHAS staff develop a working relationship with consumers that demonstrates caring, presence, hopefulness and is based upon generous listening that creates a safe space for dialogue and exploring options. Staff focus on having interactions with consumers and their families that are characterized by listening and dialogue that seeks to understand the humanity behind the person's words and letting go of preconceived notions about the consumer.

During the initial development of the IRP, staff explore the natural supports that the consumer has within their life and helps the consumer to identify appropriate interventions that utilize these natural supports and help lead them towards their Life Goals. This often involves facilitating connections to community recovery supports and wellness activities. The IRP is continually reviewed with consumers during the course of treatment or services they are receiving and updates to the IRP are made based on the consumers ideas and preferences.

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

In Connecticut person centered planning is an ongoing individual planning process that is designed to capture a person's dreams and desires and translate them into a plan of action. Person centered planning is a way to listen and take direction from the person and the people who know them best. It focuses on the person's preferences, strengths, and talents rather than their limitations. Person centered planning organizes and uses natural supports like family, friends and acquaintances and formal community supports and services to help the person achieve the things that are important to them.

Connecticut utilizes several different types of tools for person centered planning. Some examples of planning tools include Planning Alternative Tomorrows with Hope (PATH), Making Action Plans (MAPS), Essential Lifestyle Planning (ELP) and Personal Futures Planning (PFP). All the tools share the common values shared above and have similar steps. The planning tool use is not as important as the outcomes of the plan.

Person-centered planning incorporates the following into recovery planning:

• The plan uses “person-first” language (i.e., a person living with schizophrenia NOT a schizophrenic) and/or the individual’s name throughout the document.
• The goal statements on the plan are about having a meaningful life in the community, not only symptom reduction or compliance.
• The goal statements are written in positive terms. e.g., instead of “I just want to be less depressed.” Consider “I want to feel good enough to take care of my daughter.”
• Goal statements are written in the individual’s own words.
• A diverse range of strengths are identified in the plan, e.g., skills, interests, natural supports, previous successes, faith-based resources, motivation for change, etc.
• The plan actively incorporates the person’s identified strengths into the goals, objectives, or interventions/ action steps. Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017.
• The plan makes clear how barriers are relevant in interfering with identified goals, e.g., depression and excessive sleep have led to chronic absenteeism at work.
• Barriers included go beyond diagnosis to describe the individual’s unique experience of symptoms and distress.
• It is clear in the plan how functional impairments relate to mental health/addictions related issues, e.g., not simply “poor budgeting” but cognitive/concentration issues associated with psychosis interfere with budgeting tasks.
• Plan objectives are logically linked to reducing/removing a barrier, i.e., it should be clear which documented MH or SA barrier you are working on overcoming to achieve the short-term objective.
• Objectives are understandable/meaningful to the person served.
• Objectives meet the SMART criteria. They are written simply (understandable to the reader), are measurable (they happened or not, “as evidenced by…”), are achievable, relevant, and time limited.
• The target dates of short-term objectives on the plan are individualized rather than all objectives defaulting to a standard update cycle, e.g., every 90 days.
• Objectives go beyond service participation to capture a positive/meaningful change in behavior/change in functioning/change in status. Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017.
• Professional interventions meet the criteria of the key W’s: who is providing the service (staff member), what (billable service), when (frequency and duration), and why (purpose and intent).
• The plan goes beyond professional clinical/rehab interventions to include at least one self-directed action step and at least one action step by natural supporters, as available.
• Self-directed actions focus on personal, strengths-based activities the person will do in support of their plan, and NOT only on the act of attending professional services.
• The plan describes attempts to help the person to connect with chosen activities in the community rather than the plan being carried out solely within the context of agency-based MH services.
• The original recovery plan and the plan update is developed collaboratively and there is evidence of direct input from the person, e.g., includes quotes from the individual and/or statements such as “Jose stated…”
• There is evidence in the record that the person was offered a copy of their plan.
• The plan is written so that the person can understand it.
Person-centered planning, at its core, is about recognizing that people served in the DMHAS system generally want the exact same things in life as ALL people. People want to thrive, not just survive.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

DMHAS promotes awareness and education related to Advance Directives through formal department policy and procedures and workforce training activities. The DMHAS Policy and Procedure related to Advance Directives (Chapter613pdf.pdf (ct.gov)) directs that when possible a “patient” should be asked whether they have an advance directive and connected with an advocacy organization which can help them prepare one. Additionally, DMHAS includes a section on Advance Directives and how to support clients in developing directives within Client Rights trainings that are provided to all staff working within state operated mental health facilities. In addition, DMHAS has collaborated with the Connecticut Legal Rights Project (CLRP), which provides legal services to low-income individuals with mental health conditions, to train volunteers to help mental healthcare consumers prepare advance directives. CLRP attorneys/paralegals notarize the directives and maintain them on file for the individual.

6. Please indicate areas of technical assistance needs related to this section.

NA

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG 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 SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary 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 behavioral health services funded by the MHBG and SUPTRS BG. 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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?

The state conveys federal program requirements for the Mental Health Block Grant and the Substance Use Prevention, Treatment and Recovery services block grants by including specific language in contracts with all block grant sub-grantees. The language included in contracts outlines the specific requirements, limitations, and regulations that providers receiving block grant funding must adhere to. The DMHAS contracts division and the block grant state planner provide requesting sub-grantees with technical assistance to help them adhere to block grant requirements. This technical assistance can include direct meetings with providers as well as presentations and Q&A sessions to explain block grant requirements and help providers understand how they can maintain compliance with these requirements.

4. Please indicate areas of technical assistance needs related to this section.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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):

- **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)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☑ Archival indicators (Please list)

US Census; HIDTA National Drug Threat Assessment, CT Office of the Chief Medical Examiner, SWORD

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☑ Communities that Care

g) ☑ State-developed survey instrument

h) ☑ Other (please list)

Surveys and other data collected from community-based organizations, service organizations universities and special studies.

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

Priorities identified in regional needs assessment reports are used to inform funding decisions.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) 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 primary prevention workforce? (●) Yes ( ) No

a) 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

a) 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 2022. We are in the process of restructuring survey and process and plan to launch in 2026.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Due to recent retirements, the Evidence-Based Workgroup is currently on hiatus but will resume soon. This bi-monthly workgroup plays a vital role in guiding the selection of evidence-based strategies, considering factors such as SAMHSA recommendations and evaluator research. Additionally, the workgroup has developed a suite of Fidelity Tools designed to help communities assess the effectiveness of commonly used strategies and ensure their implementation remains aligned with best practices.

Narratve Question

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Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one 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 SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, 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

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in WebBGAS

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☐ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

Prevention and Health Promotion Division

Strategic Plan
2021-2024

Authorized by:
DMHAS Prevention and Health Promotion Division

dmhas

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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 DMHAS 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 7&8 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.

DMHAS activates a network of statewide service delivery agents to provide technical assistance, training, and prevention-related delivery.

Please refer to the Infrastructure section beginning on page 5 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 8 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

Among high school students, 11.7% reported having their first drink before age 13.

YRBS, 2019

alcohol by youth *(Underage Drinking in Connecticut: The Facts,* PIRE). In 2019, 14.1% of CT high school students reported riding in 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%).

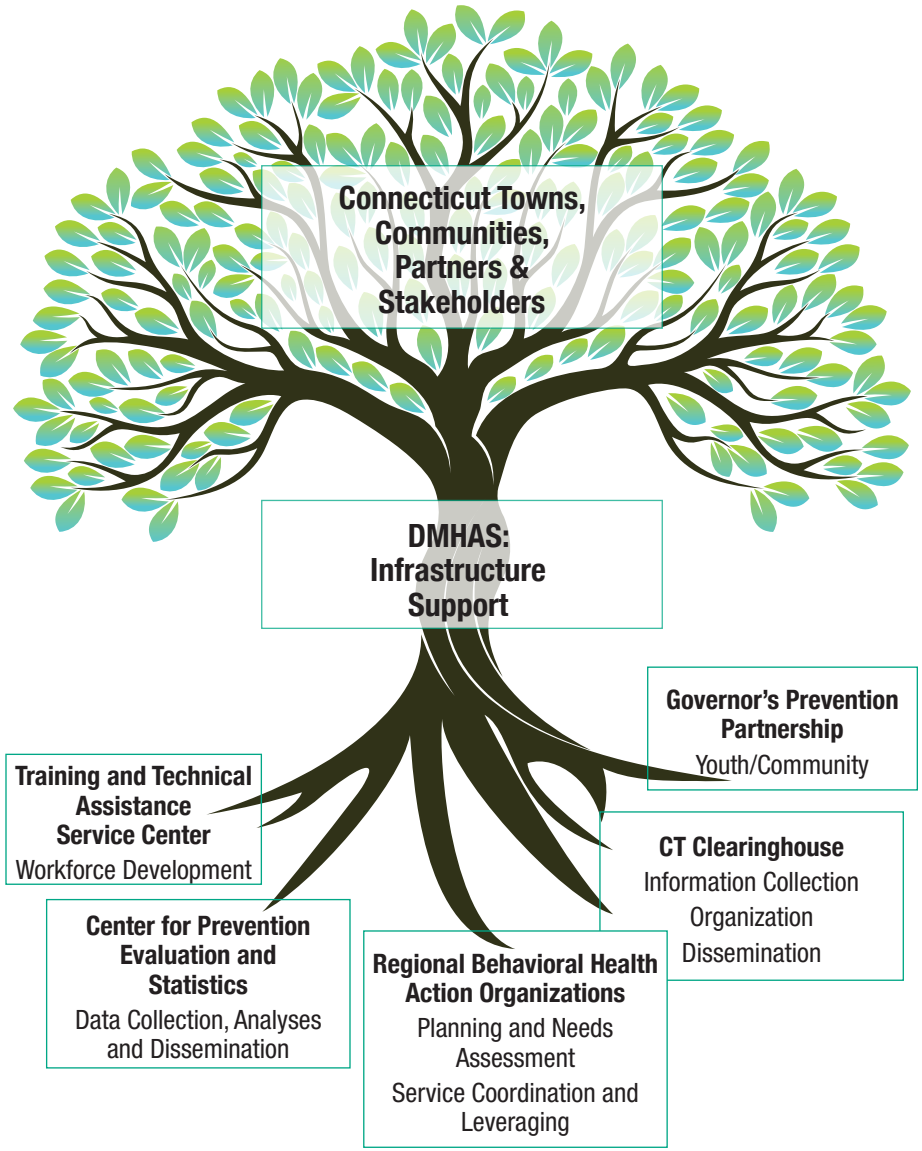
Marijuana: Marijuana remains the second most commonly used drug in Connecticut *(CSHS, 2019)*. Marijuana usage in the state remains higher than the national average. Among 18-25 year olds in Connecticut 30.1% reported past month marijuana use compared to 22.1% nationally. Among youth 12-17 in Connecticut 16.1% reported past year use, and 8.4% reported past month use—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



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 DMHAS, (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 (TTASC)'s** 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)** equips, empowers, and connects organizations, communities, and families to prevent substance abuse, underage drinking, and violence among youth and promotes positive outcomes for all young people in Connecticut. The Partnership provides ongoing training and technical assistance to promote mentoring recruitment and best practices, safe school environments, and healthy communities. Additionally, The Partnership builds awareness of youth prevention programs through its partnerships with 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. In 2018, gambling prevention efforts were also added into the overall mission, funding and deliverables of the RBHAOs as youth who gamble are more likely to engage in other risk-taking activities, such as alcohol, tobacco, vaping and other drugs. 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, RBHAOs, TTASC and CPES helps create a cost-effective, strategic use of resources and align priorities across the system.

- **Campus/Community-Based ATOD Prevention Initiatives including:**

  - 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.

  - 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.

  - The SPF for Prescription Drugs (SPF-Rx) is awarded to 4 health districts to reduce non-medical use of prescription drugs and prevent 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 five 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 RBHAOs, 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 RBHAO 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

DMHAS PREVENTION GOALS

Based on available data, and Connecticut's needs, DMHAS identified the following prevention goals:

GOAL ONE — Reduce current alcohol, tobacco and other drug use by youth under age 21

Objective 1: To decrease percent of students who report first drink/use of tobacco before age 13

Objective 2: To increase perception of harm of alcohol, tobacco, and other drug use among youth and their peers

Objective 3: To decrease the negative consequences of substance use among those 20 and under

Objective 4: Increase the perception of harm of misusing prescription drugs among school-age youth and their families

GOAL TWO — Reduce deaths from opioids among Connecticut residents

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

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

Objective 3: To increase access to behavioral health services by residents who suffer from opioid use disorder and experience barriers to services

GOAL THREE 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

Objective 1: Identify the capacity-building needs of the Connecticut behavioral health workforce

Objective 2: Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3: Retain experienced prevention professionals by providing strong professional development opportunities and increasing pay equity and other benefits

GOAL FOUR 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

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

GOAL FIVE Advance the goals and objectives of PLAN 2025 to reduce suicide attempts and deaths by 10% across the lifespan in CT by 2026

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

Objective 2. Ensure the CT National Suicide Prevention Lifeline (NSPL) 988 services are securely funded

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)

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.

GOAL ONE: 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 is 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 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 1 (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, RBHAOs	# of checks
	Enforce State Tobacco and ENDS access laws	Tobacco and ENDS compliance inspections	Ongoing		SYNAR-Tobacco Prevention and Enforcement Program	# inspections

Objective 1 (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 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		Governor's Prevention Partnership	# 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 monthy		Governor's Prevention Partnership	# of ATOD messages distributed
		Website	Ongoing		Courage to Speak Foundation	# of visits to the website
		Enhanced ATOD Materials	Ongoing		Wheeler Clinic/ Connecticut Clearinghouse	# of new or updated materials
	Educational Strategies	Healthy Campus Initiative	Ongoing		Wheeler Clinic/ Connecticut Clearinghouse	# of campuses funded # of of in-person events #of virtual events # of participants at all events

Objective 1 (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		
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 2 (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	Program/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		Governor's Prevention Partnership	# of SADD youth members
Understand the dangers of alcohol and drug use	Educational Strategies	Change the Script www.drugfreect.org	Ongoing		Wheeler Clinic/ 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 misuse and non-prescription opioid use	Trainings to improve school climate		Ongoing		Governor's Prevention Partnership	# of schools that engage in a training # of school personnel trained
	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 3 (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	Program/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		Wheeler Clinic/ Connecticut Clearinghouse	# of page views # of users Average # of page views per day # of Households who received mailings

Objective 4 (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	Program/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		Wheeler Clinic/ Connecticut 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

GOAL TWO: REDUCE DEATHS FROM OPIOIDS AMONG CONNECTICUT RESIDENTS

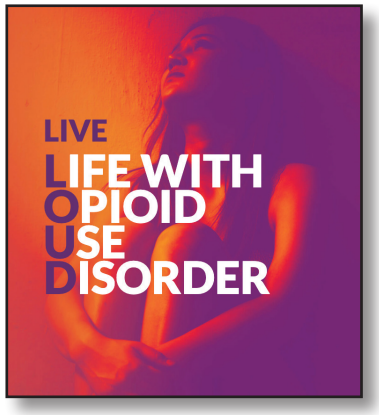
Assessment Summary: In recent years, Connecticut has seen an increase in accidental deaths due to prescription drugs and heroin use. The deaths often include a mix of substances including illicit opioids, and a variety of prescription medications, including methadone, tramadol, and benzodiazepines. While 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



GOAL TWO
Reduce Deaths from Opioids Among Connecticut Residents

IMPLEMENTATION PLAN

2021-2024
Strategic Plan

Objective 1 (with direct target populations)(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

Intermediate Outcome: (align with Change the Script Evaluation)

- Decrease the number of people who progress from misusing prescription drugs to opioids
- Increase in heroin admissions to treatment system and opioid overdose deaths and reversal
- Lack of awareness of the dangers of sharing medications, the risks of overprescribing and overdose death prevention strategies

Immediate Outcomes	Program/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 Wheeler Clinic/ Connecticut Clearinghouse	# of coalitions funded # of messages promoted

Objective 1 (with direct target populations)(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

Intermediate Outcome: (align with Change the Script Evaluation)

- Decrease the number of people who progress from misusing prescription drugs to opioids
- Increase in heroin admissions to treatment system and opioid overdose deaths and reversal
- Lack of awareness of the dangers of sharing medications, the risks of overprescribing and overdose death prevention strategies

Immediate Outcomes	Program/Strategy	Activities	Timeline		Entity responsible	Outputs
			Start Date	End Date		
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		Wheeler Clinic/ Connecticut Clearinghouse (SOR)	# of library stops # of patrons # of Naloxone inquiries
Raising awareness of the dangers of medication, heroin addiction, and overprescribing	Multimedia Strategy	Academic Detailing Initiative	Ongoing		Local Health Districts (SPF-Rx)	# of health districts implementing modules # of modules implemented # of prescribers successfully completed modules # of pharmacists successfully completed modules
	Online trainings		Fall 2020, Ongoing		Wheeler Clinic/ Connecticut Clearinghouse TTASC	# of trainings # of participants

Objective 2 (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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Increase awareness of the dangers of sharing medications, the risks of overprescribing and overdose death prevention strategies	Safe Storage and Disposal	Drug disposal programs	Ongoing		RBHAOs 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		Wheeler Clinic/ 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

Objective 2 (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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
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		Wheeler Clinic/ Connecticut Clearinghouse	# of campuses funded # of of in-person events #of virtual events # of participants at all events # of naloxone kits distributed

Objective 3 (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	Program/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	Referral and support services	Ongoing		National Suicide Prevention Lifeline/ United Way of CT	# of calls to NSPL # of referrals to support services

GOAL THREE: RECRUIT AND RETAIN A WELL-TRAINED, DIVERSE WORKFORCE

Assessment Summary: Recruiting a diverse workforce, and retaining an experienced 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 1 (with indirect target populations): Identify the capacity-building needs of the Connecticut behavioral health workforce needs

Objective 2 (with indirect target populations): Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3 (with indirect target populations): 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	Program/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

Objective 1 (with indirect target populations): Identify the capacity-building needs of the Connecticut behavioral health workforce needs

Objective 2 (with indirect target populations): Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3 (with indirect target populations): 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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
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

Objective 1 (with indirect target populations): Identify the capacity-building needs of the Connecticut behavioral health workforce needs

Objective 2 (with indirect target populations): Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3 (with indirect target populations): 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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
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

Objective 1 (with indirect target populations): Identify the capacity-building needs of the Connecticut behavioral health workforce needs

Objective 2 (with indirect target populations): Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3 (with indirect target populations): 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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Retain experienced prevention professionals by develop providing strong professional development opportunities and increasing pay equity and other benefits *(continued)*	Explore alternate ways to compensate prevention professionals by exploring creative use of existing resources *(continued)*	Provide existing staff with opportunities to continue pursuing educational opportunities and certification by reimbursing for expenses, and allowing for worktime studying for the certification exam	Annually		All Prevention Entities	Development of a comprehensive list of professional development opportunities
		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

Objective 1 (with indirect target populations): Identify the capacity-building needs of the Connecticut behavioral health workforce needs

Objective 2 (with indirect target populations): Diversify the workforce by creating a strong prevention career pathway by working with youth and workforce preparedness organizations

Objective 3 (with indirect target populations): 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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Retain experienced prevention professionals by develop providing strong professional development opportunities and increasing pay equity and other benefits *(continued)*	Explore alternate ways to compensate prevention professionals by exploring creative use of existing resources *(continued)*	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

GOAL FOUR: INCREASE USE OF DATA TO IDENTIFY PREVENTION PRIORITIES

Assessment Summary: DMHAS 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 helpful in identifying the local conditions that could best be addressed to improve behavioral health outcomes.

Problem Statement: 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 1 (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	Program/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	Update Profile
		Data presentations to the Alcohol and Drug Policy Council	Every 2 years		DMHAS	# 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, DMHAS, 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

Objective 1 (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	Program/Strategy	Activities	Timeline		Entity Responsible	Outputs
			Start Date	End Date		
Increased understanding of need for more local-level data	Enhancing community-level knowledge	Support community-level surveying	Ongoing		CPES	# of requests for support # 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

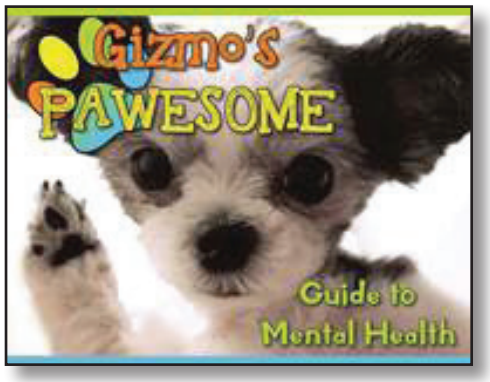
GOAL FIVE: REDUCE SUICIDE AMONG CONNECTICUT RESIDENTS

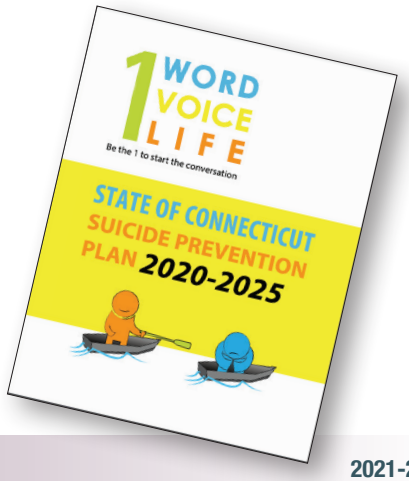
Assessment Summary: Suicide and related risk factors remain a concern, especially among those under 25. Of students in grades 9-12, almost 31% have felt sad or hopeless almost every day for at least two consecutive weeks in the past year *(CSHS, 2019)*, and 12.7% have had serious thoughts of suicide 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 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.





GOAL FIVE
Reduce suicide among Connecticut residents

IMPLEMENTATION PLAN

2021-2024
Strategic Plan

Objective 1 (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

Immediate Outcomes	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 survivor-ship to build the CTSAB's infrastructure capacity	Formalize the Regional Suicide Advisory Boards in DMHAS contracts	Contracts Updated by 2021		DMHAS	# of contracts signed
	Host CTSAB meetings virtually to increase access	Monthly		DMHAS	# of virtual meetings # of participants per meeting
	Identify and engage speakers for CTSAB meetings to provide membership continuing education	Monthly		DMHAS	# of new speakers
	Engage diverse key stakeholders to join the CTSAB and partner to advance suicide prevention	Ongoing		DMHAS	# 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 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	Ongoing		DMHAS	# of plans developed # of new collaborations
	Update the CTSAB website to make it more user friendly	By October 2022		DMHAS	Updated website # of new users to the website

Objective 1 (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

Immediate Outcomes	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 *(continued)*	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		DMHAS	# 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		DMHAS	# 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		DMHAS	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		DMHAS	Development of process to report annual numbers
	Increase CT Suicide Prevention Advocacy via a functioning Advocacy Subcommittee	By October 2021		DMHAS	Development of Advocacy Subcommittee
	Identify, support and promote suicide prevention policy priorities	Ongoing		DMHAS	Identify prevention policy priorities # of policies supported
	Engage key stakeholders who will support suicide prevention policy	Ongoing		DMHAS	# of key stakeholders supporting policies

Objective 1 (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

Immediate Outcomes	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 survivor-ship to build the CTSAB's infrastructure capacity *(continued)*	Build capacity to respond to legislative requests and queries	Ongoing		DMHAS	# of materials to support policies
	Acquire funding for a statewide Suicide Prevention Coordinator position	By October 2025		DMHAS	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		DMHAS	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		DMHAS	# 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		DDMHAS	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		DMHAS	Increased access to gatekeepers

Objective 1 (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

Immediate Outcomes	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 survivor-ship to build the CTSAB's infrastructure capacity *(continued)*	Engage the CTSAB Lethal Means Subcommittee to distribute lockboxes and materials co-promoting the 1 WORD campaign and Change the Script to 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	By October 2022		DMHAS	# of lockboxes distributed # of materials developed
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		DMHAS	Development of a fund
	Ensure the new telecommunications fund collects fees for one year in advance of 988 implementation	By July 2021		DMHAS	Number of dollars set aside
	Advocate that the 988 funds support staff, continuing training and education, administration, and crisis response	By July 2021		DMHAS	# of advocacy initiatives

Objective 1 (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

Immediate Outcomes	Program/Strategy/Activities	Timeline		Entity Responsible	Outputs
		Start Date	End Date		
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		DMHAS	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		DMHAS	Identify deliverables Identify timelines
	Utilize data to drive strategic decision-making and funding of resources statewide and at the regional level	Ongoing until October 2025		DMHAS	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		DMHAS	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		DMHAS	Identify opportunities to use the evaluation for the pledge
	Expand resources related to "Gizmo's Pawesome Guide to Mental Health"	Ongoing until October 2025		DMHAS	Identify additional resources

Objective 1 (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

Immediate Outcomes	Program/Strategy/Activities	Timeline		Entity Responsible	Outputs
		Start Date	End Date		
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		DMHAS	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		DMHAS	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		DMHAS	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 20178-2018	Ages 12-17	12.6%	TBD
			Ages 18-25	68.4%	TBD
			Ages 26 & older	66.7%	TBD
	First drink before age 13	YRBS 2019	Grades 9-12	11.7%	TBD
	Binge Drinking	NSDUH 20178-2018	Ages 12-17	6.2%	TBD
			Ages 18-25	47.0%	TBD
			Ages 26 & 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 & older	44.7%	TBD
	Rode in car in past 30 days, when driver been drinking	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 & older	5.5%	TBD
	% of driving fatalities involving alcohol-impairment	NHTSA, 2018	All ages		TBD

DOMAIN	INDICATOR	DATA SOURCE	POPULATION	BASELINE*	FIVE YEAR TARGET*
PRESCRIPTION DRUGS					
Consumption	Non-medical use of prescription drugs (NMUPD)- Pain relievers	NSDUH, 2017-2018	Ages 12-17	2.3%	TBD
			Ages 18-25	7.0%	TBD
			Ages 26 & 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 & 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					
Consumption	Lifetime heroin use	YRBS, 2019	Grade 9-12	1.8%	TBD
					TBD
					TBD
	Past year use of Heroin	NSDUH, 2017-2018	Ages 12-17	0.1%	TBD
			Ages 18-25	0.6%	TBD
			Ages 26 & 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 & older	90.2%	TBD
Consequences	Heroin-involved overdose deaths	CT Office of Chief Medical Examiner, 2019	All ages	387	TBD
	Fentanyl-involved overdose deaths	CT Office of Chief Medical Examiner, 2019	All ages	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

DOMAIN	INDICATOR	DATA SOURCE	POPULATION	BASELINE*	FIVE YEAR TARGET*
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
	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

DOMAIN	INDICATOR	DATA SOURCE	POPULATION	BASELINE*	FIVE YEAR TARGET*
CANNABIS					
Consumption	30-day marijuana use	NSDUH 2017-2018	Ages 12-17	8.4%	TBD
			Ages 18-25	30.1%	TBD
			Ages 26 & older	9.6%	TBD
	First use before age 13	Connecticut School Health Survey, 2019	Grades 9-12	3.8%	TBD
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	6.2%	TBD
			Ages 26 & older	1.6%	TBD
	Lifetime use of any form of cocaine	Connecticut School Health Survey, 2019	Grades 9-12	2.6%	TBD
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

DOMAIN	INDICATOR	DATA SOURCE	POPULATION	BASELINE*	FIVE YEAR TARGET*
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
	Had serious thoughts of suicide in the past year	NSDUH 2017-2018	Ages 18-25	11.7%	TBD
			Ages 26 & older	3.3%	TBD
	Major depressive episode in the past year	NSDUH 2017-2018	Ages 12-17	14.2%	TBD
			Ages 18-25	13.7%	TBD
			Ages 26 & 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

DOMAIN	INDICATOR	DATA SOURCE	POPULATION	BASELINE*	FIVE YEAR TARGET*
SUICIDE DATA					
Risk Factors	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 those above, got help they needed			24.1%	26.6%
	Attempted suicide in past year			6.7%	6.0%
	Seriously considered attempting suicide in past year			12.7%	11.4%
	Had thoughts of suicide in past year	NSDUH 2017-2018	Ages 18-25	11.7%	10.5%
			Ages 26 & older	3.3%	3.0%
	Major depressive episode in the past year		Ages 12-17	14.2%	12.8%
			Ages 18-25	13.7%	12.3%
			Ages 26 & older	5.9%	5.3%
Consequences	Suicide Attempts	CHIME Hospital Discharge Data (2016-2018)	All ages	4,658 (130/100K)	4,192 (117/100K)**
			Ages 10-17	1,048 (285/100K)	943 (256/100K)**
			Ages 18-24	872 (253/100K)	784 (228/100K)**
			Ages 35-64 Non-Hispanic, White, Males	542 (108/100K)	487 (97/100K)**
	Suicide Deaths	CT Violent Death Reporting System (2016-2018)	All ages	403*** (11/100K)	363 (10/100K)**
			Ages 10-17	10*** (3/100K)	9 (2/100K)**
			Ages 18-24	34*** (10/100K)	31 (8/100K)**
			Ages 35-64 Non-Hispanic, White, Males	147*** (29/100K)	132 (26/100K)**

5 year - 10% reduction* * 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:

- **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.
- **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.
- **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).
- **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.
- **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 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
	RBHAOs	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

GOAL	INFRASTRUCTURE SUPPORT	FUNDING SOURCE
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 DMHAS 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.

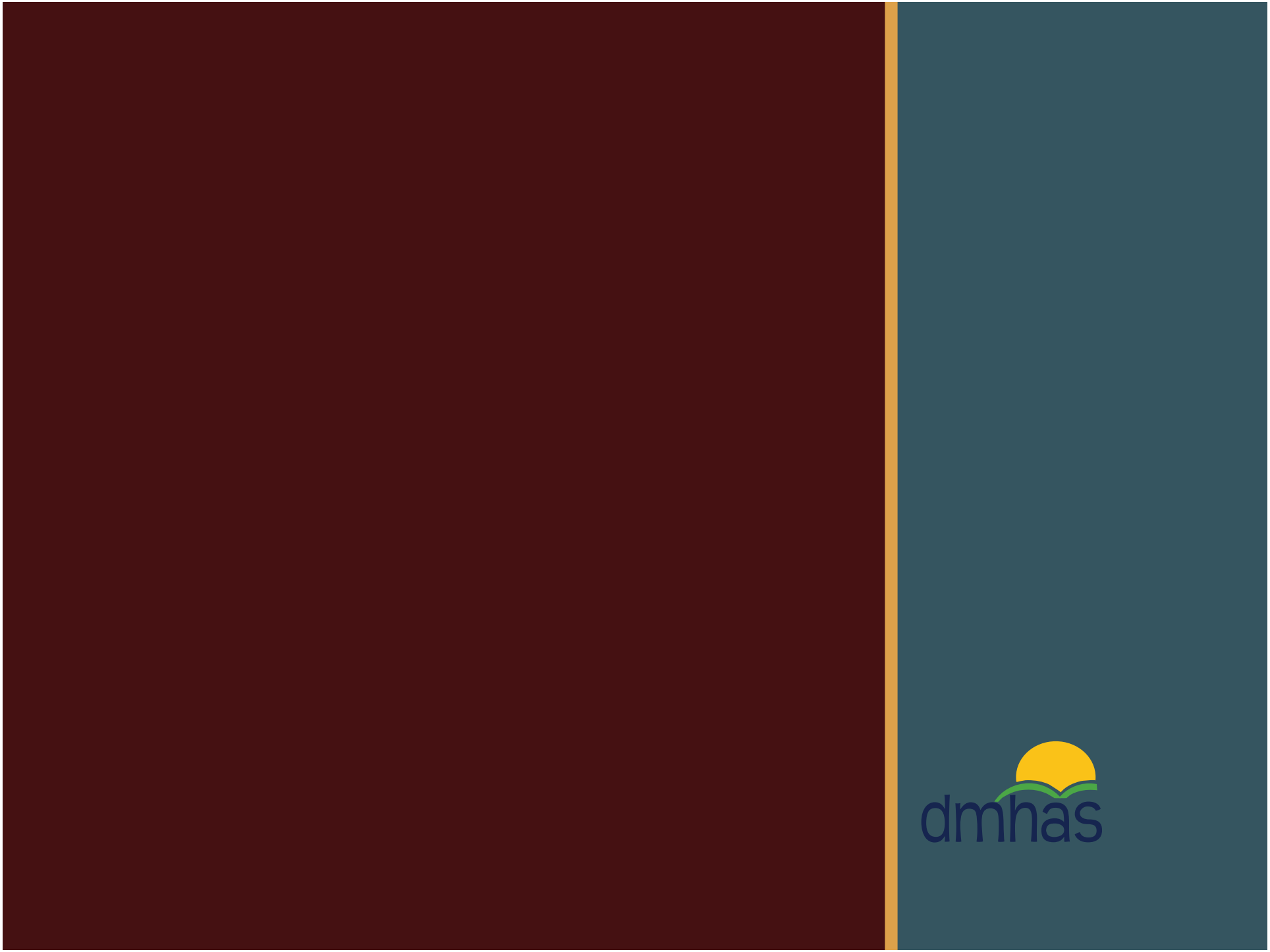
Finally, as the DMHAS begins looking at its next funding cycle, it will examine the funding formulas currently in use to ensure that the funding is directed towards those entities who have

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	DMHAS
	Identify what resources are necessary to sustain those efforts	DMHAS
	Develop a sustainability plan	DMHAS
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	DMHAS
	Identify which processes to sustain	DMHAS
	Identify what resources and infrastructure components are necessary to sustain those processes	DMHAS
	Add action steps relating to sustaining effective processes to sustainability plan	DMHAS
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 DMHAS	DMHAS, Alcohol & Drug Policy Council, CTSAB & RBHAOs
	Identify communities with no prevention resources	DMHAS, Alcohol & Drug Policy Council, CTSAB & RBHAOs

OBJECTIVE	TASK	RESPONSIBILITY
Increase capacity of communities without prevention funding to develop a prevention infrastructure	Identify communities with negative behavioral health outcomes (i.e., high suicide rates, high SUD treatment rates)	CPES, SEOW
	Identify the overlap between the above two types of communities	DMHAS
	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	DMHAS, CTSAB
	Working with the community, develop a plan to conduct a needs and resource assessment	DMHAS, TTASC, CPES
Increase capacity of the workforce to engage in sustainability	Identify state requirements for community sustainability work	DMHAS, 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	DMHAS, TTASC
	Identify workforce sustainability needs and provide appropriate training for existing grantees.	TTASC
	Require communities to develop a sustainability plan	DMHAS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Environmental Factors and Plan

6. 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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

For Adults with SMI, Connecticut's network of Local Mental Health Authorities (LMHAs) offer a wide range of therapeutic programs and crisis intervention services, which enable individuals with SMI to remain in the community and function outside of inpatient or residential institutions. There are also other private non-profit DMHAS funded agencies that provide services as well. Mobile emergency crisis services provided through the LMHAs intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert individuals from the emergency department and controlled settings to the full extent possible. As part of this effort DMHAS also trains law enforcement officers in responding to mental health emergencies, with a focus on de-escalation and referral to appropriate services. Many regions of the state have Crisis Intervention Teams which reflect a partnership between local law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families, with the goal of supporting individuals with SMI to remain in community and out of institutional settings.

In addition to first line mobile crisis services, LMHAs provide an array of community-based services for individuals with SMI to support their ability to continue to reside in the community. These services include Assertive Community Treatment (ACT), Community Support Program (CSP), Supported Employment, Supported Education, Clubhouses/Social Rehabilitation, Outpatient Treatment, and Supportive Housing.

For children and youth, Connecticut has made many efforts to prevent children and youth from needing to leave their homes to secure necessary treatment. One such effort is DCF's Family First Initiative. DCF began its Family First planning process on November 18, 2019. Over the next year and a half, DCF convened eight workgroups made up of providers, families, former foster youth, DCF staff, and sister state agencies. The plan was ultimately submitted in July 2021 and approved by the federal government in March 2022. Connecticut's prevention plan is unique. It expands access to evidence-based treatment interventions to children and their caregivers to address unique needs and characteristics. Connecticut has contracted with a Care Management Entity to administer services. A care management entity is an organizational entity that will serve as a centralized hub responsible for coordinating, managing, and overseeing all services for community pathways families. Through a variety of community pathways (e.g., schools, other state agencies, 211, first responders, judicial, and community or faith-based organizations), the care management entity will assess families to determine their strengths and needs to link them to any service(s). Connecticut sees this as a groundbreaking opportunity to extend services and supports to families without increasing surveillance, particularly to communities of color.

Treatment options 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. These services include Mobile Crisis Intervention Services, Care Coordination, Intensive Care Coordination, Urgent Care Centers, Sub-Acute Center, Functional Family Therapy, Multi-Dimensional Family Therapy Programs, and many more.

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 use prevention and SUD treatment services	(●) Yes	( ) No
h)	Medical and dental services	(●) Yes	( ) No
i)	Recovery 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.)

Case management services are provided within many levels of care that serve individuals with SED/SMI and co-occurring M/SUDs. As discussed further in our answer to question 3 below, case management is provided with the intention of connecting an individual to services and coordinating across the services in a wrap-around format to help improve functioning in all domains of the persons life. Additionally, LMHAs provide the Behavioral Health Home model of care for individuals with SMI, which brings together care teams that coordinate health and behavioral healthcare for individuals with SMI that have severe and chronic health and behavioral health needs.

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 supportive housing receive case management that assists them with training, guidance and support to meet their needs and allow them to continue to reside in the community. Case management services are provided in a "wrap around" format to address integrated care needs. For homeless individuals with mental health and/or substance use conditions, outreach and Case Management services are provided in an attempt to engage them in care and support their connection to services and stable housing. For individuals with SMI who are connected to care at one of the state's LMHAs, case management services are provided 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. DMHAS has converted most of our 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 state's ACT teams include TCM and non-TCM case management services as well.
For children and youth CT DCF has contracted with a Care Management Entity, which is an organizational entity that serves as a centralized accountable hub to coordinate all care for youth with complex behavioral health challenges who are involved in multiple systems, and their families. CME provides: (1) a youth guided and family-family driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; (3) home- and community based services and peer supports as alternatives to costly residential and hospital care for children and adolescents with severe behavioral health challenges.

4. Describe activities intended to reduce hospitalizations and hospital stays.

For Adults with SMI, Connecticut's network of Local Mental Health Authorities (LMHAs) offer a wide range of therapeutic programs and crisis intervention services which aim to enable individuals with SMI to remain in the community and reduce unnecessary hospitalizations. Mobile emergency crisis services provided through the LMHAs intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert individuals from the emergency department and controlled settings to the full extent possible. As part of this effort DMHAS also trains law enforcement officers in responding to mental health emergencies, with a focus on de-escalation and referral to appropriate services. Many regions of the state have Crisis Intervention Teams which reflect a partnership between local law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families, with the goal of supporting individuals with SMI to remain in community and out of institutional settings.
In addition to first line mobile crisis services, LMHAs provide an array of community-based services for individuals with SMI to support their ability to continue to reside in the community. These services include Assertive Community Treatment (ACT), Community Support Program (CSP), Supported Employment, Supported Education, Clubhouses/Social Rehabilitation, group/individual Outpatient Treatment, and Supportive Housing. DMHAS also operates or funds community-based respite programs (100 beds) and these provide a short-term stay that can often prevent a hospitalization or be a step-down from a hospital stay. Lastly, the state has recently opened its first Crisis Stabilization center and its first Peer operated Crisis Respite program. Both programs provide a safe alternative to the emergency department for individuals experiencing a behavioral health crisis. The Crisis Stabilization center provides rapid evaluation, stabilization and treatment for individuals who can be admitted at any time and stay for less than 24 hours. The Peer Respite program provides a safe, home-like environment staffed by a clinician and individuals with lived experience who can provide peer support. Individuals can stay at the respite program for up to 7 days, often instead of going to an emergency department.

For children with SED, Mobile Crisis Intervention Service is available 24 hours a day, 365 days a year. CT has recently implemented Urgent Care Centers, less than 24 hour assessment of children and youth at risk of needing imminent emergency department care. Urgent Crisis Centers are operational and one of the two and Sub-Acute Center have been in operation while the other continues

renovations. Care Coordination and Intensive Care Coordination (over 95 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.

5. Please indicate areas of technical assistance needs related to this section.

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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	156,024	44,074
2.Children with SED	42,520	43,408

2. 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.

For statewide prevalence of adults with SMI and children with SED, Connecticut used the most recent prevalence estimates provided by the Center for Behavioral Health Statistics and Quality (CBHSQ) and updated by Hendall. These estimates were provided to states as part of the annual URS table reporting for the MHBG. For statewide incidence of adults with SMI, DMHAS used its Annual Statistical Report, which identifies the number of adults diagnosed/treated with SMI in the state during the fiscal year.

3. Please indicate areas of technical assistance needs related to this section.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention 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 systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

Access to the DMHAS behavioral health service array among rural populations is ensured through the regional administration and coordination of services in Connecticut. The regional administration and coordination of services in these regions takes into account their rural nature and low service density by focusing on access to treatment through transportation services, satellite offices, mobile services, and outreach programs that can reach people where they live in the community. To this end, DMHAS has recently increased staffing of mobile MAT Teams and increased recovery supports among providers serving rural regions. Newly funded services include recovery coaches, located at 23 hospital EDs across the state, many of which serve patients from nearby rural towns. In addition, DMHAS has established the 24/7 Access Line to facilitate access to treatment for substance use disorders among populations with minimal access to transportation. Individuals from anywhere in Connecticut may call the Access line. For access to mental health services, DMHAS contracts with EdAdvance in the Northwest region and Reliance Health in the Northeast region, to provide transportation to mental treatment for individuals and families. As a note, these transportation services funded by DMHAS are in addition to transportation services that are available to Medicaid populations in Connecticut, to ensure that all insured and uninsured populations without transportation or proximity to service providers are able to access behavioral health services.

In addition to ensuring physical access to treatment, DMHAS works to ensure that rural communities have behavioral health services that reflect their unique needs and preferences by contracting with local service providers that specifically serve rural regions of the state. Through the regional administration of behavioral health services, DMHAS outlines catchment areas for service providers in a way that allows them to focus on the needs of specific populations, regions, and communities. DMHAS contracts with Western Connecticut Mental Health Center to serve the northwest region of the state, and with United Services to serve the northeast region of the state. These providers have long histories of serving their respective rural communities and receive ongoing funds from DMHAS to obtain additional training and technical assistance related to serving rural populations.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

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. Furthermore, DMHAS was awarded approximately $13 million in federal Housing and Urban Development (HUD) funding through the 2022 Special Notice of Funding Opportunity (SNOFO) to target, through outreach and supportive housing funding, the unsheltered homeless population. This funding is distributed throughout the Balance of State Continuum of Care (CTBOS CoC).
In addition to the homeless outreach teams, DMHAS also has SSI/SSDI Outreach, Access, and Recovery (SOAR) staff operating in each service region of the state. SOAR staff support adults who are experiencing homelessness or who are at risk of experiencing homelessness and have a mental illness and/or a co-occurring substance use disorder. SOAR staff help these individuals complete the SSI/SSDI application to assist them in gaining access to stable income through disability income benefit programs, with the overall goal of helping to stabilize the individual and support their recovery.
DMHAS also coordinates with the Connecticut Department of Housing (DOH) and HUD to implement Supportive Housing for individuals with SMI/SUD who experience chronic homelessness. Supportive 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.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

DMHAS' Long Term Services and Supports (LTSS) unit works to coordinate targeted services to the older adult population in Connecticut through state agency collaboration and program implementation. DMHAS LTSS currently 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 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) which focuses on diverting older adults with behavioral health needs from long term care and developing home and community based services to assist older adults with aging in place. 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 work to identify the appropriate level of care for people and assist in community planning to help older adults aging in place. The program provides education and training to Residential Care Homes and service providers across the state. Training topics include boundaries and power struggles, crisis de-escalations, healthy communications and mental illness 101.

d. Please indicate areas of technical assistance needs related to this section.

NA

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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

1. Describe your state's management systems.

Financial Resources, Staffing, and Training:

In table 2 of the application, the state and federal financial resources necessary to implement the block grant plan are outlined. In specific regard to the block grant funding, a portion of these funds will be used to support staffing among community providers of mental health and addiction services who treat individuals with SMI, SED, and primary SUD. Private non-profit providers form the backbone of the behavioral health continuum of care in Connecticut and block grant funds are used to supplement state funds to these providers for the delivery of community-based SMI/SED and SUD services. Staffing required to implement the state plan and block grant funded services include case managers, peer specialists, recovery support specialists (including peers), clinicians, nurses, community outreach staff, mental health counselors, and addiction counselors. In addition to staffing, specialized training is also necessary to support the implementation of the state plan and address identified priority areas. These trainings include: infectious disease control trainings (EIS, HIV, TB) for SABG funded program staff; trauma-based EBP and EBT trainings for clinicians working with adults with SMI and children with SED; FEP training opportunities across the state to expand access to FEP/ESMI services; workforce development training for staff working with adults with SMI; suicide prevention and crisis response training for staff serving SMI/SED populations, as well as training and consultation for clinicians related to treatment of co-occurring SMI and SUD. These trainings are made available to staff working within state operated facilities and staff working for private non-profit providers. The trainings are offered virtually and in-person depending on the content.

Training of Providers of Emergency Health Services:

DMHAS provides various trainings to first responders and emergency health services providers on engaging with individuals with SMI and SED. The Crisis Intervention Team (CIT) training trains law enforcement officers and emergency medical staff on responding to mental health emergencies, including de-escalation tactics and connection to community resources. In addition, Mobile Crisis teams funded through the block grants provide ongoing training and assistance to emergency first responders in their catchment area on how to effectively engage with individuals with SMI and SED. Mobile crisis staff work hand-in-hand with law enforcement and emergency medical staff in responding to mental health crises and are able to identify and address ongoing training and technical assistance needs among first responders.

State 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 behavioral health continuum of care overseen by DMHAS is financially supported through a mixture of state appropriations, Medicaid and Medicare reimbursements, federal grants, and other sources. The management systems in place to oversee the expenditure of these funds and the implementation of the behavioral health continuum of care are equally diverse and include an array of statewide and regional oversite bodies. With specific regard to the state block grant plan, the Behavioral Health Planning council has the most direct role. The Behavioral Health Planning Council takes part in a statewide priority setting and needs assessment process conducted by the state’s Regional Behavioral Health Action Organizations (RBHAOs) which annually evaluates the DMHAS system for strengths, needs, and gaps. The results of the prioritization process and needs assessment are shared with the Behavioral Health Planning Council and DMHAS leadership for planning purposes and are used to inform the block grant application and priorities. The Connecticut state legislature also has purview over the block grant planning process and DMHAS is required to submit annual MHBG and SUPTRSBG Allocation Plans which describe how block grant funds will be spent. These plans require approval from the CT Office of Policy and Management (OPM) prior to presentation to committees of cognizance in the State Legislature, which vote to approve the allocation plans and may request modifications.

To manage block grant planning and expenditure related to SED, DMHAS conducts regular meetings with the Department of Children and Families (DCF) who receives the children’s mental health set-aside. DCF also coordinates and oversees the Children’s Planning Council (Children’s Behavioral Health Advisory Council), which among other tasks, oversees and informs block grant planning related to SED.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource

guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Within the Connecticut Behavioral Health System, Telehealth has historically been used on a limited basis to deliver certain outpatient services for individuals facing barriers to in-person care. With the onset of the COVID-19 Public Health Emergency (PHE), Telehealth as a mode of service delivery was drastically expanded and DMHAS made significant investments to support the Telehealth infrastructure within the Connecticut behavioral health system. During the PHE, DMHAS provided significant funding to MH/SUD providers to support their procurement of technology and resources that could be used to implement Telehealth. DMHAS distributed Telehealth funding across most levels of care within the behavioral health system and provided training/guidance to state and private non-profit providers regarding the levels of care and services that were appropriate for Telehealth. The department also provided guidance regarding the effective implementation of Telehealth and mechanisms for ensuring client confidentiality while providing virtual services. Through these efforts, Telehealth and hybrid models were used during the PHE to implement many services that were previously provided in the community and through these efforts service utilization for certain levels of care, such as outpatient treatment, increased during the PHE. While many services have returned to in-person delivery as the result of decreased community spread of COVID-19, Telehealth continues to be used where appropriate to serve individuals who may be disengaging from in-person services or who prefer the Telehealth modality. While individuals with SMI/SED and primary SUD often have acute symptoms that benefit from more intensive in-person treatment and services, Telehealth sessions may be used to increase service utilization over a specific period of time and Telehealth is often used to deliver adjunctive care coordination/care management services to these target populations.

3. Please indicate areas of technical assistance needs related to this section.

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

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 (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

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. Does your state 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.

The DMHAS Women's Services unit is responsible for oversight of PWWDC programs. Women's Services staff conduct an on-site annual contract monitoring site visit with each of the department's contracted PWWDC providers. This annual monitoring visit 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 PWWDC programs participate in a bi-monthly learning collaboratives which provides them with best practices, ongoing opportunities for learning, and training around new department initiatives.

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)** 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.

The DMHAS Community Services Division (CSD) and other DMHAS Divisions are responsible for monitoring all clinical and recovery support providers with DMHAS contracts to ensure the delivery of quality services that are appropriate to the needs, are in compliance with DMHAS policies and contract requirements (including block grant requirements if the provider is block grant funded), and facilitate the development of a publicly managed, integrated, behavioral health system of care. DMHAS Program staff work closely with other DMHAS units to assure a complete picture of provider performance is developed. This includes EQMI (Evaluation, Quality Management, and Improvement) which develops reports and other tools for monitoring and oversight activities and to identify additional information for analysis of contract performance. It also includes the Human Services Contract Unit regarding fiscal concerns. Monitoring activities vary in intensity and impact on the agency. When a performance issue is identified, Program staff will evaluate the significance of the issue and determine the appropriate course of action. Responses range from requesting a corrective action plan to a site visit. Monitoring occurs across all behavioral health services funded by DMHAS and incorporates activities of varying intensity including routine and non-routine monitoring. Routine monitoring visits are based on when a program was last reviewed, program performance, and modality performance. At a minimum, routine monitoring occurs bi-annually. Contracts describe the scope of work purchased by DMHAS, performance requirements that identify expectations for activities and interventions, and models of service to be delivered. For providers that receive block grant funding, contracts also include block grant regulations, requirements, and program expectations as they pertain to PWID. Compliance with PWID requirements among block grant funded providers is assessed as part of routine monitoring. Routine monitoring also includes data analysis/provider quality report reviews, evaluation of provider compliance with DMHAS regulations/requirements, CEO/provider meetings, site visits, fidelity reviews for evidence-based practices, and corrective action plan compliance. An on-site monitoring visit may also be triggered by critical incidents, consumer complaint, a Department of Public Health finding, fiscal irregularity, etc. All on-site visits generate a findings report.

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.

SUD treatment programs are required to submit data quarterly to DMHAS related to TB, including the number of TB tests conducted, number of persons referred for confirmatory testing, number of persons who complied with confirmatory appointment, and the actual number of positive results. Additionally, site monitoring visits are conducted every two years or more often if needed. A review of policies and procedures, MOUs, and clinical charts are all part of the site monitoring visit to ensure compliance.

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 such 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

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

● Yes ○ No

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 members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered 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 system, adult criminal justice system, 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

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.

a) 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

If the answer is No to any of the above, please explain the reason.

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[1] (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) SMI Adviser ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ◉ Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

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.

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

The state currently maintains two distinct data collection systems which collect client level data from state operated facilities and from DMHAS-funded community non-profit providers. The Web Infrastructure for Treatment Services (WITS) system collects client data from state-operated services and the DMHAS Data Performance (DDaP) system collects client data from DMHAS-State of Connecticut-funded community non-profit providers. Through these systems, client level data is obtained at admission, during the course of treatment, and at discharge. Data from both of these systems is then combined, stored, and centrally managed through the department’s Enterprise Data Warehouse (EDW). It is through the EDW that CT DMHAS is then able to analyze and

report out on statewide behavioral health data.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

   The SMHA's two data collection systems collect client level data related to mental health and substance use services. The state has separate state agencies and data systems which oversee and collect data related to Medicaid and child welfare.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   The SMHA is able to link data when a data sharing agreement is in place. There are very few agreements in place at this time and agreements are only made under very specific circumstances and with very specific goals in mind to ensure client data is protected and ensure compliance with HIPAA. Because state agencies use different data collection systems, linking data can be time consuming and complex.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   As noted in our response to question one, the department collects client level data (including NOMS) from all state-operated and funded behavioral health services. This includes the collection of client level data from all Coordinated Specialty Care (FEP) programs as well as all behavioral health crisis services. As such, the SMHA is able to report comprehensive outcome data for these services at the client level.

5. Briefly describe the limitations of the SMHA 's existing data system.

   Basic client level treatment/service data are collected for reporting to the federal government, to understand if providers are meeting contractual obligations, and to evaluate the behavioral health system of care across the state. The specific data collection systems and the data warehouse, where data are collected and stored, are not flexible. When providers submit data that are not recognized or when submitted in an unfamiliar format, the system will not store the data. Providers are then expected to view an error report and make data corrections as necessary. CT DMHAS does not regularly make upgrades to the system because the data that is collected meets the reporting needs in the state and providers have become proficient in their data collection and submission practices. So, although the systems are inflexible, the systems are adept at holding large amounts of treatment data that then can be used for various reports and analysis.

6. What strategies are being employed by the SMHA to enhance data quality?

   Improving data quality is ongoing and a top priority. There is a dedicated team comprised of two health program assistants and one program manager. This team's primary goal is to ensure that providers are submitting accurate information and that it is submitted on time. The team reviews monthly reports and quarterly dashboards in order to evaluate the quality of the data being collected. There are also monthly provider meetings that are held to review data trends, describe new initiatives, and provide technical assistance. Monthly trainings on DDaP and the EDW have been established to train new providers, and individual trainings/meetings are offered as needed to support data submission efforts. In addition to planned meetings and trainings, the team is available for real-time troubleshooting/guidance during business hours.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   At this time, CT DMHAS collects and reports data to the federal government without any significant barriers. CT DMHAS has created a streamlined process over the past few years that allows us to report data efficiently and accurately.

8. Please indicate areas of technical assistance needs related to this section.

   CT DMHAS does not have technical assistance needs at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention 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, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Connecticut has a robust mental/behavioral health crisis system for children and adults: the Department of Mental Health and Addiction Services (DMHAS) Mobile Crisis Service serves all adults in the State of Connecticut who are 18 years of age or older and the Department of Children and Families (DCF) Mobile Crisis Intervention Service serves all children in the State.
Someone to Talk to
988 Suicide and Crisis Lifeline is available telephonically 24/7 and will soon expand text and chat availability to 24/7. The United Way of Connecticut (UWC), in partnership with DMHAS and DCF, have worked together to implement and operate CT's 988 Suicide & Crisis Lifeline since

July of 2022. United Way of CT is also the provider of the Adult Crisis Telephone Interventions and Options Network (ACTION) Line and Youth Mobile Crisis Intervention Services crisis line making UWC the centralized access point for individuals in crisis across the lifespan.

The ACTION line was implemented in 2021 specifically for adults 18 years of age or older who are in the community and in the midst of a psychiatric or emotional crisis for which an immediate response may be required. The ACTION Line is a centralized phone number answered by crisis contact center specialists trained to offer an array of supports and options to individuals in distress, including: telephonic support, referrals and information about community resources and services; warm-transfer to the Mobile Crisis Team (MCT) of their area; and when necessary, direct connection to 911. The ACTION line operates 24 hours a day, seven days a week, 365 days a year (24/7/365) with the availability of multilingual staff or interpreters as needed. The services and supports offered through the ACTION line are available to all residents of Connecticut at no financial cost to the caller. The ACTION line team is comprised of dedicated contact specialists some of which have lived experience with mental health and substance use/addiction and licensed clinicians. The DMHAS mobile crisis teams and ACTION Line staff work in collaboration with family members, peer-run organizations, faith-based communities, law enforcement, and other civic and community organizations to ensure that persons in distress and their families/friends/supporters have the support and resources they need within their local community.

United Way of CT meets and exceeds the highest national standards for a call center. It is a National Suicide Prevention Lifeline (NSPL) provider that maintains national accreditations from the Alliance for Information and Referral Services (AIRS) and the American Association of Suicidology (AAS).

In regard to children and youth, The CT Department of Children and Families (DCF) funds the Youth MCIS line available to individuals under the age of 18 in crisis, also in partnership with UWC. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1. Under state contract, the UWCT has served as the sole call center hub for the child system for over 10 years, and for the adult system since fall 2020. Both crisis call lines are available 24/7/365.

988- DMHAS and DCF have worked together to implement CT's 988 Suicide & Crisis Lifeline. United Way of CT is also the provider of the 988 line making UWC the centralized access point for individuals in crisis across the lifespan. We are currently exploring the addition of text and chat on the 988 line.

Someone to Respond

The mission of the DMHAS mobile crisis program is to provide persons in distress (crisis) immediate access to a continuum of crisis response services and/or supports of their choice including, mobile clinical services and community supports; to promote the prevention of crises among persons and families; and to provide post-intervention activities that support persons in developing a meaningful sense of belonging in their communities.

Mobile Crisis Team staff provide immediate assistance to people in distress by identifying options and resources that meet the unique needs expressed by the individual. The adult Mobile Crisis Teams are mostly located across the DMHAS Local Mental Health Authority (LMHA) Network and DMHAS funds and operates 18 mobile crisis teams (MCT) throughout the state. MCT services are mobile, readily accessible, short-term services for individuals and families experiencing acute mental health and/or substance use/addiction crises offered in a rapid response framework. MCTs aim to promote the prevention of crises among persons and families and post-intervention activities that support persons in developing a meaningful sense of belonging in their communities. Mobile Crisis Teams are comprised of a multidisciplinary team which may include licensed master's level social workers, licensed clinical social workers, licensed professional counselors, peer support specialists, nurses, mental health workers and psychologists.

Adult MCTs work closely with first responders including EMS, Law Enforcement and local Fire Departments. MCT clinicians collaborate with and assist local police officers to de-escalate crises and provide diversion to alternative settings rather than incarcerations or hospitalizations. 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 local and State police as well as MCT staff.

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, promote safety for persons in crisis, the community, and the police officers who respond to crisis calls. There is a mixture of models throughout the state; most mobile crisis teams are "stand-alone" but are able to request police support when needed. Conversely, most police departments have strong working relationships with their local mobile crisis teams and will also reach out to request a clinician to accompany them on a call. Additionally, some mobile crisis teams have clinicians embedded within police departments. We have also seen an increase in police departments hiring their own social workers/clinicians.

For children and youth, the statewide Mobile Crisis network is comprised of over 200 trained mental health professionals who can respond in-person within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purposes of the program are to serve children in their homes, schools, and communities; reduce the number of visits to hospital emergency rooms; and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative. Mobile Crisis is implemented by six primary contractors, most of whom have satellite offices or subcontracted agencies. A total of 14 Mobile Crisis sites collectively provide coverage for every town and city in Connecticut. Access to youth Mobile Crisis is through the Call Center and there is an average annual call volume of 15,000 calls. These calls are transferred to local Mobile Crisis providers and all youth Mobile Crisis providers are contracted to respond to 90% of crisis calls in person for a face-to-face assessment. These calls must be responded to within 45 minutes or less. All providers have consistently met, and most exceed these goals. Those responding include clinicians, support staff and at times caregivers with lived experience. Youth Mobile Crisis clinicians are also available to support a youth/family for 45 days post-crisis assessment. This time is used to connect children to services and supports needed. DCF also funds a Performance Improvement Center for ongoing quality management for Mobile Crisis.

Place to Go

The first 23-hour crisis stabilization unit in Connecticut opened its doors in May of 2024. The Rapid Evaluation, Stabilization and Treatment (REST) Center is operated by Continuum of Care and offers adults with mental health and/or substance use issues voluntary services including basic needs, a medical and psychiatric assessment, MAT induction, community referrals to detox and/or substance use treatment and access to additional supported living including non-congregate and crisis transitional beds. Located in New Haven, the REST center will accept anyone over the age of 18 from anywhere in the State. Between 5/1/24-4/30/2025, the REST program has served a total of 238 unduplicated clients.

The Gloria House, CT's first peer respite, opened in July of 2024. The peer respite is staffed by Certified Peer Support Specialist 24 hours a day, 7 days a week, 365 days a year offering voluntary, short-term respite services as an alternative to traditional psychiatric stays.

DMHAS also has crisis respite services (100 beds across 16 programs). However, these are not the same as CSUs and offer a more treatment focused model.
For children and youth, DCF recently established three Community based Behavioral Health Urgent Crisis Assessment Centers as well as a sub-acute crisis stabilization program for short-term care.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

Someone to talk to
CT launched the 988 Suicide and Crisis Lifeline on July 16th 2022. The average wait times for callers to 988 is 5 seconds and 97% of calls are answered in state. Adult and youth Mobile Crisis calls are managed by the same call center at United Way. The average wait time for a caller on these lines is under one minute. Information is collected by the call specialist and the calls are transferred to the responding clinician within 10 minutes on an average. Youth Mobile Crisis clinicians must respond within 45 minutes of the initial call. The largest challenges CT is facing with the 988 and ACTION Line crisis call lines are staff retention and identifying sustainable funding sources. United Way, our CT call center provider, has been working with their recruitment staff to develop a marketing campaign, “Hiring Heroes”, to attract more applicants for vacant positions. They have also offered flexible work schedules, telework, and increased salaries for call takers. They have also incorporated a review of sample crisis calls during their interview process to help identify the best candidates for the position. The crisis call lines are currently funded through a mixture of supplemental federal funding received during the Pandemic (COVID-19 Supplemental MHBG, ARPA MHBG, etc.). However, funding is short-term and there are no sufficient long-term funding sources available at this time. In terms of text/chat capabilities, United Way is currently handling text and chat 7 days a week from 8:00 AM-3:30 PM with the National Backup Center answering any CT text and chat contacts outside of those hours. However, funding to support the expansion of 988 text and chat was included in the governor’s approved budget and expansion to 24/7 is expected in the near future.
Someone to respond
CT has both adult and youth mobile crisis teams that provide in-person crisis response as needed to all residents statewide. However, hours of operation and availability of the adult mobile crisis teams vary. Connecticut is actively working to expand all adult mobile crisis teams to be able to provide a mobile response 24/7. Additional funding has been legislatively appropriated for the purpose of hiring additional staff and expanding mobile crisis services to 24/7 in-person response. Staffing and hiring second and third shift clinicians have been the biggest barrier towards achieving this goal. Legislation allowing Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) working on a DMHAS mobile crisis team to issue an emergency certificate has helped with the workforce shortage. All 8 private non-profit mobile crisis providers are available 24/7. Other teams are considering flexible work schedules (4, 10-hour day work weeks, triaging calls from home instead of the office but will go out if a mobile response is needed).
Youth Mobile Crisis now provides in-person mobile crisis assessments 24 hours per day 7 days per week. In January 2023, Youth MC was expanded to offer mobile responses 24/7/365. The service is being utilized by the community.
Place to go
DMHAS now has a Crisis Stabilization Unit and a Peer Respite servicing adults in our state for the last one year. DMHAS also has crisis respite services (100 beds across 16 programs), but these are not the same as CSUs, so we have a lower stage of implementation on the “place to go” variable below.
For children and youth, DCF has invested $23 million to develop three community based Behavioral Health Urgent Crisis Assessment Centers and 1 Hospital Based Urgent Crisis Center, as well as a 1-14 day bedded Sub-Acute Crisis Stabilization Centers. All of the Urgent Crisis Centers and 1 of

the 2 Sub-Acute Centers are operational. Additionally, for youth, there are: Inpatient beds, additional 30-to-90-day, sub-acute settings under the state's Psychiatric Residential Treatment Facilities (PRTF); and a variety of intermediate level of care locations for Partial Hospitals Program (PHP), Intensive Outpatient (IOP) and finally the Outpatient array of providers serving children and youth in CT.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

The CT crisis call lines including 988 meets all minimum expectations outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care. The call lines operate 24/7/365 and contact center specialists include peer support specialists who provide engagement, assessment of needs and referrals. The crisis call line will follow a warm-transfer protocol to the mobile crisis teams in the individual caller's area or an active rescue as needed. Administrative staff are licensed clinical professionals who are available during all shifts and provide supervision to contact center specialists. DMHAS has a real-time bed registry for substance use and mental health beds available throughout the state. DCF is exploring the development of a bed registry for children's services. A best practice component CT has not implemented is GPS-enabled technology, which would allow the call center hub to identify where the mobile crisis team staff are physically located and be able to dispatch the team geographically located closest to the individual in distress. DMHAS received grant funding and has partnered with Veoci, a web-based software, to develop real time, geo-location which will allow for more efficient and effective movement of mobile crisis staff from one individual to the next and timelier responses to crises for both adults. While not a dispatch model, the application will allow mobile crisis teams to communicate and coordinate a crisis response. An adult mobile crisis team provider in the south-central part of the State will pilot the program. The team comprised of 30 clinicians, case managers and administrators, have been trained and are prepared to launch the utilization of the geolocation software by August 2025. DCF has received grant funding to explore and consider purchasing GPS-enabled technology and real-time appointment scheduling. The process for identifying the software application underway.
Mobile crisis teams are comprised of multidisciplinary team members including but not limited to licensed clinicians, nurses, mental health workers and case managers. We hope to incorporate peers within all mobile crisis teams. Mobile crisis team staff provide triage/screening and are available to respond in person, where the individual is located in the community for a crisis assessment/evaluation. Focus is on de-escalation/resolution, identifying supports and resources available in the community and diverting the need for hospitalization. DMHAS MCTs are required to follow up with individuals who have been seen for a crisis assessment within 48 hours. DMHAS MCTs are working towards 24/7 availability of mobile crisis services. Youth Mobile Crisis clinicians are required to response to 90% of the calls face to face. 80% of the face to face responses must be within 45 minutes. The statewide average is 85%.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 5

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 5
b. Integrated with public safety first responder structures (police, paramedic, fire): 5
c. Number that utilizes peer recovery services as a core component of the model: 2

Safe place to be

a. Number of Emergency Departments: 5
b. Number of Emergency Departments that operate a specialized behavioral health component: 5
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 4

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The 5% set-aside of the base MHBG will be used to support each part of our crisis service continuum. Set aside funds will be used to support our 988 call center and Mobile Crisis Statewide Call Center, which serve as the entry point for our crisis system and provide access to mobile intervention services for youth and adults in the state. Set aside funds will also be used to support our adult mobile crisis teams that serve defined geographic service regions. Set aside funds will also be used to support three crisis respite programs that provide a safe alternative to the emergency department for adults experiencing a mental health crisis.

7. Please indicate areas of technical assistance needs related to this section.

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10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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) Use Block Grant funds for recovery support services? Yes No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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 a range of recovery support services for people with SMI/SED that are included within the mental health service continuum. These services include peer support, peer vocational services, community-based peer bridging services, parenting support and parenting rights education for parents with psychiatric disabilities, as well as supported education and employment. These services provide coaching, education about alternative approaches to healing and recovery, skill building for self-management, family support, as well as connection to resources and supports. Connecticut also has a number of Warm Lines operating throughout the state through which individuals can receive telephonic support services from people who have experience/expertise with mutual support. Recovery services and peer recovery staff are also integrated within various levels of care within the behavioral health system. DMHAS requires all state-operated and funded Assertive Community Teams (ACT), Community Support Program (CSP) teams and Supported Employment teams to employ at least one certified Recovery Support Specialist (RSS). All of DMHAS-operated programs have multiple RSSs embedded within various programs. Connecticut Valley Hospital, the state operated psychiatric facility, has a Director of Recovery Services to supervise the RSS team and provide continued learning. Connecticut's 988 Crisis & Suicide Line has also incorporated the use of peer support and has employed at least one certified RSS. In addition, six hospital emergency departments (ED) throughout the state have Recovery Support Specialists who provide on call support to individuals admitted to the ED for a behavioral health related need.

These programs and services identified above are staffed with individuals holding at least one of two certifications as recovery support specialists. DMHAS has been in the process of developing a centralized Certified Peer Support & Recovery Professional credential that is administered by the Connecticut Certification Board. The credential will apply to all behavioral health recovery peer workers in Connecticut. All approved training organizations are incorporating SAMHSA's Twelve Core Competencies with each indictor and Connecticut's updated Code of Ethics & Values, which was developed for recommendation by the Peer Advisory Committee. This will ensure all participants have the same base knowledge and skills. Each training organization has their own specialty. With this new certification, employers will gain a better understanding of the peer support role and have knowledge of the peer workers base skill set.

At a statewide level, DMHAS has the Office of Recovery Community Affairs (ORCA) within the office of the Commissioner. This office and its director act as a liaison between DMHAS and the whole recovery community, including the state's peer led organizations. Through this office, DMHAS promotes multiple pathways to and in recovery. The director is often in the community, joining the participants art groups, relaxation and mediation groups, though mostly listening to hear from them what's helping and what's needed for their recovery/wellness.

ORCA has an Advisory Committee consisting of 21 people, of which 19 have either personal lived experience or family experience. The other 3 are allies. RSS', people that had or are receiving services, and people from the community are involved. This very diverse group of people have broadened the scope of the ORCA.

DMHAS measures the impact of consumer and recovery community outreach activities in a variety of way through its Office of Recovery Community Affairs (ORCA). DMHAS ORCA utilizes social media analytics to evaluate the reach and impact of social media campaigns and social media outreach activities targeting the recovery community. An example of a social medica campaign is the "Recovery Happens Here" campaign that began in 2023. Through this initiative, ORCA records short videos of people sharing their wellness skills and recovery journeys to inspire hope in others and show there are various ways to care for their mental health and overall wellbeing. The initiative also included artwork, poems, and pictures. Social media analytics were utilized to identify the reach and viewership of these videos, and a brief survey was utilized to evaluate whether the videos and campaign helped to change individual views of recovery. ORCA also utilized the campaign at community events throughout the state to educate and measure the effectiveness of reducing stigma.

In regard to recovery support services for children and youth with SED, the CT Department of Children and Families (DCF) funds Substance Use Services that are designed to offer children and youth with SED, their caregivers, and their families a range of services for mental health, psychiatric, and substance use disorders that are grounded in best practice and evidence. These services are provided in the home or community, often preventing the need for more intensive or restrictive care such as hospital, residential, or group home services. The adolescent substance use service array is available to all families in the community Statewide and do not require DCF involvement. DCF offers several Recovery Support Services for individuals with SED. For example, Substance Screening, Treatment and Recovery for Youth (SSTRY) is a family-focused outpatient (office-based) substance use treatment that uses the Community Reinforcement Approach-Assertive Continuing Care (CRA-ACC) model. CRA helps youth develop positive relationships and connect to social activities; set goals and build life skills; access other health services when needed; and move toward reduction and abstinence of alcohol and other drugs. ACC starts when CRA treatment is ending. ACC helps youth build and sustain substance use recovery by emphasizing follow-through with needed education services, justice compliance, accessing healthcare, and other programs-social activities. ACC is delivered in the family's home or other community setting. Drug tests are completed at the evaluation and randomly throughout treatment. Individualized crisis response plans and child safety plans, if applicable, are completed with every youth. Additionally, Helping Youth and Parents Enter (HYPE) Recovery provides weekly in-home family-focused treatment for youth up to 21 years old with opioid use problems. HYPE Recovery combines three services: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Monitoring

and Support (RMS) to reduce opioid use and commonly associated substance use problems and offers up to 6 months of support after treatment ends. MDFT is an intensive, family-centered treatment for youth with substance use and co-co-occurring mental health problems. MAT for opioid use problems is available through the program for those youth who need and want it. RMS provides post-treatment recovery monitoring and re-connection to community services and peer supports. On-call clinicians are available for crisis intervention 24 hours per day, seven days a week including weekends and holidays during MDFT treatment. Also, SMART Recovery is the leading evidence-based addiction recovery peer-support program. SMART Recovery is particularly appealing to young populations compared to other programs because interaction during the meeting is encouraged, and inclusion of spirituality is optional. In the free, facilitated weekly meetings, participants learn self-empowering skills and tools for addiction recovery based on scientific research.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Connecticut offers a range of recovery support services for people with substance use disorders that are included within the substance use service continuum. These services include certified Recovery Coaches (RC) in all levels of treatment programs including MAT programs, emergency rooms, vocational services in sober housing, and a wide variety of support groups at peer-led organizations. RCs provide coaching and mentoring, they introduce people to multiple pathways to recovery and to sustain recovery.
DMHAS provides funding for four recovery community centers (New Haven, Windham, Bridgeport, and Hartford), and bridged funding for three centers (New London, Torrington and Waterbury) as they secured funding through other resources. These centers offer a place to go and spend time with others in recovery from substance use. 12-Step, All Recovery, and other Alternative support groups are offered. Group activities, such as Street and Beach clean-up days, are also offered to encourage connection with each other and the community. Telephonic services are offered through each of these centers, which provide telephonic peer support to individuals who are early in their recovery and requesting support.
DMHAS also supports five harm reduction drop-in centers across the state. These sites all employ people with lived experience, many of them are certified Recovery Coaches.

5. Does the state have any activities that it would like to highlight?

DMHAS, along with other state agencies and stakeholders, have been vested in the Recovery Friendly initiative started by SAMHSA. The Recovery Friendly Workplace was spearheaded by DMHAS Prevention Division, and the Recovery Friendly Campuses and Recovery Friendly Communities consisted of combined groups, including DMHAS Opioid Division and Office of Recovery Community Affairs, other state agencies, and multiple stakeholders. We came together and placed each name under “Recovery Friendly Connecticut” to promote recovery-friendly initiatives across workplaces, communities, and educational systems. This comprehensive approach has been a huge asset in combating stigma, nurturing understanding, transforming cultural norms, and empowering individuals in recovery to thrive. Our Recovery Friendly Workplace website is being redesigned to be the central repository of information for all the Recovery Friendly initiatives.?Each initiative’s toolkit with relevant materials and supporting resources will be accessible and revised to match the redesign of the website. Recovery Friendly Communities and Campuses will each have access to post upcoming events under their own tag. A listing of Recovery Friendly Workplaces will be posted along with testimonials from both the employee and employer to encourage other employers to become Recovery Friendly.

6. Please indicate areas of technical assistance needs related to this section.

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11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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 disorder 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.[1] 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.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]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**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The 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) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) 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 use 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

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Connecticut BHP is a Partnership that consists of the Department of Children and Families (DCF), the Department of Social

Services (DSS) and the Department of Mental Health and Addiction Services (DMHAS). Consultation is provided to the CT BHP by a legislatively mandated Oversight Council. The Departments contracted with Carelon Behavioral Health to serve as the Administrative Services Organization (ASO). Expanded in 2011 to include DMHAS, the contract is designed to create an integrated behavioral health service system for Connecticut's Medicaid populations, including children and families who are enrolled in HUSKY Health and DCF Limited Benefit programs. The Partnership's goal is to provide access to a more complete, coordinated, and effective system of community based behavioral health services and support. This goal is achieved by making enhancements to the current system of care in order to: Provide access to a more complete, coordinated and effective system of community-based behavioral health services and supports; Support recovery and access to community services, ensuring the delivery of quality services to prevent unnecessary care in the most restrictive settings; Enhance communication and collaboration within the behavioral health delivery system and with the medical community, thereby improving coordination of care; Improve network access and quality; and, Recruit and retain traditional and non-traditional providers.

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. Utilizing the 2014 federal System of Care CONNECT grant, 6 regional Networks of Care were created statewide. Subsequent CONNECT grants were used to create a CareHub, which is designed to enhance collaboration and coordination in the existing infrastructure and service system for youth that will result in reduced behavioral health visits to EDs, utilization of PRTFs, and inpatient utilization, and reduced suicide among youth/young adults. Connecting to Care workgroups are open to the public. Past workgroups included Data Integration, Fiscal Mapping, Early Identification & Screening and Network of Care Analysis. Current Connecting to Care workgroups include Culturally and Linguistically Appropriate Services (CLAS), Family Care Connections, Social Marketing and Communications, Trauma-Informed School Mental Health and Workforce Development.

8. Please indicate areas of technical assistance needs related to this section.

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12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? ○ 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. Under PA 22-58, Section 64, the CTSAB is co-chaired by the CT Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF), and a representative of the Lived Experience community. The CTSAB leads the implementation of the 5-year state plan and advises all suicide-related federally funded initiatives directed by state departments (e.g., SAMHSA and CDC block grants; SAMHSA-988 grant (2023-26); SAMHSA-Garrett Lee Smith Grants (2023-28), CDC-CT Violent Death Reporting System, CDC-CT Suicide Prevention Initiative (2020-25/pending 26). Many subcommittees lead efforts to reduce suicides and attempts including: the Armed Forces Committee for the Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Families; 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; Attempt Survivors/Lived Experience Advocacy; and Education and 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 service 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, which is updated every five years (next release fall 2025), data monitoring and CTSAB members. Examples of recent successes include the implementation of the various grant initiatives noted above; the development of a new public-facing data dashboard for planning purposes; CTSAB member presentations at meetings and at state and national conferences, as well as increased suicide prevention-related training resources for the state; 988 Suicide & Crisis Lifeline co-branded with the state suicide prevention campaign on social media; ongoing posting of Lifeline signage at data-driven sites where people have made attempts-bridges, overpasses, railway stations, parking garages; medication lock box dissemination; expansion of the Gizmo's Pawesome Guide to Mental Health© Read-Along Program and social media pledges for pre-school through adults; continuing 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; multiple evidence-based, best practice trainers for suicide prevention, intervention and response in CT; ongoing suicide prevention and postvention response planning trainings; and expanded joint community helper (formerly gatekeeper) training with narcan training and kit dissemination to address the intersection of suicide and opioid use disorders.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

The Zero Suicide Learning Community (ZSLC) for Health & Behavioral Healthcare Systems and the Attempt Survivor/Lived Experience Advocacy Committee are both subcommittees of the CTSAB, and there are people with lived experience on the ZSLC. We are promoting the ZS framework and recommended evidence-based practices, and incorporate input from persons with lived experience regularly to inform the providers. The DMHAS and DCF also encourage the EDs to engage mobile crisis services in the process of discharge planning when a person does not already have care providers in place. DCF requires each mobile crisis team to have a MOA with the local EDs.
Connecticut recently established 3 community based Statewide Urgent Crisis Care Centers to both alleviate emergency department overflow and assist suicidal children & youth. A sub-acute crisis stabilization program for short-term care was opened with a focus on behavioral health needs, transition planning and resourcing to assist with the child's return home. DCF is also in the process of establishing a separate program for short-term term care. Lastly, youth Mobile Crisis provides bridging services for youth

discharging from inpatient care and awaiting an appropriate outpatient level of care.
Lastly, the Garrett Lee Smith grant is working with five school systems and their communities to update protocols that will help facilitate continuity of care and follow-up services for youth identified to be at risk for suicide, including those who have been discharged from emergency department and inpatient psychiatric units.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

DMHAS received and is implementing the Cooperative Agreements for States and Territories to Improve Local 988 Capacity (9/30/23 -9/29/26) to serve the lifespan. DMHAS also received and is implementing the Cooperative Agreements for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Program (9/30/23-9/29/28) to serve youth and young adults age 24 and under. Lastly, the CT Suicide Advisory Board initiated a new state suicide prevention planning process in September 2024 to be completed September 2025 with the release of Plan 2030.

6. Please indicate areas of technical assistance needs related to this section.

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13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 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 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Connecticut has strong interdepartmental relationships between the State behavioral health agencies, the State Medicaid Agency, community providers, advocacy organizations and persons with lived experience through our Connecticut Behavioral Health Partnership. The state utilizes this Partnership as a mechanism to increase coordination and improve services between these entities. The Connecticut Behavioral Health Partnership (CTBHP) is a working collaborative between the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), the Department of Social Services (DSS), Carelon and a legislatively mandated Oversight Council. Carelon serves as the contracted Administrative Services Organization (ASO) for the CTBHP. The CTBHP is designed to create and provide timely access to an integrated, high quality behavioral health service system for Connecticut's Medicaid populations, including Husky A, B, C (Aged, Blind and Disabled) and D (Low Income Adults). The goals of the CTBHP include: (1)Providing access to a more complete, coordinated and effective system of community-based behavioral health services and supports; (2) Supporting recovery and access to community services, ensuring the delivery of high quality services in order to prevent unnecessary care in the most restrictive settings; (3) Enhance communication and collaboration within the behavioral health delivery system and with the medical community, thereby improving coordination of care; (4) Improve provider network access and quality; and (5) Recruit and retain traditional and non-traditional providers.
Connecticut will continue to leverage the Connecticut Behavioral Health Partnership to advance services that maximize efficiency, effectiveness, quality and cost-effectiveness and secure the best outcomes for consumers. The Department of Mental Health and Addiction Services (DMHAS) currently partners with our State Medicaid Agency, The Department of Social Services (DSS), on several initiatives that are designed to promote integrated approaches to behavioral and physical health needs that, when left unaddressed, often lead to the over utilization of inpatient and residential levels of care. DMHAS and DSS have partnered on a Behavioral Health Home initiative since 2012 and now oversee the provision of integrated services at 14 agencies statewide. Behavioral Health Homes are a healthcare service delivery model focused on the integration of primary care, mental health services, and social services and supports for adults and children diagnosed with mental illness. The Behavioral Health Home model of care uses a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. Services provided within this model include (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care; (5) individual and family support; and (6) referral to community and support services. Connecticut intends to continue supporting the health homes to meeting their goals on increasing access to and utilization of routine and preventative health care services, improved health outcomes, providing higher quality of treatment, improving consumer experience with care; and improving cost effectiveness through declines in the use of hospitals, emergency departments, and other costly inpatient care.
DMHAS also collaborates with state partners related to demonstration waiver projects. In April 2022, The State of Connecticut Department of Social Services, working in collaboration with the Department of Mental Health and Addiction Services and the Department of Children and Families, was approved by the Centers for Medicare and Medicaid Services for a five-year demonstration waiver under Section 1115 of the Social Security Act for substance use disorder (SUD) treatment for adults and children. Under Connecticut's 1115 SUD Demonstration increased fee-for-service payment rates were developed within Connecticut's Medical Assistance Program for substance use treatment. In alignment with the milestones of the Demonstration, SUD treatment services provided in the Medicaid fee-for-service (FFS) delivery system will comply with the current American Society of Addiction Medicine's (ASAM) criteria for activities including authorizations, utilization review decisions, multi-dimensional assessments and individualized treatment plans. The goals of Connecticut's SUD Demonstration are to (1) increase rates of identification, initiation and engagement in treatment for OUD and other SUDs; (2) increase adherence to and retention in treatment for OUD and other SUDs; (3) reduce overdose deaths, particularly those due to opioids; (4) reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; (5) experience fewer admissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs; and (6) improve access to care for physical health conditions among beneficiaries with OUD and other SUDs.
Since approval of the Demonstration, the State Partner agencies have met frequently both interdepartmentally and with the administrative services organizations assigned to this project, Carelon and Advanced Behavioral Health. Connecticut has utilized the first year of the Demonstration to develop and implement training, data collection, monitoring, and quality improvement

frameworks to improve access to critical levels of care for OUD and other SUDs; implement widespread use of evidence-based, SUD-specific patient placement criteria including the American Society of Addiction Medicine's Criteria, continue the adoption of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications, assess sufficient provider capacity at each level of care, including medication assisted treatment (MAT); implement comprehensive treatment and prevention strategies to address opioid misuse and OUD; and improve care coordination and transitions between levels of care. Connecticut intends to continue this work for the duration of the Demonstration and achieve the outlined goals.

DMHAS collaborates with other pertinent state partners to ensure alignment of state regulations and procedures related to substance use treatment. Beginning in July 2021, the State Agency partners including Department of Public Health (DPH), Department of Social Services (DSS), Department of Consumer Protection (DCP) and DMHAS began to meet to review Federal Regulatory Standards to allow Mobile Opioid Treatment Programs (OTPs) to operate within the State. The initial meetings focused on identifying areas of needed regulatory and/or statutory changes. In May 2022, HB 5430 was passed allowing for methadone to be transported and dispensed in a mobile unit (DCP) as well as allowing for multi-care institutions to provide SUD and MH services from a mobile OTP. State partners are meeting on a bi-weekly basis to continue to develop policy and process guidance for providers.

DMHAS and DPH collaborate on an initiative to increase access to residential services for individuals receiving medication for opioid use disorders (MOUD) specifically in skilled nursing facilities. There is a monthly meeting with stakeholders including area hospitals, skilled nursing facilities as well as opioid treatment programs. In addition, DMHAS collaborates with the DPH to gather and analyze public health data related to opioids and to support harm reduction efforts throughout the state. Due to the prohibition of using block grant funding to purchase syringes, DMHAS collaborates with DPH to leverage their resources and expertise to support syringe exchange programs throughout the state.

DMHAS collaborates with the Connecticut Department of Children and Families (DCF) on information dissemination such as fentanyl awareness and safe storage of medications, to ensure that parents and children receive this important information.

DMHAS collaborates with the Connecticut Department of Corrections (DOC) to ensure individuals with OUD that are incarcerated or residing within an inpatient setting have access to medication for opioid use disorder (MOUD). The state currently has nine facilities capable of providing MOUD to individuals who are incarcerated. These facilities also provide naloxone kits to those leaving their system. To address individuals with OUD within the juvenile justice system, DMHAS also collaborates with the Connecticut Court Support Services Division (CSSD) to provide arrest diversion programming and screening for justice involved juveniles who may have OUD.

DMHAS Women's Services has collaborative partnerships with a variety of state partners, including the Department of Social Services (DSS), the Department of Public Health (DPH), the Department of Children and Families (DCF), the Office of Early Childhood (OEC), and the Office of the Child Advocate. DMHAS works closely with DCF area offices to provide support and interventions for families at risk of child abuse or neglect, including families experiencing SUD. DMHAS also works closely with and provides funding to additional key stakeholders, including the Connecticut Coalition Against Domestic Violence (CCADV), Carelon Behavioral Health, CT Hospital Association (CHA,) Wheeler Clinic, and CT Women's Consortium (CWC.)

The CT Women and Opioids Workgroup (CT WOW), was created in 2016 following an invitational symposium sponsored by the U.S. Department of Health and Human Services (US DHHS), Office of Women's Health. CT WOW is chaired by DMHAS and comprised of state partners (DCF, CT Department of Public Health, University of CT, and CT Office of the Child Advocate), CHA, CWC, SEPI CT, SUD residential providers, women's health providers, and members of our (Parents Recovering from Opioid use Disorder) PROUD leadership. By embedding the CT-MSTART work within the purview of this stakeholder group, we will be able to capitalize on an existing resource with a broad and relevant reach.

Another area of collaboration related to Women's services is the Substance Exposed Pregnancy Initiative of CT (SEPI CT), which aims to strengthen capacity at the community, provider, and systems levels to improve the health and well-being of infants born substance-exposed through supporting the recovery of pregnant people and their families. This initiative is funded by CT DMHAS and CT Department of Children and Families and contracted through the Wheeler clinic. To date, SEPI has supported the production of four informational animation videos on the topics of Child Abuse Prevention & Treatment Act (CAPTA), Family Care Plans, substance use during pregnancy support, and secure storage of medications and drugs. These videos, targeted at both professionals and individuals impacted by substance use, have been very well received and celebrated for their innovation and efficiency in delivering important information. SEPI CT will provide the technical support necessary to further enhance ACCESS Mental Health for Moms marketing efforts through the development of such animation videos highlighting the program and enrollment.

In collaboration with the Office of Early Childhood, DMHAS participates in the Statewide Partnership meeting, Together for CT Families- Collaborate. Partner. Serve. This group works together to ensure cross training between DMHAS, DCF, and early intervention services to improve outcomes for families with complex needs, especially those impacted by prenatal substance use.

Regarding coordination with healthcare organizations, DMHAS collaborates closely with the Connecticut Hospital Association (CHA) on various statewide initiatives. CHA is a not-for-profit membership organization that represents hospitals and health-related organizations. With more than 90 members, CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are committed to advancing health and health equity. To date, DMHAS and CHA have worked collaboratively to develop and provide trainings and conferences for the healthcare community on topics such as, trauma-informed care, the impact of bias and social determinants of health, health literacy, clinical prescribing and treatment for substance use and opioid use disorders, neonatal abstinence syndrome, fetal alcohol spectrum disorders, harm reduction, equitable care, and the Child Abuse Prevention and Treatment Act legislation implementation and Family Care Plans.

DMHAS also works closely with Carelon, the state's behavioral health Administrative Service Organization for Medicaid recipients. Carelon has more than 30 years of experience in managing behavioral health services for federal agencies, states, counties, health plans, and employers, including managing Medicaid behavioral health programs in 25 states and the District of Columbia. DMHAS

currently collaboarates with Carelon on the ACCESS Mental Health for Youth and ACCESS Mental Health for Moms programs which provide clinical consultation to medical providers who are providing care to a patient with a behavioral health disorder.
DMHAS Housing and Homeless Services has collaborative partnerships with a variety of stakeholders in homeless services, including the CT Department of Housing (DOH), Department of Children and Families (DCF), Department of Social Services, Department of Developmental Services (DDS) and the CT Department of Transportation (DOT). DMHAS and DOH oversee funding and operations for various aspects of Connecticut's Homeless Response system including street outreach, emergency shelter, rapid rehousing, and permanent supportive housing programs. DOT collaborates to identify supports for individuals residing in train and bus stations while experiencing homelessness. Over the years, DMHAS, DOH, DCF, DSS, DDS and the Court Support Services Division of the Department of Correction have collaborated to develop and implement various Permanent Supportive Housing initiatives to address homelessness among various populations. DMHAS also serves as one of the chairs and is the Collaborative Applicant of the Connecticut Balance of State Continuum of Care, a collaborative group which applies for federal homeless services funding from the Department of Housing and Urban Development (HUD). DMHAS collaborates with Fairfield County's Continuum of Care, Opening Doors Fairfield County. DMHAS is an active on a series of statewide working groups overseen by the Connecticut Coalition to End Homelessness, focused on supporting various aspects of the homeless services system. DMHAS is an active participant of national homeless and housing workgroups whose main focus in decreasing homelessness and increase PSH and affordable housing options.
DMHAS Housing and Homeless Services has also begun collaborating with the state Department of Transportation (DOT) regarding unhoused individuals with behavioral health disorders that are sleeping in train stations, near train tracks and bus depot areas that are managed by DOT. This effort has resulted in a new program that deploys homeless outreach staff to transportation hubs managed by DOT.
Regarding children with SED the Connecticut Department of Children and Families (DCF) coordinates with multiple state agencies. DCF partners with the Court Support Services Division (CSSD) of the Judicial Branch to work collaboratively on school-based diversion of children by intervening around mental health crises that might otherwise lead to arrest. Additionally, we will continue to support DCF's school-based suicide prevention and mental health promotion activities that support Connecticut's children and families.
The Court Support Services Division (CSSD) will continue to strengthen the shared service network developed for those youth that are involved with the child welfare and juvenile justice systems; continue to share blended funding for the delivery of certain evidence-based treatments such as multi-systemic family therapy and intensive in-home child and adolescent psychiatric serv1ces; collaborate on state and federally funded initiatives to better integrate care for youth that are involved with the child welfare and juvenile justice systems; and continue to fund and manage with DMHAS two programs for adults with mental illness and/ or co-occurring disorders, including the Sierra Pretrial Program, a transitional housing facility to pretrial defendants, and the Advanced Supervision and Intervention Support Team (ASIST) program which combines criminal justice supervision with clinical services for pretrial defendants and probationers a risk of violation.
The focus of CT's interagency work between DCF and the Department of Developmental Services (DDS), is the coordination of services for clients who are either involved with both DCF and DDS or may be eligible for Voluntary Services through DSS. Joint planning activities include service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice and program evaluation.
CT DCF and the Department of Social Services (DSS) coordinate with one another to support the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for the Medicaid eligible population. The agencies will continue working collaboratively to identify strategies and resources to advance evidence-based child/family treatments. These strategies will focus on improving access, quality and child/family outcomes through ongoing collaboration. Continuing support for outpatient clinics to focus on integrated primary care and treatment for persons with co-occurring mental health and substance use disorders will also occur.
The Department of Children and Families (DCF), has a strong partnership with the Connecticut State Department of Education (CSDE) in efforts to provide behavioral health services to students with particular focus on students with disabilities or in need of special education services. The services offered and joint initiatives are designed to help students by supporting students' emotional and social well-being. One such joint initiative is the Connecticut Network of Care Transformation (CONNECT) initiative, which is currently focused on building the capacity of Connecticut schools to implement comprehensive school mental health supports and strengthen connections with community-based behavioral health services. One key resource is the Connecting Schools to Care IV Students: School Mental Health Resource and Support Guide, developed in partnership with the Child Health and Development Institute (CHDI). This guide helps schools and districts understand and utilize the state's behavioral health care system for children and youth. DCF and CSDE are also partners on a variety of initiatives such as sitting on the School Based Diversion Advisory Committee, and the Trauma Informed School Based Mental Health committee, and are jointly members of the Connecticut Suicide Advisory Board (CTSAB). In collaboration with DCF, CSDE provides various resources and materials related to student mental health, including toolkits and guides aimed at supporting schools and families.

4. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

CHILDREN'S BEHAVIORAL HEALTH ADVISORY COMMITTEE

The Honorable Jodi Hill-Lilly, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

July 29, 2025

Dear Commissioner Hill-Lilly:

Within the past year, The Children's Behavioral Health Advisory Committee (CBHAC) has met consistently to continue exploring opportunities to enhance our child serving behavioral health system and support the evolving needs of children and families in CT. We are in the process of building connections to other key committees, including the newly formed Transforming Children's Behavioral Health committee that includes legislators. This intentional step towards integration includes potential streamlining of recommendations related to children's mental health in CT.

DCF remains a key partner and active participant in CBHAC meetings, providing information on the activities, initiatives, and resources that are in progress at the department. These updates include information about block grant activities.

Elements of the Block Grant application/plan have been shared over the course of the planning period with CBHAC. However, due to the need for certain contracts to be amended as part of the process, careful consideration was given to the timing and way information was presented prior to full contract execution. Additional discussion will be scheduled for the September 2025 CBHAC meeting. Recommendations regarding the children's behavioral health system received from CBHAC have been incorporated into the application/plan in accordance with SAMHSA requirements.

CBHAC looks forward to continuing collaboration with DCF to serve the behavioral health needs of the children and families of Connecticut.

Sincerely,

Gabrielle Hall

Gabrielle Hall
Co-Chair

Jo Hawke

Jo Hawke
Interim co-chair

State of Connecticut
JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR
COURT SUPPORT SERVICES DIVISION
455 Winding Brook Drive, Glastonbury, CT 06033

July 1, 2025

The Honorable Nancy Navarretta, M.A., LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor, Hartford, CT 06134

Jodi Hill-Lilly, LMSW
Commissioner
Department of Children and Families
505 Hudson Street, 10th Floor, Hartford, CT 06106

RE: Letter of Support for JBCSSD FY26-27

Dear Commissioners:

I am pleased to provide a letter of support for Connecticut's FY 2026-27 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Judicial Branch Court Support Services Division (JB-CSSD) will continue its strategic partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to and the quality of behavioral health and support services for adults and children with moderate to serious mental illness and/ or substance use disorders.

In partnership with DMHAS and DCF, JB-CSSD will:

1. Continue to strengthen the shared service network developed for those youth that are involved with the child welfare and juvenile justice systems.
2. Continue to share blended funding for the delivery of certain evidence-based treatments such as multi-systemic family therapy and intensive in-home child and adolescent psychiatric services.
3. Collaborate on state and federally funded initiatives to better integrate care for youth that are involved with the child welfare and juvenile justice systems.
4. Continue to fund and manage with DMHAS two programs for adults with mental illness and/ or co-occurring disorders, including the Sierra Pretrial Program, a transitional housing facility to pretrial defendants, and the Advanced Supervision and Intervention Support Team (ASIST) program which combines criminal justice supervision with clinical services for pretrial defendants and probationers a risk of violation.

We look forward to advancing a statewide agenda for a comprehensive, effective community-based system for juveniles and adults who are court-involved and in need of behavioral health treatment and support services.

Sincerely,

Gary A. Roberge
Executive Director

State of Connecticut
Department of Developmental Services

Ned Lamont
Governor

Jordan A. Scheff
Commissioner

Elisa F. Velardo
Deputy Commissioner

July 1, 2025

Jodi Hill-Lilly, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

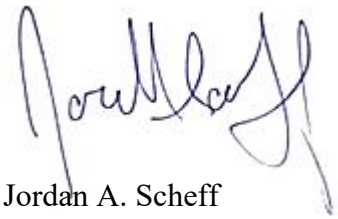
Dear Commissioner Hill-Lilly,

I am pleased to provide a letter of support for Connecticut's FY2026-2027 Community Mental Health Services Block Grant application. We will continue our strategic partnership with the Department of Children and Families (DCF) to assist with the implementation of priorities that are identified in the Children's State Plan. The primary purpose of our collaboration is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.

The focus of our interagency work is the coordination of services between DCF and the Department of Developmental Services (DDS) for clients who are either involved with both DCF and DDS or may be eligible for Voluntary Services through DSS. Joint planning activities will include: service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice and program evaluation.

We look forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Sincerely,



Jordan A. Scheff
Commissioner, Department of Developmental Services

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460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov

Commissioner Nancy Navarretta, MA, LPC, NCC
Department of Mental Health and Addiction Services

CONNECTICUT

July 1, 2025

Jodi Hill-Lilly
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Hill-Lilly,

On behalf of Department of Mental Health and Addiction Services (DMHAS), I am pleased to provide a letter of support for Connecticut's FY 2026-2027 Community Mental Health Services Block Grant application. DMHS will continue its' strategic partnership with the Department of Children and Families (DCF) to assist in the implementation of priorities identified in the grant application for those with mental illness.

Specific activities that DMHAS will support include:

- Continuing our strategic partnership with DCF to assist with implementing priorities that are identified in the 2026-2027 application. The primary purpose of this collaboration is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.
- Participating in the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for Medicaid eligible children and adults.
- Facilitating the coordination of services between DMHAS and DCF for clients who are under the care of DCF (committed or voluntary) or who are eligible for services through DMHAS. Specific activities will include: joint planning of all aspects of transition services; regular communication to monitor the referral process; identification and resolution of issues; and ongoing operational support.

DMHAS looks forward to advancing Connecticut's agenda to establish a comprehensive and effective community-based mental health system of care. Thank you for this opportunity to continue our strong collaboration in this area.

Sincerely,

Nancy Navarretta, M.A., LPC
Commissioner

410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7000

ct.gov/dmhas

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

Andrea Barton Reeves, J.D.
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

OFFICE OF THE COMMISSIONER

July 1, 2025

Nancy Navarretta, M.A., LPC, NCC, Commissioner
Department of Mental Health and Addiction
Services 410 Capitol Avenue, 4dl Floor
Hartford, CT 06134

Jodi Hill-Lilly, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioners,

I am pleased to provide a letter of support for the Connecticut's FY 2026-2027 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Social Services (DSS) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to and the quality of behavioral health services for those with a serious emotional disturbance or mental or substance use disorder.

Specific activities supported by DSS include:

- Continuing its participation in and support of the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for the Medicaid eligible population.
- Working collaboratively to identify strategies and resources to advance evidence-based child/family treatments.
- Improving access, quality and child/family outcomes through ongoing collaboration.
- Continuing support for outpatient clinics to focus on integrated primary care and treatment for persons with co-occuning mental health and substance use disorders

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DSS looks forward to advancing the agenda to establish a comprehensive, effective community-based system of care for those with a behavioral health disorder.

Sincerely,

Andrea Barton Reeves, J.D.
Commissioner, CT Department of Social Services

July 18, 2025

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4" Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

The Department of Aging and Disability Services (ADS) provides a wide range of services to individuals with disabilities and older adults who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living.

On behalf of state residents who are older or have disabilities, ADS:

- Delivers integrated aging and disability services responsive to the needs of Connecticut citizens;
- Provides leadership on aging and disability issues statewide;
- Provides and coordinates aging and disability programs and services in the areas of employment, education, independent living, accessibility and advocacy;
- Advocates for the rights of Connecticut citizens with disabilities and older adults; and
- Serves as a resource on aging and disability issues at the state level.

ADS supports Connecticut's FY 2026-2027 combined Community Mental Health Services and Substance Use Prevention, Treatment, and Recovery Services Block Grant application. We appreciate the opportunity for continued partnership with the Department of Mental Health and Addiction Services (DMHAS), assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders.

With a focus on the needs of Connecticut's older adults and people with disabilities, ADS will continue to collaborate with DMHAS on the grant efforts as outlined above, to strive toward an accessible, integrated, multi-disciplinary system of behavioral health care services that promote improved health, wellness and recovery for older adults and people with disabilities in Connecticut.

We look forward to advancing the agenda for a comprehensive, effective, community-based system of care for those with behavioral health disorders.

Sincerely,

Amy Porter
Commissioner

55 Farmington Avenue, 12th floor.
Hartford, CT 06105
860-424-5055

CONNECTICUT HOUSING FINANCE AUTHORITY
Unlocking Solutions, Building Strong Communities.

Nandini Natarajan
Chief Executive Officer-Executive Director

July 28, 2025

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4" Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

The Connecticut Housing Finance Authority (CHFA) has been working on behalf of the citizens of Connecticut since 1969. Over this period, CHFA has partnered with and supported the State of Connecticut in achieving its policy goals. Importantly, CHFA has partnered with the Department of Mental Health and Addiction Services (DMHAS) in its work to end homelessness for over 25 years.

CHFA supports Connecticut's FFY 2026 – 2027 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services block grant application. CHFA will continue its partnership with DMHAS, assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS in collaboration with state and community partners, proposes to promote community integration and inclusion through the provision of permanent housing for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder.

CHFA, as a collaborative partner, supports DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the DMHAS population. CHFA will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness. Our goal is to expand access to permanent supportive housing and increase the affordable housing stock by providing funding opportunities when available for supportive housing development projects.

CHFA looks forward to working with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Natarajan
Nandini Natarajan- Chief Executive Officer

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Commissioner
Jodi Hill-Lilly, MSW

Ned Lamont
Governor

July 1, 2025

Nancy Navarretta, M.A., LPC, NCC
Commissioner
Department of Mental Health and Addiction
Services 410 Capitol Avenue, 4th Floor, Hartford,
CT 06134

Dear Commissioner Navarretta,

On behalf of Connecticut State Department of Children and Families (DCF), I am pleased to provide a letter of support for Connecticut's FY 2026-2027 Community Mental Health Services Block Grant application. The DCF will continue its' strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) to assist in the implementation of priorities identified in the grant application for those with mental illness.

Specific activities that DCF will support include:

- Continuing our strategic partnership with DMHAS to assist with implementing priorities that are identified in the 2024-2025 application. The primary purpose of this collab01'ation is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.

- Participating in the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for Medicaid eligible children and adults.

- Facilitating the coordination of services between DMHAS and DCF for clients who are under the care of DCF (committed or voluntary) or who are eligible for services thi'ough DMHAS. Specific activities will include: joint planning of all aspects of transition services; regular communication to monitor the referral process; identification and resolution of issues; and ongoing operational support.

DCF looks forward to advancing Connecticut's agenda to establish a comprehensive and effective community-based mental health system of care. Thank you for this opportunity to continue our strong collaboration in this area.

Sincerely,

Jodi Hill-Lilly, LMSW
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION

Sharonda T. Carlos
Deputy Commissioner

Phone 860-692-7871
Fax 860-692-7876

July 22, 2025

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4" Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

I am pleased to provide a letter of support, on behalf of Commissioner Quiros, for Connecticut's FY 2026-2027 combined Community Mental Health Services and Substance Use Prevention, Treatment, and Recovery Services Block Grant application. The Connecticut Department of Correction (CT DOC) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) to assist with the implementation of priorities that are identified in the application regarding the criminal-justice population. The primary purpose of this collaboration is to improve access to and the quality of behavioral health and support services for adults with moderate to serious mental illness and/or substance use disorders.

Specific activities that the CT DOC will support include:

1. Continuing to refer to DMHAS on discharging sentenced inmates with serious mental illness (SMI);
2. Supporting Reentry Counselors in their work with offenders being discharged from CT DOC custody to connect them to resources that may include criminal risk factor treatment, housing, employment, necessary identification papers, and governmental entitlements, and in health services discharge planning for medical services, mental health and/or substance use services;
3. Participating in monthly interagency meetings that include CT DOC Health Services staff, CT DOC Parole and Community Services, Judicial Branch Court Support Services/Probation, Board of Pardons and Paroles, and DMHAS Local Mental Health Authorities to resolve system issues that impact continuity of care, focusing on complex cases that require special coordination of all agencies; and
4. Continuing to support the Advance Supervision Intervention and Support Team (ASIST) initiative targeted to individuals with a moderate to severe psychiatric disability. This effort is designed to increase the number of individuals with psychiatric disorders who are diverted from jail or released early from jail or prison providing multi-agency support to improve their success in the community and *reduce* recidivism and re-incarceration.

Commissioner Quiros and the CT DOC staff look forward to working in partnership with DMHAS to promote a comprehensive and effective community-based system of care for persons who are criminally-involved and in need of behavioral health and support services.

Sincerely,

DocuSigned by:
Sharonda Carlos
C6BCA7D74342481...

Sharonda T. Carlos, M.P.A., CADC
Deputy Commissioner

Phone: 860.692.7482 ◆ Fax: 860.692.7483
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STATE OF CONNECTICUT
DEPARTMENT OF HOUSING

Ned Lamont
Governor

Seila Mosquera-Bruno
Commissioner

July 18, 2025

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4" Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

The Department of Housing (DOH) supports Connecticut's FY 2026-2027 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. DOH will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS), assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS, in collaboration with state and community partners, proposes to promote community integration and inclusion for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder through the provision of permanent housing.

DOH, as a collaborative partner, will assist DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the DMHAS population. DOH will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness to expand access to permanent supportive housing by assisting in the financing of supportive housing development projects.

DOH looks forward to working with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Seila Mosquera-Bruno

Seila Mosquera-Bruno
Commissioner
Connecticut Department of Housing

CONNECTICUT
Social Services

Andrea Barton Reeves, J.D.
Commissioner.

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4" Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

I am pleased to provide a letter of support for Connecticut's FY 2026-2027 combined Community Mental Health Services and Substance Use Prevention, Treatment, and Recovery Services Block Grant application. The Department of Social Services (DSS) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application.

The primary purpose of this collaboration is to improve access to and the quality of behavioral health services for those with a serious emotional disturbance or mental or substance use disorder. Specific activities supported by DSS include:

- Continuing its participation in and support of the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for the Medicaid eligible population.
- Working collaboratively to identify strategies and resources to advance evidence-based child/family treatments.
- Improving access, quality and child/family outcomes through ongoing collaboration.
- Continuing support for outpatient clinics to focus on integrated primary care and treatment for persons with co-occurring mental health and substance use disorders

DSS looks forward to advancing the agenda to establish a comprehensive, effective community-based system of care for those with a behavioral health disorder.

Sincerely,

Andrea Barton Reeves, JD

Commissioner, CT Department of Social Services

55 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06105

ct.gov/dss

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Nancy Navarretta, MA, LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor
Hartford, CT 06134

Dear Commissioner Navarretta,

I am pleased to provide a letter of support for Connecticut's FFY 2026-2027 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services Block Grant application. The Department of Public Health (DPH) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to, and the quality of, behavioral health services, as well as the primary healthcare needs of those with a serious emotional disturbance or a mental or substance use disorder.

In partnership with DMHAS and DCF, DPH will:

1. Work collaboratively to promote integration and coordination of behavioral health and primary care services among federally qualified health centers and community mental health providers;
2. Support efforts to identify health disparities relating to both physical and behavioral health services and build awareness of and compel action to address such disparities;
3. Support activities to strengthen existing School Based Health Centers and Expanded School Health sites;
4. Support implementation of a medical home model of care; and
5. Promote quality behavioral health services through routine sharing of licensing and other quality review reports with DMHAS staff, and coordinate licensing rules and regulations for child-serving agencies.

Sincerely,

Manisha Juthani, MD
Commissioner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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August 13, 2025

Jodi Hill-Lilly, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Hill-Lilly,

On behalf of Connecticut State Department of Education (CSDE), I am pleased to provide a letter of support for Connecticut's FFY 2026-27 Community Mental Health Block Grant application.

We will continue our strategic partnership with the Connecticut Department of Children and Families (DCF) to assist with the implementation of priorities outlined in *Connecticut's Behavioral Health Plan for Children*. A key focus of our collaboration has been to strengthen the connection between schools and community organizations to enhance in-school supports and connect youth and families to appropriate services and resources.

In addition, CSDE and DCF work closely to provide additional supports and guidance to schools following a loss or crisis. This fall, we are also jointly launching the *Student Support Series: Professional Learning for Mental and Behavioral Health*. This monthly series will offer school mental health professionals the opportunity to further develop their skills and ability to deliver expert, comprehensive mental and behavioral health support to Connecticut's students.

The CSDE, in partnership with DCF and the Court Support Services Division (CSSD) of the Connecticut Judicial Branch will continue to work collaboratively on supports for students experiencing a behavioral health crisis that might otherwise lead to arrest. Additionally, we will continue to engage in school-based suicide prevention and mental health promotion activities for Connecticut's children and families.

We look forward to advancing the statewide agenda for a comprehensive and effective school and community-based system of care.

Sincerely,

Charlene M. Russell-Tucker
Commissioner of Education

Cc: Sinthia Sone-Moyano, Deputy Commissioner

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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

The Behavioral Health Planning council is directly involved in planning for the allocation of block grant resources and statewide planning for the implementation of community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services. This year, two separate Planning Council meetings were conducted to provide members an opportunity to review and provide feedback on the FFY 2026 allocation plans (spending plans) for both block grants, as well as the FFY 2026-27 combined block grant application. Additionally, the state planner conducted an orientation to both block grants for new and existing members of the Council to provide members with the knowledge and information necessary to understand the block grants and to provide meaningful feedback on state plans for the block grants. Presentations were provided to the Planning Council on the programs and services funded with the block grants, to provide members with an opportunity to provide input and feedback on block grant funded services and their implementation. Lastly, the state's draft FFY 2026-27 combined block grant application (state plan) was shared directly with the planning council for their review and feedback.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support 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 independent advocacy and planning entities from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) into integrated Regional Behavioral Health Action Organizations (RBHAOs). The RBHAOs are statutorily mandated independent entities that are tasked with a range of advocacy, evaluation, and planning activities. Connecticut is divided into five service regions for adult behavioral health services and each RBHAO is responsible for completing these tasks within their specified region of the state. Specifically, the RBHAOs are tasked with the annual review of their regional behavioral health service system and the regional priority setting process, both of which inform statewide planning. The regional prioritization process provides an 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. This regional process results in data that is aggregated and analyzed to assess behavioral health needs statewide. This needs assessment is then utilized to inform allocation of state and federal resources and to plan the implementation of community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services.
The Adult Behavioral Health Planning Council is considered a key stakeholder and plays a central role in the assessment of

strengths and needs within the behavioral health system, and in statewide planning for community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services. An annual survey is conducted with planning council members to gather their perspective on the strengths, needs, and gaps within the state's behavioral health system. This data is used alongside the aggregated data from the regional prioritization process discussed above, to inform behavioral health priorities and allocation planning.

In addition to the Adult Behavioral Health Planning Council, that state convenes other significant statewide advisory bodies that play an important role in statewide planning processes for community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services. The Connecticut Alcohol and Drug Policy Council (ADPC) is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from substance use, and other stakeholders in a coordinated statewide response to alcohol, tobacco, and other drug (ATOD) use and abuse in Connecticut. The Council, co-chaired by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), is charged with developing recommendations to address substance-use related priorities from all state agencies on behalf of Connecticut's citizens, across the lifespan and from all regions of the state. The State Advisory Board is a separate legislatively mandated body which consists of gubernatorial appointees and Regional Behavioral Health Action Organization (RBHAO) chairs and designees. The board is required by statute to include membership from Connecticut's recovery community, as well as individuals receiving services within the state behavioral health system. The board meets monthly with the Commissioner of DMHAS and advises the Commissioner on programs, policies, and plans for the Department.

In regard to planning for children's behavioral health, Connecticut's Children's Behavioral Health Advisory Committee (CBHAC) was formally established by the state legislature through Public Act No. 00-188, with the mission to promote and enhance the provision of behavioral health services for all children in the State of Connecticut. Appointed members and community guests attend the monthly meeting to address these needs of the state. CBHAC serves in an advisory capacity on system of care issues to the State Advisory Council. Additionally, the Statewide Council of Community Collaboratives (SCCC) is comprised of the chairpersons of the 25 community collaboratives and chairpersons of other community initiatives. The SCCC meets at a minimum of two times a year to share statewide updates, best practices, and data pertaining to the development of community collaboratives and the networks of care. On a regional level, DCF partners with the Regional Behavioral Health Action Organizations (RBHAOs) to advise in the establishment and maintenance of a comprehensive system of services for children, youth and Families within the Region. Pursuant to Connecticut General Statutes 17a-30 (formerly 17-434) the mission of CBHAC is:

• To advise the Commissioner of the Department of Children and Families on the development and delivery of services in the Region; and

• To facilitate the coordination of services for children, youth and their families in the Region

On the local level, Community Collaboratives bring providers, community members, caregivers, family members and youth together in their communities to work collaboratively to most effectively utilize resources and ensure services meet the changing social, emotional, and behavioral needs of children, adolescents and their families. The Collaboratives track service/resource gaps and advocate for system level change. Collaborative meetings are open to everyone in the community.

Lastly, Local Interagency Service Teams (LIST) is a system development strategy for the establishment of an integrated system for planning, implementation and evaluation of juvenile justice service delivery in Connecticut. The LIST provides a venue for community-level interagency coordination and formal communication and planning between state agencies and local communities around juvenile justice issues.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

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

6. 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 duties of the Behavioral Health Planning Council include: to review the combined SUBG/MHBG application/plan provided by DMHAS and to submit any recommendations for modifications of those plans; to serve as advocates for adults with SMI and children with SED and their families, as well as others with behavioral health problems; to monitor, review, and evaluate, at least annually, the allocation and adequacy of behavioral health services in Connecticut.

Behavioral Health Planning Council membership includes representation from the RBHAOs, state agencies, other public and private entities concerned with the need, planning, operation, funding, and use of behavioral health services; family members of adults with SMI and children with SED; persons in recovery from behavioral health conditions; representatives of organizations of individuals with mental health and/or substance use disorders and their families and community groups advocating on their behalf. Members act as advocates for their respective constituencies and in this way provide meaningful input and a voice for their community during planning council proceedings. Stakeholders from communities across Connecticut will find their interests well represented by the RBHAO representatives who are members of the planning council. As part of their regional responsibilities, the RBHAOs hold focus groups and community conversations with regional stakeholders and other interested parties to collect information on the service system, including strengths, needs and barriers, and to gather feedback and recommendations for improvement. Representatives from each RBHAO utilize the information gathered through this stakeholder engagement to provide meaningful input and advocate for individuals with SMI and SED within planning council proceedings.

7. Please indicate areas of technical assistance needs related to this section.

NA

Footnotes:

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Thursday, August 8th, 2024 | 2:00 – 4:00 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Laura Watson, Allyson Nadeau, Jennifer Abbatemarco, Allison Fulton, Kathy Flaherty, Pamela Mautte, Will Erdman, Ellen Econs, Jennifer Buckley, Katherine Gallo, Heidi Pettersen, Zachary Nailon, Rita Natale, Herb Boyd, Giovanna Mozzo	
Staff Present:	Kyle Barrette, Sarju Shah, Liz Feder, Elsa Ward	
AGENDA ITEM:		**ACTION**
Solicitation for Nominations: Angela Duhaime, Chair	Angela announced that she is stepping down as Chair of the Planning Council due to her accepting a position with DMHAS. Angela solicited nominations for chairperson and for the new role of vice chairperson. Members thanked Angela for her time and commitment as Chair person.	Members interested in serving as Chair or Vice Chair will contact Kyle Barrette to submit their information. Council will hold a vote and elect new Chair and Vice Chair at next meeting.
Block Grant updates: Kyle Barrette, DMHAS	Kyle provided updates on the FFY 2025 projected budget for the Mental Health and Substance Use Block Grants. • House and Senate have each released their proposed budgets. Each budget includes additional funding for both block grants. However, final approved budget not likely before election and we may not know final block grant funding amount until early 2025. • Presidents proposed budget for the Substance Use Block Grant includes new 10% set aside for Recovery Support Services. Proposed budget for the Mental Health Block Grant includes a 5% set aside for Mental Health Prevention and Promotion but likely to be removed. Kyle provided updates regarding the allocation plan for both block grants. • Kyle provided an overview of how DMHAS is proposing to spend both block grants during FFY 2025. Spending is consistent with previous years. Some service categories are seeing an increase as DMHAS plans to use block grant funding to sustain certain services that were expanded with Pandemic related funds (ARPA). • Allocation plan for both block grants have been prepared and submitted to OPM. Next step is to have the plans approved by the committees of cognizance	Kyle will send out presentation slides and link to DMHAS webpage where council members can review the FFY 2025 Block Grant application. Members wishing to provide feedback or comments on the application will submit this information to Kyle through email.

	within the state legislature. DMHAS Commissioner will testify at public hearing in September. Kyle provided updates on the FFY2025 combined block grant application. • This application is a "mini" application and includes updated projections for FFY 2025 expenditures. • Application should be completed by August 16th and will then be posted to the DMHAS website for review and public comment. Link to review the application will be sent out to Council member by email. Council members can comment and provide feedback on the application by emailing Kyle.	
Recovery Campaign: Elsa Ward, Director, Office of Recovery Community Affairs, DMHAS	Elsa provided updates on Recovery Media campaign • Media campaign (Recovery Happens Here) is being continued for a second year and incorporates both mental health and substance use recovery. • Elsa working with vendor to record additional videos of individuals sharing their story of recovery. The campaign will also incorporate art, music and other creative products developed by individuals in recovery. Campaign attempting to reduce stigma. • Elsa is looking to broaden the campaign to include more individuals and clarified that people don't need to self-identify as in recovery to participate • Individuals interested in taking part in the recovery campaign can reach out to Elsa by phone or email. Elsa provided updates on plans for Recovery month 2024 • Elsa shared plans for an event to celebrate recovery month. Current plan is to hold the event in Manchester and to collaborate with the organization Pathfinders to host the event. Event will include music, wellness activities, and speakers throughout the day. The focus will be on all forms or recovery, and all are welcome. • Elsa noted that she will be hanging artwork created by individuals in recovery at OOC in the entrance off the elevator. The artwork will rotate out every three months. People are welcome to come by to view and can purchase (if for sale by the artist) through the artist's QR code.	Elsa will disseminate the flyer for the Recovery Media Campaign to members.
DMHAS updates: Dana Begin, Director, Evidence Based Practices, DMHAS-State of Connecticut	Dana was unable to attend. Kyle provided updates related to the statewide First-Episode Psychosis initiative in her absence: • Early Detection and Assessment Coordinators (EDACs) have been deployed to each DMHAS service region (5). • Consultation line has been established that treatment providers can utilize to get support in caring for an individual with first-episode psychosis. • Statewide awareness and outreach campaign (MindMap) is in full swing and includes social media campaign as well as media campaign. Look for signage on public transit and billboards.	Kyle will disseminate presentation slide to council members which includes website information, toolkit, and resources.

Meeting Planning: Angela Duhaime	Angela solicited presentation ideas and potential agenda items for the next Planning Council meeting. One member suggested a presentation on state's new Peer Respite program (Gloria House). Elsa Ward requested time at the next meeting to present on the Recovery Happens Here campaign.	
Next Meeting:	November 14th, 2024, 2:00-4:00pm via Microsoft Teams	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Thursday, November 14th, 2024 | 2:00 – 4:00 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Laura Watson, Jennifer Abbatemarco, Allison Fulton, Kathy Flaherty, Will Erdman, Ellen Econs, Kate Bohannan, Katherine Gallo, Heidi Pettersen, Herb Boyd	
Staff Present:	Kyle Barrette, Dana Begin, Liz Feder, Elsa Ward, Angela Duhaime	
AGENDA ITEM:		**ACTION**
Chair and Vice Chair Nominations: Kyle Barrette, DMHAS	Will Erdman and Heidi Pettersen were presented as nominees for the Chair and Vice Chair roles. Will and Heidi discussed their interest in the roles and their applicable experience to support their leadership.	Will Erdman elected as Chair and Heidi Pettersen elected as Vice Chair. Kyle will coordinate meeting with Will and Heidi to discuss next steps.
Crisis Continuum Updates: Dana Begin, Director of Evidence Based Practices and Grants, DMHAS	Dana provided an overview of the state's new Peer Respite program and Crisis Stabilization program. • The Crisis Stabilization program, called the REST Center (Rapid Evaluation, Stabilization and Treatment) is located in New Haven and is operated by Continuum of Care, in close collaboration with Connecticut Mental Health Center (CMHC). The program operates as a 23-hour rapid stabilization center and offers an alternative to Emergency Room care for individuals experiencing a behavioral health crisis. • The Peer Respite Program, Gloria House, is located in New Britain and is operated by New Life II. The program operates 24/7 as a short-term (few days to a week), non-clinical respite for individuals experiencing a mental health crisis or stressors that could be addressed through the program. The program is staffed by Peers with lived-experience and provides peer-to-peer support in a safe and supportive environment.	Kyle will send out links to the website for each program. Council members who have questions about the programs will reach Dana by email.
Block Grant updates: Kyle Barrette, DMHAS	Kyle provided updates on the FFY 2025 projected budget for the Mental Health and Substance Use Block Grants. • House and Senate have each released their proposed budgets. Each budget includes additional funding for both block grants. However, final approved budget has yet to be finalized. • New administration will likely make changes to the proposed budgets so we may not know our final block grant amounts until 2025.	Kyle will send out presentation slides.

	Kyle provided updates on the FFY2025 combined block grant application and annual report. • The combined block grant application was submitted on September 1st. • The Substance Use Block Grant annual report and Mental Health Block Grant annual report will be submitted by December 1st.	
Recovery Campaign: Elsa Ward, Director, Office of Recovery Community Affairs, DMHAS	Elsa provided updates on Recovery Media campaign • Media campaign (Recovery Happens Here) is being continued for a second year and incorporates both mental health and substance use recovery. • Elsa working with vendor to record additional videos of individuals sharing their story of recovery. The campaign will also incorporate art, music and other creative products developed by individuals in recovery. Campaign attempting to reduce stigma. • Elsa is looking to broaden the campaign to include more individuals and clarified that people don't need to self-identify as in recovery to participate • Individuals interested in taking part in the recovery campaign can reach out to Elsa by phone or email. Elsa provided updates on plans for Recovery month 2024 • Elsa shared plans for an event to celebrate recovery month. Current plan is to hold the event in Manchester and to collaborate with the organization Pathfinders to host the event. Event will include music, wellness activities, and speakers throughout the day. The focus will be on all forms or recovery, and all are welcome. • Elsa noted that she will be hanging artwork created by individuals in recovery at OOC in the entrance off the elevator. The artwork will rotate out every three months. People are welcome to come by to view and can purchase (if for sale by the artist) through the artist's QR code.	Elsa will disseminate the flyer for the Recovery Media Campaign to members.
Recovery System updates: Elsa Ward, Director, Office of Recovery Community Affairs, DMHAS	Elsa provided updates on the "Recovery Happens Here" campaign and website. • The campaign and website developed to help bring about awareness, reduce stigma, and remind everyone that recovery is possible. • Updated website includes videos, art, poetry, and testimonials as part of "Faces of Recovery" which highlights stories of recovery and wellness. • Individuals interested in submitting art, poetry, or a video testimonial can do so by emailing the contact listed on the website and submitting a consent form.	Kyle will send out a link to the website to council member.
Planning Council business: Kyle Barrette, DMHAS	Kyle provided updates on a new DMHAS webpage being created for the Planning Council that will provide an overview of the council, its role within the state, by-laws, agendas and minutes, as well as contact information for anyone interested in joining the council. Kyle sought feedback from Planning Council members regarding the website.	

	• Members suggested including meeting presentation slides, resource links, “reasons to join” for interested parties, testimonials from council members. • Members suggested including link to Planning Council webpage in prominent place on DMHAS website and/or social medial channels.	
Next Meeting:	February 6th, 2025, 2:00-4:00pm via Microsoft Teams	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Thursday, February 6th, 2025 | 2:00 – 4:00 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Laura Watson, Jennifer Abbatemarco, Allison Fulton, Kathy Flaherty, Will Erdman, Ellen Econs, Kate Bohannan, Katherine Gallo, Heidi Pettersen, Pamela Mautte, Michaela Fissel, Allyson Nadeau, Giovanna Mozzo	
Staff Present:	Kyle Barrette, Justin Mehl, Liz Feder, Elsa Ward, Sarju Shah, Dana Begin	
AGENDA ITEM:		**ACTION**
SafeSpot Overdose Hotline: Stephen Murray, Boston Medical Center	Stephen Murray provided a presentation on the SafeSpot Overdose Hotline. The Hotline provides telephonic support to individuals at risk of overdose and provides resources and information to interested individuals. Stephen shared that the hotline is in the process of being extended to cover Connecticut, as the organization was recently approved for OSAC funding.	Stephen to share presentation slides
Connecticut Harm Reduction Centers: Justine Mehl, DMHAS	Justine Mehl provided an overview of Connecticut's new Harm Reduction Centers (HRC). These programs operate as drop-in centers and provide low barrier access for individuals at risk for overdose. The goals of the services are to reduce unintentional overdose fatalities, reduce disease transmission and provide wound care, and increase access to treatment and recovery support. There are currently three HRCs in CT, located in Waterbury, New London, and New Haven.	Justin to share presentation slides
Block Grant updates: Kyle Barrette, DMHAS	Kyle provided updates on the FFY 2025 projected budget for the Mental Health and Substance Use Block Grants. Agreement on the FFY2025 budget has not been reached and states have yet to receive confirmation of their FFY2025 award amounts. While previously proposed budgets from the house and senate included increased funding for both block grants, the new administration has made efforts to reduce funding. The federal government is currently operating under a continuing resolution that ends on March 15th and we should know more about the potential block grant awards amounts by that time.	Kyle to share block grant award information when federal budget is passed
DMHAS Updates: Sarju Shah, Director, Prevention and Health Promotion	Sarju provided updates about the Regional Prioritization process that is currently taking place to evaluate the gaps, needs, and strengths of our behavioral health system. The Regional Behavioral Health Action Organizations RBHAOs implement this process and are currently conducting data collection in each of their regions. One of the planning council members asked about how they could become involved with this process in their region to provide input regarding peer and recovery services. The RBHAO representatives clarified how members could receive the regional survey and join stakeholder meetings.	Sarju to follow up with member to discuss how they can share their input as part of the regional data collection process

Planning Council business: Heidi Pettersen, Vice Chair	Heidi engaged members in a discussion about potential agenda items for upcoming meetings • Michaela Fissel requested an overview of the new Peer Certification process	Kyle or Elsa will send out information regarding the new peer certification requirements as well information about upcoming town halls that will provide this information in the community
Next Meeting:	May 8th, 2025, 2:00-4:00pm via Microsoft Teams	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Thursday, May 8th, 2025 | 2:00 – 4:00 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Laura Watson, Jennifer Abbatemarco, Herb Boyd, Rita Natale, Kathy Flaherty, Will Erdman, Katherine Gallo, Heidi Pettersen, Pamela Mautte	
Staff Present:	Kyle Barrette, Dana Begin, Julienne Giard, Sara Moriarty, Liz Feder, Elsa Ward, Denique Weidema-Lewis	
AGENDA ITEM:		**ACTION**
Local Mental Health Authority system overview: Julienne Giard, Section Chief, Community Services Division, DMHAS	Julienne provided an overview of the Local Mental Health Authority system in CT. Julienne described the regions covered by each Local Mental Health Authority (LMHA) as well as the services they provide.	Julienne to share presentation slides
NORA Saves overview: Sara Moriarty, Health Program Associate, Department of Public Health	Sara provided background and overview of the NORA Saves website and app. NORA Saves is a website application developed by the Department of Public Health aimed at helping to prevent overdose deaths in Connecticut (https://egov.ct.gov/norasaves/#/HomePage). The website provides information on how to recognize the symptoms of an overdose and how to apply Naloxone to someone experiencing an overdose. Additional information provided includes where to obtain Naloxone and training. The NORA Saves website was originally created for mostly state employee audiences but will be undergoing a wider public relaunch in June. During the discussion, members asked for information on where they could obtain Naloxone directly. One of the members identified that Naloxone and Naloxone training can be accessed through the Regional Behavioral Health Action Organizations.	Sara to share presentation slides
Block Grant updates: Kyle Barrette, DMHAS	Kyle provided updates on the FFY 2026 projected budget for the Mental Health and Substance Use Block Grants. The president's budget has yet to be fully completed but there may be the potential for cuts to the block grants in FFY 2026. The FFY 2026 spending plans for each block grant (allocation plans) are currently being drafted based on the assumption of flat funding. Kyle provided an overview of the projected spending plan based on flat funding, including the specific programs and services that will receive funding.	Kyle to share presentation slides Kyle to send out survey link and survey information

	Kyle discussed that the FFY 2026-2027 Combined Block Grant application is currently being drafted and will be open for public comment by mid-August. Lastly, Kyle discussed a survey that has been developed to gather the input and feedback from Planning Council members regarding gaps and needs within the CT Behavioral Health system. The survey will be sent out to all Planning Council members and the results will be utilized to inform the final block grant spending plans and will be included within the block grant application.	
DMHAS Updates: Dana Begin, Director, Evidence Based Practices, DMHAS Denique Weidema-Lewis, Program Manager, Prevention and Health Promotion, DMHAS Elsa Ward, Director, Office of Recovery Community Affairs, DMHAS	Dana provided brief updates about the Crisis Services system. Dana noted that Mobile Crisis Teams continue to work towards 24/7 coverage. The state's new Peer Respite in New Britain, and 23-hour Crisis Respite in New Haven continue to operate successfully. Each of these programs offer a different type of service but both offer an alternative to the emergency department for individuals experiencing a behavioral health crisis. These programs offer assessment, rapid stabilization, and support within a home-like environment. Denique provided brief updates regarding the Regional Priority Report process. The priority reports, developed by the Regional Behavioral Health Action Organizations, have recently been completed and UCONN is currently working to aggregate the results of these reports. Elsa provided an overview of Peer Support training cohorts currently taking plan. These cohorts are running for six months and include recovery coaches and recovery support specialists, together. The training sessions focus on skill development, reflective learning, and integrated care. Elsa also discussed developments related to the state's new Peer Support exam which will be used as part of the state's new Peer Support credential. The Office of Recovery Community Affairs (ORCA) is holding listening sessions to gather input and feedback regarding the exam and credential requirements. The next sessions will take place in July and further details are posted on the ORCA webpage (https://portal.ct.gov/dmhas/divisions/divisions/recovery-community-affairs)	
Planning Council business: Heidi Pettersen, Vice Chair	Heidi provided an overview of proposed agenda items for the next meeting and requested additional ideas from members. No additional ideas were proposed by members.	
Next Meeting:	August 14th, 2025, 2:00-4:00pm via Microsoft Teams	

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, October 04, 2024

Attendance: Abby, Adrianna Ramirez, Aimee Gelinas, Alexandrino Rivera, Alice Farrell, Amy Hilario, Andre Gibbs, April Mayo, Benita Toussaint, Briana Miller, Briannali Rivera, Carmen Almodovar, Carmen Cirioli, Carmen Hernandez, Carmen Teresa Rosario, Carolyn Westerholm, Chastity Leak, Christian Rodriguez, Christina Main, Connie HD, Connie M Estanislau, Consuelo Spanish Interpreter, Cynthia Cruz, Daniela Giordano, De Popkin, Denise Qualey, Donald Vail, Dorothy Cimmino, Dr. Alice Farrell, Dr. Marie Spivey, Dreau Foster, Drew Lavallee, Elsa, Elsa Cordova, Emuna Patterson, Erica Aldieri, Gabrielle Hall, Jade Siqueira, Jamie LoCurto, Janissa Vidal, Jean Alberghini, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Joe Drane, Jules Calabro, Karen Delane, Karen Hurdle, Kate Bohannan, Kathy G. Carbine, Kathy H. Nguyen, Katie Johnson, Keisha Martin-Velez, Kelly Waterhouse, Kristin Graham, K Sanchez, Kymani Scarlett, L Castel, Latasha Thomas, Lena Esposito, Lindsay Kyle, Lindsey Brennan, Lisa Girard, Lisa Palazzo, Liz Sitler, Llina Hilario, Lorna Thomas- Farquharson, Lyne Landry, Mai Kader, Manisha Srivastava, Maria Brereton, Marie B, Marlene Gomez, Martin Geertsma, Mary Hryniewicz, Maureen O'Neil-Davis, Melanie Wilde-Lane, Melissa Gillies, Michael Wynne, Michelle Rodriguez, Mikhela Hull, Neiima Edwards, Neva Caldwell, Paige Trevethan, Pam Williams, Paul Guerrero, Paula Patton, Paulette Phillips, Penny Lemery, Pinkneys, Quiana Mayo, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rossie, Sadie Witherspoon, Sandra Rivera, Sandra Williams, Sebastian Spencer, Sharon Hanford, Shi-maine Holmes, Solai's Demorest, Stella Guitandjiev, Stephanie Bozak, Stephanie Joanis, Stephney Springer, Tania Santana, Tarsha, Tom Cosker, Tom Cosker, Tory Soucy, Trisha Costa, V.Thaxter, Victor Jones, Xavier Williams, Zach Nailon, Zosh Flammia, Zosh Flammia, and three numbers

Welcome and Introductions

- CBHAC's mission, purpose and priority areas were reviewed.
- Due to the co-chair vacancy, Jo Hawke has offered to fill in as Interim.

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (September 2024)

- Review and approval of July meeting minutes.
- Review of CBHAC voting member application. Jenny Bridges from FAVOR is now a voting member.
- Discussion related to vacant co-chair position and plan for interim chair.
- Final discussion of suggested edits to annual recommendations
- Planning related to upcoming meeting of CBHAC chair with DCF Statewide Advisory Council (SAC) and CT Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB) chairs.

Agency Updates

1. Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco

- DMHAS has spent the last few months training groups of people on a substance use treatment training model.
- The model is tailored for the developmental needs of the young adult population between the ages of 18-25.
- Among those trained were internal DMHAS employees, state operated & non-profit programs funded by DMHAS.
- Some trainings were co-facilitated with DCF in order to give providers additional tools and resources to work with young people who are experiencing mental health issues as well as dealing with substance use.

- Training modules are specific to trauma, harm reduction, motivational interviewing and medication assisted treatment (MAT)
- DMHAS can be available to other providers for these trainings so if there are interest, they are encouraged to reach out directly to Jenn so that she can connect to the trainers.
- They are also training all their providers in a trauma treatment model right now called Cognitive Restructuring for post-traumatic stress disorder (CR PTSD)
- The initial trainings for that model have been conducted, and now they have identified clinicians in each of teams statewide that will continue to receive specific training from a consultant to implement that treatment model.
- **Q**: What about with the children whohave no verbal is they are available to benefit from the CR for PTSD? **A**: Typically, DMHAS does not work with non-verbal youth
- **Q**: What if a youth is offered this program and then turns 25, are there any services they can receive? **A**: After, they turn 25 they would still remain with DMHAS if they are in need of mental health support, and we have a lot of adult program options
- **Q**: Is there any way for parents to be able to do that training? **A**: The CR PTSD training model is for clinicians in their therapy approach, but DMHAS offers other trainings such as the ARC model which covers self-regulation and competence. There is a portion of that training that focuses on caregivers who are caring for young people who have experienced trauma.
- **Q**: How long is the CR PTSD training program? **A**: The CR PTSD training and supervision will be ongoing monthly for the clinicians who have been trained to provide the service in that model, the substance use training is a six-module training done over a period of a couple of months, and each training block is about three hours
- **Q**: Is there a specific intervention that DMHAS is using? **A**: It is a training series that was developed within the department with individuals who have expertise in substance use. So, it draws from a number of different areas: motivational interviewing, harm reduction approaches, trauma related treatments, some of which are evidence based practices.
- **Q**: Are there any models to implement CR PTSD for people over 25? **A**: Not at DMHAS however, DCF stated they do support specific models for family work, but it would be dependent on the referring reasons. One tool that can help with resources is AIM tool that can be found on the Connecting to Care website https://www.connectingtocarect.org/supports-services/aim/

2. Department of Education (DOE)– Kate Bohannan

- State Department of Education has an upcoming three-part webinar series for parents and families called "Supporting your child's health and well-being during the school year". Flyer was shared in the chat.
- These are free for families and caregivers, or anyone interested and will be held evening between 5-6 p.m. They will take place on 10/10/24, 10/24/24 and 11/7/24.
- They will be presented in English, but they will also be recorded and translated into several languages, and those translations will be available the following week.
- Topics include ways to support children's well-being both at home and school, how to prepare for cold and flu season and how to protect our youth with a community approach to suicide prevention.
- This past summer in CT there were 10 suicide deaths for children under 18 and while it is difficult to talk about it is really important for parents and caregivers to have the tools to talk about mental health and suicide with their children, particularly during those times when the support children may receive from school may not be available, such as, school vacations and breaks
- **Q**: How are the webinars being advertised to families and caregivers? **A**: The department is sharing with all students and their families but asking groups such as this to share with as many families as possible

3. Court Support Services Division (CSSD) –Carmen Hernandez

- Effective immediately, the LISTs (Local Interagency Service Teams) were cut due to budget restrictions.
- This was affected because it was one of the things services that did not work directly with clients so the programs that did were prioritized.
- A comment was made that the LIST was a key partner in making recommendations on what support and services were needed in the community and if there is a way to bring them back that should be considered. More information may follow at next month's meeting.
- A diversion program out of Urban Community Alliance (UCA) in New Haven shared their information in the chat for anyone looking to connect youth transitioning out of programs such as residential.

4. Department of Social Services (DSS) – Connie Estanislau (no report)

- **Q:** What are the new policies on medical transportation as there seems to be a 10 mile limitation to make it to appointments? **A:** Due to the nature of specific concerns, information on who to contact as going to be shared in the chat so that they can be connected to someone who can investigate that and assist in troubleshooting

5. Department of Children and Families (DCF)– Stephanie Bozak

- DCF's annual report reported that the three community-based Urgent Crisis Centers (UCCs), The Village for Families and Children, Wellmore and Child and Family Agency of Southeastern Connecticut saw over 1000 children and youth from July-June 2023.
- 97% of those youth were able to discharge back home into the community.
- Data continues to be collected and feedback from some parents is that if they would not have the UCC they probably would have gone to an emergency department.
- DCF and DSS continue to strategize around funding to sustain the UCCS.
- Data tracking of how many children and youth were transported to the UCCs via ambulance and initial findings are that the numbers are low.
- **Q**: Is the Yale UCC still in operation? **A**: Yes, but since it is located within an Emergency Department the collection of data is still being analyzed for accuracy. They are currently also working on enhancing it to have a dedicated space for the UCC itself.
- **Q**: Are you tracking the data on whether there's family engagement in the referral recommendations? **A**: Not at the moment but it is something that can be looked at to be incorporated as the data collection progresses and improves
- **Q**: Will the state departments be looking to increase the capacity of different community organizations because due to the amount of wait list for needed services? **A**: The Governor had a roundtable where DCF and all state organizations participated with Senator Murphy to discuss resources, and we are working through barriers. Everyone is encouraged to reach out to delegates and legislators so that your voice can be heard about the continued need for these crucial services.
- **Q**: What percentage of the 90% of children and youth sent home after a UCC stay, return to the UCC? **A**: This information is just starting to be analyzed so we do not have an answer at the moment.
- In addition to the UCCs there is also a Sub-Acute Crisis Center, at The Village where a youth could stay up to 14 days if they find the immediate crisis destabilization is not helping.
- During that stay, staff work with family intensively to come up with a crisis safety plan and a discharge plan to get back in community.
- CHR is renovating their facility to also open a Sub-Acute in the near future.
- **Q**: Are you seeing any decline in the number of youths seen at outpatient or inpatient facilities like IOL or Solnit? **A**: There is a challenge on the data that is received depending on who is managing it however all partners are working on ways to help share data more efficiently

  Internal process for child protective side of DCF. In the past, low to moderate risk families identified through a report to the Careline would go through the Differential Response

System to be assessed and assigned, when possible, to receive supportive services, rather than immediately going into investigations. Moving forward, any family with a child under 5 years of age in the household will automatically go into investigations. This change in procedures does not affect families without a child under 5 years of age. That determination took place because we recognize that children under the age of five really had some unique risk factors that DCF wants to ensure they take time to investigate.

- **Q**: Do you know if this change of policy for kids under five has come because of some of the cases that have made the news over the last six to nine months? **A**: Not sure of the specifics but I imagine that it probably did influence a decision to look at internal policies.
- **Q**: If the referral comes in through Careline for a youth over the age of five, what track will it take? **A**: Not sure but will ask CPS and bring the information back to CBHAC.
  Follow up from DCF: 1. There was a question related to whether families with children under 5 would still be referred to investigations even if the call to Careline was not related to the youth under 5 years of age. The answer is yes, this change in practice for families to go through investigations rather than a Family Assistance Referral (FAR) is for any family with a youth under the age of 5.
  2. There was conversation about the impact this change in practice/policy of FAR/Investigations would have on Community Support for Families referrals. Given the feedback from providers, changes are being made to the contract to allow for referrals to Community Support for Families programs that would have previously been eligible.

6. Office of Early Childhood (OEC)- Lorna Thomas-Farquharson (no report)

- Last month's webinar in partnership with the Department of Education: "A Path forward, creating a climate that promotes success for all". Keynote Speaker: Opening Keynote from Donzaleigh Abernathy, actress, author, and civil rights activist https://www.ctoec.org/behavioral-health-initiative-draft/behavioral-health-initiative-webinars/
- Its purpose highlighted one of CBHAC's priorities regarding disparities and access to culturally appropriate care.
- The webinar focused how to create an environment of learning where it helps to support children and adults reach their fullest potential.
- Next webinar is There's No Place Like Home: Supporting families experiencing housing insecurity and its impact on young children on 10/31/24,
- That will focus on the reality of insecure housing and homelessness across the nation but in particular CT.
- **Q**: Are there interpretation services available for the webinars? **A**: Yes. Also, OEC has webinars posted on their YouTube channel and closed captioning can be in several languages.

Monthly Presentation- None

Community Announcements

- Consumer Youth and Family Group thanked everyone who helped and participated in the iCAN event.
- Amplify is hosting a Mind Map CT event on 10/23 from 1:30 p.m.-2:30 p.m. and shared a flyerthat included registration information. The event will focus on First Episode Psychosis (FEP)
- Family Forward Advocacy CT is hosting its first fundraiser luncheon on 11/7/24 at The Pond House. Doriana Vicedomini will be honored for her outstanding advocacy and a parent advocate will be given that award in her honor. Both her children will be in attendance. For information and tickets https://www.zeffy.com/en-US/ticketing/062dffd6-cfc2-4c3b-bd44-46cc7f6c00e9
- The Hartford Public Library has programs for the community such as ESL and Citizenship which take place on Saturdays from 9:30-2:30 p.m.

Voting Member Meeting

- Minutes approval for September
- Recommendations and annual report-nearly finalized and will be shared with DCF commissioner and also voting members by late October.
- Review of plan to coordinate with other groups and upcoming 10/7/24 meeting with Statewide Advisory Council (SAC) and the Children's Behavioral Health Plan Implementation Advisory Board.

Next meeting November 1st, 2024

Comité Asesor de Salud Conductual Infantil (CBHAC)
Minutas - Viernes 04 de octubre de 2024

Asistencia:

Abby, Adrianna Ramirez, Aimee Gelinas, Alexandrino Rivera, Alice Farrell, Amy Hilario, Andre Gibbs, April Mayo, Benita Toussaint, Briana Miller, Briannali Rivera, Carmen Almodovar, Carmen Cirioli, Carmen Hernandez, Carmen Teresa Rosario, Carolyn Westerholm, Chastity Leak, Christian Rodriguez, Christina Main, Connie HD, Connie M Estanislau, Consuelo Spanish Interpreter, Cynthia Cruz, Daniela Giordano, De Popkin, Denise Qualey, Donald Vail, Dorothy Cimmino, Dr. Alice Farrell, Dr. Marie Spivey, Dreau Foster, Drew Lavallee, Elsa, Elsa Cordova, Emuna Patterson, Erica Aldieri, Gabrielle Hall, Jade Siqueira, Jamie LoCurto, Janissa Vidal, Jean Alberghini, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Joe Drane, Jules Calabro, Karen Delane, Karen Hurdle, Kate Bohannan, Kathy G. Carbine, Kathy H. Nguyen, Katie Johnson, Keisha Martin-Velez, Kelly Waterhouse, Kristin Graham, K Sanchez, Kymani Scarlett, L Castel, Latasha Thomas, Lena Esposito, Lindsay Kyle, Lindsey Brennan, Lisa Girard, Lisa Palazzo, Liz Sitler, Llina Hilario, Lorna Thomas- Farquharson, Lyne Landry, Mai Kader, Manisha Srivastava, Maria Brereton, Marie B, Marlene Gomez, Martin Geertsma, Mary Hryniewicz, Maureen O'Neil-Davis, Melanie Wilde-Lane, Melissa Gillies, Michael Wynne, Michelle Rodriguez, Mikhela Hull, Neiima Edwards, Neva Caldwell, Paige Trevethan, Pam Williams, Paul Guerrero, Paula Patton, Paulette Phillips, Penny Lemery, Pinkneys, Quiana Mayo, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rossie, Sadie Witherspoon, Sandra Rivera, Sandra Williams, Sebastian Spencer, Sharon Hanford, Shi-maine Holmes, Solai's Demorest, Stella Guitandjiev, Stephanie Bozak, Stephanie Joanis, Stephney Springer, Tania Santana, Tarsha, Tom Cosker, Tom Cosker, Tory Soucy, Trisha Costa, V.Thaxter, Victor Jones, Xavier Williams, Zach Nailon, Zosh Flammia, Zosh Flammia, and three numbers

Bienvenida y presentaciones

- Se revisaron la misión, el propósito y las áreas prioritarias del Comité Asesor de Salud Conductual Infantil (CBHAC, por sus siglas en inglés).
- Debido a la vacante de la copresidencia, Jo Hawke se ha ofrecido a ocupar el puesto como interina.

Revisión de las áreas prioritarias de 2022-2025

1. Integración de la atención pediátrica primaria y de atención de la salud conductual
2. Desigualdades y acceso a una atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (septiembre de 2024)

- Revisión y aprobación de las minutas de la reunión de julio
- Revisión de la solicitud de miembros con derecho a voto del CBHAC Jenny Bridges, de FAVOR es ahora nuevo miembro con derecho a voto.
- Debate en relación a la vacante de la copresidencia y plan para un cargo interino.
- Debate final sobre las propuestas de modificación de las recomendaciones anuales
- Planificación relacionada con la próxima reunión del presidente del CBHAC con los presidentes del Consejo Asesor Estatal (SAC, por sus siglas en inglés) del Departamento de Niños y Familias (DCF, por sus siglas en inglés) y de la Junta Asesora de Implementación del Plan de Salud Conductual Infantil (CBHPIAB, por sus siglas en inglés).

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco**
   - El Departamento de Servicios para la Salud Mental y la Adicción (DMHAS, por sus siglas en inglés) ha pasado los últimos meses capacitando a grupos de personas en un modelo de formación para el tratamiento por consumo de sustancias.

- El modelo está adaptado a la necesidades de desarrollo de la población de jóvenes adultos de entre 18 y 25 años de edad.
- Entre los formados había empleados internos del DMHAS, programas de gestión estatal y programas sin fines de lucro financiados por el DMHAS.
- Algunas capacitaciones fueron facilitadas conjuntamente con el DCF para brindar a los proveedores herramientas y recursos adicionales para trabajar con personas jóvenes que experimentan problemas de salud mental, además de afrontar el consumo de sustancias.
- Los módulos de formación son específicos de trauma, reducción del daño, entrevista motivacional y tratamiento asistido con medicamentos (MAT, por sus siglas en inglés).
- El DMHAS puede estar disponible para otros proveedores para estas formaciones, así que si hay interés, se les anima a comunicarse directamente con Jenn para que ella pueda ponerlos en contacto con los formadores.
- También están formando actualmente a todos sus proveedores en un modelo de tratamiento del trauma llamado Restructuración cognitiva para trastorno de estrés postraumático (CR PSTD, por sus siglas en inglés).
- Ya se han realizado las formaciones iniciales para ese modelo y ahora han identificado a los terapeutas de cada uno de los equipos de todo el estado que seguirán recibiendo formación específica de parte de un consultor para implementar ese modelo de tratamiento.
- **P**: ¿Qué ocurre con los menores que no se expresan verbalmente, podrán beneficiarse de la CR para PTSD? **R**: Habitualmente, el DMHAS no trabaja con jóvenes que no se expresan verbalmente.
- **P**: ¿Qué ocurre si a un joven se el ofrece este programa y cumple 25 años, hay algunos servicios que pueda recibir? **R**: Luego de cumplir 25 años permanecería con el DMHAS si necesita apoyo de salud mental, y tenemos muchas opciones de programas para adultos.
- **P**: ¿Existe alguna forma en que los padres puedan recibir esa formación? **R**: El modelo de formación de la CR PTSD es para los terapeutas en su abordaje terapéutico, pero el DMHAS ofrece otras formaciones tales como el modelo ARC que abarca la autorregulación y la competencia. Hay una parte de esa formación que se centra en los cuidadores que atienden a personas jóvenes que han experimentado un trauma.
- **P**: ¿Cuál es la duración del programa de formación del CR PTSD? **R**: La formación y supervisión del CR PTSD será mensual para los terapeutas que han sido formados para prestar el servicio con ese modelo, la formación en materia de consumo de sustancias es una formación de seis módulos que se realiza en un período de unos dos meses, y cada bloque de formación es de aproximadamente tres horas.
- **P**: ¿Existe una intervención específica que el DMHAS esté usando? **R**: Es una serie de formación que fue desarrollada en el departamento con personas que han experimentado el consumo de sustancias. Por ello, se basa en una serie de áreas diferentes: entrevista motivacional, enfoques de reducción de daños y tratamientos relacionados con el trauma, algunos de los cuales son prácticas basadas en pruebas.
- **P**: ¿Existe algún modelo para implementar el CR PTSD en personas mayores de 25 años? **R**: No en el DMHAS, sin embargo, el DCF declaró que apoyan modelos específicos para el trabajo familiar, pero dependería de las razones de la derivación. Una herramienta que puede ayudar con recursos es la herramienta AIM que se encuentra en el sitio web de Connecting to Care (Conexión con la asistencia) https://www.connectingtocarect.org/supports-services/aim/

2. Departamento de Educación (DOE) - Kate Bohannan

- El Departamento de Educación (DOE, por sus siglas en inglés) del estado tiene una próxima serie de seminarios web de tres partes, para padres y familias, llamada «Apoyo a la salud y bienestar de su hijo durante el año escolar». El folleto se compartió por el chat.
- Estos (seminarios web) son gratuitos para las familias y cuidadores, o para cualquier persona interesada y se realizarán de 5 a 6 p. m. Se llevarán a cabo el 10/10/24, 10/24/24 y 11/7/24.

- Se presentarán en inglés, pero también se grabarán y traducirán a diversos idiomas, y esas traducciones estarán disponibles la semana siguiente.
- Los temas incluyen formas de apoyar el bienestar de los hijos tanto en casa como en la escuela, cómo prepararse para la temporada de gripe y resfriados, y cómo proteger a nuestros jóvenes con un enfoque comunitario de prevención del suicidio.
- El verano pasado en CT hubo 10 muertes por suicidio de chicos menores de 18 años y aunque es difícil hablar de ello es realmente importante que los padres y cuidadores tengan herramientas para hablar de la salud mental y del suicidio con sus hijos, particularmente durante esos momentos en los que el apoyo que los menores reciben en la escuela puede no estar disponibles, como en las vacaciones y recesos escolares.
- **P**: ¿Cómo están siendo publicitados los seminarios web a las familias y los cuidadores? **R**: El departamento está compartiendo con todos los estudiantes y sus familias, pero le está pidiendo a grupos como este que lo compartan con tantas familias como sea posible.

3. División de Servicios de Apoyo al Tribunal (CSSD): Carmen Hernandez

- Con efecto inmediato, los Equipos Locales de Servicios Interinstitucionales (LIST, por sus siglas en inglés) fueron recortados debido a restricciones presupuestarias.
- Se vieron afectados porque eran uno de los servicios que no trabajaba directamente con los clientes, por lo que se dio prioridad a los programas que sí lo hacían.
- Se comentó que el LIST era un aliado clave en la recomendación de cuáles apoyos y servicios eran necesarios en la comunidad y si hay alguna forma de recuperarlo debe considerarse. Puede haber más información en la reunión del próximo mes.
- Un programa de diversión de la Alianza Comunitaria Urbana (UCA, por sus siglas en inglés) de New Haven compartió su información en el chat para cualquiera que esté buscando conectar a los jóvenes que están haciendo la transición al salir de programas tales como los residenciales.

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau (no presentó informe)

- **P:** ¿Cuáles son las nuevas políticas sobre transporte médico ya que parece haber un limitación de 10 millas para acudir a las citas? **R:** Debido a la naturaleza de los problemas específicos, se compartirá en el chat la información sobre a quién contactar para que puedan conectarse con alguien que pueda investigarlo y ayudar a solucionar el problema.

5. Departamento de Niños y Familias (DCF) – Stephanie Bozak

- El informe anual del DCF señaló que los tres Centros de Crisis Urgentes (UCC, por sus siglas en inglés) comunitarios, The Village for Families and Children (La Villa para Familias y Niños), Wellmore and Child (Wellmore y el Niño) y Family Agency of Southeastern Connecticut (Agencia para las familias del sureste de Connecticut) atendieron más de 1000 niños y jóvenes desde julio-junio 2023.
- 97 % de esos jóvenes pueden ser dados de alta de regreso a casa y a la comunidad.
- Se siguen recopilando datos y según la opinión de algunos padres si no tuvieran el UCC probablemente habrían ido a un departamento de emergencias.
- El DCF y el DSS siguen creando estrategias de financiamiento para mantener los UUC.
- Se ha hecho el seguimiento de datos de cuántos niños y jóvenes fueron transportados a los UCC por una ambulancia y según las conclusiones iniciales las cifras son bajas.
- **P**: ¿El UCC de Yale aún está en funcionamiento? **R**: Sí, pero como está ubicado dentro de un Departamento de Emergencias aún se está analizando la precisión de los datos. Actualmente ellos también están trabajando para mejorarlo y tener un espacio exclusivo para el UCC.
- **P**: ¿Se está haciendo seguimiento a los datos de si hay participación familiar en las recomendaciones de derivación? **R**: No en este momento, pero es algo que se puede revisar para incorporarlo a medida que avanza y mejora la recopilación de datos.
- **P**: ¿Intentarán los departamentos estatales aumentar la capacidad de las distintas organizaciones comunitarias debido a la cantidad de listas de espera para recibir los servicios

necesarios? **R**: El Gobernador celebró una mesa redonda en la que participaron el DCF y todas las organizaciones estatales con el Senador Murphy para discutir los recursos, y estamos trabajando en los obstáculos. Se anima a todos a comunicarse con los delegados y legisladores para que su voz sea escuchada en relación a la continua necesidad de estos servicios cruciales.

- **P**: ¿Qué porcentaje del 90 % de niños y jóvenes que son enviados de regreso a casa después de su permanencia en el UCC, regresan al UCC? **R**: Esta información está empezando a analizarse, por lo que no tenemos una respuesta por el momento.
- Además de los UCC también existe un Centro de Crisis Subaguda, en The Village, en el que los jóvenes pueden permanecer 14 días si consideran que la desestabilización inmediata de la crisis no está ayudando.
- Durante su permanencia, el personal trabaja con la familia de forma intensiva para idear un plan de seguridad ante la crisis y un plan de alta para regresar a la comunidad.
- Recursos de Salud Comunitaria (CHR, por sus siglas en inglés) está renovando sus instalaciones para abrir también un Centro de Crisis Subaguda en un futuro cercano.
- **P**: ¿Están observando alguna disminución en la cantidad de jóvenes que son vistos en instalaciones de atención ambulatoria u hospitalización como el Instituto para la Vida (IOL, por sus siglas en inglés) o Solnit? **R**: Existe una dificultad con los datos que se reciben en función de quién los gestione, pero todos los socios están trabajando para compartirlos de forma más eficaz.

  Proceso interno para la parte de protección de menores del DCF. En el pasado, las familias con un riesgo de bajo a moderado identificadas mediante un reporte a la Línea de atención pasaban por un Sistema de respuesta diferencial para ser evaluadas y asignadas, cuando era posible, para recibir servicios de apoyo, en lugar de pasar inmediatamente a investigaciones. En adelante, cualquier familia con un niño menor de 5 años de edad en el grupo familiar pasa automáticamente a investigaciones. Este cambio en los procedimientos no afecta a las familias que no tienen un niño menor de 5 años de edad. Se tomó esa decisión porque reconocemos que los niños menores de cinco años realmente tenían algunos factores de riesgo únicos que el DCF quiere asegurarse de tomar el tiempo para investigar.
- **P**: ¿Sabe si este cambio en la política para niños menores de cinco años se ha realizado por algunos de los casos que han salido en las noticias en los últimos seis o nueve meses? **R**: No estoy segura de los datos específicos, pero imagino que probablemente sí influyó en la decisión de revisar las políticas internas.
- **P**: Si la derivación llega por la Línea de atención para un chico mayor de cinco años, ¿qué vía seguirá? **R**: No estoy segura, pero preguntaré al Servicio de Protección Infantil y traeré la información al CBHAC.
  Seguimiento de parte del DCF: 1. Hubo una pregunta relacionada con el hecho de si las familias con niños menores de 5 años aún serían derivadas para investigaciones incluso si la llamada a la Línea de atención no estaba relacionada con el niño menor de 5 años de edad. La respuesta es «sí», este cambio en la práctica de que las familias sean investigadas en lugar de realizar una Derivación a Asistencia Familiar (FAR, por sus siglas en inglés) es para cualquier familia con un niño menor de 5 años de edad.
  2. Se habló del impacto que este cambio en la práctica/política de FAR/Investigaciones tendría sobre las derivaciones a Community Support for Families (Apoyo Comunitario a las Familias). En vista de los comentarios de los proveedores, se están introduciendo cambios en el contrato para permitir las derivaciones a los programas de Apoyo Comunitario a las Familias que antes hubiesen sido elegibles.

6. Oficina de la Primera Infancia (OEC, por sus siglas en inglés) - Lorna Thomas-Farquharson (no presentó informe)

- Seminario web del mes pasado en colaboración con el Departamento de Educación: «Un camino hacia adelante, creando un clima que promueva el éxito para todos». Orador principal: Discurso inaugural de Donzaleigh Abernathy, actriz, escritora y activista de los derechos civiles https://www.ctoec.org/behavioral-health-initiative-draft/behavioral-health-initiative-webinars/
- Su propósito destacaba una de las prioridades del CBHAC en relación con las desigualdades y el acceso a una atención culturalmente apropiada.
- El seminario web se centró en cómo crear un entorno de aprendizaje que ayude a niños y adultos a alcanzar su máximo potencial.
- El próximo seminario web será No hay lugar como el hogar: Apoyo a las familias que sufren inseguridad habitacional y el impacto de la misma en los niños pequeños, el 10/31/24,
- Se centrará en la realidad de la inseguridad habitacional y falta de vivienda de toda la nación, pero particularmente de CT.
- **P**: ¿Hay servicios de interpretación disponibles para los seminarios web? **R**: Sí. Además, la OEC publica seminarios web en su canal de YouTube y tienen subtítulos en varios idiomas.

Presentación mensual - Ninguna

Anuncios a la comunidad

- El Grupo de Consumidores Jóvenes y Familias agradeció a todos aquellos que ayudaron y participaron en el evento iCAN (yo puedo).
- Amplify (Amplificar) organizará un evento de Mind Map CT (Mapa mental CT) el 23 de octubre de 1.30 a 2.30 p. m. y compartió un folleto con información sobre la inscripción. El evento se centrará en el Primer episodio de psicosis (FEP, por su siglas en inglés).
- Family Forward Advocacy CT (Defensoría Familiar de CT) celebrará su primer almuerzo de recaudación de fondos el 11/7/24 en The Pond House. Doriana Vicedomini será galardonada por su destacada labor de defensoría y un padre defensor recibirá ese premio en honor a ella. Los dos hijos de ella asistirán. Para obtener información y adquirir los boletos visite https://www.zeffy.com/en-US/ticketing/062dffd6-cfc2-4c3b-bd44-46cc7f6c00e9
- La Biblioteca Pública de Hartford tiene programas para la comunidad tales como Inglés como segundo idioma (ESL, por sus sigla en inglés) y Ciudadanía, que se llevan a cabo los sábados de 9:30 a 2:30 p. m.

Reunión de miembros con derecho a voto

- Aprobación de las minutas de septiembre
- Las recomendaciones y el informe anual están casi terminados y se compartirán con el comisionado del DCF y los miembros con derecho a voto a finales de octubre.
- Revisión del plan de coordinación con otros grupos y próxima reunión el 10/7/24 con el Consejo Asesor Estatal (SAC) y la Junta Asesora de Implementación del Plan de Salud Conductual Infantil.

La próxima reunión será el 1.° de noviembre de 2024.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, November 01, 2024

Attendance:

Adrianna Ramirez, Alexandrino Rivera, Alice Farrell, Amy Hilario, Amy Lupoli, Andre Gibbs, April Mayo, Ari Steinberg, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Manzari, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Chastity Leak, Cheryl Kohler, Christina Main, Christian Rodriguez, Connie, Connie M Estanislau, Consuelo Spanish Interpreter, Crystal Williams, Cynthia Cruz, Daniela Giordano, Deb Kelleher, Denise Wyrick, Donyale Pina, Dr. Marie Spivey, Dreau Foster, Drew Lavallee, Elsa, Emily Farina, emuna Patterson, Erica Aldieri, Falinda King, Gabrielle Hall, George McDonald, Gina Bisogno, Heidi Pugliese, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Jules Calabro, Julie Nesteruk, Kate Bohannan, Kathy H. Nguyen, K Santagata, Kayla Pantoja, Keisha Martin-Velez, Kelly Waterhouse, Kristin Graham, Kristin H., Kymani Scarlett, K David, Latasha Thomas, Lindsay Jamieson, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Liz Sitler, Lois Berkowitz, Lori Stanczyc, Lorna Thomas-Farquharson, Lyne Landry, Maguena Deslandes, Mai Kader, Manisha Srivastava, Marelin Recinos, Mariel Conception, Maylin R., Mary Hryniewicz, Maureen O'Neil-Davis, Melanie Wilde-Lane, Meredith Turkey, Michelle Rodriguez, Mikhela Hull, Neiima Edwards, Pam Williams, Patricia Gaylord, Paul Guerrero, Paulette Phillips, Penny Lemery, Quiana Mayo, Renee Wright, R Caro, Ronnie Vollano, Rosie Breindel, Rossie, Sebastian Spencer, Shannon Quinones, Solai Demorest, Stacey Kabasakalian, Stephanie Bozak, Stephanie Joanis, Tania Santana, Tara Zimmerman, Tarsha, Taylor DeGraffenried, Theresa, T'Kai Howard, Tom Cosker, V.Thaxter, Yvette Young, Zach Nailon, Zosh Flammia, and seven phone numbers

Welcome and Introductions

- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (September 2024)

- Review and approval of September meeting minutes
- Additional planning related to meeting with DCF Statewide Advisory Council (SAC) and Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB)
- Final review of recommendations in annual report

Agency Updates

1. Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco

- DMHAS Commissioner traveled to Bridges on 10/23/24 for the Access Center Open House
- There are four of these drop-in access centers for young adults ages 18-25 who may be experiencing mental health, substance use issues, at risk for homelessness or unstable housing so they can get connected to resources and supports in the community
- Locations in Milford, New London, Norwalk and New Haven
- They can also get access to life skills development and support recreation and social activities
- **Q**: How are young adults being connected to the resources in their community? **A**: Assertive outreach and engagement via trainings and community wide events. Local hospitals may connect youth to the drop-in centers especially if treatment is recommended after the hospital stay
- **Q**: Is there a current plan to expand options for other sites across the state? **A**: Not at this time

2. Department of Education (DOE)– Kate Bohannan

- The State Department of Education Webinar Series: Held first webinar on 10/10/24 on Supporting Child and Family Wellness with Dr. Robert Petter a Developmental Pediatrician from Connecticut Children's Hospital and there were 73 participants
- The second event held on 10/24/24 was regarding Preparing Family for Cold and Flu Season with Dr. Vermont from Yale and there were 33 participants
- Our final event for this series is 11/7/24 and it's called Protecting our Youth, a community approach to suicide prevention and Dr. Stephanie Bozak from DCF is one of the presenters along with two colleagues from DMHAS; So far 144 participants are registered
- Last month there were questions regarding translation and due to the type of Zoom Webinar it is there is the option to translate the closed captions into dozens of different languages there everyone is encouraged to attend
- The webinars will be translated to CSDE website into the five languages most represented in CT which are Spanish, Portuguese, Haitian Creole, and two others that were put in the chat

3. Court Support Services Division (CSSD) –Carmen Hernandez

- Information was submitted to be shared at CBHAC regarding Juvenile Residential Services provided while justice involved youth are involved in care
- More information to be shared in March
- **Q**: What is CSSDs plan to replace the Local Interagency Service Teams (LISTs) or what is going to be the new protocol for kids that are in the juvenile justice if we don't have the LIST? **A**: CSSD prioritized maintaining funding for direct services. LISTs were not a direct service and families are encouraged to talk about those issues they are impacted by at any local meeting such as Regional Advisory Councils and Community Collaboratives and/or Racial Ethnic Disparities (RED) groups
- Discussion regarding the need for parent involvement and engagement at the meetings mentioned above. Specifically at the community collaborative level as there is a need for 51% family member participation and many communities are struggling to reach that percentage. Lots of ideas were discussed about how to sustain including, times of meetings, transportation, stipends, etc.

4. Department of Social Services (DSS) – Connie Estanislau (no report)

- **Request was made for DSS to bring back information regarding the funding for IICAPS**

5. Department of Children and Families (DCF)– Stephanie Bozak

- Dr. Stephanie Bozak will be presenting at the 11/7/24 State Department of Education webinar series on suicide prevention and resources that are available in the state for children
- Last month, changes to DCF investigation for zero to five population were discussed and clarification was requested
- Clarification is as follows: It is for any family that has a child under the age of five, even if that call to Careline was not related to that child because the home has a child under the age of five, there is a new process now that that that case will go into investigations versus the Family Assessment Response (FAR) track
- The reasoning for this is that the involvement potentially impacts the contracts that DCF has with the Community Support for Families (CSF) providers, because referrals for this are received from those who are going through the FAR track
- They have changed the contract to make sure that they are still able to receive referrals, even if it's through investigation so if they had previously qualified for the CSF program, they will still now be able to receive those services.
- "There's a few pending things that DCF is working on, and I'm hopeful that I'll have more information for folks next month. As mentioned earlier, there's been a lot of work with the various statewide bodies."

- **Q**: Doesn't this new process have the potential to escalate substantiations? **A**: This process will be regularly assessed as there could be a potential. What DCF is trying to do is to collect data and see the long-term impact and adjust and revise policy
- The reason for the change to this policy and procedure however is that we recognize that children who are between 0-5 years old have a unique vulnerability that we want to make sure that we are investigating and ensuring proper supports for families
- **Q**: Will DCF be implementing parent surveys for those going from investigation to FAR? **A**: Will need to those who work on Child Protection Services and bring back feedback
- **Q**: Is DCF looking to enhance current in home programs such as Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) as there are huge wait lists? **A**: IICAPS is not a DCF contracted program as it is funded by Medicaid. However, what DCF has done is received funding through the American Rescue Plan Act (ARPA) to provide that funding to our providers to increase some of the staffing, recognizing that even though we didn't have contracts with IICAPS that we were seeing the same trends and wanted to ensure their sustainability
- **Q**: What does DCF do when a facility has been deemed neglectful due to an investigation and is still operating? **A**: If there is still suspected neglect anyone who has knowledge whether direct or indirect should contact the Careline. Then an investigation unit specific to facilities follows up and investigates the claims

6. Office of Early Childhood (OEC)- Lorna Thomas-Farquharson (no report)

- On Wednesday, 10/30/24 the Home Visiting Program held a Home Visitor Meeting at Connecticut Central State University
- The intent was to go over policies, challenges they are facing in the field, successes, wellnesses and networking, those that participated found it very useful
- OEC working on the third Annual Home Visiting Network Conference, which is scheduled for 12/06/2024, in Bristol, CT
- On 10/31/24 monthly webinar "There's no place like home, supporting families experiencing housing insecurity and its impact on young children"
- Very informative and many shared their experiences and on how homelessness impacted them
- **Q**: Will future conferences be held in key areas like Hartford, Waterbury etc as transportation to these events can be difficult? **A**: Webinars are virtual so anyone can attend from anywhere and for in person conferences OEC does tons of engagement all over the state
- **Q**: What is the definition of a home or being homeless? A: The definition of a home is a place where one lives permanently, especially as a member of a family or household, and so recognizing the permanent state, state and nature. Many people experience insecure housing when they live out of a car or couch surf so often times providers are not aware and individuals fall under the radar in terms of being helped
- **Q**: Can the OEC webinars allow for live questions and answers? **A**: OEC will look into this for future planning as the webinars are designed to be informative and engaging
- **Q**: How is OEC addressing family engagement if parents are not able to share their voice during a webinar? A: OEC has many opportunities where family voice is utilized such as Two Gen and parent ambassadors in the communities as well as a parent cabinet that informs OECs work

Monthly Presentation- Community Collaboratives by Drew Lavallee, Carelon Network of Care Manager
-See handouts

Community Announcements

- Discussion regarding the need for parent involvement and engagement at the meetings mentioned above. Specifically at the community collaborative level as there is a need for 51% family member participation and many communities are struggling to reach that percentage. Lots of ideas were discussed about how to sustain including, times of meetings, transportation, stipends, etc.
- Current community collaborative and RAC chairs expressed the strain put on provider chairs and the expectation is to do more with less and that is how it has been playing out for years. Suggestion to make more recommendations to fund the collaboratives again so that the type of engagement and sustainability is achievable
- CBHAC annual report was completed and submitted to DCF which includes the survey information from the collaboratives and there are various efforts across the state to look at how we can better integrate between CHBAC and Statewide Council of Community Collaboratives

Next meeting December 6th, 2024

Comité Asesor de Salud Conductual Infantil (CBHAC)
Acta - Viernes 1 de noviembre de 2024

Asistencia:

Adrianna Ramirez, Alexandrino Rivera, Alice Farrell, Amy Hilario, Amy Lupoli, Andre Gibbs, April Mayo, Ari Steinberg, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Manzari, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Chastity Leak, Cheryl Kohler, Christina Main, Christian Rodriguez, Connie, Connie M Estanislau, Consuelo Spanish Interpreter, Crystal Williams, Cynthia Cruz, Daniela Giordano, Deb Kelleher, Denise Wyrick, Donyale Pina, Dr. Marie Spivey, Dreau Foster, Drew Lavallee, Elsa, Emily Farina, emuna Patterson, Erica Aldieri, Falinda King, Gabrielle Hall, George McDonald, Gina Bisogno, Heidi Pugliese, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Jules Calabro, Julie Nesteruk, Kate Bohannan, Kathy H. Nguyen, K Santagata, Kayla Pantoja, Keisha Martin-Velez, Kelly Waterhouse, Kristin Graham, Kristin H., Kymani Scarlett, K David, Latasha Thomas, Lindsay Jamieson, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Liz Sitler, Lois Berkowitz, Lori Stanczyc, Lorna Thomas-Farquharson, Lyne Landry, Maguena Deslandes, Mai Kader, Manisha Srivastava, Marelin Recinos, Mariel Conception, Maylin R., Mary Hryniewicz, Maureen O'Neil-Davis, Melanie Wilde-Lane, Meredith Turkey, Michelle Rodriguez, Mikhela Hull, Neiima Edwards, Pam Williams, Patricia Gaylord, Paul Guerrero, Paulette Phillips, Penny Lemery, Quiana Mayo, Renee Wright, R Caro, Ronnie Vollano, Rosie Breindel, Rossie, Sebastian Spencer, Shannon Quinones, Solai Demorest, Stacey Kabasakalian, Stephanie Bozak, Stephanie Joanis, Tania Santana, Tara Zimmerman, Tarsha, Taylor DeGraffenried, Theresa, T'Kai Howard, Tom Cosker, V.Thaxter, Yvette Young, Zach Nailon, Zosh Flammia, and seven phone numbers

Bienvenida y presentaciones

- Se revisaron la misión, el propósito y las áreas prioritarias del Comité Asesor de Salud Conductual Infantil (CBHAC, por sus siglas en inglés).

Revisión de las áreas prioritarias de 2022-2025

1. Integración de la atención pediátrica primaria y de atención de la salud conductual
2. Desigualdades y acceso a una atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (septiembre de 2024)

- Revisión y aprobación de las minutas de la reunión de septiembre
- Planificación adicional relacionada con la reunión del presidente del CBHAC con el Consejo Asesor Estatal (SAC, por sus siglas en inglés) del Departamento de Niños y Familias (DCF, por sus siglas en inglés) y de la Junta Asesora de Implementación del Plan de Salud Conductual Infantil (CBHPIAB, por sus siglas en inglés).
- Revisión final de las recomendaciones del informe anual

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco**
   - El comisionado del DMHAS viajó a Bridges el 10/23/24 para el evento de puertas abiertas de Access Center.
   - Existen cuatro centros de acogida para jóvenes de 18 a 25 años con problemas de salud mental, consumo de drogas, riesgo de quedarse sin hogar o vivienda inestable, para que puedan ponerse en contacto con los recursos y ayudas de la comunidad.
   - Los centros se encuentran en Milford, New London, Norwalk y New Haven.
   - También pueden acceder al desarrollo de habilidades para la vida y a actividades recreativas y sociales de apoyo.

- **P**: ¿Cómo se conectan los adultos jóvenes con los recursos de la comunidad? **R**: Extensión y participación asertivas a través de cursos de capacitación y eventos en toda la comunidad. Los hospitales locales pueden poner en contacto a los jóvenes con los centros de acogida, especialmente si se recomienda un tratamiento tras la hospitalización.
- **P**: ¿Hay algún plan para ampliar las opciones a otros lugares del estado? **R**: En este momento no.

2. Departamento de Educación (DOE) - Kate Bohannan

- Serie de seminarios web del Departamento Estatal de Educación: Se llevó a cabo el primer seminario web el 10/10/24 sobre apoyo al bienestar del niño y la familia con el Dr. Robert Petter, pediatra del desarrollo de Connecticut Children's Hospital, al que asistieron 73 participantes.
- El segundo evento realizado el 10/24/24 se trató sobre la preparación de la familia para la temporada de gripe y resfriados con el Dr. Vermont de Yale, al que asistieron 33 participantes.
- Nuestro evento final de esta serie es el 11/7/24 y se llama "Proteger a nuestros jóvenes", un enfoque comunitario sobre la prevención del suicidio. La Dra. Stephanie Bozak del DCF es uno de los presentadores junto con dos colegas del DMHAS. Hasta ahora hay 144 participantes registrados.
- El mes pasado hubo preguntas sobre la traducción y, debido a la naturaleza de los seminarios web de Zoom, existe la posibilidad de traducir los subtítulos a docenas de idiomas diferentes, por lo que se anima a todo el mundo a asistir.
- Los seminarios web se traducirán en el sitio web del CSDE a los cinco idiomas más representados en CT, que son el español, el portugués, el criollo haitiano y otras dos que se incluirán en el chat.

3. División de Servicios de Apoyo al Tribunal (CSSD): Carmen Hernandez

- Se presentó información para compartir en el CBHAC sobre los Servicios Residenciales Juveniles que se prestan mientras los jóvenes implicados en la justicia están bajo tutela.
- Se compartirá más información en marzo.
- **P**: ¿Cuál es el plan del CSSD para sustituir a los Equipos Locales de Servicios Interinstitucionales (LIST, por sus siglas en inglés) o cuál va a ser el nuevo protocolo para los chicos que están en la justicia de menores si no tenemos el LIST? **R**: El CSSD priorizó mantener la financiación para los servicios directos. Los LIST no eran un servicio directo, por lo que se anima a las familias a que hablen de los temas que les afectan en cualquier reunión local, como los Consejos Consultivos Regionales y los grupos de Colaboración Comunitaria o Disparidades Étnicas y Raciales (RED, por sus siglas en inglés).
- Se analizó la necesidad de participación y compromiso de los padres en las reuniones mencionadas. Específicamente a nivel de colaboración comunitaria, ya que se necesita un 51 % de participación de los miembros de las familias y muchas comunidades tienen dificultades para alcanzar ese porcentaje. Se analizaron muchas ideas sobre cómo apoyar, que incluyen horas de las reuniones, transporte, estipendios, entre otras.

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau (no presentó informe)

- **Se pidió al DSS que informara sobre la financiación de los IICAPS.**

5. Departamento de Niños y Familias (DCF) – Stephanie Bozak

- La Dra. Stephanie Bozak hará una presentación en la serie de seminarios web del Departamento de Educación del Estado sobre la prevención del suicidio y los recursos disponibles en el estado para los niños el 11/7/24.
- El mes pasado, se analizaron y aclararon los cambios a la investigación del DCF para la población de uno a cinco años.

- La aclaración es la siguiente: Para cualquier familia que tenga un niño menor de cinco años, incluso si la llamada a la línea Careline no estaba relacionada con ese niño porque el hogar tiene un niño menor de cinco años, hay un nuevo proceso ahora que ese caso pasará a las investigaciones frente a la vía de Respuesta de evaluación de la familia (FAR, por sus siglas en inglés).
- La razón de esto es que la participación afecta potencialmente los contratos que el DCF tiene con los proveedores de Apoyo Comunitario a las Familias (CSF, por sus siglas en inglés), porque las derivaciones para esto se reciben de los que utilizan la vía FAR.
- Han modificado el contrato para asegurarse de que puedan seguir recibiendo derivaciones, aunque sea a través de una investigación, de modo que si antes podían acogerse al programa CSF, ahora podrán seguir recibiendo esos servicios.
- "El DCF está trabajando en algunas cosas, y espero tener más información para los interesados el próximo mes. Como se mencionó antes, se ha trabajado mucho con diversos organismos estatales."
- **P**: ¿Este nuevo proceso no tiene el potencial de aumentar las corroboraciones? **R**: Este proceso se evaluará periódicamente porque podría existir la posibilidad. Lo que el DCF está intentando hacer es recopilar datos y ver el impacto a largo plazo de forma de ajustar y revisar la política.
- Sin embargo, la razón del cambio de esta política y procedimiento es que reconocemos que los niños de entre 0 y 5 años tienen una vulnerabilidad única que queremos asegurarnos de investigar y garantizar el apoyo adecuado a las familias.
- **P**: ¿Implementará el DCF encuestas para padres para aquellos que pasan de investigación a FAR? **R**: Habrá que consultar a los que trabajan en los servicios de protección de la infancia y hacerles llegar sus comentarios.
- **P**: ¿Busca el DCF mejorar los actuales programas a domicilio, como los Servicios Psiquiátricos Intensivos a Domicilio para Niños y Adolescentes (IICAPS, por sus siglas en inglés), ya que hay enormes listas de espera? **R**: Los IICAPS no son un programa con contrato con el DCF ya que los financia Medicaid. Sin embargo, lo que el DCF ha hecho es recibir financiación a través de la Ley del Plan de Rescate Estadounidense (ARPA, por sus siglas en inglés) para proporcionar esa financiación a nuestros proveedores para aumentar parte del personal, reconociendo que a pesar de que no teníamos contratos con los IICAPS estábamos viendo las mismas tendencias y queríamos asegurar su sostenibilidad.
- **P**: ¿Qué hace el DCF cuando un centro ha sido considerado negligente a raíz de una investigación y sigue funcionando? **R**: Si sigue habiendo sospechas de negligencia, cualquier persona que tenga conocimiento de ello, ya sea directo o indirecto, debe ponerse en contacto con la línea Careline. A continuación, una unidad de investigación específica de los centros hace un seguimiento e investiga las denuncias.

6. Oficina de la Primera Infancia (OEC, por sus siglas en inglés) - Lorna Thomas-Farquharson (no presentó informe)

- El miércoles 10/30/24, el Programa de visitas a domicilio realizó una reunión de visitantes domiciliarios en Connecticut Central State University.
- La intención era repasar las políticas, los retos a los que se enfrentan en el campo, los éxitos, el bienestar y la creación de redes.
- La OEC está trabajando en la tercera Conferencia Anual de la Red de Visitas a Domicilio, prevista para el 12/06/2024, en Bristol, CT.
- El 10/31/24 se realizó el seminario web mensual "No hay lugar como el hogar, apoyo a las familias que sufren inseguridad en la vivienda y su impacto en los niños pequeños".

- Aportó mucha información y muchos compartieron sus experiencias y cómo la falta de vivienda los afectó.
- **P**: ¿Se celebrarán futuras conferencias en zonas clave como Hartford, Waterbury, etc., ya que el transporte a estos eventos puede resultar difícil? **R**: Los seminarios web son virtuales, por lo que cualquiera puede asistir desde cualquier parte y, en el caso de las conferencias presenciales, la OEC realiza un gran número de actividades en todo el estado.
- **P**: ¿Cuál es la definición de "hogar" o de "no tener hogar"? R: La definición de hogar es un lugar donde se vive de forma permanente, en especial como miembro de una familia o de un grupo familiar, por lo que reconoce el estado permanente, el estado y la naturaleza. Muchas personas sufren inseguridad en la vivienda cuando viven en el automóvil o duermen en casas de conocidos, por lo que a menudo los proveedores no son conscientes de ello y las personas pasan desapercibidas a la hora de recibir ayuda.
- **P**: ¿Pueden los seminarios web de la OEC permitir preguntas y respuestas en vivo? **R**: La OEC estudiará esta cuestión para la planificación futura, ya que los seminarios web están diseñados para ser informativos y participativos.
- **P**: ¿Cómo aborda la OEC la participación familiar si los padres no pueden hacer oír su voz durante un seminario web? R: La OEC tiene muchas oportunidades para escuchar la voz de las familias, como los embajadores de Two Gen y de los padres en las comunidades, así como un gabinete de padres que informa el trabajo de la OEC.

Presentación mensual - Colaboraciones comunitarias a cargo de Drew Lavallee, gerente de Carelon Network of Care
-Consultar los folletos.

Anuncios a la comunidad

- Se analizó la necesidad de participación y compromiso de los padres en las reuniones mencionadas. Específicamente a nivel de colaboración comunitaria, ya que se necesita un 51 % de participación de los miembros de las familias y muchas comunidades tienen dificultades para alcanzar ese porcentaje. Se analizaron muchas ideas sobre cómo apoyar, que incluyen horas de las reuniones, transporte, estipendios, entre otras.
- Los actuales presidentes de los comités de colaboración comunitaria y de los consejos consultivos regionales expresaron la presión a la que están sometidos los presidentes de los proveedores y la expectativa de hacer más con menos, que es lo que se lleva haciendo desde hace años. Se sugirió hacer más recomendaciones para financiar de nuevo las colaboraciones de modo que el tipo de compromiso y sostenibilidad sea alcanzable.
- El informe anual del CBHAC se completó y se presentó a DCF que incluye la información de la encuesta de los colaboradores y hay varios esfuerzos en todo el estado para ver cómo podemos integrar mejor entre CHBAC y el Consejo Estatal de Representantes de la Comunidad.

La próximo reunión se realizará el 26 de diciembre de 2024.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, December 6, 2024

Attendance:

A. Steinberg, Aimee Gelinas, Alexandrino Rivera, Amy Grenier, Amy Hilario, Andrea Richardson, April Mayo, BangaloreS, Brenetta Henry, Briannali Rivera, Cara Klaneski, Carmen Almodovar, Chastity Leak, Christian Rodriguez, Connie M Estanislau, Consuelo V - Spanish Interpreter, Cynthia Cruz, Derrick Shelton, Diana Perry, donald vail, Dorothy Cimmino, Dreau Foster, Drew Lavallee, Ellender Mathis, Elsa Cordova, Emily Farina, Emuna Patterson, Erica Aldieri, Gab Hall, Gina Bisogno, Ginny Gerena, Gloria, Graciela, Janessa Stawitz, Janissa Vidal, Jennifer Abbatemarco, Jenny Bridges, Jess Greenwood, John Cotten, Joyce Meyerholz, jsimilien, Karen Delane, Kate Bohannan, Kathy Nguyen, Kayla Pantoja, Keisha Martin Velez, Keishla Sanchez, Kelly Waterhouse, Kristin, Kristin, Kristin Graham, Kymani Scarlett, Lindsay Kyle, Lisa Palazzo, Liz Sitler, Lois Berkowitz, Lorna Thomas-Farquharson, Maguena Deslandes, Manisha Srivastava, Maria Brereton, Mariel Concepción, Martin Geertsma, Maureen ONeill Davis, Melissa Gillies, Michelle Queen, Michelle Rodriguez, Mikhela Hull, Mai Kader, Benita Toussaint, Neiima Edwards, Neva Caldwell, Olivia Newman, Patrick McCormack, Paul Guerrero, Penny Lemery, Pinkneys, Quiana Mayo, rcaro, Renee Wright, Ronnie Vollano, Rosa V Alvis Alvarado, Rossie, Sabra Mayo, Sadaf, Sandra Rivera, Sandra Williams, Sarah Gibson, Sebastian Spencer, Sergio Alvarez, Shi-maine Holmes, Shirley Ellis-West, Solai Demorest, Stephanie Joanis, Steve, Tania Santana, Tara Wilczynski, Tarsha Calloway, Teresa, T'Kai Howard, Tyrone & Christy Calloway, UCA Managers, V Thaxter, Xavier Williams, Zach Nailon, and four phone numbers

Welcome and Introductions

- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (November 2024)

- Review and approval of October meeting minutes
- Discussion regarding joint meeting with Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB)

Agency Updates

1. **Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco**
   - No update
2. **Department of Education (DOE)– Kate Bohannan**
   - Three-part webinar series concluded with an average of 120 registered between all session
   - The three sessions were promoting social/emotional wellness, preparing for cold and flu season, and a community approach to suicide prevention
   - Translation of the webinar videos should be completed shortly and will be available on the CSDE website
   - The State Department of Education has officially joined the Supervisory group for the Connect IV grant and the goal of the grant is to connect schools to mental health supports and services
   - **Q**: Is SDE being proactive about planning based on the new federal administration threats to cut services for students in 2025? **A**: It is early to tell but as of now there is no plan to diminish any state funding. SDE is prepared to respond.

- **Q:** What are the goals of the CONNECT grant and what are the goals? **A:** CONNECT team has presented at CBHAC before but they will be asked to come and update on the goals
- **Q:** Is SDE prepping for the new administration's threats to American students and their immigrant families? **A:** Both the Director of Equity and Languages as well as our School Climate Consultant have been having conversations with districts and superintendents and leadership across the state about this matter

3. **Court Support Services Division (CSSD) –Carmen Hernandez**
   - No update
4. **Department of Social Services (DSS) – Connie Estanislau**
   - No update
5. **Department of Children and Families (DCF)– Stephanie Bozak**
   - No update

6. **Office of Early Childhood (OEC)- Lorna Thomas-Farquharson**
   - OECs Home visiting department, 3rd Annual conference 12/6/24 and will focus on Connection and Collaboration
   - At the conclusion of the conference, the annual home visitor distinguished award will be given out to six regions within CT, the winners chosen by the Parent Cabinet members from OEC
   - January Webinar is currently being planned
   - OEC shared various family engagement efforts they have: Parent's Cabinet, Two Gen and Parent Ambassadors to help inform their work

Monthly Presentation- Racial Justice Initiative by Maguena Deslandes & Stephen Rodriguez, Urban Community Alliance (UCA)
-see handout

Community Announcements

- A request was made to review voting membership so that CBHAC participants know who is representing the family voice
- CBHAC governance will plan to add to a future meeting agenda

Next meeting January 3rd, 2024 (WILL BE VIRTUAL OR IN-PERSON-both options available) at Carelon- 500 Enterprise Dr, Hartford Room- 3rd floor, Rocky Hill, CT 06067

Children's Behavioral Health Advisory Committee (CBHAC) and Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB) Joint Meeting
Minutes – Friday, January 3rd, 2025

Attendance:
A Green, Adrianna Ramirez, Alex Sargent, Alexandrino Rivera, Alice Forrester, Amy Hilario, Amy Lupoli, Amy Marracino, Andre Gibbs, April Mayo, Ari Steinberg, Ashley Adams, BangaloreS, Benita Toussaint, Brenetta Henry, Briana Miller, Briannali Rivera, Brittany Jackson, Carmen Almodovar, Carolyn Westerholm, Christian Rodriguez, Christie Calloway, Christina Main, Connie M Estanislau, Crystal Williams, Crystal Wyler, Derrick Shelton, Diana Perry, Donyale Pina, Dorothy Cimmino, Dreau Foster, Drew Lavallee, Elsa, emuna Patterson, Erica Aldieri, Fatmata Williams, Gabrielle Hall, Gerard O'Sullivan, Gina Bisogno, Grace Grinnell, Heidi Pugliese, Isaez, Jamie LoCurto, Janissa Vidal, Jean Rienzo, Jeana Bracey, Jennifer Abbatemarco, Jenny Bridges, Jesuca Maurice, Jo Hawke, Joe Drane, John Frassinelli, jsimilien, Jules Calabro, Karen Delane, Kathy H. Nguyen, Kayla Pantoja, Kdavid, Kelli Price, Kristin Graham, Kymani Scarlett, Latasha Capellan, Linda Bolton, Lindsey Brennan, Lisa Girard, Lisa Palazzo, Lori Stanczyc, Lyne Landry, Mai Kader, Manisha Srivastava, Mariel Conception, Marylou Woynar, Maureen O'Neil-Davis, Maylin R., Meredith Turkey, Mr. Calloway, Ms. Neva Caldwell, Neiima Edwards, Nicole Taylor, Nohemi Valdivia, Patricia Gaylord, Paul Guerrero, Penny Lemery, Pinkneys, Princess, rcaro, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sandi Carbonari, Sandra Rivera, Sebastian Spencer, Solai Demorest, Steve Rodriguez, Tammy Venenga, Tania Santana, Tanya Barret, Tara Zimmerman, Tarsha, Taylor DeGraffenried, Teresa,
Teri Altomaro, Theresa Andriulli, Tom Cosker, V.Thaxter, Yvette Young, Zani Imetovski, Zosh Flammia, and seven phone numbers

Welcome and Introductions
- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas
1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (December 2024)
- Review of meeting minute's process and translation. Goal is to look for efficiencies to get minutes out to attendees in a timely manner
- Discussion of priority areas and possible shift to voting in early part of calendar year vs. December
- General discussion about cross communication given voting members attend and participate in other meetings/boards

Agency Updates

1. **Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco & Amy Garcia**
   - January is Human Trafficking Awareness Month, and they continue to partner closely with the Department of Children and Families
   - Next month will report out on kind of activities planned
   - **Q**: Does DMHAS utilize the Urgent Crisis Centers for any young adult that may need that level of care? **A**: DMHAC Urgent Crisis center in New Haven recently opened up and it has been a great resource for individuals to be screened and seen that very day and admitted for services. Some services include: respite crisis evaluation and assessment, medication management, connection with other services to really help individuals to navigate through a crisis and avoid them having to go to an emergency department

- **Q**: Will there be more DMHAS Urgent Crisis centers opening up in the state? **A**: Yes that is a possibility they have to see the pilots' outcomes
- **Q:** How has that report put out by the US Marshals (18 mos ago) influenced how Connecticut has shifted in addressing the issues of human trafficking? **A**: Both DMHAS and DCF have cross agency collaboration on this issue as they are very aware of the vulnerability of victims of trafficking

2. **Department of Education (DOE)– John Frassinelli & Kate Bohannan**
   - Connecticut State Department of Education received $28,000,00 from the American Rescue Plan Act (ARPA).
   - The funds were used to provide support to districts in order to hire and retain school social workers, counselors, psychologists, trauma specialists, etc.
   - All of those funds have been obligated and there are about 100 mostly social workers, but other staff as well, in districts across the state and there are also 85 recipients for summer mental health program
   - Many of those are hired folks for the summer, or continued school staff for the summer, or are contracting with outside providers for behavioral health support so that funding is in place for the next two school years
   - **Q**: What is the State Department of Education's Plan after the ARPA funds run out in two years? **A**: A couple of things for a number of programs are being thought out however they are conducting an analysis of the effectiveness of the hiring of additional staff for districts, this will include reports from all of the recipients of the program to help support the recommendation to continue the funding through legislative advocacy
3. **Court Support Services Division (CSSD) –Alex Sargent for Carmen Hernandez**
   - Brief overview was given: CSSD work with community based programs and services, and serve youth that are involved in the juvenile probation. If any youth has an active case with juvenile probation, they provide programs for them
   - These programs are state funded
   - There are currently no active or new bids out
4. **Department of Social Services (DSS) – Connie Estanislau**
   - No update
   - **Q**: News report referenced: What is going to happen with the families that applied for Husky and due to a system error those applications were not fulfilled and families were told that children would not be receiving services? **A**: Can't speak to media reports however families are encouraged to contact DSS to speak about any specific issues they may have- 855-626-6632 or online
   - Information regarding the The Qualified Medicare Savings Program can also be found online but specifics were shared with participants
5. **Department of Children and Families (DCF)– Stephanie Bozak**
   - Similar to the State Department of Education, DCF, also received ARPA funding and it has been obligated and sent to all of the behavioral health programs contracted with to help stabilize the workforce and the funding will also be available for the next two years
   - DCF in collaboration with DMHAS and CSDE are going to have the Garrett Lee Smith Grant kickoff towards the end of this month 1/30/25
   - The collaboration will take place with five school districts who expressed interested in participating in suicide prevention efforts
   - DCF also received a TTI Award, which is a transformation technology transfer initiative
   - That funding will go towards suicide prevention, specifically for the LGBTQ population
   - **Q**: What are the five school districts? **A**: Southington, Darien, Wallingford, New Milford and Thompson
   - **Q**: How will this impact what the CONNECT grant is doing? **A**: There is communication with CHDI project staff regarding efforts so that those districts receive the appropriate level of needed support
6. **Office of Early Childhood (OEC)- Lorna Thomas-Farquharson**

- No update

Monthly Presentation- Children's Behavioral Health Implementation Plan Advisory Board (CBHIPAB) Annual Report and Recommendations presented by Tri-Chairs Dr. Elisabeth Cannata, Ann Smith and Carl Schiessl (see handout)

- **Q**: Is Transforming Childrens' Behavioral Health Committee (TCB) actively doing the fiscal mapping? Are they searching for someone to do this, or is it already happening? What's going on with the fiscal mapping? **A:** The TCB is focusing right now on a series of recommendations for this legislative session such as raising the Medicaid rates but realize that the fiscal mapping is needed
- A recommendation was made to also speak with the Behavioral Health Partnership Oversight Council on similar priorities and recommendations

Community Announcements

- None

Next meeting February 7th, 2025 via Zoom

Reunión conjunta del Comité Asesor en Salud Conductual Infantil (CBHAC) y la Junta Asesora para la Implementación del Plan de Salud Conductual Infantil (CBHPIAB)
Acta - viernes 3 de enero de 2025

Asistencia:
A Green, Adrianna Ramirez, Alex Sargent, Alexandrino Rivera, Alice Forrester, Amy Hilario, Amy Lupoli, Amy Marracino, Andre Gibbs, April Mayo, Ari Steinberg, Ashley Adams, BangaloreS, Benita Toussaint, Brenetta Henry, Briana Miller, Briannali Rivera, Brittany Jackson, Carmen Almodovar, Carolyn Westerholm, Christian Rodriguez, Christie Calloway, Christina Main, Connie M Estanislau, Crystal Williams, Crystal Wyler, Derrick Shelton, Diana Perry, Donyale Pina, Dorothy Cimmino, Dreau Foster, Drew Lavallee, Elsa, emuna Patterson, Erica Aldieri, Fatmata Williams, Gabrielle Hall, Gerard O'Sullivan, Gina Bisogno, Grace Grinnell, Heidi Pugliese, Isaez, Jamie LoCurto, Janissa Vidal, Jean Rienzo, Jeana Bracey, Jennifer Abbatemarco, Jenny Bridges, Jesuca Maurice, Jo Hawke, Joe Drane, John Frassinelli, jsimilien, Jules Calabro, Karen Delane, Kathy H. Nguyen, Kayla Pantoja, Kdavid, Kelli Price, Kristin Graham, Kymani Scarlett, Latasha Capellan, Linda Bolton, Lindsey Brennan, Lisa Girard, Lisa Palazzo, Lori Stanczyc, Lyne Landry, Mai Kader, Manisha Srivastava, Mariel Conception, Marylou Woynar, Maureen O'Neil-Davis, Maylin R., Meredith Turkey, Mr. Calloway, Ms. Neva Caldwell, Neiima Edwards, Nicole Taylor, Nohemi Valdivia, Patricia Gaylord, Paul Guerrero, Penny Lemery, Pinkneys, Princess, rcaro, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sandi Carbonari, Sandra Rivera, Sebastian Spencer, Solai Demorest, Steve Rodriguez, Tammy Venenga, Tania Santana, Tanya Barret, Tara Zimmerman, Tarsha, Taylor DeGraffenried, Teresa,
Teri Altomaro, Theresa Andriulli, Tom Cosker, V.Thaxter, Yvette Young, Zani Imetovski, Zosh Flammia, and seven phone numbers

Bienvenida y presentaciones
- Se revisaron la misión, el propósito y las áreas prioritarias del Comité Asesor en Salud Conductual Infantil (CBHAC, por sus siglas en inglés).

Revisión de las áreas prioritarias de 2022-2025
1. Integración de la atención pediátrica primaria y de la atención de la salud conductual
2. Desigualdades y acceso a una atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité Asesor en Salud Conductual Infantil (CBHAC) (diciembre de 2024)
- Revisión del proceso y traducción del acta de la reunión. El objetivo es buscar formas eficientes de hacer llegar las actas a los asistentes a tiempo.
- Debate sobre las áreas prioritarias y posible cambio a la votación a principios de año frente a diciembre.
- Debate general sobre la comunicación cruzada, dado que los miembros con derecho a voto asisten y participan en otras reuniones/consejos.

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco y Amy Garcia**
   - Enero es el Mes de Concientización sobre la Trata de Personas, y siguen colaborando estrechamente con el Departamento de Niños y Familias.
   - El próximo mes se informará sobre el tipo de actividades previstas.
   - **P**: ¿Utiliza el DMHAS los Centros de Crisis Urgentes para cualquier adulto joven que pueda necesitar ese nivel de atención? **R**: El Centro de Crisis Urgente de DMHAC en New Haven abrió recientemente y ha sido un gran recurso para examinar y atender a las personas ese mismo día y admitirlas para recibir servicios. Algunos de los servicios son: evaluación y valoración de la crisis,

gestión de la medicación, conexión con otros servicios para ayudar a las personas a superar la crisis y evitar que tengan que acudir a un departamento de emergencias.
- **P**: ¿Se abrirán más Centros de crisis urgentes del DMHAS en el estado? **R**: Sí, es una posibilidad, tienen que ver los resultados de los pilotos.
- **P:** ¿En qué medida influyó el informe publicado por los US Marshals (hace 18 meses) en el modo en que Connecticut ha abordado los problemas de la trata de personas? **R**: Tanto el DMHAS como el DCF colaboran entre sí en esta cuestión, ya que son muy conscientes de la vulnerabilidad de las víctimas de trata.

2. Departamento de Educación (DOE) - John Frassinelli y Kate Bohannan
- El Departamento de Educación del Estado de Connecticut recibió $28,000,00 de la Ley del Plan de Rescate Estadounidense (ARPA).
- Los fondos se utilizaron para ayudar a los distritos a contratar y retener a trabajadores sociales escolares, consejeros, psicólogos, especialistas en trauma, etc.
- Se han gastado todos esos fondos y hay unos 100 trabajadores, en su mayoría trabajadores sociales, pero también personal de otro tipo, en distritos de todo el estado, y también 85 beneficiarios del programa de salud mental de verano.
- Muchos de ellos son personas contratadas para el verano, o personal escolar que continúa durante el verano, o están contratando a proveedores externos para el apoyo de la salud conductual, de modo que la financiación está en marcha para los próximos dos años escolares.
- **P**: ¿Cuál es el plan del Departamento de Educación cuando se agoten los fondos ARPA dentro de dos años? **R**: Se están pensando un par de cosas para una serie de programas, sin embargo, están llevando a cabo un análisis de la eficacia de la contratación de personal adicional para los distritos, que incluirá informes de todos los beneficiarios del programa para ayudar a apoyar la recomendación de continuar la financiación a través de la defensa legislativa.

3. División de Servicios de Apoyo al Tribunal (CSSD): Alex Sargent en representación de Carmen Hernandez
- Se ofreció una breve descripción general: CSSD trabaja con programas y servicios de la comunidad, y presta servicios a jóvenes que se encuentran en libertad condicional juvenil. Si algún joven tiene un caso activo con libertad condicional juvenil, se ofrecen programas para ellos.
- Estos programas están financiados por el estado.
- Actualmente no hay ofertas activas o nuevas.

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau
- Sin actualizaciones
- **P**: Noticia de referencia: ¿Qué va a ocurrir con las familias que solicitaron Husky y que, debido a un error del sistema, no recibieron las solicitudes y se les comunicó que los niños no recibirían los servicios? **R**: No podemos hablar de los informes de los medios de comunicación, pero alentamos a las familias a que se pongan en contacto con el DSS para hablar de cualquier problema específico que puedan tener (855-626-6632 o en línea).
- También se puede encontrar información en línea sobre el Programa de Ahorro Medicare Calificado, pero se compartieron los detalles con los participantes.

5. Departamento de Niños y Familias (DCF) – Stephanie Bozak
- Al igual que el Departamento de Educación del Estado, el DCF también recibió fondos ARPA, que fueron asignados y enviados a todos los programas de salud conductual contratados para ayudar a estabilizar el personal, y los fondos también estarán disponibles durante los próximos dos años.
- El DCF en colaboración con DMHAS y CSDE van a lanzar la subvención Garrett Lee Smith a finales de este mes 1/30/25.
- La colaboración se llevará a cabo con cinco distritos escolares que manifestaron su interés en participar en los esfuerzos de prevención del suicidio.
- El DCF también recibió un Premio TTI, que es una iniciativa de transferencia de tecnología de transformación.
- Esa financiación se destinará a la prevención del suicidio, en concreto para la población LGBTQ.

- **P**: ¿Cuáles son los cinco distritos escolares? **R**: Southington, Darien, Wallingford, New Milford y Thompson
- **P**: ¿Cómo impactará esto en lo que se está haciendo con la subvención CONNECT? **R**: Existe comunicación con el personal del proyecto CHDI en relación con los esfuerzos para que esos distritos reciban el nivel adecuado de apoyo necesario.

6. Oficina de la Primera Infancia (OEC)- Lorna Thomas-Farquharson

- Sin actualizaciones

Presentación mensual: informe anual y recomendaciones de la Junta Asesora del Plan de Implementación de Salud Mental Infantil (CBHIPAB) presentados por los tres presidentes, la Dra. Elisabeth Cannata, Ann Smith y Carl Schiessl (ver folleto).

- **P**: ¿Está el Comité de Transformación de la Salud Conductual Infantil (TCB) realizando activamente la planificación fiscal? ¿Están buscando a alguien que lo haga o ya se está haciendo? ¿Qué está pasando con la planificación fiscal? **R:** El TCB se está centrando ahora mismo en una serie de recomendaciones para esta sesión legislativa, como el aumento de las tasas de Medicaid, pero es consciente de que se necesita una planificación fiscal.
- Se recomendó hablar también con el Consejo de Supervisión de la Asociación de Salud Mental sobre prioridades y recomendaciones similares.

Anuncios a la comunidad

- Ninguno

Próxima reunión: 7 de febrero de 2025, por Zoom.

Children's Behavioral Health Advisory Committee (CBHAC) Meeting
Minutes – Friday, February 7th, 2025

Attendance:
Adrianna Ramirez, AJ Smith, Aleece Kelly, Alexandrino Rivera, Alexis Mohammed, Amy Hilario, Amy Lupoli, April Mayo, Ari Steinberg, BangaloreS, Benita Toussaint, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Christian Rodriguez, Christina Main, Christine Montgomery, Connie, Consuelo Spanish Interpreter, Cynthia Cruz, Damaris (Dami) Cox, Daniela Giordano, David Schmardel, Derrick Shelton, Diana Perry, Donald Vail, Donyale Pina, Dr. Alice Farrell, Dr. Diaz, Dreau Foster, Drew Lavallee, Ellender Mathis, Elsa Cordova, Emuna Patterson, Erica Aldieri, Gabrielle Hall, Gina Bisogno, Jackie Cook, Jamie LoCurto, Janesse Stawitz, Janissa Vidal, Jennifer Abbatemarco, Jenny Bridges, Jess Greenwood, Jo Hawke, Joyce, J Santiago, J Similien, Jules Calabro, Karen, Karen Delane, Karen Hurdle, Kate Bohannan, Kathy H. Nguyen, Katrina Norton, Kayla Pantoja, K David, Keisha Martin-Velez, Keishla Sanchez, Kelly Waterhouse, Kristin, Kristin Graham, Kymani Scarlett, Latasha Capellan, Laurie Klanchar, Lindsay Kyle, Lisa Girard,Lisa Palazzo, Liz Sitler, Lois Berkowitz, Lori Stanczyc, Lorna Thomas- Farquharson, Lyne Landry, Lynne Ringer, M. Alex Geertsma, Mai Kader, Manisha Srivastava, Marelin Recinos, Maria Alexander, Maria Brereton, Mariel Conception, Mary Hryniewicz, Maureen O'Neil-Davis, Maylin R., Melissa Niver, Michelle Queen, M Mcdonough, Mr. Calloway, Myke Halpin, Neiima Edwards, Neva Caldwell, Olivia Newman, Patricia Gaylord, Paul Guerrero, Paulette Phillips, Penny Lemery, Quiana Mayo, Rangeloff, R Caro, Rebecca LaMarre, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sadaf, Sadie Witherspoon, Sandra Rivera, Sandra Williams, Sarah Gibson, Sarah Lockery, Sebastian Spencer, Shawn Thiele Sacks, Shi-maine Holmes, Solai Demorest, Stacey Kabasakalian, Stephanie Bozak, Stephney Springer, Steve Rodriguez, Tania Santana, Tarsha, Taylor DeGraffenried, Teresa, T'Kai Howard, Tonya, Tory Soucy, V.Thaxter, Xavier Williams, Yvette Young, and seven phone numbers.

Welcome and Introductions
- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas
1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (January 2024)
- No meeting
- January was joint meeting with Children's Behavioral Health Plan Implementation Advisory Board to discuss annual recommendations and opportunities for collaboration

Agency Updates

1. Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco
- DMHAS held their Young Adult Leadership Summit at the end of January which was hosted by Join Rise Be Program through Advocacy. Approximately 90 young adults and young adult allies participated. The summit provided them with opportunity to network, develop leadership skills and solidify interest in the Peer Support Specialist Certification Program
- The RFP for the Dialectical Behavior Therapy residential program for young adults between the ages of 18 and 25 has been granted to Continuum of Care in New Haven. It will offer an opportunity for five young people between the ages of 18 and 25 all genders, for DBT focused treatment: with a DBT trained clinician, prescriber, case management, access to peer support specialists, as well as a high individual to staff ratio within the home, and nursing services on site

- **Q**: Has the department looked into what will happen with individuals who are on psychotropic medication if they are deported? **A**: The question deferred to other state departments as they deal with adults over age of 18

2. State Department of Education (SDE)– Kate Bohannan

- SDE, in collaboration with the Governor's office, released guidance to districts regarding ICE and immigration. That document is available in multiple languages and the link to it was provided to the participants in the chat. School districts are doing their own trainings and internal conversations, looking at their policies and procedures for how to address ICE or any third party that attempts to enter school. Some are also providing training to teachers on how to discuss this with their students and to support the district's efforts in educating all of our students
- The virtual house call three part series has an info flyer that includes the links for people to be able to view them and that has also been translated into multiple languages
- In the Governor's budget for 2027 he is proposing to establish a grant program to increase the capacity of districts to provide special education services, either in district or regionally, with some partnering districts to reduce the number of outplacements and to keep students within their home districts

3. Court Support Services Division (CSSD) – Carmen Hernandez

- A new request for proposal (RFP) for a secure residential services will be going out for bid
- **Q**: Is this RFP for a male or female facility? **A**: Male secure treatment

4. Department of Social Services (DSS) – Connie Estanislau

- No update

5. Department of Children and Families (DCF)– Stephanie Bozak

- DCF also released an internal document to its staff reminding them about their policy. Policy states that "DCF shall actively serve all persons who come under its purview, regardless of immigration status"
- The DCF mandated reporter training has been updated and now includes a secondary video at the end of it, which provides information to viewers about the various resources that people can access help. It includes information for resources, including 988, FAVOR, Connecting to Care, Urgent Crisis Centers and the voluntary care management program
- In the process of updating their website, as well as creating a video called "We Are Connecticut", highlighting the resources that are available for people in the community.
- **Q**: How does the department handle investigations into schools when a parent makes a 136 report? **A**: There is a unit that works on calls against schools and more information can be provided as to what they use to determine if they will investigate
- **Q**: What updates have occurred in mandated reporter training that help address schools over reporting? **A**: There has been current legislation changed that allows people who are mandated to ask some additional questions and to not report if determined unnecessary

6. Office of Early Childhood (OEC)- Lorna Thomas-Farquharson

- The home visiting program, Mind Over Mood, provides mental health services in support of those in early childhood care, some more specifically, it addresses mental health and early childhood home visiting information was provided to the participants
- The most recent Behavioral Health webinar focused on providing supports for providers, the provider toolbox as it relates to behavioral health and importance for providers to promote self-awareness so that they are in a better place to care for others
- Next webinar will be on February 25th is focusing on the parent caregiver toolbox and providing resources and helpful dialog and conversation about parents and caregivers and their need to be mindful of how they're doing and their own mental health

Monthly Presentation- Statewide Advisory Council (SAC) annual report recommendations (see handout) & Mercer Focus Group

- A comment was made that the CRPs (Citizen Review Panels) should seek to collaborate more with community/consumers that have been informing the child protection work for the past 20 years
- A request was made for the SAC membership to be shared with CBHAC so that communities know who is representing them in that group

Community Announcements

- None

Next meeting March 7th, 2025 via Zoom

Reunión del Comité Asesor de Salud Conductual Infantil (CBHAC)
Minutas - viernes 7 de febrero de 2025

Asistencia:
Adrianna Ramirez, AJ Smith, Aleece Kelly, Alexandrino Rivera, Alexis Mohammed, Amy Hilario, Amy Lupoli, April Mayo, Ari Steinberg, BangaloreS, Benita Toussaint, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Christian Rodriguez, Christina Main, Christine Montgomery, Connie, Consuelo Spanish Interpreter, Cynthia Cruz, Damaris (Dami) Cox, Daniela Giordano, David Schmardel, Derrick Shelton, Diana Perry, Donald Vail, Donyale Pina, Dr. Alice Farrell, Dr. Diaz, Dreau Foster, Drew Lavallee, Ellender Mathis, Elsa Cordova, Emuna Patterson, Erica Aldieri, Gabrielle Hall, Gina Bisogno, Jackie Cook, Jamie LoCurto, Janesse Stawitz, Janissa Vidal, Jennifer Abbatemarco, Jenny Bridges, Jess Greenwood, Jo Hawke, Joyce, J Santiago, J Similien, Jules Calabro, Karen, Karen Delane, Karen Hurdle, Kate Bohannan, Kathy H. Nguyen, Katrina Norton, Kayla Pantoja, K David, Keisha Martin-Velez, Keishla Sanchez, Kelly Waterhouse, Kristin, Kristin Graham, Kymani Scarlett, Latasha Capellan, Laurie Klanchar, Lindsay Kyle, Lisa Girard,Lisa Palazzo, Liz Sitler, Lois Berkowitz, Lori Stanczyc, Lorna Thomas- Farquharson, Lyne Landry, Lynne Ringer, M. Alex Geertsma, Mai Kader, Manisha Srivastava, Marelin Recinos, Maria Alexander, Maria Brereton, Mariel Conception, Mary Hryniewicz, Maureen O'Neil-Davis, Maylin R., Melissa Niver, Michelle Queen, M Mcdonough, Mr. Calloway, Myke Halpin, Neiima Edwards, Neva Caldwell, Olivia Newman, Patricia Gaylord, Paul Guerrero, Paulette Phillips, Penny Lemery, Quiana Mayo, Rangeloff, R Caro, Rebecca LaMarre, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sadaf, Sadie Witherspoon, Sandra Rivera, Sandra Williams, Sarah Gibson, Sarah Lockery, Sebastian Spencer, Shawn Thiele Sacks, Shi-maine Holmes, Solai Demorest, Stacey Kabasakalian, Stephanie Bozak, Stephney Springer, Steve Rodriguez, Tania Santana, Tarsha, Taylor DeGraffenried, Teresa, T'Kai Howard, Tonya, Tory Soucy, V.Thaxter, Xavier Williams, Yvette Young, and seven phone numbers.

Bienvenida y presentaciones
- Se revisaron la misión, el propósito y las áreas prioritarias del Comité Asesor de Salud Conductual Infantil (CBHAC, por sus siglas en inglés).

Revisión de las áreas prioritarias de 2022-2025
1. Integración de la atención pediátrica primaria y de la atención de la salud conductual
2. Desigualdades y acceso a una atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (enero de 2024)
- No hubo reunión
- En enero se realizó la reunión conjunta con la Junta Asesora de Implementación del Plan de Salud Conductual Infantil para discutir las recomendaciones anuales y las oportunidades de colaboración

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco**
   - El Departamento de Servicios para la Salud Mental y la Adicción (DMHAS, por sus siglas en inglés) celebró su Cumbre de Liderazgo de los Jóvenes Adultos a finales de enero, que fue organizada por el Programa Join Rise Be a través de Advocacy. Participaron aproximadamente 90 jóvenes adultos y jóvenes adultos aliados. La cumbre les brindó la oportunidad de crear redes, desarrollar habilidades de liderazgo y solidificar el interés en el Programa de Certificación de Especialistas en Apoyo a Pares.

- El programa residencial de Terapia Dialéctica Conductual (RFP, por sus siglas en inglés) para jóvenes adultos de entre 18 y 25 años, se ha concedido a Continuum of Care de New Haven Ofrecerá la oportunidad de tratamiento centrado en la terapia dialéctica conductual (DBT, por sus siglas en inglés) a cinco jóvenes de entre 18 y 25 años de todos los géneros: con profesional clínico formado en DBT, prescriptor, gestión de casos, acceso a especialistas en apoyo entre pares, así como una alta proporción de persona a miembros del personal dentro del hogar, y servicios de enfermería en el sitio.
- **P**: ¿Ha analizado el departamento qué ocurriría con las personas que toman medicamentos psicotrópicos si son deportados? **R**: La pregunta fue diferida a otros departamentos estatales ya que se ocupan de adultos mayores de 18 años

2. Departamento de Educación del Estado (SDE) -Kate Bohannan

- El Departamento de Educación del Estado (SDE, por sus siglas en inglés), en colaboración con la oficina del Gobernador, publicó una guía para los distritos en relación al Servicio de Control de Inmigración y Aduanas (ICE, por sus siglas en inglés) y a la inmigración. Ese documento está disponible en múltiples idiomas y el enlace al mismo fue suministrado a los participantes en el chat. Los distritos escolares realizan sus propias capacitaciones y conversaciones internas, estudiando sus políticas y procedimientos sobre cómo actuar ante el ICE o cualquier tercero que intente entrar en la escuela. Algunos también están capacitando a los docentes sobre cómo discutir esto con sus estudiantes y apoyar los esfuerzos del distrito para la educación de todos nuestros estudiantes.
- La serie de tres partes de visitas a domicilio virtuales tiene un folleto informativo que incluye los enlaces para que las personas puedan verla y también se ha traducido a múltiples idiomas.
- En el presupuesto de 2027 del gobernador él propone establecer un programa de subvenciones para aumentar la capacidad de los distritos de proporcionar servicios de educación especial, ya sea en el distrito o regionalmente, con algunos distritos asociados para reducir el número de desplazamientos y mantener a los estudiantes dentro de sus distritos de origen.

3. División de Servicios de Apoyo en Tribunales (CSSD, por sus siglas en inglés) - Carmen Hernández

- Saldrá a licitación una nueva solicitud de propuestas (RFP) para servicios residenciales seguros
- **P**: ¿Es esta RFP para un centro masculino o femenino? **R**: Tratamiento masculino seguro

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau

- No hay actualizaciones

5. Departamento de Niños y Familias (DCF, por sus siglas en inglés) – Stephanie Bozak

- El DCF también publicó un documento interno para su personal recordándole su política. La política indica que el «DCF prestará servicio activamente a todas las personas que entren en su ámbito de actuación, independientemente de su estatus migratorio».
- Se ha actualizado la capacitación de informantes obligados del DCF y ahora incluye un video secundario al final de la misma, que brinda información a espectador sobre los diversos recursos a los que las personas pueden acceder para obtener ayuda. Incluye información para recursos, incluso 988, FAVOR, Connecting to Care (conexión con la atención), Centros de Crisis Urgentes y el programa de gestión voluntaria de la atención sanitaria.
- Están en proceso de actualización de su sitio web, así como también de creación de un video llamado «We Are Connecticut» (Nosotros somos Connecticut), que resalta los recursos disponibles para las personas de la comunidad
- **P**: ¿Cómo maneja el departamento las investigaciones en el interior de las escuelas cuando un padre/una madre realiza una denuncia 136? **R**: Hay una unidad que trabaja en las denuncias contra las escuelas y se puede brindar más información respecto a lo que utilizan para determinar si van a investigar.

- **P**: ¿Qué actualizaciones se han llevado a cabo en la capacitación de los informantes obligatorios que ayudan a atender (el asunto de) las escuelas que denuncian demasiado? **R**: Ha habido cambios en la legislación actual que permiten que los informantes obligatorios formulen algunas preguntas adicionales y no lo notifiquen si determinan que es innecesario.

6. Oficina de la Primera Infancia (OEC, por sus siglas en inglés)- Lorna Thomas-Farquharson

- El programa de visitas a domicilio, Mind Over Mood (la mente sobre el estado de ánimo), presta servicios de salud mental en apoyo de quienes reciben atención en la primera infancia, algunos de forma más específica. Aborda la salud mental y se brindó a los participantes información sobre las visitas a domicilio para la primera infancia.
- El más reciente seminario web de salud conductual se centró en brindar apoyos a los proveedores, la caja de herramientas del proveedor en lo que respecta a la salud conductual y la importancia de que los proveedores promuevan el autoconocimiento para estar en mejores condiciones de atender a los demás.
- El próximo seminario web será el 25 de febrero y se centra en la caja de herramientas para padres cuidadores y en proporcionar recursos y diálogos y conversaciones útiles sobre los padres y cuidadores y su necesidad de ser conscientes de cómo están y de su propia salud mental.

Presentación mensual - Recomendaciones del informe anual del Consejo Asesor Estatal (SAC, por sus siglas en inglés) (véase el folleto) y el Grupo de discusión Mercer

- Se comentó que los grupos de revisión ciudadana (CRP, por sus siglas en inglés) deben buscar colaborar más con la comunidad/los usuarios que han estado informando sobre el trabajo de protección del menor durante los últimos 20 años.
- Se solicitó que la membresía del SAC se compartiera con el CBHAC de tal forma que las comunidades sepan quien los representa en ese grupo.

Anuncios a la comunidad

- Ninguno

Próxima reunión: 7 de marzo de 2025, por Zoom.

Children's Behavioral Health Advisory Committee (CBHAC) Meeting
Minutes – Friday, March 7th, 2025

Attendance: Alex Rivera, Amy Hilario, Amy Marracino, Andre Gibbs, Andrew Lavallee, April Mayo, Ari Steinberg, BangaloreS, Benita Toussaint, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Carmen Almodovar, Carmen Hernandez, Carmen Teresa Rosario, Carolyn Westerholm, Cheryl Kohler, Christian Rodriguez, Connie, Connie M Estanislau, Consuelo Spanish Interpreter, Crystal Wyler, Cynthia Petronio-Vazquez, Damaris (Dami) Cox, David McSergi, Deb Kelleher, Derrick Shelton, Donald Vail, Donyale Pina, Dorothy Cimmino, Dreau Foster, Elsa, Emily Farina, Emuna Patterson, Erica Aldieri, Gabrielle Hall, George McDonald, Gina Bisogno, Jackie Cook, Janesse Stawitz, Janissa Vidal, Jen Salls, Jenny Bridges, Jo Hawke, Joe Drane, Jon Jacaruso, Joyce, J Similien, Jules Calabro, Karen Hurdle, Kate Bohannan, Kate Mascia, Kathy H. Nguyen, Kayla Pantoja, K David, Keisha Martin-Velez, Keishla Sanchez, Kristin, Kristin Graham, Kymani Scarlett, Lillianna Hyman, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Lori Stanczyc, Lorna Thomas- Farquharson, Lyne Landry, Mai Kader, Manisha Srivastava, Marelin Recinos, Mariel Conception, Martin Geertsma, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Maylin Rosario, Melanie Wilde-Lane, Melissa Mills, Melissa Niver, Meredith Turkey, Mikhela Hull, Neva Caldwell, Neiima Edwards, Olivia Newman, Paul Guerrero, Penny Lemery, Pinkneys, Quiana Mayo, R Caro, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa I. Serrano, Rosa V Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sadaf, Sandra Williams, Sarah Gibson, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, Stephanie Bozak, Stephney Springer, Steve Rodriguez, Tania Santana, Tarsha, Taylor DeGraffenried, Theresa "Teri" Altomaro, Theresa Andriulli, T'Kai Howard, Tory Soucy, V.Thaxter, Vinn Russo, Zach Nailon, Zosh Flammia, and four phone numbers

Welcome and Introductions

- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (February 2024)

- Voting Membership and System Structure
  - Current Voting Members List (Jo H.)
  - Geographic Representation of CBHAC Membership March 2025 (Jo H.)
- CBHAC Structure Chart Explanation (Gab)
  - Subcommittees
    - Statewide Council of Community Collaborators (Gab)
      - Met 2/25
      - How do we get families to come to the table?
    - Statewide CLAS Advisory Council (Jo H.)
      - Met 1/31
  - Q&A about CBHAC Structure (Gab & Jo H.)
    - Where? – need representation from Bridgeport & south of the state but also anyone welcome to apply to be a voting member regardless of location
    - Are there recruitment materials to share with perspective members? – Yes, there is a one pager we can share
    - How long are current members in place and when do they change? – some have been members a long time, was easier to manage membership prior to COVID, before it was a two year commitment

Agency Updates

1. **Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco**

    - Jennifer A. absent, Amy M. covering updates: two new training opportunities, housing and homeless services teams trained on outreach, self-care, Naloxone training. Representation from 18 agencies. Highlighting "Healing Paws"
    - Questions: Can they share the info provided? – Yes

2. **Department of Education (DOE)– Kate Bohannan**
    - Updates: hosted a webinar for youth/ young adult providers for suicide prevention, intervention and postvention. Over 230 participants came and were engaged. Partnered with Stephanie & DCF. Representation from a variety of providers and school staff. Scheduling regional follow up sessions so teams can learn and connect locally. Plan to provide more schools to connect resources and care for families.
    - Questions: Shouldn't some of these be mandatory for school leaders? – It is not mandatory. There is a state requirement for training and personal development, most schools use these opportunities to connect with regional resources and community providers.
    - Were school staff at Hartford a part of this? – They do have that information, not specific off the top, but there was participation from schools in Hartford.

3. **Court Support Services Division (CSSD) – Carmen Hernandez**

    - Updates: $1 million grant awarded to enhance services for youth who come in at a high risk. 3 year pilot to integrate restorative justice models and practices.
    - Questions: How do we make sure these dollars roll into urban areas? – This funding is for juvenile probation, specifically using the RESTORE model

4. **Department of Social Services (DSS) – Connie Estanislau**
    - No update

5. **Department of Children and Families (DCF)– Stephanie Bozak**

    - Updates: resources were sent out to everyone who registered, Connecting to Care was included. Info shared with police chiefs about resources.
    - Vin Russo, CT DCF – Legislature Update: bills are still in development and in discussion in committees. The Children's Committee wrapped up yesterday. Lengthy list of recommendations: studying Medicare rates, sustaining services. HB 7109 – Community Behavioral Health Centers, Medicaid, Behavioral Analysts (potential issues & suggestions), Governor's budget. Emergency Mobil – additional funding to increase services - $6.8 million – appropriations discussions start next Monday. Urgent Crisis Centers looking to go to Medicaid funding, more to come as the budget process unfolds. SEN Bill 11 – Bulk drug purchasing – through UCONN Health for affordability, implementation plan being developed. Peer Services and Medicaid funding for Peer Services.

- Questions: Is there anything in place in case there are cuts to Medicaid? – yes, meetings are happening with the Gov's office to be proactive. H&HS Commissioner has been meeting regularly with the DCF Commissioner to strategize the potential Medicaid cuts. We're hopeful the cuts don't come.
- What has happened since the Governor's recent veto? – The issue with that bill as it was past, it would have busted the constitutional spending gap by 40 million dollars. A new version was passed, with a new spending cap using ARPA interest money. That occurred on Wednesday, the Governor signed the bill yesterday.

6. Office of Early Childhood (OEC)- Lorna Thomas-Farquharson

- No current updates

Monthly Presentation- (see handout)

Community Announcements

- Advocacy Opportunities : CT General Assembly and Committee on Children
- Community Resources
    - CBHAC Minutes are online
    - Regional Resource List on C2C Website
    - AiM tool on C2C Website
    - 1 Word 1 Voice 1 Life
    - Community Pathways Program
    - Carelon Child & Family Division (regardless of insurance)
    - Network Area Contacts
    - Connect via Social Media
    - CBHAC Co Chair Contact Info

Voting Member Meeting

- Reviewed and approved meeting minutes for January and February 2025
- Discussion related to updating CBHAC priority areas no later than July vs. December
    - Exploring a small workgroup of voting members to review what has been accomplished within our system, respective to the priority areas, over the past few years.
- Discussed possibly looking at data in future regarding youth with developmental disabilities and connections to treatment. Also emphasized importance of collaboration with police and schools to support diversion strategies.

Next meeting April 4th , 2025 via Zoom

Reunión del Comité Asesor en Salud Conductual Infantil (CBHAC)
Acta - Viernes, 7 de marzo de 2025

Asistencia: Alex Rivera, Amy Hilario, Amy Marracino, Andre Gibbs, Andrew Lavallee, April Mayo, Ari Steinberg, BangaloreS, Benita Toussaint, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Carmen Almodovar, Carmen Hernandez, Carmen Teresa Rosario, Carolyn Westerholm, Cheryl Kohler, Christian Rodriguez, Connie, Connie M Estanislau, Consuelo Spanish Interpreter, Crystal Wyler, Cynthia Petronio-Vazquez, Damaris (Dami) Cox, David McSergi, Deb Kelleher, Derrick Shelton, Donald Vail, Donyale Pina, Dorothy Cimmino, Dreau Foster, Elsa, Emily Farina, Emuna Patterson, Erica Aldieri, Gabrielle Hall, George McDonald, Gina Bisogno, Jackie Cook, Janesse Stawitz, Janissa Vidal, Jen Salls, Jenny Bridges, Jo Hawke, Joe Drane, Jon Jacaruso, Joyce, J Similien, Jules Calabro, Karen Hurdle, Kate Bohannan, Kate Mascia, Kathy H. Nguyen, Kayla Pantoja, K David, Keisha Martin-Velez, Keishla Sanchez, Kristin, Kristin Graham, Kymani Scarlett, Lillianna Hyman, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Lori Stanczyc, Lorna Thomas- Farquharson, Lyne Landry, Mai Kader, Manisha Srivastava, Marelin Recinos, Mariel Conception, Martin Geertsma, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Maylin Rosario, Melanie Wilde-Lane, Melissa Mills, Melissa Niver, Meredith Turkey, Mikhela Hull, Neva Caldwell, Neiima Edwards, Olivia Newman, Paul Guerrero, Penny Lemery, Pinkneys, Quiana Mayo, R Caro, Rebekah Behan, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa I. Serrano, Rosa V Alvis Alvarado, Rosie Breindel, Rossie, Sabra Mayo, Sadaf, Sandra Williams, Sarah Gibson, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, Stephanie Bozak, Stephney Springer, Steve Rodriguez, Tania Santana, Tarsha, Taylor DeGraffenried, Theresa "Teri" Altomaro, Theresa Andriulli, T'Kai Howard, Tory Soucy, V.Thaxter, Vinn Russo, Zach Nailon, Zosh Flammia, and four phone numbers

Bienvenida y presentaciones

- Se revisaron la misión, el propósito y las áreas de prioridad del Comité Asesor en Salud Conductual Infantil (CBHAC).

Revisión de las áreas prioritarias de 2022-2025

1. Integración de la atención primaria pediátrica y la atención de la salud conductual
2. Desigualdades y acceso a atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (febrero de 2024)

- Miembros con derecho a voto y estructura del sistema
    - Lista actual de miembros con derecho a voto (Jo H.)
    - Representación geográfica de los miembros del CBHAC en marzo de 2025 (Jo H.)
- Explicación del organigrama del CBHAC (Gab)
    - Subcomités
        - Consejo Estatal de Representantes de la Comunidad (Gab)
            - Reunión 2/25
            - ¿Cómo conseguimos que las familias se sienten a la mesa?
        - Consejo Consultivo Estatal sobre CLAS (Jo H.)
            - Reunión 1/31
    - Preguntas y respuestas sobre la estructura del CBHAC (Gab & Jo H.)
        - ¿Dónde? - Se necesita representación de Bridgeport y del sur del estado, pero cualquier persona puede solicitar ser miembro con derecho a voto independientemente de su ubicación.
        - ¿Hay material de captación para compartir con los posibles miembros? - Sí, hay un folleto que podemos compartir.

- ¿Cuánto tiempo llevan los miembros actuales y cuándo cambian? - Algunos son miembros desde hace mucho tiempo, era más fácil gestionar la participación antes de la COVID. Antes era un compromiso de dos años.

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco**

   - Jennifer A. ausente, Amy M. cubriendo actualizaciones: dos nuevas oportunidades de formación, equipos de servicios de vivienda y para personas sin hogar formados en divulgación, autocuidado y Naloxona. Representación de 18 agencias. Poniendo de relieve "Healing Paws".
   - Preguntas: ¿Pueden compartir la información facilitada? - Sí

2. **Departamento de Educación (DOE) - Kate Bohannan**
   - Actualizaciones: organizó un seminario web para proveedores de servicios de prevención, intervención y posvención en materia de suicidio para jóvenes y adultos jóvenes. Más de 230 participantes acudieron y se involucraron. En colaboración con Stephanie y el DCF. Representación de diversos proveedores y personal escolar. Programar sesiones regionales de seguimiento para que los equipos puedan aprender y conectarse localmente. Plan para que más escuelas conecten recursos y atención para las familias.
   - Preguntas: ¿No deberían ser obligatorias algunas de ellas para los directivos de centros escolares? - No es obligatorio. Existe un requisito estatal de formación y desarrollo personal; la mayoría de las escuelas aprovechan estas oportunidades para conectar con recursos regionales y proveedores de la comunidad.
   - ¿Participó el personal escolar de Hartford? - Tienen esa información; no sé exactamente cuántos, pero hubo participación de las escuelas en Hartford.

3. **División de Servicios de Apoyo en Tribunales (CSSD) - Carmen Hernández**

   - Actualizaciones: Concesión de una subvención de un millón de dólares para mejorar los servicios para jóvenes que llegan en situación de alto riesgo. Proyecto piloto de 3 años para integrar modelos y prácticas de justicia reparadora.
   - Preguntas: ¿Cómo nos aseguramos de que estos fondos lleguen a las zonas urbanas? - Esta financiación es para la libertad condicional juvenil, específicamente utilizando el modelo RESTORE.

4. **Departamento de Servicios Sociales (DSS) - Connie Estanislau**
   - No hay actualizaciones

5. **Departamento de Niños y Familias (DCF) – Stephanie Bozak**

   - Actualizaciones: se enviaron recursos a todos los que se inscribieron; se incluyó Connecting to Care. Se compartió información sobre recursos con los jefes de policía.
   - Vin Russo, CT DCF - Actualización de la Legislatura: los proyectos de ley están todavía en desarrollo y en discusión en los comités. El Comité de menores terminó ayer. Larga lista de

recomendaciones: estudiar las tarifas de Medicare, mantener los servicios. Proyecto de ley de la Cámara 7109 - Centros comunitarios de salud conductual, Medicaid, Analistas del comportamiento (posibles problemas y sugerencias), presupuesto del gobernador. Móvil de emergencia - financiación adicional para aumentar los servicios - $6.8 millones - los debates sobre las asignaciones comienzan el próximo lunes. Los Centros de Crisis Urgentes buscan recurrir a la financiación de Medicaid; habrá más información a medida que se desarrolle el proceso presupuestario. Proyecto de Ley del Senado 11 - Compra de medicamentos a granel - a través de UCONN Health para que sean asequibles; se está desarrollando un plan de implementación. Servicios entre pares y financiación de Medicaid para los servicios entre pares.

- Preguntas: ¿Hay algo previsto en caso de que se produzcan recortes en Medicaid? - Sí, se están realizando reuniones con la oficina del Gobernador para ser proactivos. El Comisionado de Salud y Servicios Humanos se ha reunido regularmente con el Comisionado del DCF para elaborar estrategias sobre los posibles recortes de Medicaid. Esperamos que los recortes no lleguen.
- ¿Qué ha pasado desde el reciente veto del Gobernador? - La cuestión con ese proyecto de ley como se pasó es que habría roto la brecha de gasto constitucional por 40 millones de dólares. Se aprobó una nueva versión, con un nuevo límite de gasto utilizando el dinero de los intereses de ARPA. Eso ocurrió el miércoles, el Gobernador firmó el proyecto de ley ayer.

6. Oficina de la Primera Infancia (OEC)- Lorna Thomas-Farquharson

- Sin actualizaciones

Presentación mensual - (Ver folleto)

Anuncios a la comunidad

- Oportunidades de defensa : Asamblea General de CT y Comité de Menores
- Recursos comunitarios
    - Las actas del CBHAC están en línea
    - Lista de recursos regionales en el sitio web de C2C
    - Herramienta AiM en el sitio web de C2C
    - 1 Word 1 Voice 1 Life
    - Programa comunitario Pathways
    - División de Niños y Familias de Carelon (independientemente del seguro)
    - Contactos del área de la red
    - Conectar a través de las redes sociales
    - Información de contacto del Codirector del CBHAC

Reunión de miembros con derecho a voto

- Revisión y aprobación de las actas de las reuniones de enero y febrero de 2025.
- Debate sobre la actualización de las áreas prioritarias del CBHAC a más tardar en julio en lugar de diciembre.
    - Explorar un grupo de trabajo reducido de miembros con derecho a voto para revisar lo que se ha logrado en nuestro sistema en relación con las áreas prioritarias en los últimos años.
- Se habló de la posibilidad de examinar en el futuro los datos relativos a los jóvenes con discapacidades de desarrollo y las conexiones con el tratamiento. También se destacó la importancia de la colaboración con la policía y las escuelas para apoyar las estrategias alternativas.

Próxima reunión: 4 de abril de 2025, por Zoom.

Children's Behavioral Health Advisory Committee (CBHAC) Meeting
Minutes – Friday, April 4th, 2025

Attendance: Adrianna Ramirez, Aimee Gelinas, Alex Rivera, Amy Hilario, Ari Steinberg, Benita Toussaint, Brenetta Henry, Briannali Rivera, Briana Miller, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carmen Teresa Rosario, Christie Calloway, Christina Rodriguez, Connie, Connie M Estanislau, Crystal Williams, Consuelo-Spanish Interpreter, Carolyn Westerholm, Cynthia Petronio-Vazquez, Daniela Giordano, Diana Perry, Derrick Shelton, Donald Vail, Donyale Pina, Dorothy Cimmino, Dreau Foster, Elsa Cordova, Emily Farina, Erika Sharillo, Fatmata Williams, Erica Aldieri,Gabrielle Hall, Heather LaSelle, Jacob Hasson, Jamie LoCurto, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Joe Drane, Karen Delane, Karen Hurdle, Kate Bohannan, Kate Mascia, Kathy G. Carbine, Kayla Pantoja, Keisha Martin-Velez, Kristin, Kristin Graham, Kristen Granatek, Kymani Scarlett, Liliana Jaimes, Liz Sitler, Lisa Girard, Luz Villfane, Lois Berkowitz, M. Alex Geertsma, Lorna Thomas- Farquharson, Mai Kader, Mariel Conception, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Maylin Rosario, Michelle Rodriguez, Mikhela Hull, Pam Williams, Olivia Newman, Peter Samenfink, Paul Guerrero, Penny Lemery, Rebecca LaMarre, Quiana Mayo, Rebekah Behan, Renee Wright, Robert Plant, Richard Pimentel, Ronnie Vollano, Rosa I. Serrano, Rob Haswell, Sabra Mayo, Sandra Rivera, Sandra Williams, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, Stephanie Joanis, Steven Rodriguez, Stephney Springer, Tania Santana, Tarsha, Taylor DeGraffenried, Tory Soucy, Xavier Williams, Yvette Young, Zach Nailon, Zosh Flammia, and seven phone numbers

Welcome and Introductions

- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (March 2024)

- Review and approval of meeting minutes from previous two months
- Discussed forming small workgroup of voting members to review system achievement and successes, respective to CBHAC priority areas, to help guide voting on new priority areas by July
- Ongoing activities: Recruitment of individuals to fill vacant voting member positions; collaborating and integrating with other committees (recent meeting with TCB support staff from TOW Youth Justice Institute); planning related to key presentations

Agency Updates

1. Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco

- Press event occurred end of last month where the governor, the DMHAS commissioner and two young adults from the YAS (Young Adult Services) program spoke about their positive experience with the program
- One young adult is currently receiving services through YAS and the other was a graduate of the program

2. Department of Education (DOE)– Kate Bohannan

- State Department of Education is holding regional meetings or webinar sessions based on the regional suicide advisory board regions to connect school mental health staff with the teams in their regions providing crisis supports

- Speakers from the (UCCs) urgent crisis centers, mobile crisis the regional suicide advisory board, as well as the Center for School Safety and crisis preparation so that schools have the ability to get resources and ask questions

3. **Court Support Services Division (CSSD) – Carmen Hernandez**
   - No report
4. **Department of Social Services (DSS) – Connie Estanislau**
   - No update

5. **Department of Children and Families (DCF)– Crystal Williams reporting for Dr. Stephanie Bozak**
   - The DCF Director of the Fatherhood Engagement- Anthony Gay, is looking for fathers who have been involved with DCF or other systems who would be willing to participate on the statewide DCF fatherhood steering committee.
   - The steering committee is charged with providing input and advocacy for policies and practice for decision making and case planning
   - Fathers will receive a $20 Walmart gift card for every hour they commit to meetings that last about 90 minutes and usually occur 1-2 times a month
   - They can be adoptive, foster, psychological or biological fathers; contact Anthony Gay if interested or to learn more
   - Virtual group series called Shared Learning Group and the opportunities to dive into important topics regarding sharing resources, information, ideas to better support people with intellectual and developmental disabilities. Flyer with dates and times will be shared and those interested will have to register for these sessions
   - DCF Chief of Gov't Relations & Policy, Vinny Russo and his team have been contacted to do a report out to CBHAC following the legislative session
   - **Q**: Can fathers who are not able to see their children but have not been DCF involved still participate in the steering committee? **A**: Not sure, will ask Mr. Gay to clarify and get back to the group

6. **Office of Early Childhood (OEC)- Lorna Thomas-Farquharson**
   - Universal Home Visiting is under (OEC) Office of Early Childhood division now
   - The new Norwich location is officially seeing clients
   - In March, OEC held a webinar entitled "Women in History Educating Young Children: Reflections from the past, Shining Light in the Present, Enlightening Forward Movement." The purpose for this webinar was to recognize the valuable contributions of women in educating young children

Monthly Presentation- (see handout) Department of Social Services presentation by Fatimata Williams, Dr. Springer and Rob Haswell

- **Q**: Is there a metric in place to ensure that the 51% goal of family member is representative of the entire state? **A**: That is one of the criteria that will be looked at to ensure various representations: children, adults, individuals with different expertise within mental health, race, and statewide community presence as much as possible

Community Announcements

- Amplify will be hosting a mental health event on May 27 and the Save the Date flyer will be shared with CBHAC
- May is Mental Health Awareness Month and there will be a lot of opportunities for community involvement and awareness statewide
- Advocacy Opportunities
  - 1 Word 1 Voice 1 Life
  - Community Pathways Program

- Carelon Child & Family Division (regardless of insurance)
- Network Area Contacts
- Connect via Social Media
- CBHAC Co Chair Contact Info

Voting Member Meeting

- Approval of minutes from the previous month
- Identified voting members willing to participate in small workgroup to support priority areas for CBHAC
- Planning for May 2025 CBHAC
- Request to engage DDS to participate again in CBHAC meetings

Next meeting May 2nd, 2025 via Zoom

Reunión del Comité Asesor en Salud Conductual Infantil (CBHAC)
Acta - Viernes 4 de abril de 2025

Asistencia: Adrianna Ramirez, Aimee Gelinas, Alex Rivera, Amy Hilario, Ari Steinberg, Benita Toussaint, Brenetta Henry, Briannali Rivera, Briana Miller, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carmen Teresa Rosario, Christie Calloway, Christina Rodriguez, Connie, Connie M Estanislau, Crystal Williams, Consuelo-Spanish Interpreter, Carolyn Westerholm, Cynthia Petronio-Vazquez, Daniela Giordano, Diana Perry, Derrick Shelton, Donald Vail, Donyale Pina, Dorothy Cimmino, Dreau Foster, Elsa Cordova, Emily Farina, Erika Sharillo, Fatmata Williams, Erica Aldieri,Gabrielle Hall, Heather LaSelle, Jacob Hasson, Jamie LoCurto, Jennifer Abbatemarco, Jenny Bridges, Jo Hawke, Joe Drane, Karen Delane, Karen Hurdle, Kate Bohannan, Kate Mascia, Kathy G. Carbine, Kayla Pantoja, Keisha Martin-Velez, Kristin, Kristin Graham, Kristen Granatek, Kymani Scarlett, Liliana Jaimes, Liz Sitler, Lisa Girard, Luz Villfane, Lois Berkowitz, M. Alex Geertsma, Lorna Thomas- Farquharson, Mai Kader, Mariel Conception, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Maylin Rosario, Michelle Rodriguez, Mikhela Hull, Pam Williams, Olivia Newman, Peter Samenfink, Paul Guerrero, Penny Lemery, Rebecca LaMarre, Quiana Mayo, Rebekah Behan, Renee Wright, Robert Plant, Richard Pimentel, Ronnie Vollano, Rosa I. Serrano, Rob Haswell, Sabra Mayo, Sandra Rivera, Sandra Williams, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, Stephanie Joanis, Steven Rodriguez, Stephney Springer, Tania Santana, Tarsha, Taylor DeGraffenried, Tory Soucy, Xavier Williams, Yvette Young, Zach Nailon, Zosh Flammia, and seven phone numbers

Bienvenida y presentaciones

- Se revisaron la misión, el propósito y las áreas de prioridad del Comité Asesor en Salud Conductual Infantil (CBHAC).

Revisión de las áreas prioritarias de 2022-2025

1. Integración de la atención primaria pediátrica y la atención de la salud conductual
2. Desigualdades y acceso a atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (marzo de 2024)

- Revisión y aprobación del acta de la reunión de los dos meses anteriores.
- Se debatió la formación de un pequeño grupo de trabajo de miembros con derecho a voto para examinar los logros y éxitos del sistema, en relación con las áreas prioritarias del CBHAC, con el fin de orientar la votación de nuevas áreas prioritarias antes de julio.
- Actividades en curso: Reclutamiento de personas para cubrir las vacantes de miembros con derecho a voto; colaboración e integración con otros comités (reciente reunión con el personal de apoyo de TCB del TOW Youth Justice Institute); planificación relacionada con presentaciones clave.

Actualizaciones de las agencias

1. Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco

- A finales del mes pasado se realizó un evento de prensa en el que el gobernador, el comisionado del DMHAS y dos jóvenes adultos del programa YAS (Young Adult Services) hablaron sobre su experiencia positiva con el programa.
- Uno de los jóvenes recibe actualmente servicios a través de YAS y el otro se graduó del programa.

2. Departamento de Educación (DOE) - Kate Bohannan

- El Departamento de Educación del Estado está realizando reuniones regionales o sesiones de webinar basadas en las regiones que comprende la Junta consultiva regional sobre suicidio para conectar al personal de salud mental de las escuelas con los equipos de sus regiones que prestan apoyo en situaciones de crisis.
- Portavoces de los centros de crisis urgentes (UCC), de los servicios de crisis móvil, de la Junta asesora regional sobre suicidios, así como del Centro para la seguridad escolar y la preparación ante situaciones de crisis, para que las escuelas puedan obtener recursos y formular preguntas.

3. División de Servicios de Apoyo en Tribunales (CSSD) - Carmen Hernandez

- No hay informe

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau

- No hay actualizaciones

5. Departamento de Niños y Familias (DCF) – Crystal Williams en representación de la Dra. Stephanie Bozak

- El Director de Fatherhood Engagement del DCF, Anthony Gay, está buscando padres que han estado involucrados con el DCF u otros sistemas y que estén dispuestos a participar en el comité directivo estatal de paternidad del DCF.
- El comité directivo se encarga de aportar y defender políticas y prácticas para la toma de decisiones y la planificación de casos.
- Los padres recibirán una tarjeta regalo de $20 de Walmart por cada hora que dediquen a las reuniones, que duran unos 90 minutos y suelen realizarse una o dos veces al mes.
- Pueden ser padres adoptivos, de acogida, psicológicos o biológicos; póngase en contacto con Anthony Gay si está interesado o para saber más.
- Serie de grupos virtuales denominada Grupo de aprendizaje compartido y oportunidades de profundizar en temas importantes relacionados con el intercambio de recursos, información e ideas para apoyar mejor a las personas con discapacidad intelectual y del desarrollo. Se repartirá un folleto con las fechas y horas, y los interesados tendrán que inscribirse en estas sesiones.
- Nos hemos puesto en contacto con Vinny Russo, jefe de Relaciones gubernamentales y Política del DCF, y su equipo para que elaboren un informe para el CBHAC tras la sesión legislativa.
- **P**: ¿Pueden participar en el comité directivo los padres que no pueden ver a sus hijos pero con quienes no ha intervenido el DCF? **R**: No estoy segura, voy a pedirle al Sr. Gay que lo aclare y se lo comunicaré al grupo.

6. Oficina de la Primera Infancia (OEC)- Lorna Thomas-Farquharson

- Las visitas universales a domicilio dependen ahora de la Oficina de la Primera Infancia (OEC).
- La nueva sede de Norwich está recibiendo oficialmente a sus clientes.
- En marzo, la OEC organizó un webinar titulado "Women in History Educating Young Children: Reflections from the past, Shining Light in the Present, Enlightening Forward Movement." El objetivo de este webinar era reconocer la valiosa contribución de las mujeres a la educación de los niños pequeños.

Presentación mensual- (ver folleto) Presentación del Departamento de Servicios Sociales por Fatimata Williams, el Dr. Springer y Rob Haswell.

- **P**: ¿Existe algún sistema de medición que garantice que el objetivo del 51 % de miembros de la familia es representativo de todo el estado? **R**: Este es uno de los criterios que se tendrán en cuenta para garantizar una representación variada: niños, adultos, personas con diferentes conocimientos en el ámbito de la salud mental, raza, y la presencia de la comunidad de todo el estado en la medida de lo posible.

Anuncios a la comunidad

- Amplify organizará un evento sobre salud mental el 27 de mayo y el folleto Save the Date se compartirá con el CBHAC.
- Mayo es el Mes de la Concienciación sobre la Salud Mental y habrá muchas oportunidades de participación comunitaria y concienciación en todo el estado.
- Oportunidades de defensa
    - 1 Word 1 Voice 1 Life
    - Programa comunitario Pathways
    - División de Niños y Familias de Carelon (independientemente del seguro)
    - Contactos del área de la red
    - Conectar a través de las redes sociales
    - Información de contacto del Codirector del CBHAC

Reunión de miembros con derecho a voto

- Aprobación del acta del mes anterior.
- Miembros con derecho a voto dispuestos a participar en un pequeño grupo de trabajo para apoyar las áreas prioritarias del CBHAC.
- Planificación para mayo de 2025, CBHAC
- Petición para que el DDS vuelva a participar en las reuniones del CBHAC

Próxima reunión: 2 de mayo de 2025, por Zoom.

Children's Behavioral Health Advisory Committee (CBHAC) Meeting Minutes

Friday, May 2, 2025

Attendance: Ahmed Sowah, Aimee Gelinas, Aleece Kelly, Alex Rivera, Alex Sargent, Allison Daly, Amy Lupoli, Amy Rodriguez, Andre Gibbs, Andrea Goetz, Andrea Richardson, April Mayo, Avelyn Wolbach, BangaloreS, Brenetta Henry, Briana Miller, Briannali Rivera, Caitlyn Koripsky, Cara Klaneski, Carmen Almodovar, Cheryl Kohler, Christian Rodriguez, Connie M Estanislau, Connie UHD, Consuelo-Spanish Interpreter, Cynthia Cruz, Damaris (Dami) Cox, Daniela Giordano, Derrick Shelton, Donald Vail, Donyale Pina, Dreau Foster, Drew Lavallee, Elsa Cordova, Emily Farina, Emuna Patterson, Erica Aldieri, Erika Sharillo, Evan S. Dantos, Gabrielle Hall, Gina Bisogno, Jackie Cook, Janesse Stawitz, Janissa Vidal, Jeana Bracey, Jennifer Abbatemarco, Jo Hawke, Joe Drane, Jon Jacaruso, Joyce, jsimilien, Jules Calabro, Karen Delane, Kayla Pantoja, Keisha Martin-Velez, Keishla Sanchez, Kelly Waterhouse, Ken Mysogland, Keri Lloyd, Kristin, Lillianna Hyman, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Lois Berkowitz, Lori Stanczyc, Lorna Thomas- Farquharson, Luz Villfane, M. Alex Geertsma, Mai Kader, Manisha Srivastava, Maria Brereton, Maria Soto, Mariel Conception, Mary Hryniewicz, Maureen O'Neil-Davis, Maylin Rosario, Melanie Wilde-Lane, Melissa Niver, Michelle Queen, Michelle Rodriguez, Mikhela Hull, Ms. Neva Caldwell, Olivia Newman, Paige Trevethan, Paul Guerrero, Penny Lemery, Peter Yazbak, Pinkneys, Quiana Mayo, Rebekah Behan, Renee Wright, Ronnie Vollano, Rosie Breindel, Rose Serrano, Sabra Mayo, Sadaf Muneer, Sandra Rivera, Sanmaris Rose, Sarah White, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, Stephanie Bozak, Stephanie Joanis, Stephney Springer, Steve Rodriguez, Tania Santana, Tarsha, Taylor DeGraffenried, Theresa Andriulli, Tom Cosker, Tory Soucy, Tyrone Calloway, Xavier Williams, Yvette Young, and four phone numbers

Welcome and Introductions

•CBHAC's mission, purpose and priority areas were reviewed

Review of 2022-2025 Priority Areas

1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (April 2025)

- Reviewed and approved meeting minutes for the previous month
- Identified a small work group to support the choice of priority areas upcoming for the next three years

- Discussed follow up needed to reestablish regular attendance from DDS as a CBHAC member

Agency Updates

1. Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco

- **Online live peer support that is available through:** CTSupportGroup.org: Guiding the Search for Mental Wellness

2. Department of Education (DOE)– Kate Bohannan

- No Updates

3. Court Support Services Division (CSSD) – Carmen Hernandez

- No Updates

4. Department of Social Services (DSS) – Connie Estanislau

- No changes regarding DSS budget have been announced yet

5. Department of Children and Families (DCF)– Dr. Stephanie Bozak

- Presented

6. Office of Early Childhood (OEC)- Lorna Thomas-Farquharson

- Several events happened in April working in collaboration with DCF

Monthly Presentation- (see handout)- CONNECTing Grant presented by Jeana Bracey-Sarah White

- **Q:** Who gets the intense support? **A**: The school decides what level of support. Grant partners consult with school leaders to determine their need, interest, and capacity to engage in this work and help them decide which level is most appropriate; they can build up over time as they build readiness
- **Q:** How involved are you with already established school-based health centers? How would you approach the problem with deficiencies in early childhood? **A:** The focus of the grant work is to primarily support and assist school staff.

- **Q:** Are families aware of the schools that express interest in enrolling but ultimately opt not to enroll? **A:** No, not that we are aware of however we continue to work with schools to understand any concerns they may have contributing to not enrolling.

Monthly Presentation- (see handout)- DCF new website presentation Ken Mysogland, Resource hub collaboration with DMHAS presented by Peter Yazbak, Connecticut adolescent substance abuse service array- presented by Amy Rodriquez and Carrie Lloyd from DCF, Aim tool- presented by- Elisabeth Cannata from CBHIPAB

- https://portal.ct.gov/dcf?language=en_US
- **Q:** Who can we contact if provider organizations are not listed on the website? **A:** Contact Peter.Yazbak@ct.gov and include contact information for the organization and which landing page it should be included on
- **Q:** Is there a way to identify sites that offer bilingual services? **A:** n/a
- **Q:** Do you need a referral from some of these services from a license provider? **A:** Some services like UCC no referral needed
- **Q:** Can peer-based support for parents offered by community organizations also be listed on this site? And who do we go through to either get consideration or to be added? How is this site being marketed to the public? A: To contact Peter Yazbak to be considered, they are using billboards, social media, presentations, etc.
- Q: Are these presentations on the AIM tool being provided statewide? A: Yes, presentations have occurred statewide and will continue.

Community Announcements

- 31 Days of Wellness Calendar for Mental Health Awareness month
- There is an activity every day in the month of May
- The CT Association of School Based Health Centers will be hosting a lunch and learn on May 15th from 12-130p. The registration link is below https://education.weitzmaninstitute.org/content/casbhc-lunch-and-learn-series-2025-may-15-2025#group-tabs-node-course-default4
- CASBHC is also hosting its annual conference on Nov. 11th at the Heritage Hotel and Conference Center in Southbury, CT. Early bird registration link: https://education.weitzmaninstitute.org/content/casbhc-2025-annual-conference-navigating-shifting-healthcare-landscape-how-school-based#group-tabs-node-course-default5

No CBHAC voting member meeting in May

Next meeting :

25th ANNIVERSARY of CBHAC

June 6, 2025, 10am-12pm

Acta de la reunión del Comité Asesor de Salud Conductual Infantil (CBHAC)

Viernes, 2 de mayo de 2025

Asistencia:

Bienvenida y presentaciones

•Se revisaron la misión, el propósito y las áreas de prioridad del Comité Asesor de Salud Conductual Infantil (CBHAC, por sus siglas en inglés).

Revisión de las áreas prioritarias de 2022-2025

1. Integración de la atención primaria pediátrica y la atención de la salud conductual
2. Desigualdades y acceso a atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (abril de 2025)

- Revisión y aprobación del acta de la reunión del mes anterior
- Identificación de un grupo pequeño para apoyar la elección de las áreas prioritarias para los próximos tres años.
- Se discutió el seguimiento necesario para restablecer la asistencia regular del Departamento de Servicios del Desarrollo (DDS, por sus siglas en inglés) como miembro del CBHAC

Actualizaciones de las agencias

1. Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco

- **Apoyo de pares en línea, en vivo, que está disponible a través de:** CTSupportGroup.org: Orientación de la búsqueda del bienestar mental

2. Departamento de Educación (DOE, por sus siglas en inglés) - Kate Bohannan

- Sin actualizaciones

3. División de Servicios de Apoyo en Tribunales (CSSD) - Carmen Hernandez

- Sin actualizaciones

4. Departamento de Servicios Sociales (DSS) - Connie Estanislau

- No se ha anunciado aún ningún cambio en relación al presupuesto del DSS

5. Departamento de Niños y Familias (DCF, por sus siglas en inglés) – Stephanie Bozak

- Expuso

6. Oficina de la Primera Infancia (OEC, por sus siglas en inglés)- Lorna Thomas-Farquharson

- Ocurrieron diversos eventos en abril trabajando en colaboración con el DCF

Presentación mensual - (véase el folleto) - Subvención de CONNECTing presentada por Jeana Bracey - Sarah White

- **P:** ¿Quién recibe el apoyo intensivo? **R**: La escuela decide que nivel de apoyo. Los aliados de la subvención consultan con los líderes escolares para determinar sus necesidades, intereses y capacidad de participar en este trabajo y ayudarlos a decidir qué nivel es más adecuado; pueden ir aumentando con el tiempo a medida que estén preparados.
- **P:** ¿Qué tan involucrado está usted con los centros de salud escolar ya establecidos? ¿Cómo abordaría el problema de las deficiencias en la primera infancia? **R:** El objetivo principal de la subvención es apoyar y ayudar al personal escolar.

- **P:** ¿Las familias están al tanto de las escuelas que expresan interés en inscribirse, pero que finalmente deciden no inscribirse? **R:** No. No que nosotros sepamos, sin embargo, seguimos trabajando con las escuelas para entender cualquier problema que puedan tener que contribuya a que no se inscriban.

Presentación mensual (véase el folleto)- Presentación del nuevo sitio web del DCF, Ken Mysogland; Centro de Recursos de colaboración con el DMHAS, presentado por Peter Yazbak; Conjunto de servicios de Connecticut ante el abuso de sustancias en adolescentes, presentado por Amy Rodriquez y Carrie Lloyd del DCF; Herramienta de ayuda, presentado por Elisabeth Cannata de la Junta Asesora del Plan de Implementación de Salud Mental Infantil (CBHIPAB)

- https://portal.ct.gov/dcf?language=en_US
- **P:** ¿A quién podemos contactar si las organizaciones proveedoras no figuran en el sitio web? **R:** Contacten a Peter.Yazbak@ct.gov e incluyan la información de contacto de la organización y en qué página de destino debería incluirse
- **P:** ¿Hay alguna manera de identificar los sitios que ofrecen servicios bilingües? **R:** n/c
- **P:** ¿Es necesario que un proveedor aprobado remita a alguno de estos servicios? **R:** Algunos servicios como los Centros de Crisis Urgentes (UCC, por sus siglas en inglés) no necesitan derivación
- **P:** ¿Se pueden figurar en este sitio también el apoyo de pares para padres ofrecido por organizaciones comunitarias? ¿A quién debe acudirse para ser considerado o ser

incorporado? ¿Cómo se promociona este sitio al público? R: Para comunicarse con Peter Yazbak para ser considerados, están usando carteles, redes sociales, presentaciones, etc.
- P: ¿Estas presentaciones sobre la herramienta AIM se ofrecen en todo el estado? R: Sí, se han realizado y se seguirán realizando presentaciones en todo el estado.

Anuncios a la comunidad

- Calendario de bienestar, de 31 días, para el Mes de Consciencia sobre la Salud Mental.
- Hay una actividad para cada día del mes de mayo.
- La Asociación de Centros de Salud Escolares de CT será anfitriona de un «almuerzo y aprendizaje», el 15 de mayo, de 12 a 1:30 p. m. El enlace para la inscripción es el siguiente https://education.weitzmaninstitute.org/content/casbhc-lunch-and-learn-series-2025-may-15-2025#group-tabs-node-course-default4
- La Asociación de Centros de Salud Escolares de Connecticut (CASBHC, por sus siglas en inglés) también celebrará su conferencia anual, el 11 de noviembre, en el Hotel Heritage y el Centro de Conferencias en Southbury, CT. Enlace de inscripción anticipada: https://education.weitzmaninstitute.org/content/casbhc-2025-annual-conference-navigating-shifting-healthcare-landscape-how-school-based#group-tabs-node-course-default5

En mayo, no habrá reunión de los miembros del CBHAC con derecho a voto

Próxima reunión:

25.° ANIVERSARIO del CBHAC

6 de junio de 2025, 10 a. m. a 12 p. m.

Children's Behavioral Health Advisory Committee (CBHAC) Meeting
Minutes – Friday, June 6th, 2025

Attendance:
Aimee Gelinas, Aleece Kelly, Alexandrino Rivera, Alice DeMeo, Aliyah Rosario, Amy Hilario, Andrea Richardson, April Mayo, Arthur Sandella, Ashley McAuliffe, Benita Toussiant, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Christian D, Connie M Estanislau, Connie UHD, Consuelo Spanish Interpreter, Cynthia Cruz, Cynthia Petronio-Vazquez, Daniela Giordano, Derrick Shelton, Donald Vail, Dorothy Cimmino, Drew Lavallee, E Santiago, Ellender Mathis, Emily Farina, Erica Aldieri, Evan S. Dantos, Gabrielle Hall, Gina Bisogno, Hunter K., Jamie LoCurto, Janissa Vidal, Jenny Bridges, Joe Drane, Jon Jacaruso, Joyce, jsimilien, Jules Calabro, Julia Nelligan, Karen Delane, Karen Hurdle, Kayla Pantoja, Keisha Martin-Velez, Kristin, Liliana Jaimes, Lindsay Kyle, Lindsey Brennan, Lisa Girard, Liz Downing, Liz Sitler, Lori Stanczyc, Lorna Thomas- Farquharson, Luz Villfane, Lyne Landry, M. Alex Geertsma, Mai Kader, Marelin Recinos, Mariel Conception, Marijane Carey, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Melanie Wilde-Lane, Michelle Queen, Mikhela Hull, Neisha Jones, Olivia Newman, Pam Williams, Penny Lemery, Peter Samenfink, Quiana Mayo, Rebecca LaMarre, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Sabra Mayo, Sandra Rivera, Sandra Williams, Sarah Gibson, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, SowahA, Stephanie Joanis, Steve Rodriguez, Tania Santana, Tarsha, Teresa, TH, Tom Cosker, Tory Soucy, Xavier Williams, Yvette Young, and nine phone numbers

Welcome and Introductions
- CBHAC's mission, purpose and priority areas were reviewed
- CBHAC's 25th anniversary

Review of 2022-2025 Priority Areas
1. Pediatric primary care and behavioral health care integration
2. Disparities and access to cultural appropriate care
3. Access to comprehensive array of services and support

CBHAC Committee Members Monthly Recap (May 2025)

Agency Updates

1. **Department of Mental Health and Addiction Services (DMHAS) –Jenn Abbatemarco**
   - **No updates**
2. **Department of Education (DOE)– Kate Bohannan**
   - **No Updates**
3. **Court Support Services Division (CSSD) – Carmen Hernandez**
   - a new grant that our juvenile probation services union received
4. **Department of Social Services (DSS) – Connie Estanislau**
   - Legislative session closed. Working on how to move forward at this time and more information expected in coming months.
5. **Department of Children and Families (DCF)–Alice Demeo on behalf of Dr. Stephanie Bozak**
   - Department working internally to review the governor's budget
   - Conferences and events:
     - Reminder -a flyer was sent earlier to the CBHAC listserv about the Fatherhood Conference seeking proposals for breakout sessions
     - On July 1st, the NEST HUB (consultation for foster parents) will kick off in Region 4. Region 1 will follow.
     - The Help Me Grow National Conference is being held July 14-16 in Hartford. DCF is presenting and will be discussing several protocols which were drafted for providers with

service types that work with young children (such as Child First, Parenting Support Services). These services types work with families impacted by mental health, impacted by substance use, impacted by housing instability, and with children 0-5.

6. **Office of Early Childhood (OEC)- Lorna Thomas-Farquharson**
    - The National Help Me Grow conference will be held in Hartford from July14th-16th. The opening event takes place at Dunkin Park on that Monday, July 14th; the remainder of the conference sessions will be at the CT Convention Center. Additional information can be found here: https://helpmegrownational.org/our-affiliate-network/annual-forum/.

Monthly Presentation- (see handout)

Yale PRIME Clinic on Psychosis- Presented by Emily Farina, Ph.D.

Q: Sometimes symptoms go away and then come back—does that mean the schizophrenia is gone or still present? **A**: We don't fully understand why symptoms come and go. Often it's linked to life stressors—transitions, academic pressure, etc. For some, symptoms remit with treatment; for others, they persist despite care.

Q: Does trauma play a role in psychosis? How accurate is screening when many teens are in denial? What is the population of your research? How are black and brown communities being reached, especially with known disparities? **A**: Trauma can influence psychosis. Screening is difficult when youth are in denial or unaware. Only around 5% of early cases are caught. We're now working on universal screening in mental health clinics (ages 12–25). We're also partnering with local clinics to meet youth where they are, especially in communities of color, and offering evaluations and provider consultations to improve early identification.

Q: Are justice-involved youth being screened? Kids in the system often deal with trauma and may develop psychosis—are we evaluating them? **A**: Yes, that's a vital point. We're open to partnering with justice system stakeholders, including Court Support Services, to improve access to evaluation and care for those youth. Collaboration is welcomed to begin addressing this need.

Q: Your services begin at age 12. What about younger children (e.g., age 7) who are diagnosed with psychosis or schizophrenia but denied services because they don't meet eligibility requirements? **A**: This is a major service gap. There's limited training for child providers on psychosis and adult providers aren't equipped to work with younger children. We're working to consult with providers serving young kids and build bridges to support earlier intervention.

Presentation: Carelon First Episode Psychosis (FEP)- Presented by Michelle Queen

Q: Why are there still age-based restrictions on services for children diagnosed with psychosis or schizophrenia at an early age (e.g., under 12)? **A**: Early diagnoses are increasing, but many systems still enforce age restrictions, leaving families unsupported. The lack of early intervention leads to emotional dysregulation, behavior escalation, and even hospitalization. It's a serious systemic failure that imposes emotional and financial burdens on families.

Q: What is the actual barrier preventing services for younger children? Is it due to difficulties engaging them in treatment, or a lack of parental involvement? Could focus groups help identify solutions? **A**: The system has only recently expanded services from ages 16–26 down to 12 and up. Younger children are still largely excluded, partly due to lack of trained providers and systemic limitations. Suggestions like parent focus groups are valuable and may help in developing strategies to bridge this gap.

Q: What are some clinical challenges in treating or diagnosing younger children showing early signs of psychosis? **A**: One major issue is that younger children often don't fit well with current treatment models like CBT. Many are misdiagnosed or placed on heavy psychotropic medications prematurely. Often, their behavior is a response to environmental stress (e.g., bullying), and without long-term follow-up, misdiagnosis is common. Unfortunately, intervention usually only happens after a major crisis.

Voting Member Meeting

1. Reviewed a new voting member application. Application for new member approved by those in attendance.
2. Approved date change for July CBHAC meeting to July 11th.
3. Discussed July meeting and plan to vote on priority areas. Plan to include voting members in presenting the priority areas before the vote occurs.

Next meeting

July 11th, 2025

Reunión del Comité Asesor en Salud Conductual Infantil (CBHAC)
Acta - viernes 6 de junio de 2025

Asistencia:
Aimee Gelinas, Aleece Kelly, Alexandrino Rivera, Alice DeMeo, Aliyah Rosario, Amy Hilario, Andrea Richardson, April Mayo, Arthur Sandella, Ashley McAuliffe, Benita Toussiant, Bethany Zorba, Brenetta Henry, Briana Miller, Briannali Rivera, Cara Klaneski, Carmen Almodovar, Carmen Hernandez, Carolyn Westerholm, Christian D, Connie M Estanislau, Connie UHD, Consuelo Spanish Interpreter, Cynthia Cruz, Cynthia Petronio-Vazquez, Daniela Giordano, Derrick Shelton, Donald Vail, Dorothy Cimmino, Drew Lavallee, E Santiago, Ellender Mathis, Emily Farina, Erica Aldieri, Evan S. Dantos, Gabrielle Hall, Gina Bisogno, Hunter K., Jamie LoCurto, Janissa Vidal, Jenny Bridges, Joe Drane, Jon Jacaruso, Joyce, jsimilien, Jules Calabro, Julia Nelligan, Karen Delane, Karen Hurdle, Kayla Pantoja, Keisha Martin-Velez, Kristin, Liliana Jaimes, Lindsay Kyle, Lindsey Brennan, Lisa Girard, Liz Downing, Liz Sitler, Lori Stanczyc, Lorna Thomas- Farquharson, Luz Villfane, Lyne Landry, M. Alex Geertsma, Mai Kader, Marelin Recinos, Mariel Conception, Marijane Carey, Mary Hryniewicz, Marylou Woynar, Maureen O'Neil-Davis, Melanie Wilde-Lane, Michelle Queen, Mikhela Hull, Neisha Jones, Olivia Newman, Pam Williams, Penny Lemery, Peter Samenfink, Quiana Mayo, Rebecca LaMarre, Renee Wright, Richard Pimentel, Ronnie Vollano, Rosa Alvis Alvarado, Sabra Mayo, Sandra Rivera, Sandra Williams, Sarah Gibson, Sebastian Spencer, Shi-maine Holmes, Solai's Demorest, SowahA, Stephanie Joanis, Steve Rodriguez, Tania Santana, Tarsha, Teresa, TH, Tom Cosker, Tory Soucy, Xavier Williams, Yvette Young, and nine phone numbers

Bienvenida y presentaciones
- Se revisaron la misión, el propósito y las áreas de prioridad del Comité Asesor en Salud Conductual Infantil (CBHAC).
- 25.º aniversario del CBHAC

Revisión de las áreas prioritarias de 2022-2025
1. Integración de la atención primaria pediátrica y la atención de la salud conductual
2. Desigualdades y acceso a atención culturalmente apropiada
3. Acceso a un conjunto integral de servicios y apoyos

Resumen mensual de los miembros del Comité CBHAC (mayo de 2025)

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS) - Jenn Abbatemarco**
   - **Sin actualizaciones**
2. **Departamento de Educación (DOE) - Kate Bohannan**
   - **Sin actualizaciones**
3. **División de Servicios de Apoyo en Tribunales (CSSD) - Carmen Hernandez**
   - Un nuevo subsidio que recibió nuestro sindicato de servicios de libertad condicional juvenil.
4. **Departamento de Servicios Sociales (DSS) - Connie Estanislau**
   - Se cerró la sesión legislativa. En este momento se trabaja para determinar cómo avanzar y se espera recibir más información en los próximos meses.
5. **Departamento de Niños y Familias (DCF) – Alice Demeo en representación de la Dra. Stephanie Bozak**
   - El departamento está trabajando internamente para revisar el presupuesto del gobernador.
   - La conferencia sobre paternidad está buscando propuestas para las sesiones paralelas.
   - Conferencias y eventos
6. **Oficina de la Primera Infancia (OEC)- Lorna Thomas-Farquharson**
   - Conferencias y eventos

Presentación mensual - (Ver folleto)

Clínica PRIME de Yale sobre Psicosis – Presentado por Emily Farina, Ph.D.

P: A veces los síntomas desaparecen y luego regresan, ¿eso significa que la esquizofrenia ha desaparecido o que todavía está presente? **R**: No comprendemos con exactitud por qué los síntomas van y vienen. A menudo están vinculados a factores de estrés de la vida, como transiciones, presión académica, etc. En algunas personas, los síntomas pueden remitir con el tratamiento, para otras, persisten a pesar de la atención.

P: ¿El trauma juega un papel en la psicosis? ¿Qué tan precisas son las pruebas de detección cuando muchos adolescentes están en negación? ¿Cuál es la población de su investigación? ¿Cómo se está llegando a las comunidades negras y latinas, en especial si se consideran las desigualdades conocidas? **R**: El trauma puede influir en la psicosis. La detección puede ser difícil cuando los jóvenes están en negación o desconocen la situación. Solo se detecta alrededor del 5 % de los casos. En este momento estamos trabajando en la detección universal en clínicas de salud mental (de 12 a 25 años). También estamos colaborando con clínicas locales para atender a los jóvenes en donde se encuentran, especialmente en comunidades de color, y ofrecemos evaluaciones y consultas con profesionales para mejorar la identificación temprana.

P: ¿Se está realizando la detección en jóvenes involucrados en el sistema judicial? Los jóvenes en el sistema a menudo enfrentan traumas y pueden desarrollar psicosis, ¿los estamos evaluando? **R**: Sí, ese es un punto esencial. Estamos abiertos a colaborar con las partes interesadas del sistema judicial, incluidos los servicios de apoyo judicial, para mejorar el acceso a la evaluación y atención de estos jóvenes. Se da la bienvenida a la colaboración para comenzar a atender esta necesidad.

P: Sus servicios comienzan a la edad de 12 años. ¿Qué sucede con los niños más pequeños (por ejemplo, de 7 años) que tienen diagnósticos de psicosis o esquizofrenia pero se les niegan los servicios porque no cumplen con los requisitos de elegibilidad? **R**: Esta es una brecha del servicio importante. Hay capacitación limitada para los profesionales que atienden a niños sobre psicosis, y los proveedores de adultos no están preparados para trabajar con niños más pequeños. Estamos trabajando para consultar con los proveedores que atienden a niños pequeños y tender puentes que apoyen una intervención más temprana.

Presentación: Primer Episodio de Psicosis (FEP) de Carelon – Presentado por Michelle Queen

P: ¿Por qué siguen existiendo restricciones basadas en la edad para los servicios dirigidos a niños con diagnóstico de psicosis o esquizofrenia a una edad temprana (por ejemplo, menores de 12 años)? **R**: Los diagnósticos tempranos van en aumento, pero muchos sistemas aún imponen restricciones por edad, lo que deja a las familias sin apoyo. La falta de intervención temprana produce desregulación emocional, intensificación del comportamiento e incluso hospitalización. Es una falla sistémica grave que impone cargas emocionales y financieras para las familias.

P: ¿Cuál es la barrera real que impide brindar servicios a los niños más pequeños? ¿Se debe a las dificultades para involucrarlos en el tratamiento o a la falta de participación de los padres? ¿Podrían los grupos focales ayudar a identificar soluciones? **R**: El sistema ha ampliado recientemente los servicios, que antes eran para personas de 16 a 26 años, para incluir ahora a partir de los 12 años. Los niños más pequeños siguen excluidos en gran medida, lo que se debe, en parte a la falta de proveedores capacitados y las limitaciones sistémicas. Sugerencias como la realización de grupos focales con padres son valiosas y podrían contribuir al desarrollo de estrategias para cerrar esta brecha.

P: ¿Cuáles son algunos de los desafíos clínicos al diagnosticar o tratar a niños pequeños que muestran signos tempranos de psicosis? **R**: Un problema importante es que los niños más pequeños a menudo no encajan bien con los modelos de tratamiento actuales, como la terapia cognitivo-conductual (CBT). Muchos son mal diagnosticados o reciben medicamentos psicotrópicos fuertes de manera prematura. A menudo, su comportamiento es una respuesta al estrés ambiental (por ejemplo, el acoso escolar), y sin un seguimiento a largo plazo, el diagnóstico erróneo es frecuente. Por desgracia, la intervención suele producirse después de una crisis importante.

Anuncios a la comunidad

- La División de Servicios de Apoyo Familiar de la Oficina de Primera Infancia coorganiza un próximo evento nacional del foro para niñas saludables.
    - Del 14 al 16 de julio en Hartford en Dunkin Park
- El 1 de julio se realizará el Nest Hub, que es un servicio de consulta para padres de crianza.
- La conferencia de Help Me Grow se realizará en Hartford del 14 al 16 de julio. El DCF hará una presentación.

Próxima reunión:

11 de julio de 2025

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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Jennifer Abbatemarco	State Employees			
Jennifer Abbatemarco	Youth/adolescent representative (or member from an organization serving young people)			
Donaicis Alers	State Employees			
Janice Andersen	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Nan Arnstein	Providers			
Kate Bohannan	State Employees			
Chlo-Ann Borbrowski	State Employees			
Herb Boyd	Representatives from Federally Recognized Tribes			
Stephanie Bozak	State Employees			
Eileen Bronko	Parents of children with SED			
Jennifer Bukley	Advocates/representatives who are not state employees or providers			
Craig Burns	State Employees			
Erica Charles Davy	Parents of children with SED			
Yvette Cortez	State Employees			
Ellen Econs	State Employees			
Antonia Edwards	Parents of children with SED			

William Erdman	Persons in Recovery from or providing treatment for or advocating for SUD services			
Maria Feliciano	Providers			
Maria Feliciano	Advocates/representatives who are not state employees or providers			
Michaela Fissel	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kathy Flaherty	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Allison Fulton	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Katie Gallo	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Dr. M. Alex Geertsma	Providers			
Holly Hackett	Providers			
Gabrielle Hall	Providers			
William Halsey	State Employees			
Josephine Hawke	Parents of children with SED			
Brenetta Henry	Parents of children with SED			
Carmen Hernandez	State Employees			
Lindsay Kyle	Providers			
Lynne Landry	Providers			
Pamela Mautte	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Sabra Mayo	Parents of children with SED			
George McDonald	Parents of children with SED			
Giovanna Mozzo	Advocates/representatives who are not state employees or providers			
Allyson Nadeau	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
	Family members of individuals in recovery			

Rita Natale	(family members of adults with SMI and family members who are not parents of children with SED)			
Maureen O'Neil-Davis	Parents of children with SED			
Maureen O'Neill-Davis	Parents of children with SED			
Heidi Pettersen	Persons in Recovery from or providing treatment for or advocating for SUD services			
Yolanda Stinson	Parents of children with SED			
Peter Tolisano	State Employees			
Peter Tolisano, Jr.	State Employees			
Renee Toper	Parents of children with SED			
Benita Toussaint	Parents of children with SED			
Doriana Vicedomini	Parents of children with SED			
Laura Watson	State Employees			
Yvette Young	Providers			

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	3	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	5	
3. Parents of children with SED	13	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**21**	**42.86%**
6. State Employees	13	
7. Providers	8	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**21**	**42.86%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	2	
11. Representatives from Federally Recognized Tribes	1	
12. Youth/adolescent representative (or member from an organization serving young people)	1	
13. Advocates/representatives who are not state employees or providers	3	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**7**	**14.29%**
16. Total membership (all members of the council)	**49**	

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Footnotes:

William Halsey is a representative for State social services agency, state Medicaid agency, as well as the as the state marketplace/exchange agency (the same state agency covers these areas).

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

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:

https://portal.ct.gov/DMHAS/Divisions/EQMI/Planning-Unit---Block-Grants

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

The final version of the previous application and plan was posted to the DMHAS website. However, the state only maintains the most current block grant application and plan on the DMHAS website. As such, the final application from the previous year was taken down in August 2025 and replaced by the current application and plan on the state website so there is not a unique URL for the previous year's plan.

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

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 SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG 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 SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

CT does not use SUPTRSBG funds for SSPs