Connecticut

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 11/06/2023 3.21.56 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID R2J2V5BZNGY2

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

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

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

First Name 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	8/31/2023 12:22:15 PM
Revision Date	10/23/2023 4:10:48 PM

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: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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: Connecticut

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

Signature of CEO or Designee[1]: Ned Lamont

Title: Governor

Date Signed: 7/19/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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 III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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.

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grant 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 U.S.C. 300x-9
Section 1920	Crisis Services	42 U.S.C. 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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.

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: Ned Lamont

Title: Governor

Date Signed: 7/19/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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.

Currently, Connecticut's continuum of crisis care and mental health emergency response consists 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. Historically, crisis respite beds are in high demand, limited in number, and difficult to access when needed during a mental health emergency affecting many individuals. Currently, there are no options in this portfolio for a home-like, trauma-informed, stimulation-free environment that individuals may need. Therefore, individuals in crisis are often sent to the emergency department for further evaluation when no other level of care is available or appropriate. Connecticut recognizes that our services could be augmented and expanded in a way that improves our ability to respond to mental health emergencies and to 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 second 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 a Peer Respite Center for adults 18 and older.

Peer Respite Centers offer an alternative to emergency department and psychiatric hospitalization admission by providing 23-hour crisis respite and observation in the community. Peer Respite centers are small (e.g., 6-16 beds), and are designed to be more home-like than institutional. They are 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 23-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 active psychosis and first-episode psychosis. As such, Connecticut plans to use ESMI/FEP set-aside funding from the BSCA MHBG to support 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 will make up over 10% of those admitted to the Peer Respite center. These centers offer 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 Peer Respite 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. Connecticut expects this to result in an increase in 988 call volume from school age children and youth. To prepare for this increase and 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 (2nd Allotment)

Major Need/Set Aside	Activity	Total
ESMI/FEP	Peer Respite*	$73,548
Crisis Services	Peer Respite	$441,286
Crisis Services (Children and Youth)	Fund two contact specialists within statewide crisis call center that will be focused on responding to calls from youth	$220,643
		$735,477

*Based on ED utilization data in Connecticut and existing literature, 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: 04/19/2021 Expires: 04/30/2024

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 M/SUD prevention (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 M/SUD 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 M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. 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."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State of Connecticut
Combined MHBG/SUPTRS Block Grant Application
Federal Fiscal Year 2024 - 2025

The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) prepared the State of Connecticut FFY 2024-2025 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.

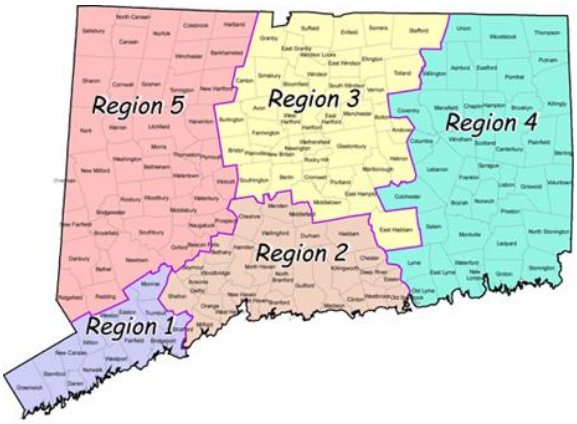
Table of Contents

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

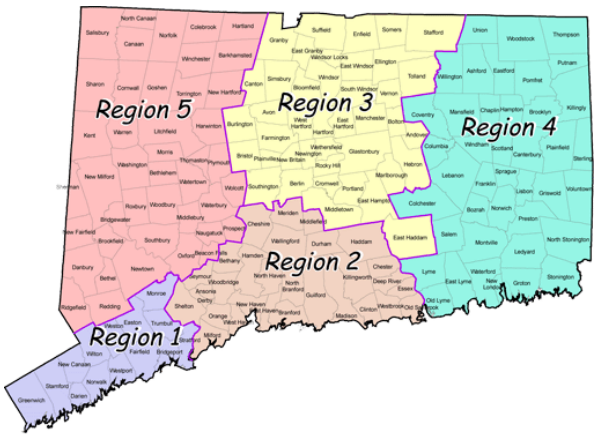
TurningPointCT.org, a website created by young adults for young adults, offers an online peer support community and uses technology to strengthen young adult engagement in mental health and substance use recovery by providing resources, developmentally relevant information, and social support. Enhancements 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.

Children's plan Step I

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

Provide an overview of the state's M/SUD prevention (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 M/SUD 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 M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

*Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. 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."*

Overview

Connecticut

Geographically, Connecticut is a small state and is ranked 48th in size by square area with approximately 5,500 square miles. Connecticut is the 29th most populated state with 3.6 million residents of whom 732,493(or 20.2%) are children and youth. CT population consists of 51% female. The racial breakdown is as follows: White alone 78.4%, Black or African American alone 12.9%; American Indian and Alaska Native alone 0.7%; Asian alone 5.2%; Native Hawaiian and Other Pacific Islander alone 0.1%; Two or More Races 2.7%; Hispanic or Latino 18.2%; White alone, not Hispanic or Latino 63.9%. The median household income in CT is $83,572, with 13% of children under 18 living in poverty. Approximately 40% of CT's children are Medicaid eligible. The contrast in Connecticut is of some of the largest gaps between the richest and poorest residents.

While approximately 10% of Connecticut (CT) youth have SED and need intensive mental health services, the use of restrictive services remains too high and there is a need for more services/supports to occur through integrated community-based care. The Department of Children and families continues to promote a system of coordinated, evidence-based services appropriate for all members of our community, including those in rural areas. Connecticut DCF identified barriers in access to treatment in many rural

areas across the state. A plan to improve access to behavioral health services includes increased partnerships with local primary care physicians to foster the integration of specialty behavioral health and primary/general medical care services. DCF has also partnered with local school districts throughout the state to offer in-school behavioral health treatment and supports to students. Some services available to youth in rural school districts are CBITS, Bounce Back and Extended Day Treatment programs. Districts also have access to the School Health Assessment and Performance Evaluation (SHAPE) System, which is a public-access, web-based platform that offers schools, districts, and states a workspace and targeted resources to support school mental health quality improvement. Connecticut's system of care continues to grow and increase access to services in our rural communities.

With data gathered from the Unites States Census from 2020, the percentage for all low income and poor children in Connecticut increased from the previous year, suggesting that more families fell into poverty. The negative impacts of poverty are well-known, including increased likelihood of child welfare engagement and foster care. The rate of children living at or below the Federal Poverty Level varies widely in Connecticut, by location, race and household structure. Hispanics & African Americans make up most people in poverty in Connecticut. DCF continues to serve disproportionately greater numbers of children of African American and Hispanic heritage, many of whom live in single parent families and all of whom have been referred for services due to abuse, neglect, mental health or juvenile justice problems. The below plan will enable CT DCF to enhance the system of community-based behavioral health services for children and their families, and better meet the needs of children with serious emotional disturbance throughout our State.

The Department of Children and Families (DCF)

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

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

provided out of the child's home, whether in foster care, residential treatment or other facilities, they are designed to return children safely and permanently back to the community.

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

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

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

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

Behavioral Health Assessment and Plan – Children's Services

Organizational Structure - State Level (DCF)

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

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

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

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

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

DCF Strategic Goals:

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

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

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

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

This means:

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

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

Role of the State Mental Health Agency for Children:

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

Children's Behavioral Health Plan:
Connecticut continues to use the behavioral health plan developed in the fall of 2014 as the blueprint to develop a comprehensive and integrated behavioral health system that meets the behavioral health needs of CT children and to prevent and/ or reduce the long term negative impact for children with mental, emotional and

behavioral health issues. The Behavioral Health Plan specifically focused on DCF addressing the following areas:

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

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

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

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

Over the last 4 years, each of the twelve agencies named has actively engaged in the design, planning, implementation and evaluative components of this work, and

while the work continues, advances have been made but challenges remain. The system has seen areas of improved integration between behavioral health, pediatrics and education as well as additional investments in community-based services, all this despite budgetary constraints and organizational shifts in mandates and oversight, the impact of which is yet to be determined.

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

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

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

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

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

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

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

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

Children's Behavioral Health Advisory Committee (CBHAC): Established by Connecticut Public Act 00-188, CBHAC fulfills the role of the statewide Coordinate Care Committee for systems of care as mandated in Public Law 97-272 and the State of Connecticut's Children's Mental Health Planning and Advisory Council pursuant to Public Laws 99-660, 101-639 and 102-321. Its mission is to promote and enhance the provision of mental health services for all children and youth in the state of Connecticut. The committee supports DCF's efforts in meeting the mental health needs of children, youth and families.

The committee meets monthly and evaluates and submits an annual report on the status of the local systems of care, reviews the practice standards for each service type, and submits recommendations to the State Advisory Council on Children and Families and the Children's Behavioral Health Plan Implementation Advisory Board. It submits biannual “recommendations concerning the provision of mental health services for all children in the state” to DCF. The committee advises on the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. CBHAC members also participate as advocates for children with serious emotional disturbance and monitor, review and evaluate the allocation and adequacy of mental health services within the state.

The committee has standing sub-committees which include: (1) Nominations and Membership; (2) Statewide Culturally and Linguistically Appropriate Services Advisory Committee; (3) Local Systems of Care / Behavioral Health Services; (4) Practice Standards Review; and (5) Mental Health Block Grant. The majority of CBHAC members must be “parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child” and appointed members are limited to three two-year terms.

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

Connecticut Community Non-Profit Alliance (The Alliance): This member based association represents Connecticut organizations that provide services for children, adults and families in the areas of mental health, substance use disorders, developmental disabilities, child and family health and well-being, and other related areas. The association’s mission is to achieve service system change, represent the voices of its members at local, state and federal levels, and support the delivery of high

quality, efficient and effective services. Member organizations deliver services to around 500,000 Connecticut residents each year. The Alliance collaborates with DCF in addressing the mental health needs of Connecticut's children, youth and families.

State Agency Collaborations

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

1. Alcohol and Drug Policy Council (DMHAS)
2. Transitioning Young Adults (DMHAS)
3. CT Strong (DMHAS)
4. Project Safe (DMHAS)
5. Project Safe RSVP, (DMHAS) - a family court diversion program.
6. Joint State Behavioral Health Planning Council (DMHAS)-to develop and evaluate the Block Grant Application and Plan as well as the Implementation Report each year
7. Management of Public Health Behavioral Health System for Medicaid Recipients (DMHAS, DSS)
8. Birth to Three Services (Office of Early Childhood)
9. Policy improvements and transportation issues related to foster children (SDE)
10. The shared dissemination of evidence-based practices such as Multi-Systemic Therapy and Multi-Dimensional Family Therapy (CSSD)
11. Adolescent Community Reinforcement Approach (CSSD)
12. School Based Diversion Initiative (CSSD)
13. IMPACT (CSSD)
14. FBR evaluation (UCONN Health Center)
15. Supportive Housing and Homelessness (DOH)
16. Elm City Project Launch (DPH)
17. Project AWARE (SDE)
18. School-Based Diversion Initiative (CSSD, SDE, DMHAS)
19. Cognitive Behavioral Intervention for Trauma in Schools (DCF, SDE)
20. Bounce Back (DCF, SDE)
21. School Health Assessment and Performance Evaluation System (DCF, SDE)

Administrative Service Organization Partnership

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

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

Licensing Mental Health and Related Services

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

Credentialing Mental Health and Related Services

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

supervised visitation services, and temporary care services. The credentialing process includes:

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

Mental Health Services Oversight

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

Description of the State Mental Health Service System for Children:

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

Access to Services:

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

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

The DCF flexible funding:

- Supports the wraparound child and family team meeting process and are tied to an objective in a child's Individualized Plan of Care. These may include a variety of non-traditional and unique services, supports or care.
- Supports families with children who have significant behavioral health needs. Assists the child and family in achieving the therapeutic goals outlined in the Plan of Care (POC).
- Helps children remain in their home and community; and achieve the highest level of functioning and life satisfaction possible as its goal.
- Must be the payer of last resort. In the case of funding for clinical services that would otherwise be reimbursed by third parties - Medicaid, private insurance, etc.

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

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

The working group consists of representatives from the following:

- Grants and Contracts Specialists
- Fiscal
- Contracts Managers
- Director of Performance Management
- Program Development Oversight Coordinator (PDOC)
- Systems Program Directors

- Administrative Case Review Manager
- Revenue Enhancement Manager
- Directors from Clinical and Community Consultation and Support Division

DCF, in partnership with the Connecticut Child Health and Development Institute, service providers and academic institutions has disseminated a range of evidence-based and best practice mental health service models. These community-based service models result in improved service outcomes for children, youth and families. They include

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

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

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

Connecticut's Human Ant trafficking Response Team (HART) is coordinated by the Department of Children and Families (DCF). DCF includes child trafficking

under its mandated reporting guidelines requiring all cases be called into the DCF Careline. This structure uniquely affords all child victims of trafficking the resources needed to ensure safety and service provision. Public Awareness is a key component of the work conducted through HART. Over the past four years, we have provided 600 trainings and reached over 14,000 individuals. We have also offered over 25 TOTs in our various curriculums resulting in over 200 trainers in the State. We currently offer 10 training curricula for professionals, youth and community members.

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

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

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

Community Based Services versus Congregate Care Services
In 2011, DCF began the process of instituting several practice changes to ensure that children and youth with mental health and related service needs grow up in families and receive their services in the community. This meant increasing the state's capacity to serve children and youth in families and the community and reducing the use of more restrictive and costly congregate care.

Historically, Connecticut had one of the highest rates of children and youth placed in congregate care in the nation. For example, in December 2010, DCF had 367 children and youth placed in congregate care settings outside of the state, and in years prior to 2010 there were times when there were more than 500 children and youth placed outside of the state. During this same period, the number of children and youth placed in congregate care settings within Connecticut were at an all-time high. Additionally, use of foster and relative families was well below the national average.

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

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

- The Department currently has 3,081 children in placement under age 18.
- As of 8/1/2023, 5.8% of all children in care under age 18 are in congregate care.
- As of 8/1/2023, 40.9% of children are placed with kin.
- As of 8/1/2023, 4 children are placed outside of Connecticut in congregate care programs.

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

Care Coordination - This service provides high fidelity "Wraparound" using the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths with serious or complex needs and is a means for maintaining youth with the most serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally

competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

Caregiver Support Team - Kinship Navigation - ConnectiKIN (C-KIN) program is an innovative statewide Kinship Navigator Program that partners with kinship caregivers to provide the connections, supports, and resources needed to raise resilient children who thrive. C-KIN also aims to provide opportunities for community outreach, connections, and collaboration so that equitable and consistent support is provided to build the confidence, connections, and self-reliance of kinship families.

Community Support for Families - This service will engage families who have received a Family Assessment Response from the Department and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership place the family in the lead role of its own service delivery. The role of the contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an array of supports and resources within their community.

Connecticut Access Mental Health- a consultative pediatric psychiatry service to be made available to all pediatric and family physician primary care provider practices ("PCPPs") treating children, youth, and young adults, including individuals up to their 22nd birthday irrespective of insurance coverage.
The purpose of ACCESS-MH is to improve access to treatment for children, youth and young adults with behavioral health or psychiatric problems, and to promote productive relationships between primary care and child psychiatry to support selective utilization of scarce resources. The program is designed to increase the competencies of Primary Care Providers to identify and treat behavioral health disorders in children and adolescents and to increase their knowledge/awareness of local resources designed to serve the needs of children and youth with these disorders. The service is to be delivered primarily through telephonic communication by members of the consulting team from each of the ACCESS-MH Provider Hubs. When warranted, circumstances may require face to face consultation with the primary care practitioner or in person behavioral health assessment of the child and/or family for whom the primary care practitioner is seeking consultative support.

Early Childhood Services - Child FIRST - This service provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect.

Extended Day Treatment - This service is a site-based, before and/or after school, treatment and support service for children and youth with behavioral health needs who have returned from out-of-home care or are at risk of placement due to mental health issues or emotional disturbance. For an average period of up to six months, a comprehensive array of clinical services supplemented with psychosocial rehabilitation activities are provided to the child/youth and his/her parent(s). A treatment plan is developed cooperatively. Transportation is provided

by or through the contractor or the Local Education Authority (LEA). Parents and DCF are full partners in all discharge planning.

Fatherhood Engagement Services - This service provides intensive outreach, case management services and 24/7 Dad© group programming to fathers involved with an open DCF case, as such services and service frequency are defined herein. The purpose of this program is to enhance the level of involvement of fathers in their DCF case planning, provision of services and positive parenting. Case management services will help to mitigate barriers to more effective engagement through assessment of needs, advocacy and linkage to supports and services, while group 24/7 Dad© services will teach skills and characteristics to strengthen the father's parenting relationship.

Fatherhood Engagement Services - Incarcerated - Fatherhood Engagement Services: CTDOC Team is a collaboration between the Department of Correction (CTDOC) and DCF. This program provides intensive outreach, support, advocacy and linkage to community-based Fatherhood Engagement Services (FES) to incarcerated fathers with an open DCF case. The purpose of the program is to strengthen the father's parenting skills and relationship with his children as well as to enhance the level of involvement of incarcerated fathers with DCF

Fetal Alcohol Spectrum Disorder (FASD) and Substance Exposed Infants (SEI) Statewide Coordination - This position oversees the implementation of a statewide plan for infants affected by substance exposure.

First Episode Psychosis (FEP) - This service provides early identification of a first episode of psychosis for youth and young adults ages 16 to 26, rapid referral to evidence-based services, and effective engagement in care coordination, which are all essential to preventing the chronic functional deterioration common in psychotic disorders.

Juvenile Review Board Support and Enhancement - This service provides funding to local Juvenile Review Board's to create, support and enhance services delivered to youth served by the Juvenile Review Board (JRB). Conducts a needs assessment of every existing JRB in the regional catchment area and determine if each JRB meets the criteria outlined in the target population to request support and enhancement funding. The specific support and enhancements needed may vary based on the number of JRB's, existing case managers and community partnerships in a locality.

Mental Health Consultation to Childcare - This service promotes and facilitates the early identification of behavioral challenges and mental health needs in children who participate in daycare and early childhood education settings. Once needs are identified, strategies which prevent children from disrupting from their homes and day care settings are implemented. Families are given opportunities to partner as active participants at multiple levels including home visits, center-based planning, child specific intervention strategies and collaborative planning and implementing strategies and activities within the classroom.

Prevention Care Management Entity - Works with families, local providers, and DCF to ensure access for Connecticut's children and their families to parenting services, behavioral

health services and other services that prevent instances of child abuse and neglect. The Contractor will provide intensive care coordination using a wraparound approach to achieve optimal outcomes for children, youth, and families through comprehensive needs assessments and the use of care management, service referral, and monitoring of ongoing progress of families.

Therapeutic Child Care - A licensed center-based facility, designed for children ages 2 years and 9 months to (but not including) kindergarten who have behavioral health and/or developmental needs. Twelve (12) of the children are served in an Intensive level (Level 1) in the Contractor's facility where they will be given interventions based upon on-going assessments that will prepare them to function in regular child care settings. Eighteen (18) of the children (Level 2) will be supported in regular child care setting until they no longer require additional supports.

Therapeutic Child Care: Trauma Informed - This service offers a range of support services for children in a childcare facility, including parent-child programs and an after-school program. The target population is children ages birth to 8 years old. The primary activity is the teaching of parenting skills as parents participate with their child in the childcare setting. With new understanding and skills on the part of the parents, DCF is less likely to become involved and children are less likely to be removed from the home.

Child, Youth and Family Evaluations

Child Abuse Centers Of Excellence - This service provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff to help ensure the safety and well-being of children. Included in medical services is consultation to DCF regarding child sexual abuse and physical abuse evaluations, which may include comprehensive and specialized medical examinations.

Multidisciplinary Examination (MDE) Clinic - This service provides a comprehensive multidisciplinary evaluation including medical, dental, mental health, developmental, psychosocial and substance abuse screening for children placed in DCF care for the first time. A comprehensive summary report of findings compiled from the multidisciplinary team and written by the Foster Clinic Coordinator is completed on each child referred for service. As appropriate, referral(s) to a specialized service are made.

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

Adolescent College Mentoring - This program is designed to improve educational equity and college graduation rates for youth who have experienced the foster care system. This service offers youth an array of services to support their post-secondary educational, career and social-emotional goals. Services are based on a four-domain framework that includes: academic mentoring, career development, advocacy and alumni networking supports.

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

Education Training Voucher Program - This is a statewide service for the purpose of distributing funds provided through the *Supporting Foster Youth and Families through the Pandemic Act* (Division X of P.L. 116-260). This Act provides Education Training Voucher (ETV) funding to assist youth who had been on track to attend or were attending post-secondary institutions or programs but had their education interrupted due to the COVID-19 pandemic. The funding is to be used to support and engage youth to explore when and how they can reconnect to their educational goals. Additionally, funding may also be used for expenses that are not part of the cost of school attendance, such as laptops or other technology necessary for virtual education; earbuds/earphones; desks; chairs; supplies; and tools for internet access.

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

Foster and Adoptive Parent Support Services - This service provides a range of recruitment, retention, support, education, training, and advocacy services to foster families, adoptive families and relative caregivers intended to address their needs, encourage and facilitate ongoing education and skill development, and promote safe and stable home settings for foster children. This service also increases the pool of foster and adoptive families who are available to serve children in the care of the Department of Children and Families.

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

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

Foster Parent Support for Medically Complex - This service, largely through the organization of a group of volunteers, provides foster care recruitment, respite and support focused on maintaining and growing the number of foster and adoptive parents who work with medically complex children in the Waterbury and Torrington area office towns. There is a child

care/activity component to the program and a limited amount of money is available for participating foster parents. There are two yearly celebrations, a holiday party and annual picnic.

Intimate Partner Violence -Family Assessment Intervention Response (IPV-FAIR) - This service establishes a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. This service provides a supportive service array of assessments, interventions and linkages to services to address the needs of families impacted by intimate partner violence. The service will respond to both caregivers and the children. Safety planning will be at the center of the service provision.

Juvenile Review Board - This service creates community based Juvenile Review Boards, i.e. panels of community volunteers, who recommend services that are then implemented in order to divert, from the juvenile justice system, first time misdemeanor or Class D Felony offenders and other qualifying children and youth under the Families with Service Needs (FWSN) statutes. The service builds relationships among community service providers and interested adults and empowering them to take responsibility for the well-being of the youth of the community. Referrals come from schools and police.

Multidisciplinary Team – This service promotes the coordination of investigations of and interventions for cases of child abuse/neglect among agencies, including DCF, police, medical, mental health, victim advocates, and prosecutors. Cases are referred to the regularly scheduled team meetings by DCF, law enforcement or other agency members of the team. A team Coordinator assumes the coordination and administrative responsibilities in addition to being an active member of the team. Training in aspects of child abuse and the investigation process is provided to the team members.

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

Quality Parenting Centers (QPC) - This service provides a site-based supervised parent/child visitation program (Family Time) designed to provide a safe and comfortable place for parents to interact with their children. The Contractor utilizes coaching and other strategies that provide parents with opportunities to learn and practice new skills and maintain the parent/child relationship.

Respite Care Services - This service provides brief and temporary home and community-based respite for children and youth, receiving care coordination who have serious emotional

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

Reunification and Therapeutic Family Time Services - This service engages, supports and intervenes with parents whose children are placed in out-of-home care by offering a menu of services designed to promote and effect successful reunification, strengthen parent/child relationships and attachments, and reduce the risk for further abuse and neglect. Three service types are used in combination with one another or may be referred for as individual components based on the needs of the family. The three service types are: 1) Reunification Readiness, 2) Reunification Services and 3) Therapeutic Family Time.

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

Statewide Family Organization - The Statewide Family Organization is responsible for the delivery of various services categories to support families who have children with serious behavioral or mental health needs. At the direct service level, "Family Advocates" provide support, both brief and long term, to parents and caregivers using wraparound and a peer support and assistance framework. At the regional level, "Family System Managers" are responsible for working closely with DCF and the Connecticut Behavioral Health Partnership (CT BHP) to assist the DCF Regions in developing linkages between local community groups and identifying and supporting informal support and service networks for families. At the statewide level, "Citizen Review Panels" are responsible for giving feedback to the Department regarding child protection services and for providing training and disseminating information to service providers and the public to enhance the ways families can positively impact the child protection and child treatment systems.

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

Supportive Housing for Families - This service provides subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency, and wellbeing of their children. Intensive case management services are

provided to assist individuals to develop and utilize a network of services in the following areas: economic, social, and health. Housing is secured in conjunction with the family and the Department of Social Services (DSS) provides a Section VIII voucher. Priority access is determined by the chronological order of referrals.

Supportive Work, Education & Transition Program (SWETP) - This service is a community-based stand alone, staffed apartment program that serves adolescents, age 16 and older, who are committed to DCF. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to: inter-personal awareness; community awareness and engagement; knowledge and management of medical conditions; and maximization of: 1) education, 2) vocation, and 3) community integration. There is on site, awake supervision, 24 hours a day, and seven days a week. Activities involving resident youth are supervised and managed at a level consistent with the nature of the activity and the individual needs of the involved youth.

Survivor Care: is an intensive community-based program designed to help youth and their families/caregivers understand, respond to, and recover from the impact of human trafficking/commercial sexual exploitation (HT/CSE) victimization. This program provides Long-Term Therapeutic Case Management services including but not limited to information and referral services, crisis intervention and safety planning, individual counseling, and advocacy and accompaniment to medical, law enforcement, court, and academic appointments. The program also offers Rapid Responses which are one-time interventions that provide children and caretakers with information, safety planning, and referral services related to HT/CSE.

Transitional Supports for Emerging Adults - This service assists Emerging Adults ("EA" or "young adult") with; securing suitable and stable housing, completing vocational and/or educational programs, obtaining sustainable employment, developing and maintaining loving, supportive, and permanent adult relationships, and developing the necessary life skills to successfully transition from DCF services. The YVLifeSet program utilizes evidence-based practices (EBPs) and best-practice interventions to support high-risk young people in their transition to adulthood. The contracted provider will be required to enter into a licensing agreement with the model Developer, Youth Villages, Inc.

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

Wendy's Wonderful Kids - This service is an evidence-based, child-focused model that has demonstrated positive outcomes regarding adoptions of DCF children in the following specialized groups: older children, children with specialized needs, and sibling groups.

Work / Learn Youth Program - This is a youth educational/vocational program providing supportive services to assist youth, ages 14 - 23, to successfully transition into adulthood. The program provides training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing. Youth also can take part in on site, youth run businesses.

Youth Empowerment - This multi -service program will engage non DCF involved at risk youth in the greater Bridgeport area in a wide array of services, supports, trainings, and recreational activities for youth. The target population for this program are at risk, low-income youth ages 13-18 living in the greater Bridgeport area.

Youth Link Mentoring - Youth Link Mentoring is defined as a supportive long-term relationship with a caring adult who has attributes and qualities in common with LGBTQIA+ adolescents which may include gender identity, gender expression, race, and ethnicity.

ZERO TO THREE Safe Babies Project - This service provides for the coordination of services to parents and children younger than 36 months in order to help speed reunification or another permanency goal when the children have been placed by court order outside of their homes for the first time.

Mental Health Treatment Services

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - CBITS is a skill-based, group intervention focused on decreasing symptoms of Post-Traumatic Stress Disorder (PTSD) and generalized anxiety among children and youth who have experienced trauma. This school-based treatment model enhances the school's mental health service array to support student's learning potential and build resiliency. CBITS minimizes developmental disruption and promotes child recovery and resiliency for students through a cognitive-behavioral therapy approach involving components of psychoeducation, relaxation, exposure, social problem solving, and cognitive restructuring. **Functional Family Therapy (FFT) -** This service provides an intensive period of clinical intervention, family support and empowerment, access to medication evaluation and management, crisis intervention and case management in order to stabilize children at risk of out-of-home placement due to mental health issues, emotional disturbance or substance abuse, or to assist in their successful return home from an alternative level of care. This service is delivered in accordance with the tenets of the evidence-based model known as Functional Family Therapy (FFT). 25% of the capacity is available to youth involved with DCF Juvenile Service - Parole. Length of service averages 4 months per youth served. Services include flexible, strength-based interventions, offered primarily in the client's home as well as in community agencies, schools and other natural settings.

Intensive Family Preservation - This service provides a short-term, intensive, in-home service designed to intervene quickly in order to reduce the risk of out of home placement and or abuse and/or neglect. Services are provided to families 24 hours per day, seven days a week with a minimum of 2 home visits per week including a minimum of 5 hours of face-to-face contact per week for up to 12 weeks. Staff work a flexible schedule, adhering to the needs of the family. A

Standardized assessment tool is used to develop a treatment plan. As needed families are linked to other therapeutic interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.

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

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - This service is a curriculum-based treatment model for children and adolescents with a DSM-V Axis I diagnosis who have complex behavioral health needs. The primary goal is to divert children and adolescents from psychiatric hospitalizations or to support discharge from inpatient levels of care. This intensive, home-based service is designed to address a child's specific psychiatric disorders while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's ability to function. This service offers five levels of intervention, from as little as 1-3 hours per week to as much as 12-20 hours per week as indicated.

Multidimensional Family Therapy (MDFT) - This service provides intensive home-based clinical interventions for children, ages **11 - 18**, with significant behavioral health service needs who are at imminent risk of removal from their home or who are returning home from a residential level of care. After a comprehensive evaluation, a strength-based Individualized Service Plan is developed to include goals, interventions, services and supports that address the issues and problems threatening the maintenance of the child in the home or the return of the child to the home. Staff work a flexible schedule, adhering to the needs of the family. Average length of service is 3 - 5 months per family.

Multidimensional Family Therapy (MDFT) Quality Assurance - Provides program development, training, clinical and programmatic consultation to providers of Multidimensional Family Therapy (MDFT) and MDFT: Helping Youth and Parents Engage in Recovery (HYPE Recovery) program. This service ensures that the MDFT providers integrate the standards and practices consistent with MDFT requirements and quality improvement programming to ensure the model fidelity that will result in improved outcomes for the families' served.

Multisystemic Therapy - Building Stronger Families - This service, using a national evidence-based treatment model, provides intensive family and community based treatment to families that are active cases with (DCF) due to the physical abuse and/or neglect of a child in the family and due to the abuse of or dependence upon marijuana and/or cocaine by at least one caregiver in the family. Core services include clinical services, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 8 months per family.

Multisystemic Therapy - Emerging Adults - This service was designed for young people aged 17-21 at the highest risk for negative outcomes – those with multiple co-occurring problems and extensive systems involvement. The Connecticut MST-EA program will serve youth between their 17th and 21st birthdays who (1) are aging out of foster care or involved in the child welfare system and (2) have a behavioral health condition(s) (i.e., serious mental health and/or substance use disorders).

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

Multisystemic Therapy: Intimate Partner Violence (MST-IPV) - This service, based upon an evidence-based treatment model, provides intensive family and community based treatment to families that are active cases with the Department of Children and Families (DCF) due to the physical abuse and/or neglect of a child in the family and due to the impact of intimate partner violence within the family.

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

New Haven Trauma Network - The New Haven Trauma Network is a collaboration led by Clifford Beers Clinic that has four (4) components: Care Coordination, Short term assessment, screening, and direct service for children; Trauma informed training & workforce development. These Four Components will be a trauma-informed collaborative network of care to address adverse childhood experiences (ACE). The network will involve the Greater New Haven community and its focus aims to: a) Create a safer, healthier community for children and families; b) Reducing community violence; c) Reduce school failure and dropout rates; d) Reduce incarceration rates; e) Improving overall health of children and families; and f) Coalition or network infrastructure support.

Outpatient Psychiatric Clinic for Children (aka Child Guidance Clinic) - This program provides a range of outpatient mental health services for children, youth and their families. The primary service is individual and family counseling. Services are designed to promote mental health and improve functioning in children, youth and families and to decrease the prevalence of and incidence of mental illness, emotional disturbance and social dysfunction. DCF referrals

receive priority consideration. The severity of each referral determines whether an appointment be given that same day, within 3 business days, within 14 calendar days or within 30 calendar days. Services are rendered at the clinic site or at a satellite site.

Outpatient Urban Trauma Network - provide outpatient mental health services for children and their families. There are three service components: (1) general outpatient mental health treatment for children and their families (2) specific outpatient treatment to a select target population of Black, Indigenous, Latinx , and other minority children and their families and (3) community-based organizational activities to support the treatment and recovery of children who have been exposed to urban and racial trauma.

Substance Abuse Treatment Services

ASSERT Treatment Model (ATM) is a service that is being piloted and introduced within four (4) existing Connecticut Multidimensional Family Therapy (MDFT) teams. ATM provides treatment for adolescents and young adults 16-21 years old with opioid use problems. ATM combines three services: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Management Checkups and Support (RMCS) to reduce opioid use and commonly associated substance use problems and offers up to 12 months of support after treatment ends.

Functional Family Therapy - Foster Care - An evidenced based in-home clinical intervention with a relational focus on the family unit for DCF-involved children receiving clinical treatment within a Therapeutic Foster Care setting. In addition to clinical treatment, FFT FC also offers corresponding case management services. Birth Families and Foster Families are the primary unit of intervention. FFT FC is built on the core FFT model; it is completed once with the foster family and again with the birth family when the youth is reunified. The Contractor and Foster Parents will receive initial training on the FFT FC Model from FFT FC Partners. Upon completion of initial training both the Contractor and Foster Parents will receive ongoing clinical consultation and booster training for the first three years of implementation.

Helping Youth & Parents Enter Recovery - Integrates three (3) evidence-based service components: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Monitoring and Support. These components are designed to deliver high quality outcomes-based substance use treatment, ensure access to medication assisted treatment (MAT) when needed and desired during treatment, and provide a period of recovery support services after the substance use treatment component is completed

SAFE Family Recovery - SAFE Family Recovery provides three evidence-based approaches in order to identify, engage in substance use treatment, and support parents/caregivers impacted by substance use. The three services are Screening, Brief Intervention, and Referral to Treatment (SBIRT), Multidimensional Family Recovery (MDFR), and Recovery Management Check-ups and Support (RMCS).

Substance Screening, Treatment and Recovery for Youth - Provides two (2) distinctive services using three (3) evidence-based approaches in order to identify, engage in substance use

treatment, and recovery support for adolescents and young adults impacted by substance use. The two services are:
Screening, Brief Intervention, and Referral to Treatment (SBIRT) - an evidence-based public health approach to identifying risky alcohol and other substance use and when appropriate using motivational interviewing to build a client's readiness to accept a referral to treatment; and community reinforcement Approach (CRA) - Assertive Continuing Care (ACC) is an evidence-based behavioral therapy and recovery support intervention that seeks to use social, recreational, familial, school, or vocational reinforcers and skill training to replace substance use by emphasizing engagement in positive social activity, positive peer relationships, improved family relationships, and case management.

Evidence Based Treatment Programs

Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC) is an evidence-based substance use outpatient substance use treatment program for adolescents ages 12 through 17 years and their caregivers. The model provides a combination of clinic, community, and home-based services, based on the individualized need of the youth and family served.

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

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

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

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

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

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

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

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

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

Multidimensional Family Therapy (MDFT) is an evidence based, comprehensive and multisystemic family-based in-home program for adolescents using substances, adolescents with

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

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

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

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

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

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Detailed information about implementing SBIRT is available in SAMHSA's Technical Assistance Publication Series 33.

SBIRT uses valid and reliable screening tools to assess the presence and level of substance use problems. Screening provides opportunities for early intervention with persons who are at-risk of substance use problems, or to engage persons with more severe substance use into treatment. The Department desires to achieve the following goals with SBIRT:

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

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

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - Trauma-Focused Cognitive Behavioral Therapy is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.

Crisis Services

Mobile Crisis Intervention Services - Mobile Crisis Intervention Services is a mobile, crisis intervention service for children experiencing behavioral health or psychiatric emergencies. The service is to be delivered through a face-to-face mobile response to the child's home, school or location preferred by the family, or in rare situations through a telephonic intervention. MCIS are available 24 hours per day, 7 days per week, 365 days per year to respond in-person to a child in crisis.

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

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

Sub-Acute Crisis Stabilization - Serve youth/young adults experiencing behavioral health crises and is responsible for de-escalating and stabilizing the youth/young adult, completing a comprehensive diagnostic assessment (screening and assessment results from the referring party may be used as relevant), developing a treatment plan, providing individual, group and family treatment, providing ongoing observation and stabilization, collaboration with caregivers, schools, primary care physicians and other pertinent treater(s) on a discharge plan, and referring to ongoing care at the appropriate level via a warm hand off with follow up when necessary to ensure needs are met. Reimbursement should be sought from Medicaid and commercial insurers for all eligible services.

Urgent Crisis Center (UCC) - Provides a full crisis assessment in a safe and effective location for youth experiencing a behavioral health crisis (mental health and/or substance use crisis. The contractor will: (1) receive youth and young adults ages 0-18 or up to age 21 if they are in DCF care or still in high school experiencing a behavioral health crisis via walk-in or police or ambulance drop off; (2) triage youth based on risk and needs; (3) provide de-escalation and crisis stabilization services; (4) offer a thorough assessment to determine appropriate level of care; (5)

develop a crisis safety plan collaboratively with the family and any current existing treater(s); and (6) based on assessment results, coordinate care for youth/young adults and families to receive the appropriate level of care and type of services to meet their needs.

Urgent Crisis Center - Emergency Department (UCC) - Provides a full crisis assessment in a safe and effective location for youth experiencing a behavioral health crisis (mental health and/or substance use crisis). Services will be provided to youth ages 0-15 and may use PCIU for youth/young adults with developmental disabilities or mitigating factors ages 16-18 or up to age 21 if they are in DCF care or still in high school. Youth/young adults ages 16-18 or up to age 21 if they are in DCF care or still in high school will receive services at Yale New Haven Hospital ED Adult Crisis Intervention Unit.

Residential

Residential Treatment Center - A congregate model of care that provides a diverse array of integrated behavioral and mental health treatment and rehabilitative support services for youth who have significant and complex emotional and behavioral disorders and their families/caregivers, in partnership with DCF and the broader system of care. The services provided will meet the individualized needs of each youth and family and will be delivered through a structured, intensive, therapeutic milieu.

DCF Behavioral Health System Strengths

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

System of Trauma-Informed Care

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

mental health 42 challenges that require special care and treatment. This has significant implications for the delivery of services. The DCF trauma aware and trauma-informed system seeks to change the engagement paradigm with children, youth and families from one that asks, "What is wrong with you?" to one that asks, "What has happened to you?"

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

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

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

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

DCF continues to expand access to Cognitive Behavioral Intervention for Trauma in Schools (CBITS); an evidenced based treatment model for children suffering from post- traumatic stress symptoms as a result of trauma experiences in their lives. Eighteen school districts and over 50 schools are offering CBITS across the state. To date, more than 800 students have received treatment in school and the vast majority have successfully completed the intervention with an additional 10% partially completing the treatment course. One percent were referred on to other treatment options. There was a 41% reduction in PTSD symptoms, a 19% reduction in behavior problems from pre to post assessment, indicating significant improvements.
The statewide Mobile Crisis Service that DCF funds and oversees has staff trained in trauma principles and conducting trauma screening. This infuses trauma informed care in the state's crisis intervention. DCF has also been involved in providing pediatric primary care providers, school personnel and police with training on identifying and responding to child and youth trauma.

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

Infant Mental Health

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

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

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

An average of 40-50 DCF staff and their partners have attended each series. Topics included I/T Development & Behavior, Attachment, Trauma (1), Trauma (2), Visitation, Culture, Observation and Reflection. Continuing education credits have been offered by the Academy to

social workers. In addition, reflective supervision training was provided and practice in reflective supervision was offered through face-to-face coaching sessions.

The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department are planning to offer 1 statewide training eight session training series in the coming year.

Family/Caregiver Involvement

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

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

Collaboration Within and Across Agencies and Systems

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

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

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

2017, CT experienced 3 suicides per 100,000 youth. Medicaid provides health insurance for 357,525 low income children in Connecticut. The youth Medicaid membership has remained stable by age group. For families of four in Connecticut, children are eligible for Medicaid with family income up to $51,758. The uninsured rate for CT children is over 3%.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), 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 and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Children's Plan Step II

Connecticut is the 29th most populated state with a total population of about 3,576,500, and about 732,493 or 20.2% are children and youth under the age of eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, approximately 10% of Connecticut children are SED and in need of mental health services in Connecticut. (20% may have behavioral health symptoms). Despite the strengths of the Connecticut behavioral health system mentioned above, a number of families with children with SED struggle to find support and treatment.

DCF collects data on the number of children served in the behavioral health system which is used to complete the URS tables. DCF collects data on the number of children served in the behavioral health system which is used to complete the URS tables. In 2023, the child serving system 49,981 youth were served, 14,585 of this number were recipients of crisis services, which were largely unduplicated. And, 35,396 unduplicated children and youth received other services in the array.

Families experience a number of barriers to treatment. The COVID 19 pandemic resulted in unforeseen obstacles in education, mental/behavioral health access to service processes and action planning during the pandemic. FAVOR FSM's/organization wide system has worked to identify learning approaches and family engagement practice that do not work well during the COVID pandemic. Supporting a strategic network collaboration between schools and community is the goal for family care connections and bridging equity gaps. FAVOR Family Systems Manager promotion for improved community linkages at the local level means identifying resources available for youth and families and identifying families that do not have access.

In 2014, Connecticut developed a comprehensive plan to guide the efforts of multiple stake holders in developing a children's behavioral health system that builds on existing strengths and addresses the challenges that exist.

As part of the plan implementation, families were consulted over five years with the Statewide Family Advocacy Agency in consultation with Yale University. FAVOR facilitated Community Conversations across the state. The below chart delineates the number of participants. Beginning in August 2021, these conversations moved from formal facilitated conversations to informal discussions that were had by Peer Specialists.

The Impact of the Family-Led Community-Based Participatory Process

Year	Conversations Statewide	Adult	Youth	Total Families Per Year
2014	22	297	86	398
2016	19	257	44	301
2017	30	333	151	484
2018	33	298	88	386
2019	36	299	154	453
2020	42	324	102	426
Total	140	1484	523	2022

2018 Community Conversations Summary

Community Conversations Regarding Youth and Caregiver Perspectives of the Connecticut Network of Care

Between September 2019 until August 2021, a replication of the Community Conversation process was completed to gather input from families and youth regarding the Network of Care in Connecticut. A total of 36 conversations were held in 2019 with a total of 453 families served. In 2020 a total of 42 conversations were held with a total family serviced being 426. All conversations were facilitated by the Family Systems Managers from FAVOR. Family Systems Managers are family members who provide leadership and support to the development of the local, regional and statewide integrated family-driven network of care. As was done in 2014, 2016 and 2017, 2018 and 2019, participants were asked the following questions:

1. What are the strengths of Connecticut's service system for children and families?

   What is working well?
   What needs are being met?
   In what ways are services accessible for families?
   Do people know about the services that are available?

2. What are the major areas of concern within Connecticut's service system for

children and families?
What is missing from our system?
What needs are not being met?
What are some of the barriers families encounter when trying to access appropriate services?
Which populations within our communities experience greater difficulties accessing services? (ask about: race/ethnicity, language, gender, sexual orientation/identity)

3. How should we fix these problems? What are your suggestions to improve our system of care?
How would you like the system to work?
What services are most important so that all of our children and families have the supports they need?
What do we need to do to improve access to care for all of Connecticut's children and families?

Information from the Community Conversations was gathered through careful notes taken by network of care staff and then analyzed using standard procedures for analyzing qualitative data (Krueger, 1994); data was coded, aggregated and synthesized by FAVOR Family Systems Managers with support from an evaluator at Yale University. Only comments made by participants across different meetings or by consensus of one group of participants are included in the summary. Thus, not everything said in the community meetings were included in the results. Similarly, much of this information comes from additional sources, such as the Children's Behavioral Health Advisory Committee, Network of Care and Regional Advisory Committee meetings.

Strengths of the Network of Care

Access to services. Parents and caregivers report that access to services such as respite, and some in-home resources have been reduced during the pandemic. This continues to be an area where access has not reached pre-pandemic levels. Efforts to change how families access these services have been made to better fit the current needs. When accessible, these services offer significant support for families. Some family members also report that they continue to be able to access information about services from 211. The Department is working with various contractors to creatively ensure that families are able to access respite and in-home resources. Youth reported that there are a number of community and school-related resources, such as after-school clubs and sports, and community resources available for them to engage in many of which contain skill-building activities.

Cultural Responsiveness. Families report that there are programs and services that are responsive to their cultural needs and these program and services are highly valued.

These programs tend to be actively involved in the community. Community members also reported that some organizations have supported services for Spanish speaking families.

Peer-to-Peer Support Families value peer support services such as support groups, advocacy and having other family members providing informing about community resources. Families appreciate when community groups come together to form supportive networks. Some community meetings have remained virtual, which reduces some of the sense of community that participants have experienced previously. In lieu of many community meetings, agencies have also been working more individually to support families one on one.

Individualized Care. Caregivers and youth report more positive results when their treatment and supports are based on the needs that they identify and when the supports encompass the whole family. Caregivers report that there are some agencies that go above and beyond to support the needs of families and youth, these agencies spend the time to understand the needs of each family and work in partnership with families to develop individualized service plans. Youth and caregivers believe that tailoring programs and services to the needs of families and youth is the best strategy.

Care Coordination. Youth and young adults indicated that when youth are supported in navigating different systems, they have better outcomes.

School Resources. Parents value the flexibility inherent in those districts and schools that encourage teachers and school staff to develop creative solutions when problems emerge. Some schools also offer specialized programs such as life skills and provide individualized attention to students which is greatly valued by parents. Families appreciate when there is partnership and collaboration between schools and community resources.

School Staff. Youth report that there are teachers within their schools who clearly enjoy their jobs as evidenced by how they interact with students both in and outside of the classroom. Parents and caregivers also report that there are some dedicated and skilled teachers and school staff who are invested in the students they work with and with their families. In recent years there have been significant staffing turnover and staffing vacancies, which impact resources that families have access to.

School Leadership. The Board of Education in some communities have established mechanisms to listen to the students encouraging them to present innovative ideas and working with the students to implement these ideas. These have remained in place during the post-pandemic and much more virtual support is offered.

Department of Children and Families. Community members noted that DCF has offered support and been responsive to families. They report that some DCF workers are doing a good job responding to the needs of families. Because many workers are teleworking, families have noted difficulty in getting in touch with workers. However, this is inconsistent, and the Department has made changes to increase accessibility for families to reach workers. While visits were mostly virtual during this time, in-person visits have resumed.

Department of Developmental Services. Families report positive interactions with the Department of Developmental Services and appreciate receiving funding for grants, respite, and camps for youth.

Community Resources. Families report that there are community services such as family resource centers, faith-based resources, and libraries that are supportive of the needs of families in the community. Families report that they value those agencies that are active in the community. Families needed some more support from the community during the pandemic. Post-pandemic efforts to increase resources have been made.

Resources Needed

Information about Services. Families and caregivers report that there is a lack of information about the services that are available. Some report that they do not have access to information about services offered in the community or the schools, and they report that school staff and community providers do not know about all services within the network of care. Families desire a directory of services that have information presented in a straightforward manner without jargon or acronyms.

Access to services. Families and caregivers report that some services are not available to them due to a lack of staff or program capacity to deliver services. Specifically, parents report a need for increased service capacity to provide: advocacy; respite; substance abuse treatment; and ABA services. Youth identified the need to have more contact with their DCF workers.

Transitions between Treatment Providers. Families report that transitions between levels of care, service providers and between the child and adult systems can be quite problematic resulting in increased stress to families and disruptions in care. More work is needed for a warm handoff between service types and coordination when different systems are working together.

Referrals to Needed Services. Parents and caregivers report that some agencies do not do a sufficient job of directing families to services that they need or helping families to

navigate different systems. Even when referrals are made appropriately, due to staffing challenges across the system long waitlists impact families' ability to access services immediately.

Culturally, Linguistically and Appropriate Services. Parents and caregivers report that there is a need for a more diverse workforce to reflect and respond to the communities being served. They indicate that there is a significant need for more culturally and linguistically appropriate services within the network of care including, but not limited to, translation of program materials for those who do not speak English and improved translation services. Students' report that in some schools there not any adults who speak the languages spoken by students within the school.

Respect in School: Youth spoke of a lack of respect in the schools and inconsistency in how students are treated by their teachers with some students getting more attention and others being left behind. Students reported that some teachers speak negatively about students who are not in honors or advanced placement classes.

School Structure: Youth reported that assigning students to tracks as early as middle school, makes it difficult for students not placed in the honors track to be able to take honors and AP classes in high school which limits their opportunities for success.

School Safety: Students want enhanced school safety including additional guards, metal detectors, and training on what to do if there is an active shooter. Families report that students need resources to help deal with concerns surrounding school shootings and bullying.

School Staff. Caregivers and youth report that students need more support in school and indicate the need for additional social workers, guidance counselors, teachers, and school staff. Youth also report that there is often a lack of support and minimal effort to engage them by teachers, guidance counselors, and other school staff.

School Resources: Students spoke of the need for enhanced resources in the schools. There is a need to ensure that the food served in school is edible (e.g., not moldy or spoiled) that restrooms are adequately cleaned, and schools are free of vermin. Youth also report that they do not have access to the resources (e.g., computers, reliable internet connections, innovative teaching strategies such as videos) they need to do their work in school or at home.

Enhanced Curricula: Students expressed the need for the curricula to be improved and to have classes on things that students need to know to be healthy and, to support their peers, including more information on physical and emotional health. Students also expressed the need for learning life skills that will help them in adulthood. The quality of the current curricula and the ability to engage students' needs improvement, they specifically recommend enhanced programs on substance abuse prevention and academics such as the ALEKS Math program.

Recreational Activities. Families note that while there are some activities for youth within communities, there is a need for additional free or low-cost community-based recreational activities.

Stable Workforce. There is a need to develop a more stable workforce of individuals who work with children and families in need of services. High staff turnover leads to a lack of continuity of care that is detrimental to families. In addition, family members advocated for new strategies to prevent school staff and teacher turnover.

Structures that Need Improvement

Families as Full Partners. In order for the network of care to be effective, families need to be full partners at systems-level and agency decision-making tables. While progress has been made in families having a seat at systems-level tables, families are not included in decision-making for state or local agencies.

Respect for Families. Not all services offered within the network of care are responsive to families and treat families with respect. Caregivers report that some agency staff does not spend the time needed to build a relationship with them that is based on mutual respect leaving some to believe that providers do not care. In addition, families report that some providers do not return phone calls or follow-up with them which can lead to a lack of trust and feeling disrespected.

Respect for Fathers. Caregivers believe that more can be done across systems to respect the role of fathers. Caregivers report that fathers are treated differently than mothers by the system as a whole, and by staff working in the system. Both parents need to be contacted when updates are made regarding a child's care.

Respect for Families Who Are Not English Speakers. Parents and caregivers who do not speak English report that their opinion is not taken into consideration in determining the plan of care for their child and family. The system needs to employ more staff who not only speak the languages of the families being served, but also understand their culture, so that all families can have a voice in treatment decisions.

Youth Voice: Mechanisms need to be in place across the network of care so that youth can offer ideas and give constructive feedback.

Family Voice. Caregivers and youth should have a say in their plan of care. Community members report not being heard by service providers regarding issues with youth. Some families report DCF making decisions in haste, not listening, and blaming families.

Communication between Providers. Participants report that some agencies do not do a good job of directing families to needed services and helping families navigate services between systems. Caregivers note that there could be better communication between state agencies including DCF, DDS, and DSS. They also report that DCF needs to improve communication between departments within their agency and with families and providers.

School Climate. Students report that the school climate in some places is negative and the students are experiencing bullying, racism, and classism that goes unaddressed. Parents report that there is a lack of respect in the schools. This includes how teachers interact with students and parents; how students interact with teachers and each other; and how parents interact with teachers. There is a need to address this culture to create a more positive educational environment.

Insurance Coverage. Parents and caregivers report frustration that the services available for their child and family are dictated by their health insurance. They report that some services are available only for families who have Husky (e.g., in-home services) and not for families who have commercial insurance.

Cost of Care. High out-of-pocket costs for services are a burden to families who are already struggling to meet their basic needs.

Transportation. Access to reliable public transportation is a barrier to accessing the services needed by families. Reliable transportation is also a barrier for youth to access activities.

Legal issues. Community members noted that the legal system could use improvement in reducing the length of time it takes for matters to come before the court. It is also noted that offenders need to be monitored more to ensure the safety of victims and the community.

Basic Needs. Community members report needing more affordable housing and more information about housing. Families also note needing more support so that they can stay employed while taking care of a child with medical or mental health needs.

Professional Development

Training for Families and Caregivers. Families appreciate the opportunities to learn during training and workshops. However, additional training is needed to enhance the capacity of family members to be the best advocates for their family. This includes training on the system including, what service options are available and how to access these services, and training for caregivers so they know the questions to ask so that they can determine the most appropriate services and providers for their family.

Staff Training on Culturally Responsive and Linguistically Appropriate Services. Across the network of care, staff needs training regarding how to partner with families and deliver services that are culturally responsive and linguistically appropriate.

Staff Training to Engage Families. Across the network of care training is needed for state department, community agency and school staff who interact with families to enhance their awareness and skills in listening to families and interacting with families in a way that is respectful and responsive. This training should be provided to all staff including service providers, educators, office staff, security staff, and agency leadership.

Staff Training on Supporting Family Voice. Training is also needed throughout the network of care for staff to carefully ask questions about family preferences regarding services and to actively listen to what families are saying, so that family voice is the driver of care decisions. This careful attention to listening to families will facilitate building rapport and enhance trust in the relationship so that families feel comfortable in their work with providers and providers actively partner with families receiving services.

Training for School Staff. Students suggest that teachers receive training on how to treat students with respect and how to interact with each student as an individual. Caregivers report that teachers, paraprofessionals, and other school staff require additional training and ongoing coaching regarding how to identify and support the needs of all children. Parents recommend that community agencies could provide support and training on issues such as working with youth impacted by trauma. In addition to providing the

training to school staff, this collaboration could help develop a partnership between community agencies and schools.

Training for the Judicial System. Families indicate that there is a need for court personnel to receive training to help them to understand mental health.

All of the above data sources were utilized to develop and support Connecticut's *"comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children."*

The Plan provided Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy development for all children. It is the findings and recommendations from this plan that identified the unmet service needs and critical gaps within the current system.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

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.

Four core values drive the development of a children's behavioral health system:

- Family-driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- Culturally and linguistically appropriate, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care;

- Trauma informed, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and mechanisms for care coordination, with families, children and youth as full participants in the governance of that system.

A Steering Team and a 36-member Advisory Committee oversaw the planning process and development of the plan. The process yielded the identification of the following seven thematic areas and specific goals that Connecticut continues to use to make significant improvements to the children's behavioral health service system:

1. System Organization, Financing and Accountability

Implementing an enhanced children's behavioral health system of care will require a significant re- structuring with respect to public financing, organizational structure, integration of commercial payers, and data reporting infrastructure.

2. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan. The plan includes strategies that employ prevention-focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services.

3. Access to a Comprehensive Array of Services and Supports

Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state and expands crisis-oriented behavioral health services to address high utilization rates in emergency departments. Assist, support and strengthen the role of schools in addressing the behavioral needs of students. Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

4. Pediatric Primary Care and Behavioral Health Care Integration

Strengthen connections between pediatric primary care and behavioral health services.

5. Disparities in Access to Culturally Appropriate Care

Develop, implement, and sustain standards of culturally and linguistically appropriate care. Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

6. Family and Youth Engagement

Include family members of children and youth with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

7. Workforce

The topic of the workforce emerged from almost every discussion held as part of the planning process. The concept of workforce is used broadly in Connecticut with respect to children's behavioral health. It includes but is not limited to: Licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support. Concerns related to workforce included: Shortages of key professionals or skills in the current workforce; lack of training capacity, including ongoing coaching, monitoring, and reinforcement in order to maintain skills; insufficient access to information for parents; and the lack of adequate knowledge among every sector of the workforce about children's behavioral health conditions and resources to address these conditions. Goals and strategies related to workforce development are reflected in 16 strategies across most of the thematic categories listed above.

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

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

Areas that will remain at the forefront of our work include continued collective commitment to fiscal mapping through a health equity lens, increased data submissions to the Governor's Open Data Portal and consideration of increased coordination through the CT Behavioral Health Partnership of all named agencies for planning purposes. These efforts inevitably impact investments in services that yield better outcomes for children and their families.

As a result of the comprehensive process and extensive work done on Connecticut's Children Behavioral Health Plan described above, CT continues to utilize the plan as the driving blueprint to enhance Connecticut system of care.

State of Connecticut
Combined MHBG/SUPTRS Block Grant Application
Federal Fiscal Year 2024 – 2025

Connecticut Adult Behavioral Health Needs Assessment

The Connecticut Behavioral Health Needs Assessment serves as the 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 evaluation of quantitative data from an array of state and national sources, as well as findings from the state's regional priority setting process which serves to gather qualitative information and data from local and regional stakeholders regarding the behavioral health needs and recommended priorities within the state. The national data sources utilized within the needs assessment include the 2021 National Survey on Drug Use and Health (NSDUH); CDC Youth Risk Behavior Surveillance System (2021); the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Report for SFY 2022; the Connecticut Behavioral Health Barometer, volume 6 (published 2020); the Connecticut Office of the Chief Medical Examiner (OCME); and US Census Data. State data sources included the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Reports; the Connecticut Office of the Chief Medical Examiner (OCME); the Connecticut Department of Public Health; the Connecticut Office of Rural Health; the Connecticut Department of Children and Families; and the Connecticut Coalition to End Homelessness.

DMHAS funds and collaborates with Connecticut's **State Epidemiological Outcomes Workgroup (SEOW)** and the Center for Prevention Evaluation and Statistics (CPES) at the University of Connecticut to support the Connecticut Behavioral Health Needs Assessment process**.** The SEOW is administered by the Center for Prevention Evaluation and Statistics (CPES) and operates through a contract with the University of Connecticut's Health Centers' Department of Community Medicine. The SEOW is comprised of an array of state partners including 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 Correction (DOC), Office of Policy and Management (OPM), Department of Emergency Services and Public Protection (DESPP), State Department of Education (SDE), Office of Early Childhood, Regional Behavioral Health Action Organizations (RBHAOs), Connecticut Hospital Association (CHA), Board of Pardons and Parole, Connecticut Data Collaborative, University of Connecticut (UConn) Health, Office of the Child Advocate, (UConn) Center for Public Health and Health Policy, CT Youth Services Association, and AIDS-CT. The SEOW conducts an array of activities to support the identification of behavioral health risks and needs throughout Connecticut, including:

- Identifying, collecting and analyzing data related to behavioral health problems
- Assessing data quality and utility
- Supporting a statewide needs assessment that measures the prevalence and distribution of substance use and mental health-related problems
- Identifying indicators of risk and protective factors for substance use and related problems
- Identifying populations experiencing health disparities
- Disseminating data to increase access to a greater number of stakeholders

Table of Contents

Prevalence and Treated Prevalence: Mental Health

Any Mental Illness

Utilizing the broadest definition for mental illness, data from the 2021 National Survey on Drug Use and Health (NSDUH) highlights that Connecticut has rates of mental illness that are in line with the region and lower than the national rate.

Any Mental Illness in the Past Year (NSDUH 2021)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	22.77%	33.67%	21.12%
Northeast	21.07%	33.23%	19.29%
Connecticut	20.21%	33.35%	18.33%

Serious Mental Illness (SMI)

Data from the DMHAS Annual Statistical Report SFY 2022 identified that nearly half of the individuals (44%) receiving clinical treatment services during SFY 2022 met criteria for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, major depression, and PTSD. This represents a reduction from SFY 2021 during which time 64% of individuals receiving clinical treatment services met criteria for SMI.

Although rates of SMI among individuals served within Connecticut's behavioral health system decreased between SFY 2021 and SFY 2022, rates of SMI within the general population in Connecticut continues to be above regional rates and slightly above national rates.

Serious Mental Illness in the Past Year (NSDUH 2021)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	5.55%	11.42%	4.66%
Northeast	4.62%	10.31%	3.79%
Connecticut	5.65%	11.57%	4.72%

Depression

During SFY 2022, 18% of individuals receiving clinical treatment services in Connecticut had a depressive disorder as their primary diagnosis, reflecting a 6% increase compared to SFY 2021. Rates of depression within the general population in Connecticut were similar to national rates and slightly higher than rates for the northeast region.

Major Depressive Episode in the Past Year (NSDUH 2021)

	Age 12 - 17	Ages 18 - 25	Ages 18 +
U.S.	8.29%	18.61%	6.72%
Northeast	7.51%	17.28%	6.07%
Connecticut	8.53%	18.51%	6.98%

At the same time Connecticut saw an increase in depressive disorders among individuals receiving clinical treatment services in SFY 2022, the state experienced a decrease in the percentage of individuals with a bi-polar related disorder (7% in SFY 2022 compared to 12% in SFY 2021).

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

Rates of Schizophrenia Spectrum disorders among individuals served within the Connecticut behavioral health system reduced significantly between SFY 2021 and SFY 2022. During SFY 2022, 7.4% of individuals served had a schizophrenia spectrum or other psychotic disorder as their primary diagnosis, compared to 14.7% during SFY 2021.

Based on international 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 individual with substance-induced psychosis or affective psychotic disorders. During SFY 2022, there were a total of 98 admissions to the state's two coordinated specialty care programs for individuals with first-episode psychosis. This points to a 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.

Suicide/Suicidal Thoughts

The rates for serious suicidal thoughts in Connecticut continue to be slightly higher than national rates, and above regional rates, with young adults ages 18-25 having the highest rate of suicidal thoughts among all geographies.

Serious Thoughts of Suicide in the Past Year (NSDUH 2021)

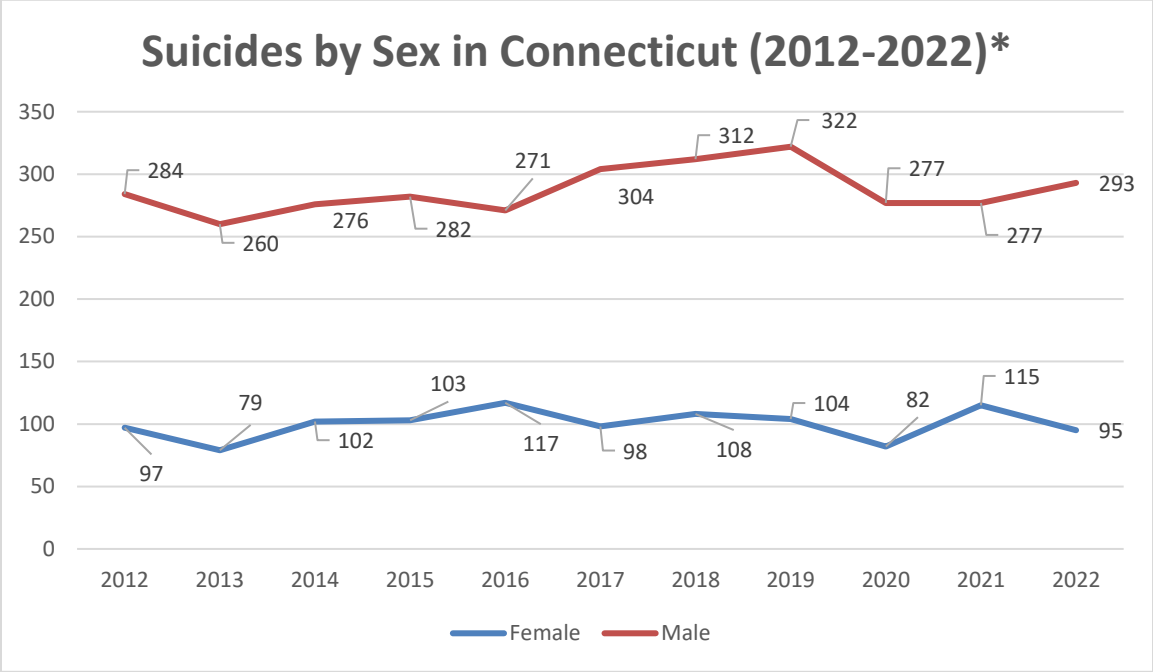
	Age 18+	Ages 18 - 25	Age 26+
U.S.	4.85%	13.02%	3.61%
Northeast	4.12%	11.96%	2.96%
Connecticut	5.16%	13.48%	3.87%

While rates of serious thoughts of suicide have trended slightly higher in Connecticut, rates of actual suicide attempts trend lower in Connecticut compared to the region and nation, especially among the adult population 26.

Attempted Suicide in the Past Year (NSDUH 2021)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	0.69%	2.70%	0.38%
Northeast	0.49%	2.26%	0.23%
Connecticut	0.41%	2.26%	0.12%

In regard to suicides, data from the Connecticut Office of the Chief Medical examiner highlights that while the total number of suicides remained stable between 2021 and 2022, there was a decrease in suicides among females and an increase among males during this time period. Historical rates of suicide have been higher among males but the divergence between sexes that occurred between 2021 and 2022 is somewhat larger compared to previous years.



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

Mental Health Treatment

In SFY 2022, there were 36,442 overall admissions to mental health programs in Connecticut and 46,861 unique individuals served within a mental health program during this time frame[1]. 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 2022, roughly half were male (51%) and half were female (49%). Most individuals were White/Caucasian (59%), followed by Black/African American (18%) and "Other" (13%). Overall, 20% of individuals served were of Hispanic/Latino origin and 9.8% identified specifically as Puerto Rican. Comparing the percentages of individuals receiving mental health services in SFY 2022 to the most recent census statistics, White/Caucasian individuals were underrepresented among the population receiving mental health services, comprising 78% of the general population and 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).

Received Mental Health Service in the Past Year (NSDUH 2021)

	Age 18+	Ages 18 - 25	Age 26+
U.S.	16.85%	19.23%	16.49%
Northeast	16.86%	20.84%	16.27%
Connecticut	18.59%	21.80%	18.09%

[1] Based on data from DMHAS Annual Statistical Report for SFY 2022: https://portal.ct.gov/-/media/DMHAS/EQMI/AnnualReports/DMHAS-Annual-Statistical-Report-FY22.pdf This report may not include service data from private and private non-profit providers who do not receive DMHAS funding.

While rates of certain mental health conditions were estimated to be higher in Connecticut compared to the region and nation according to the 2021 NSDUH, a higher number of individuals reported receipt of mental health services in Connecticut compared the region and nation.

Prevalence and Treated Prevalence: Substance Use

Alcohol

Alcohol remains the primary drug of choice among individuals served within the Connecticut behavioral health system. During SFY 2022, 39% of all admissions to a behavioral health programs in Connecticut identified alcohol as their primary drug of choice, reflecting a slight increase from 37.9% during SFY 2021.

According to the most recent NSDUH data, Connecticut rates of alcohol use and binge alcohol use among the general population have changed slightly compared to previous years. While NSDUH data from 2019 showed rates of alcohol use and binge alcohol use were higher among Connecticut residents of all age groups compared to the region and nation, 2021 data shows a more complex comparison.

Rates of alcohol use among youth were lower than or similar to the region and nation but rates of alcohol use among young adults and adults ages 18 and older were higher in Connecticut compared to these geographies.

Alcohol Use in the Past Month (NSDUH 2021)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	6.99%	50.13%	51.70%
Northeast	7.31%	55.02%	54.44%
Connecticut	7.00%	58.47%	61.01%

Binge Alcohol Use in the Past Month (NSDUH 2021)

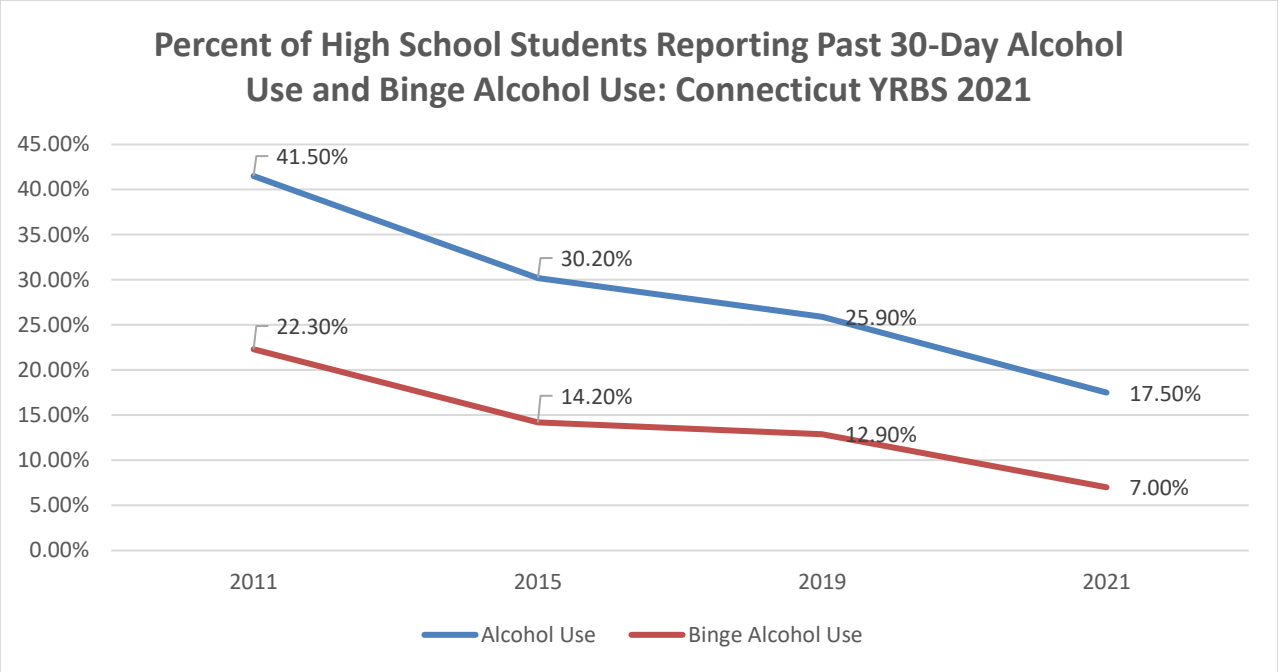
	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	3.82%	29.15%	23.26%
Northeast	4.09%	30.86%	23.54%
Connecticut	3.58%	29.27%	21.51%

Underage (12 - 20) Alcohol Use and Binge Use in the Past Month (NSDUH 2021)

	Alcohol Use in the Past Month	Binge Alcohol Use in Past Month
U.S.	15.14%	8.29%
Northeast	17.56%	9.49%
Connecticut	15.15%	8.10%

Rates of binge alcohol use in Connecticut decreased among all age groups compared to 2019 rates and were lower than the region and nation among youth and adults ages 18 and older.

Results of the most recent CDC Youth Risk Behavior Survey data from 2021 align with the 2021 NSDUH data and show a downward trend in the percentage of Connecticut high schools students reporting alcohol use or binge alcohol use in the past 30 days. Among students reporting alcohol use, females were significantly more likely to report alcohol use in the past 30 days compared to males (21.2% compared to 14.2%).



Data on persons needing but not receiving specialized treatment for alcohol use in Connecticut show a similar pattern to alcohol consumption data, with youth being more likely to receive needed treatment in Connecticut compared to the region and nation. However, the data highlights lower rates of young adults receiving needed services compared to the region and nation.

Needing but Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year (NSDUH 2021)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	3.35%	14.75%	10.92%
Northeast	3.39%	14.82%	11.14%
Connecticut	2.58%	16.31%	11.20%

Cigarettes

Connecticut residents use of tobacco products has and continues to be less than the regional or national averages for most age groups and has shown a decrease compared to previous years.

Cigarette Use in the Past Month (NSDUH 2021)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	1.51%	11.47%	17.03%
Northeast	1.42%	10.68%	15.83%
Connecticut	0.84%	10.74%	15.07%

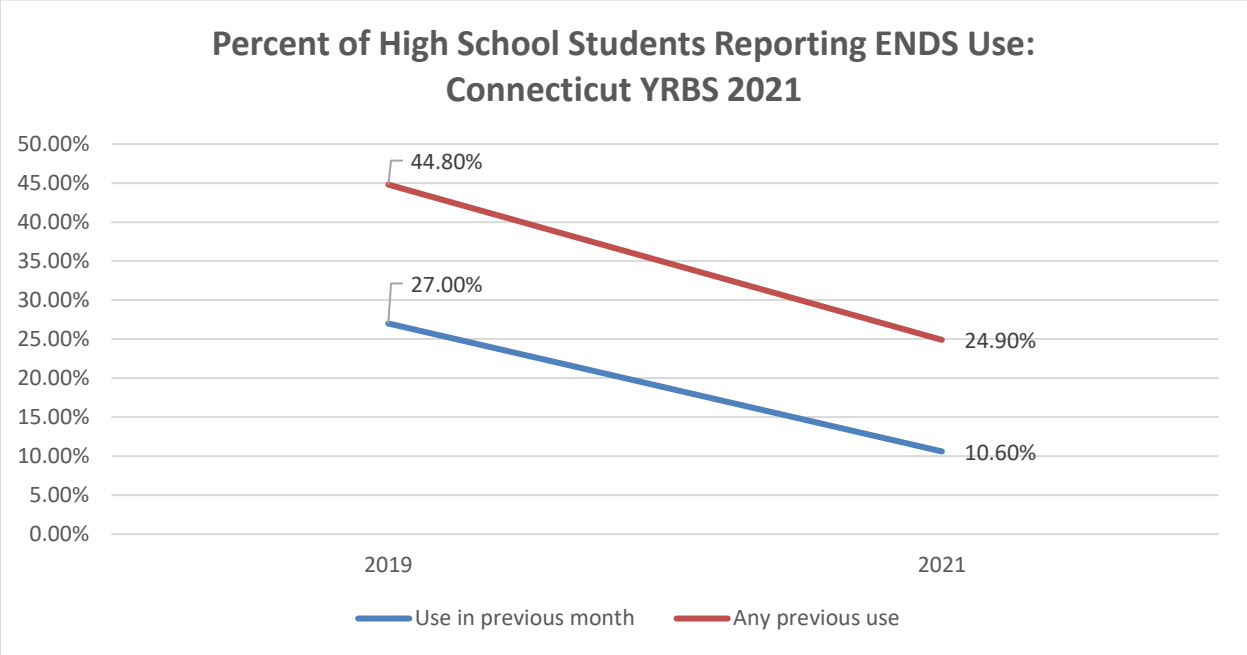
Tobacco Product Use in the Past Month (NSDUH 2021)

	Age 12- 17	Ages 18 - 25	Ages 18 +
U.S.	2.63%	16.78%	21.28%
Northeast	2.99%	15.09%	18.29%

Connecticut	2.68%	14.65%	17.74%

e-cigarettes/electronic nicotine delivery systems (ENDS)

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. Connecticut has taken legislative action in an attempt to curb the dramatic rise in the use of e-cigarettes/electronic nicotine delivery systems (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%). Comparison to regional and national data were similarly complex. Connecticut youth ages 12-17 reported higher rates of illicit drug use compared to the region and nation but young adults and all adults ages 18 and older reported similar rates to the region and nation.

Illicit Drug Use in the Past Month (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	7.09%	25.32%	15.03%
Northeast	7.94%	26.34%	16.70%
Connecticut	8.89%	25.82%	16.16%

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 rates of illicit drug use among Connecticut youth ages 12-17 and young adults ages 18-25 reduced between 2019 and 2021 but continue to be in line with regional and national rates.

Illicit Drug Use Other than Marijuana in the Past Month (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	1.83%	4.07%	3.37%
Northeast	1.74%	4.75%	3.86%
Connecticut	1.55%	4.48%	3.38%

Similar to prevalence rates for illicit drug use, those needing but not receiving treatment for illicit drug use continues to be highest among young adults ages 18 to 25.

Needing but Not Receiving Treatment at a Specialty Facility for Illicit Drug Use in the Past Year (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	5.54%	15.03%	6.90%
Northeast	5.97%	14.99%	6.44%
Connecticut	5.85%	16.01%	6.29%

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 marijuana use in Connecticut increased between 2019 and 2021, and similar increases across the region and nation were witnessed. Current rates of monthly marijuana use in Connecticut were similar to national and regional rates for youth and young adults but were lower than the region among adults ages 18 and older.

Marijuana Use in the Past Month (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	10.47%	35.37%	19.59%
Northeast	10.70%	35.15%	21.11%
Connecticut	10.08%	35.96%	20.87%

Rates of perceived risk from smoking marijuana were lowest among young adults across all geographies and were lower among Connecticut adults ages 18 and older, compared to the region and nation.

Perception of Great Risk from Smoking Marijuana Once a Month (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	23.26%	11.58%	21.42%
Northeast	22.58%	10.70%	19.82%
Connecticut	21.85%	12.17%	17.36%

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 10.5% of behavioral health admissions in SFY 2022. This was a reduction from SFY 2021, during which time 12% of all admission identified marijuana as the primary drug of choice.

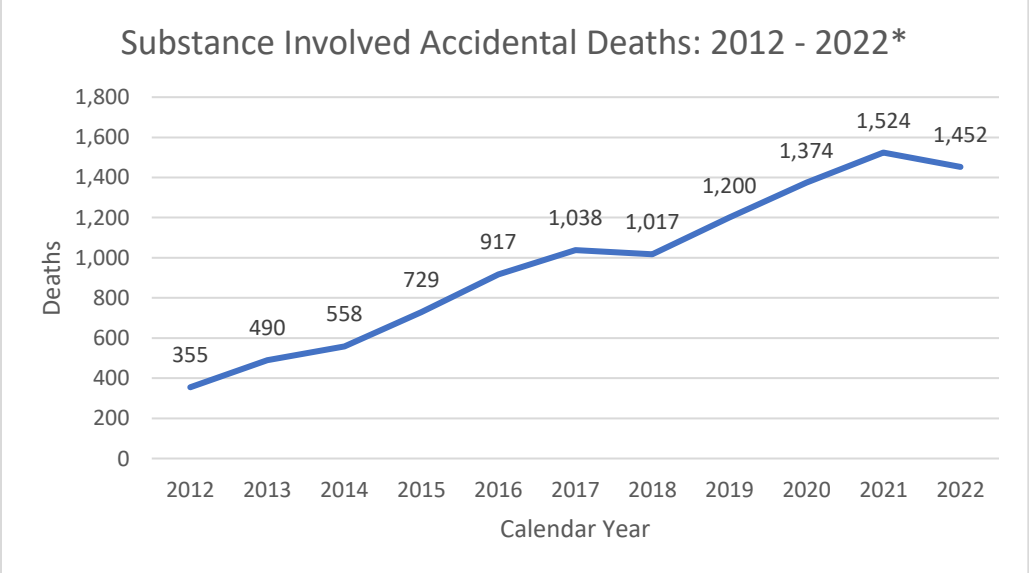
Heroin

The opioid crisis has and continues to take a significant toll on Connecticut and the Northeast region. Despite this, reported use of Heroin in Connecticut was below both regional and national averages among adults ages 18 and older. Stakeholders have noted the limitations of reported heroin use as an indicator of treatment need due to underreporting among individuals using the drug, and due to heroin use shifting towards other synthetic Opioids.

Heroin Use in the Past Year (NSDUH 2021)

	Ages 18 - 25	Age 18+
U.S.	0.20%	0.43%
Northeast	0.22%	0.57%
Connecticut	0.17%	0.32%

Given this limitation, stakeholders have looked to data on overdose reversals and overdose deaths as means for identifying prevalence of Opioid use. While data on overdose reversals is in the nascent stages of development, data on overdose deaths continues to be collected and improved. In calendar year 2022, Connecticut's Office of the Chief Medical Examiner (OCME) reported a total of 1,452 accidental deaths involving substances, 98% of which involved Opioids. This represents a reduction from 1,524 deaths in calendar year 2021 and the first year-over-year reduction since 2018. While the number of deaths remain historically high, this 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 deaths do not provide a full picture regarding Opioid use prevalence and treatment need, rates of prescription opioid 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 Opioid 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 2021 were similar across the state, region, and nation, with a slightly lower rate among adults 18 and older in Connecticut compared to other geographies.

Prescription Pain Reliever Misuse in the Past Year (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	1.91%	3.04%	3.24%
Northeast	2.12%	2.89%	3.33%
Connecticut	2.00%	2.63%	2.81%

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 28.5% of all admissions to a substance use treatment program during SFY 2022, a reduction from 33% compared to SFY 2021. However, persons identifying other opiates and synthetic opiates as their primary drug increased during this time period, with 9.2% of admissions reporting other/synthetic opiates as their primary drug in SFY 2021 compared to 13.9% in SFY 2022. 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 the same in SFY 2022 as SFY 2021.

Stimulants

In Connecticut, cocaine was identified as the primary drug of choice in 4.3% of behavioral health admissions in SFY 2022, reflecting a slight increase from 4% of admission in SFY 2021. Among the general population, rates of cocaine use in Connecticut are in line with national rates but below regional rates.

Cocaine Use in the Past Year (NSDUH 2021)

	Ages 18 - 25	Age 18+
U.S.	3.51%	1.86%
Northeast	4.05%	2.22%
Connecticut	3.34%	1.85%

Methamphetamine use has and continues to be low among both the general population and those receiving behavioral health services in Connecticut. During SFY 2022, only 0.2% of behavioral health admissions identified methamphetamine as their primary drug of choice which was the same percentage as SFY 2021. Among the general population, methamphetamine use is lower in Connecticut compared to national and regional rates among youth and adults ages 18 and older.

Methamphetamine Use in the Past Year (NSDUH 2021)

	Ages 12 - 17	Ages 18 - 25	Age 18+
U.S.	0.14%	0.50%	0.99%
Northeast	0.10%	0.52%	0.69%
Connecticut	0.06%	0.52%	0.56%

Substance Use Treatment

In SFY 2022, there were 43,385 admissions to substance use programs in Connecticut and 42,526 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 2022 were alcohol (38.1%), heroin (28.5), and other/synthetic Opioids (13.9%). Of the individuals served within a substance use program in SFY 2022, 65% were male and 35% were female. Most individuals were White/Caucasian (63%), followed by “Other” (15%), and Black/African American (14%). Twenty-three percent of clients served in DMHAS substance use programs were of Hispanic/Latino origin, with 12.5% identifying as Puerto Rican. Comparing these percentages to state census data, White/Caucasian clients were underrepresented (comprising 70% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 17% of the state population, respectively). Individuals served within a substance use program were clustered in the age groups of 26-34 (25%) and 35-44 (27%), with a mean age of 41.7 years (+ 13.1), highlighting a slightly older population of individuals receiving substance use services compared to the population receiving mental health services.

Needs Among Identified Populations

Co-Occurring Mental Health and Substance Use

Roughly one-quarter (24%) of the persons treated by DMHAS in SFY 2022 had both a mental health (SMI) and substance use diagnosis, a decrease from 9% compared to SFY 2020 (33%). 5,904 individuals received services from both mental health and substance use programs during SFY 2022, reflecting an increase from 5,547 during SFY 2021. These clients were more male (62%) than female (38%). Most were white/Caucasian (59%), 20% were black/African American and 15% were "other". Compared to substance use and mental health only clients, co-occurring clients do not appear to be significantly different demographically.

Pregnant and Parenting Persons

Between 2021 to 2022, Connecticut experienced a small reduction in the number and percentage of admissions to substance use treatment programs that identified as pregnant at admission. In 2021, 296 (>1%) admissions to a substance use treatment identified as pregnant compared to 257 (1%) in 2022. According to state CAPTA data for 2022[2], 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 of these 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.

Older Adults

According to data from America's Health Rankings Annual report[3], rates of mental health and substance use challenges among individuals age 65 and older in Connecticut are similar to national rates. In 2022, 12.7% of adults 65 and older in Connecticut reported having a depressive disorder compared to 13.1% of adults 65 and older nationally. During this same time period, 7.1% of adults 65 and older in Connecticut reported frequent mental distress compared to 8.5% of adults 65 and older nationally. Adults 65 and older in Connecticut had lower rates of suicide compared to the nation. In Connecticut, suicide rates among adults 65 and older (deaths per 100,000 adults ages 65+) was 14.2% in 2022 compared to 16.9% nationally. Older adults in Connecticut had rates of excessive drinking that were similar to national rates (7% vs 7.1%) and that were significantly lower than the general adult population in Connecticut (21.5%). The only behavioral health area where Connecticut exceeded national rates was drug related deaths. In 2022, drug related deaths among individuals 65 and older (deaths per 100,000 adults ages 65+) were higher in Connecticut (12.6%) compared to the nation (9.9%).

Homeless Population

[2] CT CAPTA Data Summary. Department of Children and Families (2022). https://www.sepict.org/Customer-Content/www/CMS/files/capta-fcp/CT_CAPTA_Data_Summary_2022_09.pdf
[3]Americas Health Rankings Annual Report (2022). United Health Foundation. https://www.americashealthrankings.org/learn/reports/2022-annual-report

According to the multi-year point-in-time count data for Connecticut[4], homelessness has been declining in Connecticut since 2016 (as of the most recent data collected and published for 2021). Overall, there was a 10.7% decline in homelessness (sheltered and unsheltered) in 2021 compared to 2020. However, unsheltered homeless (living in a place not meant for human habitation) increased by 32% during the same period. Within the general homeless population, 13.6% had a mental illness in 2021 compared to 11.9% in 2020, and 6.9% had a substance use disorder in 2021 compared to 5.7% in 2020. These percentages were much higher among the unsheltered population. Within this population, 22.8% had a mental illness in 2021 compared to 18.8% in 2020, and 12.4% had a substance use disorder in 2021 compared to 14.5% in 2020.

While homelessness among the general population in Connecticut has been on the decline, 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 slightly by 1% between calendar year 2021 and 2022. However, among individuals specifically admitted to a substance use service, homelessness increased by 3% during this time frame.

Homelessness Among Behavioral Health Admissions (Connecticut TEDS data)

	CY 2020	CY 2021	CY 2022
MH admissions	4%	3%	2%
SU admissions	10%	9%	12%
All admissions	8%	6%	7%

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, or facing potentially long drives to obtain treatment. According to a report published for the Connecticut Office of Rural Health[5], rural populations in Connecticut faced a median drive time of 14.33 minutes to the nearest substance use treatment facility in 2022, compared to a median of 12 minutes among the general state population. During this time, 12% of individuals in rural communities self-reported that their mental health was “not good” and 17.6% reported having diagnosed depression. This compares to 13% and 17% of the Connecticut general population, respectively, and points to similar rates of depression between the two groups. In regards to substance use related to overdoses, overdoses deaths increased by 67% among rural towns in the state during the period of 2017 - 2021. However, this was less than the 100% increase in overdose deaths that occurred statewide during the same time period.

LGBTQ+ Population

Rates of self-reported mental health challenges and substance use among the LGBTQ+ population remain higher than the general population and higher than the heterosexual population. According to

[4] Connecticut Coalition to End Homelessness. Multi-Year Point-In-Time Data for CT: https://cceh.org/data/interactive/PITresults/

[5] Davila, K. and Seaberry, C. (2022). Rural Health in Connecticut. New Haven, CT: DataHaven. Published June 2022. https://www.ruralhealthct.org/images/Rural_Health_in_Connecticut%20FINAL.pdf

YRBS (2019) 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 88.1% compared to 65.6% of high school students who identified as heterosexual. The percentage of high school students reporting self-harm was significantly higher among LGB students (43%) than heterosexual students (10%) as well. These rates are supported by more recent survey data from the 2022 National Survey on LGBTQ Youth Mental Health[6] which showed that 42% of LBGTQ Youth reported seriously considering suicide within the past year and 53% 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 (2019) data, 33.1% of LGB identifying students reported current alcohol use compared to 25.2% of heterosexual identifying students. Similar disparities were documented across all substance use related questions on the YRBS, with the exception of self-reported binge drinking, and were significantly disparate in terms of self-reported misuse of prescription pain medication. For this question, 21.3% of GLB identifying students reported misuse compared to 8.1% of heterosexual identifying students.

[6] https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Connecticut.pdf

Persons Served in Behavioral Health Programs

During SFY 2022, a total of 95,291 unique individuals received mental health and/or substance use services in Connecticut. Of this total, 54,620 individuals were treated within substance use programs and 52,078 were treated within mental health programs. These totals include 6,983 co-occurring clients who both mental health and substance use services and are included as a separate category in the demographic table below. An almost equal number of males and females received mental health services, while twice as many males than females participated in substance use services. Most clients were White/Caucasian (61%), followed by Black/African American (16%), and Other Race (15%). Twenty 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 99% of mental health clients and 92% of substance use clients receiving these services. For mental health clients, community-based treatment services include standard outpatient (61%), Case Management (13%), Social Rehabilitation (12%), and Crisis Services (11%). For substance use clients, community-based treatment services services include Standard Outpatient (37%), Pre-Trial Intervention (29%), and Medication for Opioid Use Disorder (29%). Residential services were the next most utilized, with 5% of mental health clients and 17% of substance use clients receiving these services. Inpatient levels of care were received by 2% of mental health clients and 4% of substance use clients. DMHAS Young Adult Services (YAS) serves the most acute, high-risk cohort of young adult in the state of Connecticut between the ages of 18 and 25. In SFY 22, YAS programs served 1,277persons (12.9% of the total 18-25 DMHAS population).

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%).

Demographics of Clients Served

	Substance Use		Mental Health		Both		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Gender								
Female	14,676	34.5%	23,112	49.3%	2,265	38.4%	40,053	42.0%
Male	27,794	65.4%	23,608	50.4%	3,636	61.6%	55,038	57.8%
Transgender	-	0.0%	36	0.1%	-	-	36	0.0%
Unknown	56	0.1%	105	0.2%	3	0.1%	164	0.2%
Total	42,526	100.0%	46,861	100.0%	5,904	100.0%	95,291	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Race								
American Indian/Alaska Native	183	0.4%	255	0.5%	52	0.9%	490	0.5%
Asian	357	0.8%	670	1.4%	23	0.4%	1,050	1.1%

Black/African American	5,798	13.6%	8,534	18.2%	1,180	20.0%	15,512	16.3%
Native Hawaiian/ Pacific Islander	75	0.2%	151	0.3%	12	0.2%	238	0.2%
White/Caucasian	26,622	62.6%	27,592	58.9%	3,457	58.6%	57,671	60.5%
More than one race	188	0.4%	283	0.6%	40	0.7%	511	0.5%
Unknown	2,806	6.6%	3,495	7.5%	244	4.1%	6,545	6.9%
Other	6,497	15.3%	5,881	12.5%	896	15.2%	13,274	13.9%
Total	42,526	100.0%	46,861	100.0%	5,904	100.0%	95,291	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Ethnicity								
Hispanic-Cuban	69	0.2%	58	0.1%	12	0.2%	139	0.1%
Hispanic – Mexican	336	0.8%	249	0.5%	29	0.5%	614	0.6%
Hispanic-Other	3,887	9.1%	4,137	8.8%	494	8.4%	8,518	8.9%
Hispanic – Puerto Rican	5,312	12.5%	4,272	9.1%	729	12.3%	10,313	10.8%
Non-Hispanic	26,474	62.3%	33,688	71.9%	4,215	71.4%	64,377	67.6%
Unknown	6,448	15.2%	4,457	9.5%	425	7.2%	11,330	11.9%
Total	42,526	100.0%	46,861	100.0%	5,904	100.0%	95,291	100.0%
	Substance Use		**Mental Health**		**Both**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age								
18 – 25	3,985	9.4%	5,586	11.9%	354	6.0%	9,925	10.4%
26 – 34	10,677	25.1%	8,009	17.1%	1,284	21.7%	19,970	21.0%
35 – 44	11,559	27.2%	8,314	17.7%	1,662	28.2%	21,535	22.6%
45 – 54	7,659	18.0%	7,811	16.7%	1,239	21.0%	16,709	17.5%
55 – 64	6,236	14.7%	10,137	21.6%	1,113	18.9%	17,486	18.4%
65+	2,139	5.0%	6,545	14.0%	252	4.3%	8,936	9.4%
Unknown	271	0.6%	459	1.0%	-	0.0%	730	0.8%
Total	42,526	100.0%	46,861	100.0%	5,904	100.0%	95,291	100.0%

Statewide Priority Setting Process

DMHAS is committed to supporting comprehensive and unified planning across its state-operated and funded mental health and substance use services. DMHAS utilizes a regional prioritization process to facilitate such planning at the local, regional, and state levels. 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 can be aggregated and analyzed to assess behavioral health needs statewide.

Background:

The 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, in addition to staff from the State Epidemiological Outcomes Workgroup (SEOW) and Center for Prevention Evaluation and Statistics (CPES) at University of Connecticut Health Center. Processes have are organized into a unified activity comprehensively assessing the entire DMHAS behavioral health service system. The basic steps in the process are:

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

Combined Results from the 2023 Regional Prioritization process

Substance Use Prioritization

Priority	Region 1	Region 2	Region 3	Region 4	Region 5
1	ENDS	Heroin/ Fentanyl	Heroin/ Fentanyl	Heroin/ Fentanyl	Alcohol
2	Heroin/ Fentanyl	Prescription Drug Misuse	Alcohol	Alcohol	ENDS
3	Alcohol	ENDS	Prescription Drug Misuse	ENDS	Heroin/Fentanyl
4	Tobacco	Marijuana	ENDS	Marijuana	Marijuana
5	Marijuana	Alcohol	Marijuana	Prescription Drug Misuse	Prescription Drug Misuse
6	Prescription Drug Misuse	Cocaine	Cocaine	Cocaine	Tobacco
7	Cocaine	Tobacco	Tobacco	Tobacco	Cocaine

Based on the results above, ranked regional substance use priorities across the lifespan were as follows:

1. Heroin/Fentanyl/Other Opioids (top 3 in 5/5 regions)
2. Alcohol (top 3 in 4/5 regions)
3. Electronic nicotine delivery systems (ENDS) (top 3 in 4/5 regions)
4. Prescription drug misuse (top 3 in 2/5 regions
5. Marijuana/Cannabis
6. Cocaine and other stimulants
7. Tobacco

Based on survey of Behavioral Health Planning Council members, ranked statewide substance use priorities across the lifespan were as follows:

1. Alcohol
2. Marijuana
3. Heroin/Fentanyl/Other Opioids
4. Electronic nicotine delivery systems (ENDS)
5. Prescriptions drug misuse
6. Tobacco
7. Cocaine and other stimulants

Mental Health Prioritization

Priority	Region 1	Region 2	Region 3	Region 4	Region 5
1	Depression	Anxiety	Suicide	Anxiety	Suicide
2	Anxiety	Depression	Depression	Suicide	Anxiety
3	Suicide	Trauma/PTSD	Trauma/PTSD	Depression	Depression
4	Trauma/PTSD	SMI-Children	SMI-Children	SMI-Children	Trauma/PTSD
5	SMI-Children	Suicide	SMI-Adults	Trauma/PTSD	SMI-Children
6	SMI-Adults	SMI-Adults	Anxiety	SMI-Adults	SMI-Adults

SMI= Serious Mental Illness

Based on the results above, ranked regional mental health priorities across the lifespan were as follows:

1. Depression (top 3 in 5/5 regions)
1. Suicide (top 3 in 4/5 regions)
2. Anxiety (top 3 in 4/5 regions)
3. Trauma/PTSD (top 3 in 2/5 regions)
4. Serious Mental Illness – Children
5. Serious Mental Illness – Adults

Based on survey of Behavioral Health Planning Council members, ranked statewide substance use priorities across the lifespan were as follows:

1. Suicide
2. Co-occurring disorders
3. Anxiety
4. Trauma/PTSD
5. Depression
6. ESMI/FEP

Emerging Issues

Substance Misuse

Emerging substance use issues spanned substances and populations of concern, with the population of greatest concern across emerging substances and practices were youth and young adults.

"Zynning," a term for use of oral nicotine pouches colloquially referred to as "Zyn" (one brand name of several) was identified as an emerging issue for youth and young adults in regions 1 and 2. Caffeine pouches similar to the nicotine version also emerged as an issue for young adults in region 2.

Xylazine, a powerful veterinary tranquilizer for large animals, topped the list of emerging substances for the second reporting year in a row, as it was noted across all five regions. This substance has been identified in accidental overdoses over the past three or more years, with its presence increasing annually, most often in combination with fentanyl.

Emerging populations of concern for Xylazine were young adults and adults in region 2. An emerging use combination of concern was Xylazine and stimulants in region 3.

Xylazine was not included in the list of substances for prioritization, so it does not appear in the substance priority listing above, but concern about Xylazine can be expected to link to concern about fentanyl, given the co-occurrence of these two substances in the overdose data.

Cannabis was identified as an emerging concern in almost all regions, in combination with ENDS/vaping ("dabbing") in regions 1 and 5, as tinctures, edibles and Delta-8 THC in region 2, and for youth and young adults (and underaged use) statewide. Accidental ingestion of edible cannabis products by children was also identified as an emerging issue in region 5, and cannabis use psychosis was identified as an emerging issue in region 1.

ENDS/vaping was also identified as an emerging concern post-COVID, but most often in combination with cannabis/THC, for youth and young adults.

Counterfeit (fake) pills emerged as a concern in regions 2, 3 and 4, in connection with fentanyl continues as both a substance of use and as a lacing agent in an evolving number of other drugs. Synthetic cathinones (bath salts) and methamphetamine were also identified as emergent substances found in counterfeit pills (region 4).

Other emerging substance issues for 2022-23 were: use of benzodiazepines, gabapentin and polysubstance use (region 1); methamphetamine and MDMA (ecstasy) among young adults and adults (region 2); alcohol use among women, teen girls, and Latinx population, and dextromethorphan, an over-the-counter (OTC) cough medicine (region 5). Access to care was identified as an emerging issues in region 3.

Mental Health and Suicide

The COVID pandemic influenced emerging mental health issues across regions.

According to RBHAO reports, suicide is the most prevalent emerging mental health concern post-COVID across most regions. Populations of concern include older adults, for whom the number of suicides is reportedly rising (region 1), suicidal ideation and attempts by youth 10-17 (region 3), and Black, Indigenous people of color (BIPOC) (region 5), among whom there have been an increase in attempts.

RBHAOs linked this emergent concern to the mental health and other effects of COVID (3 of 5 regions), including life circumstances post-pandemic.

Emerging populations of concern for mental health issues/mental illness were younger children (region 1) and the Latinx population in region 5. Region 5 also identified increased prescribing of gabapentin as an emerging issue.

Service gaps such as workforce deficiencies in treatment personnel driving unmet treatment need, and the need for trauma informed practices and culturally informed treatment were identified in regions 4 and 3 respectively.

COVID-influenced behaviors, such as increased time on electronic devices and social media (region 2) and truancy (region 3), were identified as an emerging factors connected to mental health issues post-COVID for youth and young adults.

Eating disorders and Bigorexia (a body/muscle dysmorphic disorder) were identified as emerging issues in region 1, but not in other regions.

Problem Gambling

Emerging issues related to problem gambling centered mainly on the expansion of online gambling, the onslaught of advertising, and lack of gambling awareness and outpatient resources.

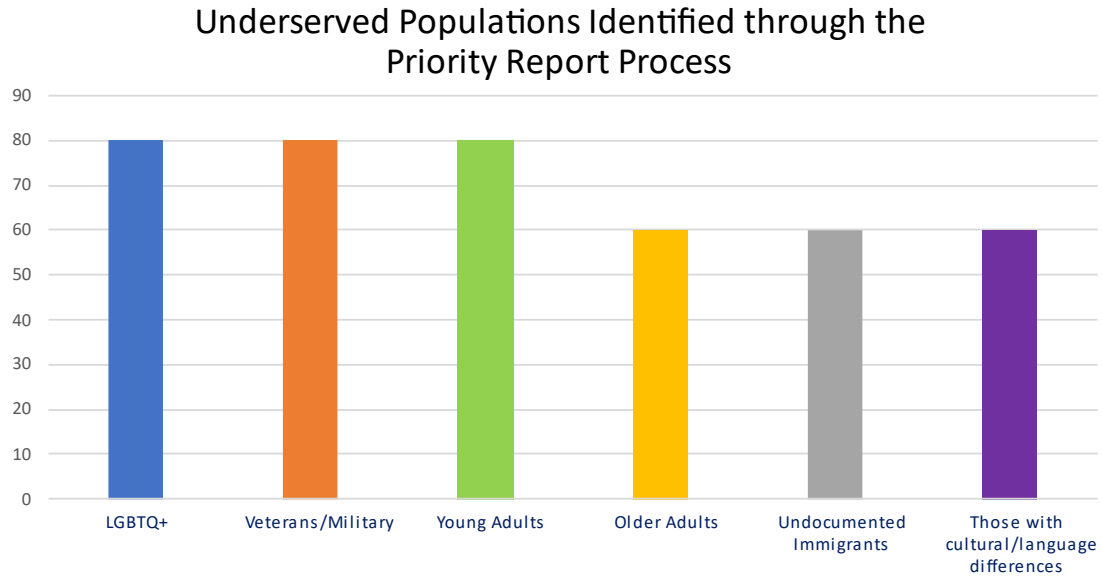
Resource Gaps and Needs

Resource gaps and needs identified by the RBHAOs fell into several categories:

- Funding, resources (human, staff, financial);
- Resources to address language, cultural barriers, and stigma, and increase access to treatment for underserved populations;
- Transportation, childcare, other basic supports to treatment/prevention;
- Substance use and mental health treatment for youth, adolescents, and young adults;
- Interdisciplinary approaches, including integration of prevention/treatment across substances, mental health, and other co-occurring issues;
- Education and awareness resources, in schools and community;
- Increased mental health screening for youth;
- In-home and family-based treatment options;
- Expanded crisis response services;
- Recovery support services (RFW, housing, gambling recovery support, etc.).

Underserved Populations

While there were a number of underserved populations identified by the RBHAOs through the priority report data collection process, those most often identified were the Lesbian, Gay, Bisexual, Transgender, Queer + (LGBTQ+) population and the Veteran/Military population.



Regional Recommendations: Substance Use

Prevention recommendations across regions focused on increases in funding support to specific prevention partners (e.g., Local Prevention Councils), education and awareness building (social marketing campaigns, educational resources for stakeholder groups, such as parents and youth), and enhanced focus on co-occurring disorders, underlying causes (e.g., risk factors) and contextual factors (e.g., social determinants of health, health disparities, and systems conditions).

Treatment recommendations focused on increases in specific treatment resources (e.g., harm reduction and crisis/sobering centers) and increasing ease of access to needed services, through community connections, warm handoffs, and linkages from emergency services and emergency departments to treatment. Expansion of culturally-informed and sensitive treatment through workforce development and community outreach was also recommended.

Recovery recommendations also focused on expansion of resources and improvement of access across populations. Recommendations included improvement of recovery support resources, both to include non-faith-based, science driven support groups and increase cultural inclusivity in existing faith-based support groups. Expansion of recovery centers and improvement of post-treatment follow up, increased use of recovery coaches and family recovery coaches, and expansion of pro-social recovery activities in the community.

Regional Recommendations: Mental Health

Mental health recommendations fell into three key categories: mental health treatment and recovery, mental health promotion, and suicide prevention.

Mental health treatment and recovery recommendations included a focus on access and inclusion, with recommendations for increases and strengthening of various service options (across levels and target populations) and expansion of bed availability and mobile crisis lines on late evenings and weekends. Specific service recommendations focused on outpatient services for youth and children, animal assisted

therapy for supportive care, respite housing and peer respite services (hospital diversion), and trauma informed practice across service levels.

Recovery recommendations included expansion of use of Certified Peer Recovery Specialists, and use of Recovery Support Specialists for mobile mental health outreach (similar to mobile homeless outreach model).

Suicide prevention recommendations focused on resource promotion, education, and early screening enhancement at the community level. Specific recommendations included education of school, community, and provider partners about mobile crisis and urgent care centers, promotion of 988, and increasing universal screening for early suicidality risk factors in community-based settings.

Mental health promotion recommendations included enhancing school-based health center ability to conduct standardized behavioral health assessments and promotion of mental health curricula like Gizmo's Pawesome Guide in concert with other social emotional learning approaches.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Crisis Services

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Enhance and expand Connecticut's Crisis Continuum

Strategies to attain the goal:

Expand all adult mobile crisis programs to 24/7 operations
Add additional staff within adult mobile crisis programs
Maintain youth crisis services available 24/7/365.
Expand Urgent Crisis Care Centers throughout the State
Support Central Hub Call Center with sufficient staffing

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adult clients receiving a completed crisis evaluation from a mobile crisis clinician during the state fiscal year (SFY)

Baseline Measurement: 8508 (Number of adult clients receiving a completed crisis evaluation during SFY23)

First-year target/outcome measurement: 8600

Second-year target/outcome measurement: 8700

Data Source:

DMHAS Enterprise Data Warehouse (EDW)

Description of Data:

A completed crisis evaluation represents a completed service with an individual requesting adult mobile crisis services. Connecticut tracks the number of crisis evaluations completed by each mobile crisis team in the state to identify the number of clients served throughout the year.

Data issues/caveats that affect outcome measures:

Indicator #: 2

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

Baseline Measurement: In SFY 2023, 7,152 children were served by Youth Mobile Crisis

First-year target/outcome measurement: 7250

Second-year target/outcome measurement: 7350

Data Source:

All MC contacts are entered into a Statewide database, Performance Information Exchange (PIE)

Description of Data:

Data includes total numbers of children served

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Opioid Services

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Reduce fatal substance-related overdoses and reduce transmission of infectious diseases

Strategies to attain the goal:

Distribution of harm reduction rovers to all community based Opioid Treatment Programs. Harm reduction rovers are large containers with multiple storage compartments that contain a variety of harm reduction supplies. These rovers offer community treatment providers a long-term supply of harm reduction supplies that can be moved to various locations based on programmatic needs.

Provision of harm reduction training and technical assistance to community based Opioid Treatment programs.

Distribution of naloxone to all community based Opioid Treatment Programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of community providers receiving a harm reduction rover

Baseline Measurement: 0

First-year target/outcome measurement: 15 (SFY 2024)

Second-year target/outcome measurement: 15 (SFY 2025)

Data Source:

Contracted vendor providing distribution of harm reduction rovers

Description of Data:

Quarterly reports from the vendor will be used to identify the name and number of community providers receiving a harm reduction rover

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of community providers receiving harm reduction training and technical assistance

Baseline Measurement: 0

First-year target/outcome measurement: 15 (SFY 2024)

Second-year target/outcome measurement: 15 (SFY 2025)

Data Source:

Contracted vendor providing training and technical assistance

Description of Data:

Training sign-in sheets will be utilized to identify the name and number of providers receiving training and technical assistance sessions.

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of naloxone kits distributed in the community by DMHAS

Baseline Measurement: 29,064 (SFY 2023)

First-year target/outcome measurement: 33,424 (SFY 2024)

Second-year target/outcome measurement: 38,438 (SFY 2025)

Data Source:

Naloxone distribution dataset

Description of Data:

The dataset compiles information on the distribution of naloxone kits within the state by DMHAS staff

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Youth Use of Alcohol

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To reduce misuse of alcohol by individuals under twenty-one.

Strategies to attain the goal:

Through the PCC grantees, communities will employ a variety of strategies and activities that increases communication and monitoring of underage and high risk drinking in communities with the intended impact to be a reduction in 30-day use of alcohol.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Alcohol – past 30-day use as reported by high school students surveyed

Baseline Measurement: 25.9 % of youth surveyed report past 30-day use of alcohol

First-year target/outcome measurement: 17.5 % of youth surveyed report past 30-day use of alcohol

Second-year target/outcome measurement: 17.1% of youth surveyed report past 30-day use of alcohol

Data Source:

Youth Risk Behavior Surveillance System (YRBSS/CT School Health Survey)

Description of Data:

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

Data issues/caveats that affect outcome measures:

The national survey conducted every 2 years by CDC. Provides data representative of 9th – 12th grade students in public and provides schools in the US.

Priority #: 4

Priority Area: Access to Substance Use and Mental Health Treatment Services

Priority Type: SUT, MHS

Population(s): SMI, PWWDC, PWID, Other

Goal of the priority area:

Increase access to substance use and mental health treatment

Strategies to attain the goal:

Increase staffing for DMHAS Access Line which responds to calls from treatment seeking individuals. Access Line staff provide assessment, referral to appropriate treatment, and connection to transportation providers who can transport individual to treatment.

Increase capacity of Access Line transportation providers so they can provide additional transports to treatment.

Increase staffing and capacity of Access Line transportation providers who transport treatment seeking individuals to intake and treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals transported to substance use or mental health treatment center

Baseline Measurement: 2913 (CY 2022)

First-year target/outcome measurement: 3050 (CY 2023)

Second-year target/outcome measurement: 3150 (CY 2024)

Data Source:

Quarterly data reports from the state's two Access line transportation providers

Description of Data:

Quarterly data reports identify the number of attempted and completed transports

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Answer rate for Access Line

Baseline Measurement: 95% (CY 2022)

First-year target/outcome measurement: 96% (CY 2023)

Second-year target/outcome measurement: 96.5% (CY 2024)

Data Source:

Monthly reports from contracted vendor that manages Access Line call center

Description of Data:

Percentage of calls answered within 30 seconds

Data issues/caveats that affect outcome measures:

Priority #: 5

Priority Area: Women and birthing individuals who use substances during their pregnancy

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

To improve care for substance exposed infants and birthing individuals who use substances

Strategies to attain the goal:

Provide training and consultation to healthcare entities and other pertinent community partners on CAPTA legislation and how to develop an effective and comprehensive Family Care Plans with women and birthing individuals who use substances

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of trainings provided to agencies, FQHCs, hospitals, and community partners educated on CAPTA and Family Care Plans

Baseline Measurement: 0

First-year target/outcome measurement: Provide a minimum of 50 trainings within the Connecticut healthcare system

Second-year target/outcome measurement: Provide an additional 50 trainings with the Connecticut healthcare system

Data Source:

SEPI-CT will track data related to agencies trained including number of individuals trained within their system

Description of Data:

Attendance list of individuals who participate in the training

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Percentage of women and birthing individuals who do not have a family care plan in place before they are discharged from the hospital after giving birth

Baseline Measurement: 20%

First-year target/outcome measurement: 15%

Second-year target/outcome measurement: 12%

Data Source:

DCF CAPTA Notification Portal Dashboard

Description of Data:

CAPTA Notification Dashboard aggregates data provided by birthing hospitals throughout the state regarding substance exposed infant notifications and care plan information

Data issues/caveats that affect outcome measures:

Priority #: 6

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.

Establish a statewide FEP consultation line that will provide telephonic clinical consultation services to any clinician or prescriber in the state that is encountering or treating an individual with psychosis.

Connecticut's Medicaid ASO (Carelon) will continue to conduct analysis of claims data to identify potential new cases of ESMI/FEP within the state's Medicaid population. Carelon's FEP Intensive Care Manager (ICM) will conduct outreach and engagement with identified individuals and provide rapid referral to evidence-based and appropriate services to pre-empt the functional deterioration occurring between onset of psychosis and appropriate care.
Establish a statewide FEP consultation line that will provide telephonic clinical consultation services to any clinician or prescriber in the state that is encountering or treating an individual with psychosis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unique individuals engaged by the regional EDACs

Baseline Measurement: 200 (SFY2023)

First-year target/outcome measurement: 400 (SFY 2024)

Second-year target/outcome measurement: 600 (SFY 2025)

Data Source:

Yale STEP clinic 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

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of contacts made to the new statewide FEP consultation line

Baseline Measurement: 0

First-year target/outcome measurement: 50 (SFY 2024)

Second-year target/outcome measurement: 100 (SFY 2025)

Data Source:

FEP call center database

Description of Data:

Data on all calls and requests to the FEP consultation line will be tracked by Yale through the FEP call center database

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: The percentage of young persons identified by Connecticut's ASO (Carelon) who agree to engage in treatment

Baseline Measurement: 20% of young persons identified with ESMI will agree to engage in treatment.

First-year target/outcome measurement: 22% of young persons identified with ESMI will agree to engage in treatment.

Second-year target/outcome measurement: 24% of young persons identified with ESMI will agree to engage in treatment.

Data Source:

Carelon (ASO), POTENTIAL and STEP programs (CSC programs)

Description of Data:

Number of youth identified, referred and engaged in treatment

Data issues/caveats that affect outcome measures:

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

Priority #: 7

Priority Area: Youth Use of Vaping Products

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To reduce the use of Electronic Nicotine Delivery Devices (ENDS) among youth

Strategies to attain the goal:

(1) Pass legislation to increase access age to tobacco and electronic cigarette products to 21.
(2) Conduct Synar and non-Synar tobacco and ENDS compliance checks to discourage sales to individuals under 21 years old during Synar inspection period and non-Synar inspection period.
(3) Produce and distribute educational and awareness materials regarding tobacco laws to tobacco and electronic cigarette merchants.
(4) Increase public awareness on youth tobacco issues and form coalitions to mobilize community support.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of students who have ever used electronic Vapor Products

Baseline Measurement: 44.8%

First-year target/outcome measurement: 44.5%

Second-year target/outcome measurement: 44.2%

Data Source:

Youth Risk Behavior Surveillance System (YRBSS/CT School Health Survey)

Description of Data:

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

Data issues/caveats that affect outcome measures:

The national survey conducted every 2 years by CDC. Provides data representative of 9th – 12th grade students in public and provides schools in the US.

Priority #: 8

Priority Area: SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Improve access to mental health and crisis services among individuals with SMI

Strategies to attain the goal:

Implement additional community-based programs and services for individuals with SMI: Implement new Crisis Stabilization Units and Peer Respite programs that will serve as community-based alternatives to inpatient care for individuals experiencing a mental health crisis

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SMI admissions to new Crisis Stabilization units and Peer Respite program

Baseline Measurement: 0

First-year target/outcome measurement: 1,400 (SFY 2024)

Second-year target/outcome measurement: 3,700 (SFY2025)

Data Source:

DMHAS Enterprise Data Warehouse (EDW)

Description of Data:

Number of completed admissions in which the individual is identified as having SMI. This client level data is gathered and assessed within the DMHAS EDW.

Data issues/caveats that affect outcome measures:

Peer Respite program is expected to be operational by 4/1/2024 but any delays in implementation will decrease total possible admissions for SFY24

Priority #: 9

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: Maintain the number of faculty trained in the curriculum

Baseline Measurement: 208 masters level graduate students received Current Trends certificate of course; 41 guest presentations and 5 family guest presentations completed

First-year target/outcome measurement: An additional 100 masters level graduate students will receive Current Trends certificate of course; an additional 25 guest presentations and 5 family guest presentations will be

completed

Second-year target/outcome measurement: An additional 100 masters level graduate students 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 students who received certificates by completion of course and required certification process, total number of guest and family presentations

Data issues/caveats that affect outcome measures:

None

Priority #: 10

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: In SFY23, 40 new clinical staff were trained to deliver MATCH-ADTC; 23 agencies were trained; and 4 new agencies joined

First-year target/outcome measurement: 20 new clinical staff will be trained, 20 agencies will receive ongoing training and 2 new agencies will join

Second-year target/outcome measurement: 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 #: 11

Priority Area: Youth Access to Tobacco

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To reduce underage access to tobacco, vapor and alternative nicotine products through retail outlets.

Strategies to attain the goal:

(1) Pass legislation to increase access age to tobacco and electronic cigarette products to 21.
(2) Conduct Synar and non-Synar tobacco and ENDS compliance checks to discourage sales to individuals under 21 years old during Synar inspection period and non-Synar inspection period.
(3) Produce and distribute educational and awareness materials regarding tobacco laws to tobacco and electronic cigarette merchants.
(4) Increase public awareness on youth tobacco issues and form coalitions to mobilize community support.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Tobacco retailers sell rate to individuals under the age of 21

Baseline Measurement: 23% retailer violation rate – SFY 2022

First-year target/outcome measurement: 20% retailer violation rate – SFY 2024

Second-year target/outcome measurement: 20% retailer violation rate – SFY 2025

Data Source:

Annual Synar Survey

Description of Data:

State is required to conduct a formal Synar survey to determine retailer compliance with tobacco youth access law and to measure the effectiveness of the enforcement of the law. The state must maintain a youth tobacco sales rate of 20% or less to underage youth during the Synar survey.

Data issues/caveats that affect outcome measures:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$30,211,442.00		$0.00	$37,114,718.00	$195,053,366.00	$0.00	$14,640,860.00		$2,670,528.00	$9,141,507.00
a. Pregnant Women and Women with Dependent Children[c]	$3,925,757.00			$429,509.00	$9,023,906.00		$319,847.00			$2,830,000.00
b. Recovery Support Services	$9,520,310.00			$6,561,105.00	$5,647,995.00				$2,444,000.00	$1,909,875.00
c. All Other	$16,765,375.00			$30,124,104.00	$180,381,465.00		$14,321,013.00		$226,528.00	$4,401,632.00
2. Primary Prevention[d]	$10,715,790.00		$0.00	$13,176,781.00	$7,822,994.00	$0.00	$1,315,755.00		$24,000.00	$1,636,598.00
a. Substance Use Primary Prevention	$10,715,790.00			$13,176,781.00	$7,822,994.00		$1,315,755.00		$24,000.00	$1,636,598.00
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately					$16,977,602.00					
12. Total	**$40,927,232.00**	**$0.00**	**$0.00**	**$50,291,499.00**	**$219,853,962.00**	**$0.00**	**$15,956,615.00**	**$0.00**	**$2,694,528.00**	**$10,778,105.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$1,325,185.00		$258,174.00	$11,601,514.00		$955,061.00				
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$2,320,122.00			$500,000.00			$240,375.00		$724,391.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$142,091,808.00	$15,875.00	$649,258,045.00		$2,789,868.00				
8. Other 24-Hour Care		$1,676,963.00	$152,527,309.00	$204,292.00	$374,642,422.00		$42,048.00				
9. Ambulatory/Community Non-24 Hour Care		$7,718,435.00		$64,898,568.00	$1,027,717,466.00		$8,670,305.00	$246,784.00		$2,169,050.00	
10. Crisis Services (5 percent set-aside)[f]		$6,501,501.00		$6,963,610.00	$28,907,627.00			$375,000.00		$7,682,589.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$30,000.00			$82,553,099.00						
12. Total	**$0.00**	**$19,572,206.00**	**$294,619,117.00**	**$72,340,519.00**	**$2,175,180,173.00**	**$0.00**	**$12,457,282.00**	**$862,159.00**	**$0.00**	**$10,576,030.00**	**$735,477.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

As of 9/1/2023 the state has spent $3,263,746 of the COVID-19 Relief MHBG award. Planned expenditures reflected under column H reflect remaining expenditures under the state's approved NCE for COVID-19 Relief MHBG. These planned expenditures will be completed and processed by the end of the NCE period on 3/14/2024.

As of 9/1/2023 the state has spent $7,277,025 of the ARP MHBG award. Planned expenditures under column J reflect all remaining expenditures to be made from the ARP MHBG award based on the currently approved proposal for this award.

Planned expenditures under column K are based on the state's second allotment of BSCA and on the proposal submitted by the state for these funds and attached to this application. The state does not plan to expend any BSCA MHBG funds on administration.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's 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, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	10,401	412
2. Women with Dependent Children	13,273	3,006
3. Individuals with a co-occurring M/SUD	77,694	12,671
4. Persons who inject drugs	31,653	8,522
5. Persons experiencing homelessness	408	5,687

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Aggregate number in need was calculated using national estimates of prevalence applied to state census data.

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$10,345,566.00	$226,528.00	$3,615,816.00
2 . Substance Use Primary Prevention	$5,357,895.00		$818,299.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$4,760,155.00	$1,936,000.00	$954,938.00
6 . Administration (SSA Level Only)			
7. Total	**$20,463,616.00**	**$2,162,528.00**	**$5,389,053.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). 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 services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$299,700		$46,643
	Selected	$6,309		$982
	Indicated	$9,464		$1,473
	Unspecified			
	Total	**$315,473**	**$0**	**$49,098**
2. Education	Universal	$1,648,350		$256,537
	Selected	$34,702		$5,401
	Indicated	$52,053		$8,101
	Unspecified			
	Total	**$1,735,105**	**$0**	**$270,039**
3. Alternatives	Universal	$49,950		$7,774
	Selected	$1,052		$164
	Indicated	$1,577		$245
	Unspecified			
	Total	**$52,579**	**$0**	**$8,183**
4. Problem Identification and Referral	Universal	$49,950		$7,774
	Selected	$1,052		$164
	Indicated	$1,577		$245
	Unspecified			
	Total	**$52,579**	**$0**	**$8,183**
	Universal	$2,097,900		$326,501

5. Community-Based Processes	Selected	$44,167		$6,874
	Indicated	$66,249		$10,311
	Unspecified			
	Total	**$2,208,316**	**$0**	**$343,686**
6. Environmental	Universal	$299,701		$46,643
	Selected	$6,309		$982
	Indicated	$9,464		$1,473
	Unspecified			
	Total	**$315,474**	**$0**	**$49,098**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated	$100,000		$0
	Unspecified			
	Total	**$100,000**	**$0**	**$0**
8. Other	Universal	$549,450		$85,512
	Selected	$11,567		$1,800
	Indicated	$17,351		$2,700
	Unspecified			
	Total	**$578,368**	**$0**	**$90,012**
Total Prevention Expenditures		**$5,357,894**	**$0**	**$818,299**
Total SUPTRS BG Award[3]		**$20,463,616**	**$2,162,528**	**$5,389,053**
Planned Primary Prevention Percentage		**26.18 %**	**0.00 %**	**15.18 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$3,417,632		$531,894
Universal Indirect	$1,577,368		$245,490
Selected	$105,158		$16,366
Indicated	$157,737		$24,549
Column Total	**$5,257,895**	**$0**	**$818,299**
Total SUPTRS BG Award[3]	**$20,463,616**	**$2,162,528**	**$5,389,053**
Planned Primary Prevention Percentage	**25.69 %**	**0.00 %**	**15.18 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☐	☑
Tobacco	☑	☐	☑
Marijuana	☑	☐	☑
Prescription Drugs	☑	☐	☑
Cocaine	☑	☐	☑
Heroin	☑	☐	☑
Inhalants	☑	☐	☑
Methamphetamine	☑	☐	☑
Fentanyl	☑	☐	☑
Prioritized Populations			
Students in College	☑	☐	☑
Military Families	☑	☐	☑
LGBTQI+	☑	☐	☑
American Indians/Alaska Natives	☑	☐	☑
African American	☑	☐	☑

Hispanic	☑	☐	☑
Persons Experiencing Homelessness	☑	☐	☑
Native Hawaiian/Other Pacific Islanders	☑	☐	☑
Asian	☑	☐	☑
Rural	☑	☐	☑
Underserved Racial and Ethnic Minorities	☑	☐	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					$127,725.00
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation				$114,162.00	
7. Training and Education	$156,750.00			$34,238.00	
8. Total	**$156,750.00**	**$0.00**	**$0.00**	**$148,400.00**	**$127,725.00**

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

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

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

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. 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 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: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. 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 seriousness 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 detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) 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) 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).

c) 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.

d) 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.

e) 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.

f) 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.

g) 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 acute care services. As a result, we invested in the expansion of pediatric inpatient psychiatric services. We have set the expectation of at least 10% greater bed capacity through a rate add-on for expanding bed capacity and an acuity-based rate add-on to improve services for highly complex children on inpatient units. Additionally, we have focused efforts on facilitating safe discharges from acute levels of care. We have committed to individualized, timely discharge through use of Statewide coverage by 12 care coordinators for discharges from emergency departments, hospital inpatient and Psychiatric Residential Treatment Facility levels of care. We also 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. Additionally, the creation of Behavioral Health Urgent Care Centers (youth/children ages 6–17 years) offers a short-term, bidirectional crisis stabilization program to avoid unnecessary emergency department stays and improve throughput for children

on inpatient levels of care. In our efforts to ensure racial and ethnic awareness in treatment, CT created an Urban Trauma Intervention/Violence and Racism, which will support a proof of concept to elevate the Urban Trauma Intervention model and to provide evidence based documentation, as well as identify threshold training, qualifications and build upon/incorporate existing service array. ACCESS Mental Health program was also expanded to enable comprehensive, local integration of primary care medical and behavioral health integration.

h) 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 an alliance among the Connecticut DMHAS, DSS (Medicaid authority) and DCF (Department of Children and Families), together creating the legislatively mandated Behavioral Health Partnership. The partnership works in conjunction to ensure parity for behavioral health services authorization and delivery. An example of an issue occurred a few years ago when authorization parameters for intermediate care for behavioral health services were changed to mirror the authorization parameters for medical health services, ensuring parity.
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 integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. 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

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) which is allowing Connecticut to further expand our integration efforts.
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. It is estimated that through high fidelity Wraparound provided by all state-funded care coordinators,

1,300 children, youth, and family members will be served each year for a total of 5,200 impacted over the four-year grant period. 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 by 15% as well as increase referrals to caregiver peer support by 10%. The State will also develop an FEP Learning Collaborative and a CHR-P Learning Collaborative that will expand over 6 agencies. These collaboratives will meet 3 times annually. 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.

4. 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

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Adults with serious mental illness and adults with SUD

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.

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.

b) 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 congregate care settings 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.

5. 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. In 2009 DMHAS created two co-occurring enhanced residential treatment programs that were procured in 2009 and continue today. Since then, one additional residential treatment program has reached co-occurring enhanced status for a total of three programs across the state.
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. Data from this screening are collected and reviewed through our statewide treatment database. Over the past year we have 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 did not want them to be limited to just the 4 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. A few accomplishments of the learning collaborative include:
1. Full day Integrative Care Conference for DMHAS employees in 2022 and 2023
2. In the fall of 2022, a half day conference was held for all DMHAS prescribers on integrated care
3. Case Consultations focused on co-occurring disorders provided to the state operated LMHAs and hospitals

Over the past year, 12 one-hour Lunch and Learn webinars were held monthly for DMHAS employees focused on aspects of integrated care for co-occurring disorders.
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 may provide, 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, 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. The 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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

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

Please respond to the following items:

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

a) Race — (●) Yes ( ) No

b) Ethnicity — (●) Yes ( ) No

c) Gender — (●) Yes ( ) No

d) Sexual orientation — ( ) Yes (●) No

e) Gender identity — ( ) Yes (●) No

f) Age — (●) Yes ( ) No

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

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

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

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

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

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

At a statewide level, Connecticut is currently undertaking an effort to collect more granular data on race and ethnicity in an attempt to identify and address racial and ethnic disparities. Through this initiative, Connecticut will significantly expand the categories it currently collects for race and ethnicity. The state is currently in process of updating its administrative databases and data collection tools to include and incorporate the additional race and ethnicity categories. As part of this initiative, DMHAS is currently updating its administrative database and data warehouse to incorporate the additional categories for race and ethnicity. This will allow DMHAS to identify and remediate more specific racial and ethnic disparities within the behavioral health system. Within DMHAS, the Office of Multicultural Health Equity (OMHE) focuses on identifying and remediating disparities in behavioral health care. OMHE uses data from a variety of sources (DMHAS, Yale University, Medicaid claims data) and responds with targeted activities. One of the main activities conducted by OMHE is the Organizational Multicultural Assessment (OMCA). The OMCA is an initiative in which behavioral health facilities are evaluated every 2 years with respect to meeting CLAS standards. Results are analyzed and reviewed with facilities. Training and technical assistance are provided as part of this process as well to support facilities in fully implementing CLAS standards. This initiative has focused on state-operated facilities, but interested private nonprofits are able to take part in this process as well.

The Multicultural Advisory Council (MCAC) brings together multicultural committees from each of the state-operated facilities statewide to strategize ways to enhance implementation of CLAS standards. Some of the activities that have occurred are facility Lunch and Learns, community conversations, as well as "Chicago Dinners" focusing on health disparities that are held in each DMHAS region of the state. DMHAS has also engaged with faith-based organizations on community building with cultural relevance, to transform and expand the Connecticut crisis response capacity to be a fully person and family-centered, trauma informed, and culturally responsive.

OMHE also provides training throughout the DMHAS system of care on Diversity, Equity & Inclusion (DEI) to enhance understanding of difference and provide skill building opportunities to better engage with clients and staff. These trainings are required of all DMHAS staff, including direct staff, managers, and leadership. To maintain sustainability of this initiative and continue DEI trainings, DMHAS engages with the Kaleidoscope Group to train DMHAS staff to take on the role of facilitators for DEI trainings.

In regard to children and youth, much work has been done to address disparities through the Connecticut Network of Care Transformation (CONNECT) SAMHSA System of Care grant. Through this effort a workgroup was developed to plan and implement a statewide process for incorporating enhanced Culturally Linguistically Appropriate Services (CLAS) standards within the children's Network of Care in Connecticut. With a goal to partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.
The outcomes and results were that cohorts were formed to participate in Connecting with CLAS. Additionally, state and agency partners support, the recruitment efforts of the Connecting with CLAS Team. 61 agencies participated and 48 agencies completed their Health Equity Plans. Technical Assistance is provided to review progress, support their efforts, and receive guidance or recommendations for next steps. This included four quarterly learning collaborative meetings and monthly calls.

Additionally, a program designed in partnership with the Department of Children and Families and Urban Trauma LLC is the Urban Trauma Network Initiative. This initiative will provide educational and training support to providers regarding both the effects of racial trauma on children and youth of color as well as how to appropriately support them in healing. A performance improvement center has been established and many State clinicians are being trained in this model.
Another initiative is a program RJI. This is the new DCF Racial Justice Provider Institute. The goals of the Institute include:
• To train and support DCF's selected service providers with expectations of service delivery to be through a racial justice and equity approach
• To ensure the standards of practice that is occurring internally is also mirroring what is happening externally with the community providers who serve our families
• To demonstrate authentic commitment to the RJ work and grounded in DCF's foundational models
• To create community sessions/focus groups including families with lived experiences of being involved with DCF and service providers, including implicit biases, to better understand the perspectives and needs of our consumers (parents, caregivers, children).
• To develop and customize anti-racism trainings and other RJ forums with voices from families and communities so others besides DCF is carrying the message to have a greater impact on eliminating racial disparities
• To collect data to measure outcomes for organizational changes in service provision, contract proposals, etc.

Another initiative to address disparities within the child/youth system is the new DCF Racial Justice Provider Institute. The goals of the Institute include:
· To train and support DCF's selected service providers with expectations of service delivery to be through a racial justice and equity approach
· To ensure the standards of practice that is occurring internally is also mirroring what is happening externally with the community providers who serve our families
· To demonstrate authentic commitment to the RJ work and grounded in DCF's foundational models
· To create community sessions/focus groups including families with lived experiences of being involved with DCF and service providers, including implicit biases, to better understand the perspectives and needs of our consumers (parents, caregivers, children).
· To develop and customize anti-racism trainings and other RJ forums with voices from families and communities so others besides DCF is carrying the message to have a greater impact on eliminating racial disparities
· To collect data to measure outcomes for organizational changes in service provision, contract proposals, etc.

Question 1: The data fields and requested demographic information within our current state data collection system are aligned with the federal demographic categories required for MH TEDS. As such, Connecticut does not currently collect gender identify and sexual orientation information outside of the TEDS demographic categories. Connecticut is currently evaluating the clinical implications and limitations to requesting gender identity and sexual orientation information from clients that pose challenges to changing our data collection systems.

Question 3: DMHAS and DCF are actively addressing linguistic disparities and language barriers, including the implementation of the National Culturally and Linguistically Appropriate Services Standards (National CLAS Standards) and Implicit Bias. Please see description of OMHE, MCAC, and DCF initiatives in the narrative above which describe this.

Question 4: Behavioral Health providers Statewide are offered training, coaching and technical assistance on the implementation of the National CLAS Standards. Within the adult behavioral health system this is conducted through the Organizational Multicultural Assessment (OMCA). The OMCA is an initiative in which behavioral health facilities are evaluated every 2 years with respect to meeting CLAS standards. Results are analyzed and reviewed with facilities. Training and technical assistance are provided as part of this process as well to support facilities in fully implementing CLAS standards. Within the child/youth system, CLAS-Ambassador meetings are held annually and have a minimum of twelve CLAS ambassadors; two for each of the DCF regions. Additional small-group, training, coaching and technical assistance on the implementation of the National CLAS Standards is offered to any small group of agencies participating in the Regional CLAS Learning Community meetings. DCF has integrated the work of improving health disparities by funding a national consultant and trainer in System of Care and cultural and linguistic competency coaching to participate in monthly meeting with Commissioner's Executive team at DCF; to attend DCF Contract Management meetings; participate in the Children's Behavioral Health Advisory Council (CBHAC) meetings; and facilitate Statewide CLAS Advisory Team meetings.

Question 6: DMHAS has a budget line for the Office of Multicultural Health Equity which is tasked with identifying and remediating disparities in M/SUD care. This budget line is funded with state funding. DCF conducts the work outlined in this section under budget a line-item for Trainings and Education.

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

---

[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

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

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

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

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

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

Since April 2022, DMHAS has partnered with the Department of Social Services, The Department of Children and Families and various stakeholders to implement a Demonstration Waiver under Section 1115 of the Social Security Act for substance use disorder (SUD) treatment for adults and children. Throughout this process, DMHAS has worked collaboratively with SUD treatment providers from throughout the treatment continuum to develop the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid which includes the criteria outlined in the 3rd edition of the American Society of Addiction Medicine. DMHAS has worked with providers since 2022 on adopting and becoming certified under these standards as part of their participation in the Connecticut Medical Assistance Program (Medicaid) payor system.

Through close partnerships with the state's Medicaid Authority, Children's Behavioral Health Authority, criminal justice system,

service providers, service utilizers and their families, DMHAS has launched multiple ASAM adoption monitoring phases and has deployed ASAM trainings to over one thousand behavioral health staff since April of 2022. DMHAS intends on continuing to provide and evolve ASAM related trainings and support to meet the needs of providers and consumers over the next five years.

Along with the transformation of SUD residential services, Connecticut continues to engage various stakeholders in developing and implementing Medicaid value-based payments for lower levels of care and seeks to leverage these payments to improve access, quality of treatment and transitions in care across the continuum." Connecticut has partnered with its administrative service organization, Carelon, to utilize and analyze credible data to help assess issues of access and quality throughout the behavioral health system and develop appropriate value-based frameworks to address these needs.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
CSC	2

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1160061	1160061

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP 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/FEP.

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.

The state does not currently monitor the fidelity of the STEP program or the Potential program but plans to begin monitoring fidelity in 2024. The state is currently in the process of reviewing fidelity monitoring tools and plans to identify a single monitoring tool to utilize beginning in 2024.

In addition to these two programs, the Connecticut Department of Children and Families (DCF) has partnered with the state's Care Management Entity (CME) to utilize Medicaid Claims data and other appropriate available data to identify, refer, and follow-up on youth and young adult Medicaid clients from 12-26 who have experienced a First Episode Psychosis (FEP). The First Episode Psychosis Intensive Care Manager (FEP-ICM) will provide early identification of FEP, rapid referral to evidence-based and appropriate services, and effective engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders. Additionally, a trained FEP Peer Specialist, will identify, refer, and connect youth potentially experiencing FEP to specialty providers. Additional activities of the FEP Peer Specialist will be to attend and participate in treatment team meetings, support transitions between providers, and provide face-to-face and telephonic support to clients and families. The FEP Peer Specialist has "lived experience" and will offer support to clients to gain access to traditional and non-traditional behavioral health services. Any youth or young adult identified as having experienced a FEP will be eligible for referral to appropriate treatment services as well as coordinating care involving assessment, planning, linkage, support and advocacy to assist these individuals in gaining access to needed medical, social, educational or other services.

In addition to providing the ESMI/FEP services outlined above, the state also contracts with the Yale University STEP program to provide training and technical assistance 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. Adult behavioral health providers can receive training and technical assistance in three different formats. The first format is a monthly case conferencing meeting where providers can seek assistance, guidance, and feedback related to individuals they are treating who have ESMI/FEP. The second format is a monthly training series where treatment providers throughout the state can attend and receive training on implementing the various components of coordinated specialty care. The third format is a learning collaborative where specific providers are intentionally identified and requested to join the learning collaborative. The focus of the next learning collaborative to take place in 2024 will be on reducing the duration of untreated psychosis and improving pathways to care for individuals with FEP. For children's behavioral health providers, DCF has contract with Yale to develop and implement two (2) Learning Collaboratives; one for the purpose of recruiting and training community providers in the treatment of First Episode Psychosis (FEP) and the second for the recruitment and training of providers to screen for Clinical High Risk for Psychosis (CHR-P). Each learning collaborative is focused on

training and supporting providers to provide screening, support and care for children, adolescents and emerging adults and their families who are experiencing early psychosis. Specifically, 6 recruitment and orientation presentations (2-hour minimum) are conducted for community providers in each of the six (6) DCF regions. The content of these presentations minimally addresses both FEP and CHR-P and include the signs and symptoms of youth with a CHR-P for mental illness and for FEP, as well as the rationale and principles of early intervention services for these youth and will highlight best practices specifically Specialized Treatment Early in Psychosis (STEP) program. Additionally, for the initial implementation of the Learning Collaborative 12 providers are to be identified based on several criteria, including the geographic areas of the state they can serve and their ability to effectively provide FEP services for youth and their families. Additionally, select up to six (6) individual clinicians to participate in the Learning Collaborative as individuals rather than as provider organizations.

5. Does the state monitor fidelity of the chosen EBP(s)?

○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

◉ Yes ○ No

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

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 for FY 2024 and FY 2025 for your state's ESMI/FEP 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 training activities and a statewide consultation line. In regards to training activities, the state is partnering with the STEP clinic at Yale University who will conduct learning collaboratives with identified Local Mental Health Authorities from each region of the state that do not currently have a CSC program in their region. These learning collaboratives will provide the LMHAs with training, skills, and knowledge related to early intervention services and seek to establish FEP care teams within each LMHA. In unison, the state is establishing an FEP consultation line that will provide telephonic clinical consultation services to any clinician or prescriber in the state that is encountering or treating an individual with psychosis.
To improve early identification and engagement with individuals experiencing FEP, the state will be deploying regional Early Detection and Engagement Specialists (EDACs) to each service region of the state. EDACs will receive all calls for assistance from families or individuals that may be experiencing first-episode psychosis. EDACs will learn about and 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. 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.
In addition to the EDACs, the Connecticut Department of Children and Families will continue to fund a full-time outreach Intensive Case Manager position. This individual will identify youth and young adults with any diagnosis related to early psychotic episodes and conduct outreach and support activities to increase enrollment at two treatment sites. The two locations are Yale's Specialized Treatment Early in Psychosis (STEP) and the Institute of Living's (IOLs) POTENTIAL program. Additionally, this funding will support the ongoing FEP Learning Collaborative for Yale's STEP and Clinical High-Risk Psychosis (CHRP) programs to provide orientation and training in STEP and CHRP services to interested behavioral health providers.

9. Please list the diagnostic categories identified for your state's ESMI/FEP 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 with a 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 with a first episode psychosis 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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

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. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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 consumers and their caregivers in making health care decisions, and enhance 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 SAMHSA's **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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and 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. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, 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 M/SUD 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

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.

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

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

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

There are two federally-recognized tribes in CT, the Mashantucket Pequot Tribal Nation (MPTN) and the Mohegan Tribe. There are also three state-recognized tribes, the Golden Hill Paugussett, Eastern Pequot and Schaghticoke.

The DMHAS Local Mental Health Authority (LMHA) in the southeastern part of the state near the MPTN and Mohegan tribes continues to participate in regional coordinating/collaborative meetings with tribal leadership as part of the Regional Human Services Coordinating Council; the Southeastern Connecticut Health Improvement Collaborative; and the Eastern Connecticut Health Collaborative. The MPTN has been very involved in the 988 coalition, and the Connecticut Suicide Advisory Board (CTSAB), co-lead by DMHAS. The MPTN has helped guide state plans, and reports out quarterly to the CTSAB on their Tribal Good Medicine SAMHSA grant efforts. Additionally, the MPTN collaborates very closely with the Regional Suicide Advisory Board in their area, and they partner for resources and training often. The MPTN is home to one of the largest casinos in the U.S., Foxwoods, and as gambling addiction is a primary risk factor for suicide, the Tribe has acquired suicide prevention materials from the state and the SAMHSA 988 Toolkit for the casino. They also posted 988 Lifeline parking garage signage made available by the CTSAB Lethal Means resources. The Tribal members of both live among the communities in the area, not on tribal land. The Tribes themselves do not have their own crisis services and utilize the state-funded services. However, they do have health services and community services, such as are provided by the grant program the Good Medicine Project. There is not currently a formal arrangement between the Tribes and local crisis services, but the Tribes are aware of the services.

The United Way of Connecticut/211, is the sole 988 provider, and is in the process of engaging the Tribes in an effort to identify training opportunities for the 988 Contact Center Specialists, Administrators, and other Information and Referral staff to better serve Native populations in CT.
December 2023, the MPTN shared with the DMHAS 988 Project Director (PD) that Mohegan and the other CT tribes, and the Narragansett Tribe in RI would like to collaborate with other New England (NE) tribes to develop 988 resources for Native populations in this region, similar to WA state, which is approximately the same size as NE. This information was shared with the SAMHSA NE Regional Director. To facilitate communication about the tribal needs and interests related to 988 in CT and RI, the MPTN and DMHAS 988 PD, with support from SAMHSA and Vibrant, pulled together a conversation with Mary Woodruff, Karen Hearod, and Taylor Bryan Turner (SAMHSA), and Jill Lloyd and Hye Won Yoon (Vibrant) on January 23, 2023. This was hopefully the first of many conversations, and it's expected that the other tribes will join in the future.

In addition to 988 and the CTSAB, the MPTN and Mohegan Tribes have also joined the CT Governor's Challenge to prevent suicide among Service Members, Veterans, and their families. This initiative is led by DMHAS and the CT National Guard. The MPTN was able to attend a June 13-15, 2023 planning meeting in Washington, D.C. with the team. We are pleased to share that the MPTN lead has accepted the position of Assistant Director of Tribal Affairs at the national Suicide Prevention Resource Center, but will still be able to participate in CT suicide prevention efforts.

In regard to children and youth, the Connecticut Department of Children and Families (DCF) contact with the Mohegan Tribe (MT) is governed by a Memorandum of Understanding. This includes confidential meetings of case specific discussion of State interventions with MT members. The State notifies the MT of all accepted reports regarding their members. Discussion is held in meetings at tribal offices. The meetings are also used as an opportunity to advise the Tribe of new State initiatives; discussions have included Structured Decision Making, Differential Response System, Child and Family Team Meetings for Considered Removals, and Permanency Team Meetings. Regarding the Mashantucket Pequot Tribal Nation (MPTN), while no formal arrangement is in place for regular meetings, there has been a single point of contact at the MPTN for many years, Director of Child Protection, with the Tribes. There have been no Indian Child Welfare Act (IWCA) compliance issues identified with the MPTN or MT over the last eight years, or with other federally recognized tribes across the nation. Within the state's Department of Children and Families, newly hired Social Workers are trained on ICWA during pre-service training. Additionally, when local training opportunities arise, invitations are often issued to the tribes.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [x] 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)** [x] Children (under age 12)
- **b)** [x] Youth (ages 12-17)

c) [x] Young adults/college age (ages 18-26)

d) [x] Adults (ages 27-54)

e) [x] Older adults (age 55 and above)

f) [x] Cultural/ethnic minorities

g) [x] Sexual/gender minorities

h) [x] Rural communities

i) [ ] Others (please list)

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

a) [x] Archival indicators (Please list)

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

b) [x] National survey on Drug Use and Health (NSDUH)

c) [x] Behavioral Risk Factor Surveillance System (BRFSS)

d) [x] Youth Risk Behavioral Surveillance System (YRBS)

e) [x] Monitoring the Future

f) [x] Communities that Care

g) [x] State - developed survey instrument

h) [x] Others (please list)

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

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?

The Evidence Based Workgroup meets bi-monthly and provides guidance for the selection of evidence-based strategies based on a number of factors including SAMHSA guidance, and research conducted by evaluators. The Evidence Based Workgroup developed an array of Fidelity Tools for the most commonly used strategies that will allow communities the ability to assess the efficacy of the selected strategy.

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

6. Does your state integrate the National CLAS standards into the assessment step? (●) Yes ( ) No

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

National CLAS standards are incorporated into the development of the Strategic and Implementation Plans at the grantee and sub-recipient levels. Action steps are identified at this time to show how organizational structures or policies will be adapted or created to meet the needs of the community / population to be served.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

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

Sustainability is integrated into all steps of the Strategic Prevention Framework. Additionally, grantees and sub-recipients incorporate how projects and programs can be sustained after current resources are unavailable in their Strategic and Implementation plans.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

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.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

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

National CLAS Standards are incorporated while looking at the capacity and readiness of community / population. Language access and organizational / community supports for cultural competence are also included while looking at the needs and potential gaps.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

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

Sustainability is integrated into all steps of the Strategic Prevention Framework. Capacity building and workforce development is done on the grantee and sub-recipient levels to ensure continued representation on coalitions, advisory

councils, and other community boards.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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 BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

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

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component (i.e., National CLAS Standards)
- **g)** ☑ Sustainability component
- **h)** ☑ Other (please list):

Finance component, evaluation component

i) ☐ Not applicable/no prevention strategic plan

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

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with 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

The Evidence Based Workgroup meets bi-monthly and provides guidance for the selection of evidence-based strategies based on a number of factors including SAMHSA guidance, and research conducted by evaluators. The Evidence Based Workgroup developed an array of Fidelity Tools for the most commonly used strategies that will allow communities the ability to assess the efficacy of the selected strategy.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

7. 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?

The Evidence Based Workgroup meets bi-monthly and provides guidance for the selection of evidence-based strategies based on a number of factors including SAMHSA guidance, and research conducted by evaluators. The Evidence Based Workgroup developed an array of Fidelity Tools for the most commonly used strategies that will allow communities the ability to assess the efficacy of the selected strategy.

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

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

National CLAS standards are incorporated into the development of the Strategic and Implementation Plans at the grantee and sub-recipient levels. Action steps are identified at this time to show how organizational structures or policies will be adapted or created to meet the needs of the community / population to be served.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

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

Sustainability is integrated into all steps of the Strategic Prevention Framework. Additionally, grantees and sub-recipients incorporate how projects and programs can be sustained after current resources are unavailable in their Strategic and Implementation plans.

b) If no, please explain in the box below.

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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) If yes, please describe.

The state provides funds through competitive bids for infrastructure services that provide prevention training, TA, youth development, needs and gap assessment, data collection, analyses, evaluation, information disseminations, etc., as well as evidence-based programs directly to target populations. The funding opportunities are usually informed by the process described in the assessment section. The state only funds prevention efforts but does not ensure that recipients have no other means of funding. If this is necessary, guidance from SAMHSA on how to ensure this is needed.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Strategies and activities are selected that will prevent behavioral health disparities among disparate subpopulations, based on the goals and objectives of the program.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Strategies and programs selected for implementation are viewed through the lens of sustainability and those that are able to or have a high probability to continue after resources / funding are over are selected.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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 BGAS by going to the **Attachments Page** and upload the plan.

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

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

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

- **a)** [x] 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 use

c) ☑ Binge 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):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

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

National CLAS standards are incorporated in the evaluation step; most surveys are available in English and Spanish.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Sustainability is in incorporated into the evaluation step; specifically as part of survey methodology.

b) If no, please explain in the box below.

Footnotes:

Prevention and Health Promotion Division

Strategic Plan
2021-2024

Authorized by:
DMHAS Prevention and Health Promotion Division

dmhas

TABLE OF CONTENTS

dmhas

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%).

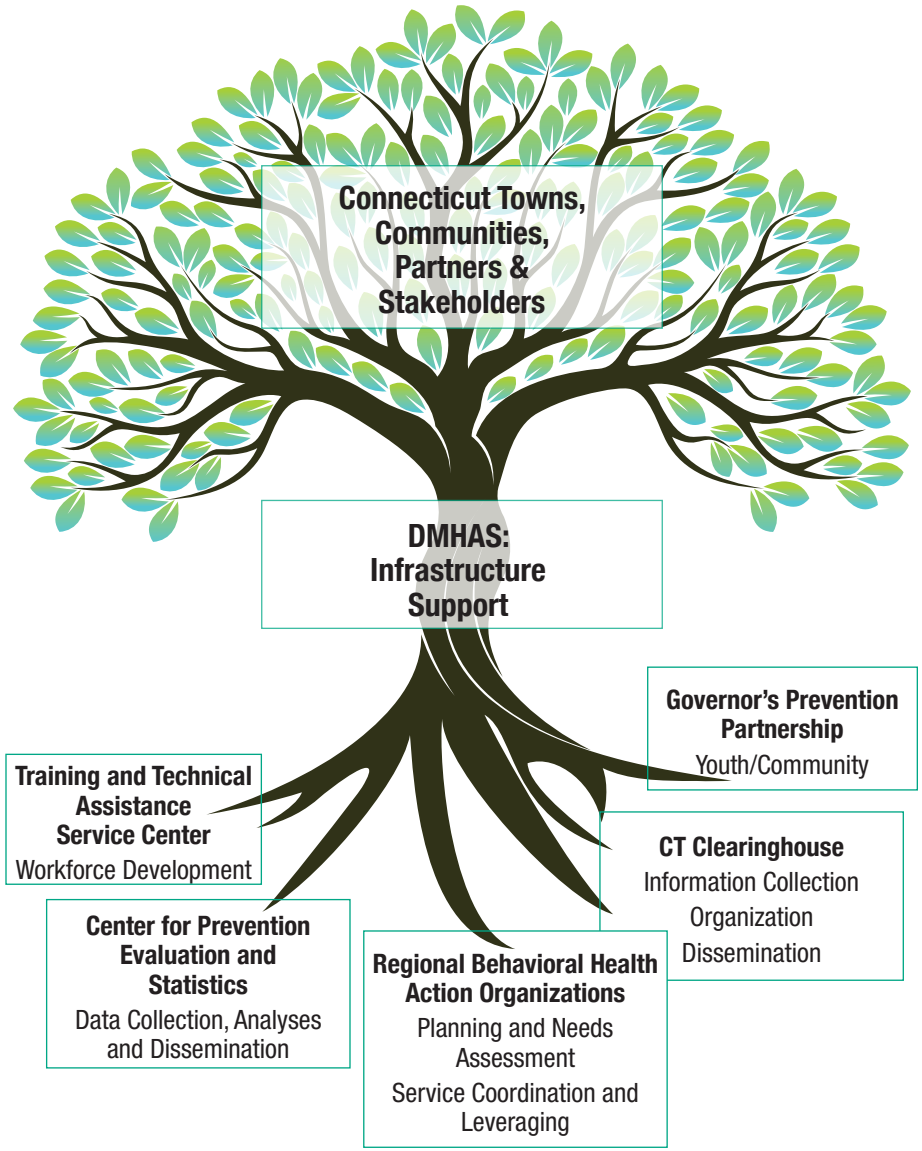
Marijuana: Marijuana remains the second most commonly used drug in Connecticut *(CSHS, 2019)*. Marijuana usage in the state remains higher than the national average. Among 18-25 year olds in Connecticut 30.1% reported past month marijuana use compared to 22.1% nationally. Among youth 12-17 in Connecticut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

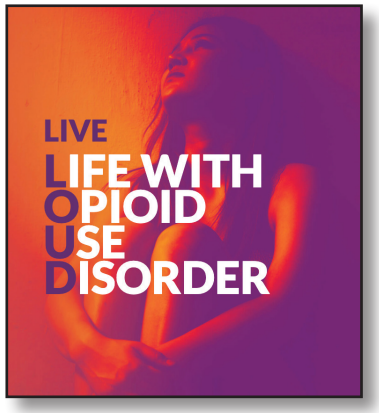
Assessment Summary: In recent years, Connecticut has seen an increase in accidental deaths due to prescription drugs and heroin use. The deaths often include a mix of substances including illicit opioids, and a variety of prescription medications, including methadone, tramadol, and benzodiazepines. While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



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

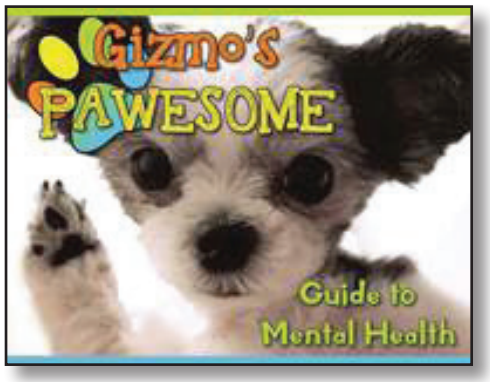
GOAL FIVE: REDUCE SUICIDE AMONG CONNECTICUT RESIDENTS

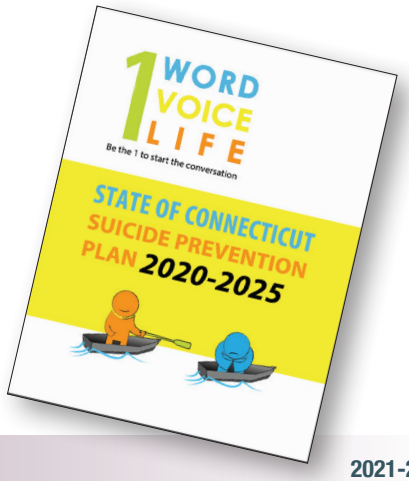
Assessment Summary: Suicide and related risk factors remain a concern, especially among those under 25. Of students in grades 9-12, almost 31% have felt sad or hopeless almost every day for at least two consecutive weeks in the past year *(CSHS, 2019)*, and 12.7% have had serious thoughts of suicide 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 survivorship 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.

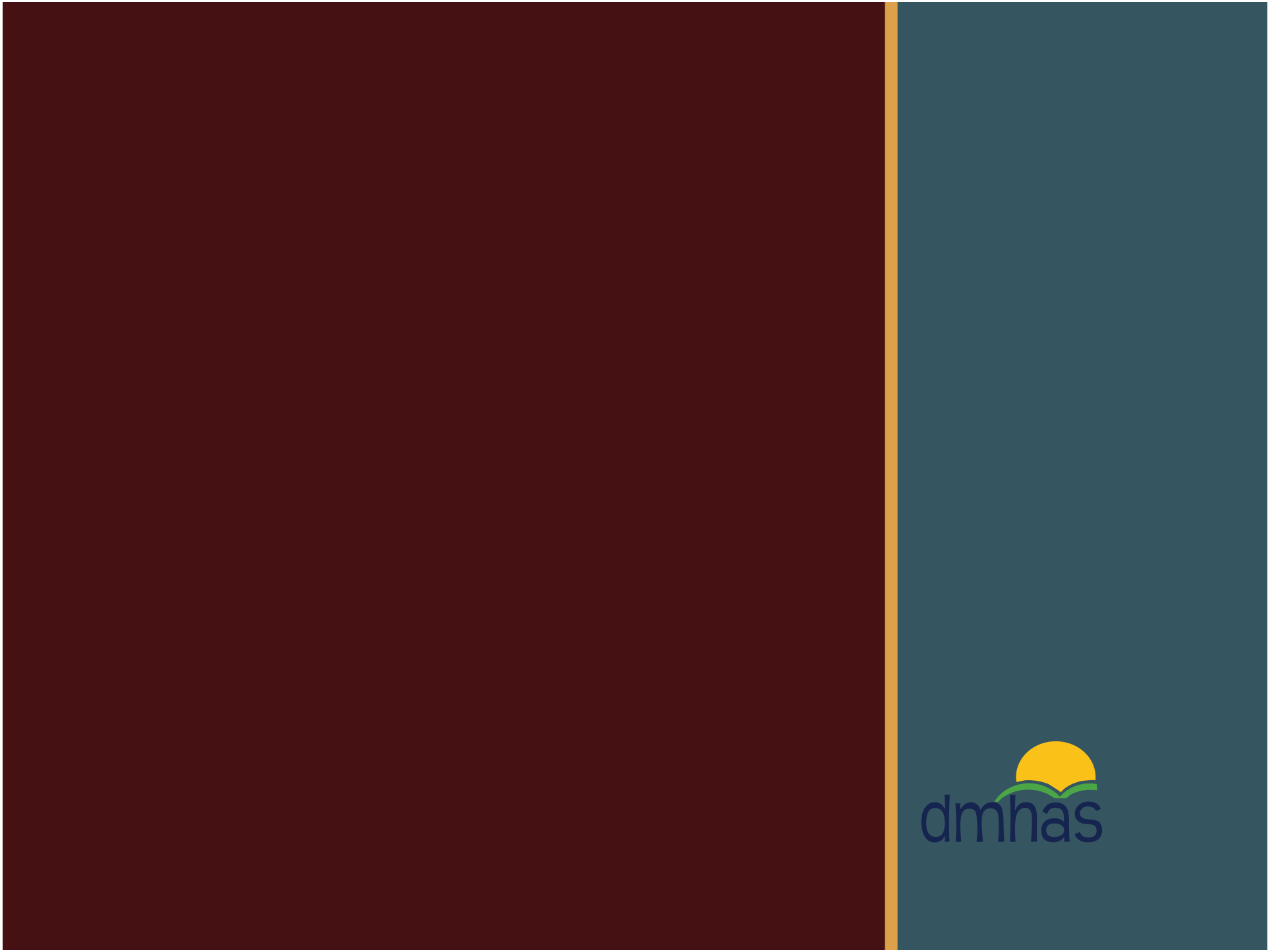
Finally, as the DMHAS begins looking at its next funding cycle, it will examine the funding formulas currently in use to ensure that the funding is directed towards those entities who have

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


dmhas

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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.

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, 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 misuse prevention and SUD treatment services	(●) Yes	( ) No
h)	Medical and dental services	(●) Yes	( ) No
i)	Support services	(●) Yes	( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes	( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes	( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Case management services are provided within many levels of care that serve individuals with 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. In 2010, DMHAS converted most of its mental health case management services to Community Support Program (CSP) teams that include a combination of TCM, non-TCM case management, and an emphasis on skill-building interventions. The 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 (CME), 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. The 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.

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. Sub-acute programs are currently in process of being developed as well. 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.

Please indicate areas of technical assistance needed 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

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	155007	41973
2.Children with SED	73249	43408

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, DMHAS used the most recent prevalence estimates for adults with Serious Mental Illness (SMI) 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.

Connecticut is the 29th most populated state with 3.6 million residents of whom 732,493 (or 20.2 are children and youth). Children with Serious Emotional and Disturbance are estimated at 10% or over 73,000 children. While approximately 10% of CT youth have SED and are in need of intensive mental health services, the use of restrictive services remains too high and there is a need for more services/supports to occur through integrated community-based care. In the child serving system 43,408 youth were served, 15,661 of this number were recipients of crisis services. which were largely unduplicated, 27,747 unduplicated children and youth received other services in the array.

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

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	● Yes	○ No
b)	Educational services, including services provided under IDEA	● Yes	○ No
c)	Juvenile justice services	● Yes	○ No
d)	Substance misuse preventiion and SUD treatment services	● Yes	○ No
e)	Health and mental health services	● Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

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

**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.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's 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 targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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 will be 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 targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

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. The program expanded in 2023 with the addition of one full time staff in each region, doubling the capacity of the program statewide.

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 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.

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

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.

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 for SAMHSA 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 or underserved 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 SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. 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.

b. 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.

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

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required 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

i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/residential)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

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. 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 collaborative 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)	Syringe services programs, if applicable	( ) Yes (●) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (●) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, 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. 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

Syringe Service Programs

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(42 U.S.CÂ§ 300x-31(a)(1)F)? — (●) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — (●) Yes ( ) No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? — ( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Syringe Services in Connecticut are provided by the Department of Public Health, not DMHAS. Some substance use programs that receive DMHAS funding do work closely with the syringe services programs in different locations around the state.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions — ○ Yes ◉ No

c) Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ◉ Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ○ Yes ◉ No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ○ Yes ◉ No

c) Updating written procedures which regulate and control access to records — ○ Yes ◉ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ○ Yes ◉ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ○ Yes ◉ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

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

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ◉ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a)	Improvement of Process for Appropriate Referrals for Treatment	○ Yes	◉ No
b)	Professional Development	○ Yes	◉ No
c)	Coordination of Various Activities and Services	○ Yes	◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.cga.ct.gov/current/pub/chap_319i.htm#sec_17a-450
Licensing of substance use disorder programs is covered under a difference state agency: Department of Public Health.

If the answer is No to any of the above, please explain the reason.

Group Homes: The state currently provides its own funding for the development and operation of sober/recovery housing. Additionally, the cap on individual loan amounts under the revolving loan statute is prohibitively low considering the current cost of housing development or acquisition, so the state has not sought to establish this.

Professional development: The state has current system in place and does not require these areas.

Waivers: The state is currently able to meet the necessary requirements related to these areas and is not seeking a waiver.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? (●) Yes ( ) No

4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

6. Does the state use an evidence-based intervention to treat trauma? (●) Yes ( ) No

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

Since 2004 DMHAS has implemented a statewide trauma initiative which has the primary goal of facilitating the delivery of behavioral health care that is sensitive and responsive to the needs of men and women who have experienced psychological trauma. The initiative focuses on training and professional development with clinicians and clinical case managers in the DMHAS system of care to prepare them to provide screening, education, and treatment groups. Trauma services are implemented based on the guiding principle that treatment must be informed by a sound scientific, clinical, culturally relevant, and humanistic

understanding of the impact and impairment caused by traumatic stress. As part of the trauma initiative, DMHAS maintains an annual contract with the CT Women's Consortium (CWC) to train providers on trauma-informed care and trauma-specific interventions. Thousands of state operated and private non-profit staff have received these trainings over the years. DMHAS, in collaboration with CWC, also implements a Trauma & Gender Practice Improvement Collaborative for agencies. Providers attend bimonthly sessions to hear presentations from varied topic experts, share best practices and learn from state agency staff. DMHAS has also published a directory of trauma specific treatment models and trauma related resources for treatment seeking individuals and providers.

The Connecticut Department of Children and Families (DCF) has Trauma-Informed Practice as one of it's six cross-cutting themes. This means delivering and offering services to children and families with an understanding of the impact that trauma can have on their lives and using interpersonal skills to ensure that our work is supportive of trauma recovery and not re-traumatizing. DCF-funded evidence-based trauma-informed services include Trauma-Focused Cognitive Behavioral Therapy, Modular Approach to Therapy for Children, Cognitive Behavioral Intervention for Trauma in Schools, Bounce Back, Child Trauma Screening and others.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

(●) Yes ( ) No

DMHAS collaborates with The CT Sentencing Commission to collect data on disparities. In addition, DMHAS's Department of Forensic Services (DFS) also meets regularly with the Judicial branch to monitor outcomes when a judge orders a Competency to Stand Trail evaluation.

Independent of DMHAS, the Connecticut judicial branch and Office of Policy Managment track data related to disparities. One such document is listed below (https://portal.ct.gov/-/media/OPM/CJPPD/CjCjpac/CJPAC-Presentations-Folder/2023-Presentations/CJPAC_ResearchUnit_Update.pdf)

In regard to Juvenile Justice, the State of Connecticut established the Juvenile Justice Policy and Oversight Committee (JJPOC) through Public Act 14-217 to oversee the continued reform of the juvenile justice system. A subgroup was created to focus specifically on strategic planning aimed at reducing racial and ethnic disparities of youth in Connecticut's juvenile justice system. The subgroup has 5 objectives. 1. Ensure the collection, review, and public reporting of race and ethnicity data at each important point of contact in the juvenile justice system. 2. Ensure that race and ethnicity data and the strategies to address disparities are interpreted 3. Enhance and support opportunities for localized review (community oversight) of school and police practices. and developed in true partnership with communities of color. 4. Promote the use of racial justice assessments of policy proposals that impact school discipline and juvenile justice. 5. Identify opportunities where inequities within the juvenile justice system can be effectively addressed.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

(●) Yes ( ) No

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

The 21st century CARES Act - Opioid State Targeted Response (STR) grant provided funds to DMHAS, some of which will be used to support the Department of Correction (DOC), Court Support Services Division (CSSD), State's Attorney, and local police efforts. DOC, DMHAS, DPH and community providers are working together to maintain incarcerated clients on methadone. Efforts are underway to expand this to more prisons. Efforts are also underway to educate DOC employees about naloxone use and inmates and parolees are now being released with narcan kits.

"Second chance" is a Governor-led and legislatively supported initiative which helps to reduce prison populations and ensure nonviolent offenders are successfully reintegrated into society and become productive workers in Connecticut's economy, by emphasizing treatment and rehabilitation over punishment for nonviolent drug crimes. Legislation also funds additional program expansion of vocational and job-based adult education, employment training, and school-based diversion initiatives (SBDI) to reduce suspensions, expulsions and school-based arrests; and supportive housing services for pregnant users or substances and individuals with mental health issues that cycle in and out of the corrections system. Reintegration units have been established for women, youth, and veterans for a focus on rehabilitation.

There are multiple jail diversion programs embedded in all arraignment courts in Connecticut:

Jail Diversion/Court Liaison Program (JD; statewide)
Clinicians in all 17 arraignment courts screen adult defendants with mental health, substance use and co-occurring disorders. JD can offer a community treatment option in lieu of jail while case proceeds through court process. JD refers clients for services, monitors compliance, reports compliance to court and provides supportive services to clients enrolled in the program

Women's Jail Diversion (JDW; New Britain, New Haven)
Offers full clinical and support services to women who have experienced trauma, most with substance use disorders and areat risk of incarceration. Clients can have pretrial cases or are on parole/probation and are at risk of violation. Services include clinical, medication management, community support, limited temp housing, client supports.

Jail Diversion Veterans (JDVets; Norwich, New London, Middletown)
Targets veterans who have current criminal charges. Can offer community treatment option in lieu of jail while case proceeds through court process. Refer clients for clinical services and specialized veteran's services, monitor compliance, report compliance to court.

Jail Diversion Substance Abuse (JDSA; Hartford)
Targets adults with substance use disorders who need immediate admission to residential detox and/or intensive residential treatment on day of arraignment or rapid admission to IOP. Includes intensive case management, sober house rent, other transitional housing options, client supports, monitor compliance, and report compliance to court.

Alternative Drug Intervention (ADI; New Haven)
Offers full services to pretrial defendants with substance use disorders in New Haven court (mostly men; women go into the JD Women's program). Services include clinical, medication management, case management, client supports.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

(●) Yes ( ) No

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

DMHAS has a large network of methadone providers and conducts on-site monitoring of all methadone clinics. There is a learning collaborative conducted at least three times a year with all methadone clinics. Given the ongoing opioid epidemic DMHAS has invested (with federal dollars) in many activities to increase and expand the use of MAT for OUD (e.g., enhanced clinics, mobile MAT) and has collaborated extensively with DOC to assist in MAT expansion for their inmates and those re-entering DMHAS services. At this time, there are 8 fully certified OTPs operating within Connecticut correctional facilities offering daily dispensing as well as induction. Additionally, the state is currently working to increase access to buprenorphine, naloxone and naltrexone. DMHAS has been partnering over the last two years with DPH, DCP, and DSS to bring mobile narcotic units to CT. A small state legislative change was required and made to facilitate this. Licensing, billing and procedures are now available for providers to implement mobile narcotics units. The state currently has 5 DMHAS-funded mobile MAT vans providing buprenorphine and naltrexone.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (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 evidenced-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 expend 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 expanding 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 will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-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 service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, 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 this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis 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
The United Way of Connecticut (UWC), in partnership with the CT Department of Mental Health and Addiction Services (DMHAS), has established the Adult Telephone Intervention and Options Network (ACTION) line 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 2-1-1 staff 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, Mobile Crisis Intervention Services (Mobile Crisis) is a mobile intervention for children and adolescents experiencing a behavioral or mental health need or crisis. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1. 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. DCF funds a Performance Improvement Center for ongoing quality management for Mobile Crisis.

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 MCT services 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 clinicians and police officers.
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, there are 6 regional youth Mobile Crisis offices that provide coverage to the entire State. 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.

Place to Go
DMHAS is currently in the process of procuring for peer respite and a crisis stabilization unit (CSU)that will provide a safe alternative to the emergency department for adults experiencing a behavioral health crisis. 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 provides overnight crisis respite to child welfare involved families only. DCF also recently established four Behavioral Health Urgent Crisis Assessment Centers and is in the process of procurement for a Sub-Acute Crisis Stabilization Center. The Sub-Acute Centers are expected to be operational by 2024.

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 SAMHSA 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 SAMHSA 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.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. 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 first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. 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 talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to
CT has launched the 988 lifeline as of July 16th 2022. Wait times for callers to 988 and ACTION line are within seconds and over 90% of calls are answered in state. Youth Mobile Crisis calls are managed by the same call center at United Way. The average wait time for a caller on this line 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. The clinician 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, identifying sustainable funding sources and 988 text/chat capability. 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 has increased their staffing capacity for call takers to ensure that calls are answered in a timely manner. However, there is concern that adding chat and text will diminish the ability of the call takers to answer calls without delays or routing to out-of-state call centers. United Way is considering all options including subcontracting with a vendor to provide chat and text services.

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 has been the biggest barrier towards achieving this goal. Some private non-profit mobile crisis providers are looking to adjust work schedules to be more flexible (4, 10 hour day work weeks, triaging calls from home instead of the office but will go out if a mobile response is needed). Legislation was just recently passed that will allow for Licensed Psychiatric Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) working on a DMHAS-funded or DMHAS-

operated mobile crisis team to issue an emergency certificate. We are hoping that this will increase the pool of applicants to more than just LCSWs.
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 is currently in the process of procuring for peer respite and crisis stabilization units that will provide a safe alternative to the emergency department for adults experiencing a behavioral health crisis. DMHAS does have 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 four Behavioral Health Urgent Crisis Assessment Centers and 1-14 day bedded Sub-Acute Crisis Stabilization Centers. While the UCC are operational, the Sub-Acute Center is expected to be operational by early 2024.
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.

3. Based on SAMHSA's National Guidelines for 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. The one 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. 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%.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The 5% set aside of the COVID-19 Supplemental and ARPA MHBG awards have been awarded to the the United Way of CT 211 for staffing of the 988, ACTION line and Youth Mobile Crisis call lines. The 5% set-aside of the base MHBG will be awarded to mobile crisis teams that serve defined geographic service regions. We want to ensure the 988 line continues to meet expectations when it comes to short wait times and percentage of calls answered in state. With the funding, data shows we are currently meeting and exceeding our goals as the average speed to answer on 988 is 5 seconds and ACTION line is less than 30 seconds. Also, current funding sources for the crisis lines are temporary and long-term funding will need to be identified for sustainability of the lines.

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block grant funding of recovery support services? (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Connecticut offers 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. CVH and Whiting Forensic Hospital employ RSSs. Connecticut's 988 Crisis & Suicide Line has also incorporated the use of peer support and has employed at least one certified Recovery Support Specialist.

These programs and services identified above are staffed with individuals holding at least one of three CT 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 (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, DMHAS also coordinates various events and initiatives related to peer and recovery services. An initiative to be noted is DMHAS' sponsorship of Connecticut's first BIPOC Faith-based Peer Organization (New Life II) to provide training of an overview of Intentional Healing to a variety of behavioral health providers, first responders, faith leaders, peer support workers and the community at large. Another initiative that was widely successful was the introduction of 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.

The Lived-Experience Leadership Committee has been committed to continued learning within the peer support workforce community and has been the leading force behind the Upward Spiral Summer Series webinars. These bi-monthly trainings include a wide range of thought-provoking topics, such as Disparities and Leading Equitably, Alternative Healing Approaches, and Advocacy and Leadership. Break-out rooms allow a safe space for participants to share and learn from one another.

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 "Faces of Recovery" campaign that began in 2023. Through this initiative, ORCA recorded short videos of people in the recovery community sharing their stories of recovery. These videos were then posted online and utilized as part of the "Faces of Recovery" campaign, which seeks to reduced stigma and put a human face to recovery. 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. In addition the "Face of Recovery" social media campaign, ORCA conducted various recovery activities and outreach during recovery month. The impact of these efforts were measured through attendance tracking as well as a survey tool that sought to evaluate whether the events helped to change the perspectives of attendees regarding their understanding of recovery.

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/GED 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

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. 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. Of the five recovery community centers, DMHAS provides funding for three (Hartford, Bridgeport and Windham). 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; this is free to all participants. 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 call a centralized number to obtain a Recovery Coach when they have a patient present with a substance-related issue (such as an overdose); the person in the ER must consent to having the Recovery Coach see them. The Recovery Coach's role is to engage with the goal of connecting with the patient, to encourage next steps towards recovery, and assist the patient to next steps if desired. This program provides this service to all 29 hospital emergency departments as of 2023.

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. DMHAS added a recovery coach to two of our withdrawal management programs. DMHAS created enhanced outpatient clinics that provide MAT, a recovery coach and supported employment.

DMHAS also funds two harm reduction drop-in centers in Hartford and is in the process of administering an RFP to fund three additional centers.

5. Does the state have any activities that it would like to highlight?

Another recovery activity that DMHAS coordinates related to the current opioid epidemic is the "Gone But Not forgotten Quilt Project" which celebrated its first event in January 2017. Family members and significant others of persons who have died as a result of substance use are offered the opportunity to make a quilt square in memory of the loved one they lost to substances. The events are held around the state and they provide an opportunity to raise awareness and reduce stigma.

After the release of the Surgeon General's report on the impact social isolation and disconnection on people's mental health and increase in substance use, DMHAS is promoting "Recovery Happens Here- Celebrating Connectedness" with five (5) Recovery Community Celebrations in September 2023 for Recovery Month. These events will highlight the importance of connectedness for recovery/wellness and support is available.

Another initiative DMHAS is undertaking to highlight "Recovery Happens Here- Celebrating Connectedness" is through a media recovery campaign. This recovery activity puts faces to Connecticut's diverse recovery community and offers hope to those still struggling. This campaign offers the opportunity to normalize mental health and substance use challenges and decrease stigma associated with these challenges to allow people to seek help.

The DMHAS Office of Recovery Community Affairs (ORCA) is currently working with NASMHPD technical assistance to engage the Connecticut recovery community and gather stakeholder input into a vision statement and three-year strategic plan for ORCA.

Their contributions will assist the direction of the office and DMHAS' Recovery-Oriented System of Care (ROSC) towards sustainability.

DMHAS sponsored and facilitated a more than two-year learning collaborative for all Local Mental Health Authorities and the two state hospitals to learn and implement Recovery Citizenship in 2020-2023. In collaboration with the Yale Program for Recovery and Community Health (PRCH), training and consultation was provided to assist providers in implementing this framework and practice. Recovering Citizenship is a culture and set of varied practices to help individuals receiving services to develop a meaningful life in the community. The emphasis is on the community and life outside of the clinic. PRCH developed the Citizenship model and includes the five Rs: Rights, Roles, Resources, Responsibilities and Relationships.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(●) Yes ( ) No
Home and community-based services	(●) Yes ( ) No
Peer support services	(●) Yes ( ) No
Employment services.	(●) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (●) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

DMHAS is an active partner in Connecticut’s rebalancing efforts and an appointed member of the Long-Term Services & Supports Committee (LTSS) with the Office and Policy Management. The Department’s Statewide Services Division at the Office of the Commissioner provides operational oversight of several LTSS programs such as the Nursing Home Diversion and Transition Program (NHDTP), Senior Outreach and Engagement (SOEP) and the Mental Health Waiver Program (MHW) – 1915 (c) waiver. These programs represent significant progress towards transforming the long-term care system in CT for persons with serious mental illness (SMI) and substance use disorders. The goal of the NHDTP program is to is to divert individuals from a higher level of care and transition to the least restrictive, most integrative community setting possible while using a person-centered, strengths-based intervention model. The Mental Health Waiver (MHW) is a Medicaid home and community-based services waiver operationalized by DMHAS and designed for adults with serious mental illness who are being discharged or diverted from nursing home care. This waiver provides participants with the medical and psychiatric services and supports necessary to live independently in the community. Service delivery emphasizes psychiatric rehabilitation and recovery from psychiatric disorders. Waiver services are provided face-to-face, in the participant’s home or in other community settings (non-office based). Individualized assessment, recovery plan development, and service delivery emphasize participant strengths and assets, client choice, utilization of natural supports and community integration.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Balancing the System:

Working Toward Real Choice for Long-Term Services and Supports in Connecticut

A Report to the General Assembly
January 2022

APPENDICES

A. Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

B. Long-Term Care Planning Committee Membership

C. Long-Term Care Advisory Council Membership

D. Sources of Public Comment

E. Long-Term Services and Supports Planning History

F. Listening Session Feedback Summary

G. State Long-Term Services and Supports Programs and Expenditures – SFY 2020-2021

APPENDIX A.

Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

CONNECTICUT GENERAL STATUTES
TITLE 17B. SOCIAL SERVICES
CHAPTER 319Y. LONG-TERM CARE

§ 17b-337. Long-term elderly care planning committee. Long-term care plan.

(a) There shall be established a Long-Term Care Planning Committee for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. Such plan shall integrate the three components of a long-term care system including home and community-based services, supportive housing arrangements and nursing facilities. Such plan shall include: (1) A vision and mission statement for a long-term care system; (2) the current number of persons receiving services; (3) the current number of persons receiving long-term care supports and services in the community and the number receiving such supports and services in institutions; (4) demographic data concerning such persons by service type; (5) the current aggregate cost of such system of services; (6) forecasts of future demand for services; (7) the type of services available and the amount of funds necessary to meet the demand; (8) projected costs for programs associated with such system; (9) strategies to promote the partnership for long-term care program; (10) resources necessary to accomplish goals for the future; (11) funding sources available; and (12) the number and types of providers needed to deliver services. The plan shall address how changes in one component of such long-term care system impact other components of such system.

(b) The Long-Term Care Planning Committee shall, within available appropriations, study issues relative to long-term care including, but not limited to, the case-mix system of Medicaid reimbursement, community-based service options, access to long-term care and geriatric psychiatric services. The committee shall evaluate issues relative to long-term care in light of the United States Supreme Court decision, Olmstead v. L.C., 119 S. Ct. 2176 (1999), requiring states to place persons with disabilities in community settings rather than in institutions when such placement is appropriate, the transfer to a less restrictive setting is not opposed by such persons and such placement can be reasonably accommodated. The committee, within available appropriations, shall evaluate available data on the average net actual Medicaid expenditures for nursing homes, in comparison

to average net actual Medicaid expenditures for home and community-based services waiver participants who require a nursing home level of care, including the number of individuals served, to assist in short-term and long-term Medicaid expenditure forecasting.

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Public Health appointed by the Commissioner of Public Health; (5) one member from the Department of Housing appointed by the Commissioner of Housing; (6) one member from the Department of Developmental Services appointed by the Commissioner of Developmental Services; (7) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (8) one member from the Department of Transportation appointed by the Commissioner of Transportation; (9) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; (10) one member from the Health Systems Planning Unit of the Office of Health Strategy appointed by the executive director of the Office of Health Strategy; and (11) one member from the Department of Aging and Disability Services appointed by the Commissioner of Aging and Disability Services. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

(d) Not later than January 1, 2018, and annually thereafter, the Long-Term Care Planning Committee shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to aging and human services on the number of persons receiving (1) long-term care supports and services in the community; and (2) long-term care supports and services in institutions.

(e) Not later than January 1, 1999, and every three years thereafter, the Long-Term Care Planning Committee shall submit a long-term care plan pursuant to subsection (a) of this section to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care, in accordance with the provisions of section 11-4a, and such plan shall serve as a guide for the actions of state agencies in developing and modifying programs that serve persons in need of long-term care.

(f) Any state agency, when developing or modifying any program that, in whole or in part, provides assistance or support to persons with long-term care needs, shall, to

the maximum extent feasible, include provisions that support care-giving provided by family members and other informal caregivers and promote consumer-directed care.

§ 17b-338. Long-Term Care Advisory Council. Membership. Duties

(a) There is established a Long-Term Care Advisory Council which shall consist of the following: (1) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee; (2) the State Nursing Home Ombudsman, or the ombudsman's designee; (3) the president of the Coalition of Presidents of Resident Councils, or the president's designee; (4) the executive director of the Legal Assistance Resource Center of Connecticut, or the executive director's designee; (5) the state president of AARP, or the president's designee; (6) one representative of a bargaining unit for health care employees, appointed by the president of the bargaining unit; (7) the president of LeadingAge Connecticut, Inc., or the president's designee; (8) the president of the Connecticut Association of Health Care Facilities, or the president's designee; (9) the president of the Connecticut Association of Residential Care Homes, or the president's designee; (10) the president of the Connecticut Hospital Association or the president's designee; (11) the executive director of the Connecticut Assisted Living Association or the executive director's designee; (12) the executive director of the Connecticut Association for Homecare or the executive director's designee; (13) the president of Connecticut Community Care, Inc. or the president's designee; (14) one member of the Connecticut Association of Area Agencies on Aging appointed by the agency; (15) the president of the Connecticut chapter of the Connecticut Alzheimer's Association; (16) one member of the Connecticut Association of Adult Day Centers appointed by the association; (17) the president of the Connecticut Chapter of the American College of Health Care Administrators, or the president's designee; (18) the president of the Connecticut Council for Persons with Disabilities, or the president's designee; (19) the president of the Connecticut Association of Community Action Agencies, or the president's designee; (20) a personal care attendant appointed by the speaker of the House of Representatives; (21) the president of the Family Support Council, or the president's designee; (22) a person who, in a home setting, cares for a person with a disability and is appointed by the president pro tempore of the Senate; (23) three persons with a disability appointed one each by the majority leader of the House of Representatives, the majority leader of the Senate and the minority leader of the House of Representatives; (24) a legislator who is a member of the Long-Term Care Planning Committee; (25) one member who is a nonunion home health aide appointed by the minority leader of the Senate; and (26) the executive director of the nonprofit entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system or the executive director's designee.

(b) The council shall advise and make recommendations to the Long-Term Care Planning Committee established under section 17b-337.

(c) The Long-Term Care Advisory Council shall seek recommendations from persons with disabilities or persons receiving long-term care services who reflect the socio-economic diversity of the state.

APPENDIX B.

Long Term Care Planning Committee Members (November 2021)

Legislators

Senator Patricia Billie Miller, Co-Chair, Aging Committee
Representative Quentin W. Phipps, Co-Chair, Aging Committee
Senator Kevin C. Kelly, Ranking Member, Aging Committee
Representative David T. Wilson, Ranking Member, Aging Committee
Senator Mary Daugherty Abrams, Co-Chair, Public Health Committee
Representative Jonathan Steinberg, Co-Chair, Public Health Committee
Senator Tony Hwang, Ranking Member, Public Health Committee
Representative William A. Petit, Ranking Member, Public Health Committee
Senator Marilyn Moore, Co-Chair, Human Services Committee
Representative Catherine F. Abercrombie, Co-Chair, Human Services Committee
Senator Eric C. Berthel, Ranking Member, Human Services Committee
Representative Jay M. Case, Ranking Member, Human Services Committee

State Agencies Representatives

David Guttchen, Office of Policy and Management (Chair)
Jennifer Cavallaro, Department of Social Services
Dr. Stephanie Bozak, Department of Children and Families
Margy Gerundo-Murkette, Department of Aging and Disability Services
Kelley Kendall, Department of Developmental Services
Erin Leavitt-Smith, Department of Mental Health and Addiction Services
Donna Ortelle, Department of Public Health
Amy Porter, Department of Aging and Disability Services
Jessica Rival, Office of Health Strategy
Lisa Rivers, Department of Transportation
Michael Santoro, Department of Housing
Laura Watson, Department of Housing

Staff

Melissa Morton, Office of Policy and Management

APPENDIX C.

Long-Term Care Advisory Council Member Organizations

CT Commission on Women, Children, Seniors, Equity and Opportunity
CT Association of Residential Care Homes
Personal Care Attendant
CT Association of Area Agencies on Aging
CT Council for Persons with Disabilities
CT Association of Health Care Facilities
CT Assisted Living Association
CT Association of Adult Day Care
Bargaining Unit for Heath Care Employees/
1199 AFL-CIO
CT Family Support Council
Consumer
AARP – CT
CT Association of Home Care, Inc.
LTC Ombudsman's Office
Legal Assistance Resource Center
CT Community Care, Inc.
CT Hospital Association
CRT/CT Assoc. of Community Action Agencies
CT Alzheimer's Association
LeadingAge CT
Family Caregiver
CT Coalition of Presidents of Resident Councils
American College of Health Care Administrators
Consumer
Consumer
Nonunion Home Health Aide

Friends of the Advisory Council
Representative Jonathan Steinberg

APPENDIX D.

Sources of Public Comment

With the assistance of the Long-Term Care Advisory Council, a draft of the Plan recommendations was distributed widely in August 2021 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports (LTSS). A draft of the full Plan and appendices was distributed for comment in December 2021. In total, public comments were received from the following organizations and members of the public.

Organizations

- Long-Term Care Advisory Council Members:
  - AARP CT: Anna Doroghazi
  - CT Alzheimer's Association: Christy Kovel
  - CT Association for Healthcare at Home: Tracy Wodatch
  - CT Hospital Association: Karen Buckley
  - Leading Age CT: Margaret Morelli
  - LTC Advisory Committee (CWCS): Steve Hernandez and Michael Werner
  - LTC Ombudsman Program: Mairead Painter

- Other Community Organizations
  - The Arc of CT: Edwin Evarts
  - InterCommunity Healthcare, Common Ground Club: Dyana Hagen
  - CT Council on Developmental Disabilities: Walter Glomb
  - Health Equity Solutions: Karen Seigel & Victoria Tran
  - CT Keep the Promise Coalition: Jordan Fairchild & Holly Hackett
  - Leeway: Jay Katz
  - Living Innovations: Joanne Malise
  - Seniorlink: Rachel M. Richards

- Members of the Public
  - 9 individual members of the general public submitted written comment on the Plan recommendations.
  - 40 individuals provided comments on the Plan through participation in four long-term services and supports user and family member listening sessions held virtually in September and October 2021. Listening sessions were held in partnership with AARP CT, the ARC of CT, Keep the Promise Coalition, and PATH Parent to Parent/Family Voices of CT.

See appendix F for a summary of public comment.

APPENDIX E.

A. Long-Term Care Planning Committee History

Establishment of the Long-Term Care Planning Committee

The Long-Term Care Planning Committee (Planning Committee), created in 1998 under Pubic Act 98-239, was established for the purpose of exchanging information on long-term services and supports issues, coordinating policy development and establishing a long-term care plan. The Planning Committee is comprised of representatives from ten State agencies and the Chairs and Ranking Members of the General Assembly's Aging, Human Services, and Public Health Committees. (See Appendix A for the authorizing statute and Appendix B for a listing of Planning Committee members.)

The Planning Committee grew out of the recommendations of a December 1996 report issued by the Legislative Program Review and Investigations Committee. The study concluded that the State's structure for planning, funding and overseeing long-term services and supports needed reinforcement and coordination. The Legislative Program Review and Investigations Committee recommended the creation of an interagency committee to "exchange information on long-term care issues, ensure coordinated policy development, and establish a long-term care plan."

In addition to the Long-Term Care Planning Committee, Public Act 98-239 also established the Long-Term Care Advisory Council (Advisory Council) to advise and make recommendations to the Planning Committee. The Advisory Council members include a balance of consumers, providers and advocates representing a wide range of interests. (See Appendix C for a listing of Advisory Council members.)

Originally, the Planning Committee was required to establish a long-term care plan for only the elderly that integrates the three components of a long-term services and supports system including home and community-based services, supportive housing arrangements and nursing facilities. Subsequently, Public Act 01-119 broadened the Planning Committee's purview by requiring a plan for all persons in need of long-term services and support.

Long-Term Care Planning Committee Products

Preliminary Long-Term Care Plan – 1999

As noted above, the Planning Committee was created by statute in 1998 and held its initial meeting in August 1998. The Planning Committee's authorizing statute required the Planning Committee to produce its first Long-Term Care Plan by January 1999. Due to the short timeframe, the Planning Committee produced a Preliminary Long-Term Care Plan that provided a description of Connecticut's long-term services and supports

system in order to develop a baseline for future Plans. In addition, the Preliminary Plan was focused on long-term services and supports for elderly persons in keeping with the original statutory charge for the Planning Committee (this requirement was later changed, through Public Act 01-119, to require the Long-Term Care Plan to address all individuals who need long-term care, regardless of age or disability). The Planning Committee then began the work to develop a comprehensive Long-Term Care Plan due to the General Assembly by January 2001 (the original statute required a Long-Term Care Plan every two years – this requirement was later changed, through Public Act 01-119, to mandate a Plan be developed every three years).

Home Care Report – 2000

In 1999, the General Assembly enacted Public Act 99-279 that required the Planning Committee to develop, by February 2000, a plan that ensures the availability of home care services for elderly persons under the Connecticut Home Care Program for Elders (CHCPE) who would otherwise qualify for the program except their income exceeds the program's established income limits. The impetus for this legislation was the fact that the CHCPE had a strict income eligibility requirement that resulted in individuals with as little as one dollar above the income level being ineligible for home care services. This contrasted with the income requirements for nursing home coverage through Medicaid that allows individuals with incomes that are not sufficient to pay for their care to be eligible while contributing most of their income towards their care.

To meet this requirement, the Planning Committee produced a report titled "Home Care for Older Adults - A Plan for Increasing Eligibility Under the Connecticut Home Care Program for Elders." that was delivered to the General Assembly in February 2000. The report concluded that the only mechanism to assure the availability of home care services under the CHCPE was to revise the income eligibility cap to mirror the income requirements utilized for nursing home care eligibility, thus allowing individuals to buy into the CHCPE.

During the 2000 legislative session, the General Assembly approved legislation that revised the income requirements for both the State-funded and Medicaid components of the CHCPE to allow individuals with incomes in excess of the income eligibility cap to become eligible for the CHCPE by buying into the program. The expanded income level was implemented for the State-funded portion of the CHCPE in October 2000. However, to implement a similar revision for the Medicaid portion of the CHCPE, federal approval was needed. The Department of Social Services (DSS) submitted a revision to their CHCPE Medicaid waiver in 2001, but the DSS proposal was not approved by the federal government.

Long-Term Care Plan - 2001

After the completion of its Preliminary Long-Term Care Plan in 1999, the next Plan from the Planning Committee was due by January 2001. Beginning in early 1999, the

Planning Committee undertook an ambitious effort to solicit public input regarding what was needed for a comprehensive Long-Term Care Plan.

In March 1999, the Planning Committee, in conjunction with the Advisory Council, held a public hearing at the Legislative Office Building where over 50 individuals provided testimony regarding Connecticut's long-term services and supports system. The Planning Committee then embarked on a series of meetings with a variety of groups and organizations involved with the long-term care system. Most of the groups were members of the Advisory Council. All told, Planning Committee and Advisory Council members held 24 forums throughout 1999 and 2000. In addition, the Planning Committee and Advisory Council held five public hearings throughout the state in 2000 to garner additional feedback and input for the Long-Term Care Plan.

The input gathered through the forums and public hearings helped develop the framework for the Planning Committee's Long-Term Care Plan that was submitted to the General Assembly in January 2001.

Long-Term Care Plan – 2004

The Long-Term Care Planning Committee's third plan was issued in January 2004 in accordance with Public Act 01-119 which required the Planning Committee to issue its long-term care plan every three years instead of every two. The Advisory Council worked in partnership with the Planning Committee in four essential areas: providing data, identifying areas of need, developing priorities and recommendations, and obtaining public input.

2004 Long-Term Care Plan Status Reports

Following the release of the 2004 Long-Term Care Plan, a status update was issued annually in June of 2004, 2005 and 2006. The first section of the Status Report described progress implementing the recommendations made in the 2004 Long-Term Care Plan by State Agencies or the legislature, along with any new funds appropriated. The second section documented the implementation of the action steps issued in Connecticut's Olmstead Plan, entitled "Choices are for Everyone", developed by the Department of Social Services in collaboration with the Long-Term Care Planning Committee and the Community Options Task Force.

Long-Term Care Website

In 2002, the General Assembly passed Public Act 02-7 (May 9 Special Session) that required the Office of Policy and Management (OPM), within existing budgetary resources and in consultation with the Select Committee on Aging, the Commission on Aging and the Long-Term Care Advisory Council, to develop a consumer-oriented website that provides comprehensive information on long-term care options that are available in Connecticut.

In September 2006, the Connecticut Long-Term Care Services and Supports website was completed and released to the public. The website provided information to all individuals in need of long-term care services and supports, regardless of age or disability.

Policy Statement Formalized into Law

Public Act 05-14 codified in law a broad philosophical statement to guide future policy and budget decisions. As a result of this legislation, the policy and planning work done through the Long-Term Care Planning Committee is required to "provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting." This statement positions Connecticut to make the necessary changes to the laws and regulations that govern the State's long-term care system to make real choices for consumers a reality.

Long-Term Care Needs Assessment

In 2006 and 2007, a needs assessment on long-term care services and supports in Connecticut was conducted by the University of Connecticut Health Center's Center on Aging. The General Assembly's Commission on Aging, in consultation with the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, contracted with the Center on Aging to conduct a comprehensive needs assessment of the unmet long-term care needs in the state and projections of the future demand for these services. This Needs Assessment was mandated by Public Act 06-188, Section 38, and funded with a $200,000 appropriation from the Connecticut General Fund and an additional $80,000 from the Connecticut Long-Term Care Ombudsman Program. Findings from the Needs Assessment informed both the 2007 and the 2010 Long-Term Care Plans, and the many of the recommendations made in the Needs Assessment have been included in the 2010 Plan. (See the Needs Assessment reports at http://www.uconn-aging.uchc.edu/res_edu/assessment.html)

Long-Term Care Plan – 2007

The Long-Term Care Planning Committee's fourth plan was issued in January 2007.

2007 Long-Term Care Plan Status Reports

Following the release of the 2007 Long-Term Care Plan, a status update was issued in June of 2007 and 2008 and in October of 2009.

Long-Term Care Plan – 2010

The Long-Term Care Planning Committee's fifth plan was issued in January 2010.

2010 Long-Term Care Plan Status Reports

Following the release of the 2010 Long-Term Care Plan, a status update was issued in June of 2010, 2011 and 2012.

Long-Term Care Plan – 2013
The Long-Term Care Planning Committee's sixth plan was issued in January 2013.

2013 Long-Term Care Plan Status Reports
Following the release of the 2013 Long-Term Care Plan, a status update was issued in June of 2013, 2014 and 2015.

Long-Term Care Plan – 2016
The Long-Term Care Planning Committee's seventh plan was issued in January 2016.

2016 Long-Term Care Plan Status Reports
Following the release of the 2016 Long-Term Care Plan, a status update was issued in June of 2017 and 2018.

Long-Term Care Plan – 2019
The Long-Term Care Planning Committee's seventh plan was issued in January 2019.

2019 Long-Term Care Plan Status Reports
Due to the COVID-19 Public Health Emergency (PHE) that impacted Connecticut and the nation in 2020 and into 2021, for the first time in the history of the Planning Committee's Long-Term Care Plans, the Committee did not issue a status update on the individual Plan recommendations as State agencies were focused on response efforts related to the PHE. The Office of Policy and Management did continue to track and submit annual status reports on long-term care rebalancing statistics to the legislature as required by statute.

B. Olmstead Planning Efforts

On June 22, 1999, the United States Supreme Court decided the *Olmstead v. L.C*. case, holding that unjustified isolation, caused by unjustified placement or retention of persons with disabilities in institutions, should be regarded as discrimination based on disability, in violation of the Americans with Disabilities Act (ADA).

Federal regulation requires public entities to make "reasonable modifications" to their policies, practices, or procedures in order to avoid discrimination on the basis of disability, unless the modifications would "fundamentally alter" the nature of the service or program. As part of the Olmstead decision, four Justices stated that one of the ways the reasonable modification standard could be met is if the State had a comprehensive, effectively working plan of placing qualified persons with disabilities in less restrictive settings.

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a

Community Options Task Force was created to take the lead in the development of the Plan. The individuals on this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

On March 25, 2002, the "Choices are for Everyone" Plan was completed as a collaboration between the Department of Social Services, the Long-Term Care Planning Committee and the Community Options Take Force.

A number of activities in Connecticut support the goals outlined in the "Choices are for Everyone" Plan, some of which are highlighted below.

"Choices are for Everyone" Plan -- Action Steps Update

"Choices are for Everyone" included a series of Action Steps. The Long-Term Care Planning Committee committed to the implementation of these Action Steps. Progress was reported in the annual Status Reports for the 2004 and 2007 Long-Term Care Plans.

Systems Change Grants

Since 2002, the goals of this Plan have been advanced through the work accomplished with the funding of seven *Systems Change for Community Living* grants awarded to Connecticut by the Centers for Medicare and Medicaid Services (CMS) as part of the federal New Freedom Initiative. These grants were designed to assist states in their efforts to remove barriers to equality for individuals living with disabilities or long-term illnesses, enabling them to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements and exercise more control over the providers of the services they receive.

- Nursing Facility Transition Grant: 2001-2004
- Real Choice Systems Change Grant: 2002- 2005
- Community-integrated Personal Assistance Services and Supports (C-PASS) Grant: 2003-2006
- Independence Plus Waiver Initiative: 2003-2006
- Quality Assurance and Improvement in Home and Community-Based Services: 2003-2006
- Mental Health Transformation Grant: October 2005 – September 2010
- Medicaid Infrastructure Grant: October 2005 – September 2010

Connecticut Behavioral Health Partnership

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and Department of Children and Families (DCF) involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to oversee an integrated public behavioral health service system for children and families. The

primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration began operation in December 2008. The objective of the MFP Rebalancing Demonstration is to rebalance long-term services and supports from institutional care to home-based services. The program serves individuals across the age span with physical disabilities, mental illness and intellectual disabilities. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of the Long-Term Services and Supports Plan:

1. Transition 5,200 people from institutions to the community.
2. Increase dollars to home and community-based services.
3. Increase hospital discharges to the community rather than to institutions.
4. Increase the probability of returning to the community during the six months following nursing home admission.
5. Increase the percentage of LTSS participants living in the community compared to the institution.

In April 2015, DSS submitted a five-year MFP Sustainability Plan to the Centers for Medicare and Medicaid Services (CMS) outlining the State's strategy to continue program efforts through 2020. From 2015 through 2020, MFP continued the provision of (1) addiction services and supports; (2) informal caregiver supports; (3) peer supports; and (4) Transitional Recovery Assistance services and implementation of new rebalancing strategies focusing on community collaboration, social determinant interventions and collaboration with no-wrong door initiatives. DSS administered the transitional program until 2018 when the last nursing home transition will be made as part of the MFP demonstration. CMS awarded DSS $236 million dollars through 2020 to implement the sustainability plan.

State Balancing Incentive Payments Program (BIP)

Connecticut received $72.8 million in 2012, and an additional $4.2 million in July 2015, to implement the BIP program. Key aspects of the BIP include development and implementation of (1) a pre-screen and a common comprehensive assessment for all persons entering the LTSS system; (2) conflict-free case management across the system; (3) a "no-wrong door" system for access to LTSS through a web-based platform branded "My Place CT." My Place CT aims to coordinate seamlessly with both ConneCT and the health insurance exchange; and (4) new LTSS aimed to address gaps that prevent people from moving to or remaining in the community**.**

Community First Choice (CFC)

On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the Affordable Care Act, enables Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct community-based services utilizing individual budgets, with the support of a fiscal intermediary. Services include transitional supports when moving from institutions to the community as well as services that increase independence or substitute for human assistance, such as personal care assistants, support and planning coaches, nurse coaches, home delivered meals, environmental accessibility modifications, Personal Emergency Response System, and assistive technology. As a parallel component to CFC implementation, all Medicaid Waivers offering self-directed services, including Personal Care Attendant and Acquired Brain Injury, were revised to remove personal care attendant services. Effective July 1, 2015, self-directed services for individuals on the affected Waivers are provided as a Medicaid State Plan service through CFC.

APPENDIX F.

LONG-TERM SERVICES AND SUPPORTS PLANNING EFFORTS

Listening Session Feedback Summary

September and October 2021

2022 Listening Session Feedback

Total Number of Participants: 40
Co-Sponsors: AARP CT, the ARC of CT, Keep the Promise Coalition, and PATH Parent to Parent/Family Voices of CT
Groups represented: Caregivers, ID/DD, Youth, Mental Health, Older Adults, Physical Disability

Summary of Feedback Received

Access to Services: The State needs to improve access to services and supports on several levels including:

- Outreach and Education - Educate state residents on the services available to them.
- Accessibility - Have staff and materials accessible to residents who are non-English speaking and/or deaf/hard of hearing; more supports to help people enter the system and to add/drop/change services and supports as needed and in a timely manner (nimbleness of the system); Address the complexity of accessing needed services and supports and provide assistance.
- Flexibility of the Service System - the ability to quickly shift supports as needs change.
- Waitlist Reduction - reduce waitlists for waivers and housing options, and ensure that individuals with multiple conditions, including high level of need physical health conditions and cognitive, behavioral and/or mental health diagnoses, have the same access to employment, social opportunities and programs as other individuals.
- Addressing Dual Diagnoses - Multiple diagnoses can mean getting shut out of many programs or needing to work with multiple State agencies. State agencies need to coordinate services and work together to create packages of supports that meet the needs of the total person in a seamless manner. The coordination should happen on the State end and not be the responsibility of individuals with disabilities who may not have the capacity physically or cognitively to do it.
- Access to Hospice Services – The State needs to improve access to Hospice services for consumers and approve access earlier.

Allied Community Resources: (1) Need to reduce hold times; and (2) Train staff so that callers do not get wrong information or different answers every time they call.

Assessment: (a) Program assessments needs to be universal across all agencies and programs and look at the total person and not pieces of an individual that lead to programs and services being provided that only address certain needs without consideration of the total person and their preferences and goals (don't cram people into boxes). There should be one assessment and one application for all State programs. (b) Transparency also needs to be improved throughout the assessment process and this includes State agencies and providers not conducting planning meetings (such as DDS PRAT) where level of care or service revision decisions are made without the presence of the consumer or his/her authorized representative. Individuals should clearly understand the criteria being used to make decisions regarding their budgets and supports.

Back-up Planning: There needs to be an increased focus on assisting families with planning for the eventuality of the primary informal caregiver(s) and/or legal representative(s) no longer being available either through death, illness or some other occurrence, to continue providing assistance.

There should be a registry of pre-approved workers (similar to substitute teacher pool) who can be called-upon in emergencies without needing to go through new-hire paperwork.

Early Intervention and Lifelong Support: Early diagnosis and intervention is key. More State funding is needed to support agencies and schools with early detection and intervention to ensure better long-term outcomes. Additionally, services and supports need to follow individuals and be adjusted as necessary during the lifetime. Individuals under the age of 21 need regular follow-up and service plan adjustments to allow them to thrive and achieve best possible outcomes.

Employment: More effort needs to be made to match individuals with employment that matches their individual interests and goals and not just placing them in any available job slot (for example, stacking grocery shelves may be a poor fit that leads to employment ending for an individual but the person loves the socialization and atmosphere of the movies so ticket-taking may have been a better fit that would have led to steady employment and greater job satisfaction). There is also the need for staff to work with individuals in job placements and continue to grow and improve their skills sets. Employment support needs to expand beyond a check-in four hours per week where a form is filled out and that is all.

Financing: (a) Revisit Spousal assessment, especially for spouses under age 65. (b) Medicaid should reimburse paid caregivers to visit consumers in the hospital and other institutional settings. Learn from COVID lessons, COVID left informal caregivers shut out of being able to provide care and social/emotional support to their loved ones while in a hospital or other institution. This cannot happen again.

Home Modifications: More funding is required for home modifications. Home modifications need to be thought of beyond physical accessibility but to include safety measures for those with behaviors (such as flight risk and self harm behaviors such as overeating or ingesting harmful products). There needs to be a budget for families to make homes safe by installing locks, fencing, cameras etc. In many cases these modifications are what make a home safe enough for the individual to remain in the community and out of an institution and they are costly.

Housing: There needs to be increased availability of supportive, affordable housing in all communities, so people do not need to choose between remaining in their familiar communities with known informal social and support networks and housing. Additionally, consideration should be given to the compatibility of residents when making placements and to ensure that those who are non-English speaking or communicate through ASL have continual access to staff and residents with whom they can communicate to avoid isolation and promote full inclusion and the quality of life to which all people are entitled.

Informal Caregiver Support: (1) Increase supports to assist informal caregivers so they avoid burnout which could lead to institutionalization of the individual receiving support such as increased respite and more ongoing service hours, (2) assistance for informal caregivers/employers of record engaged in self-direction. There needs to be a contact person for questions and support because self-direction is not easy and there is no one to go to for help, and (3) develop and support peer-to-peer and caregiver support options in local communities. (4) To prevent informal caregivers from being shut out of hospitals and nursing homes ever again, the state should adopt and pass the language from the federal Essential Caregiver Act, H.R. 3733.

Self-direction: The state should continue to support and further expand self-direction in CT so that individuals can maintain autonomy and control over their services and supports, including who provides the support and how it is administered.

School Systems: The State and municipalities need to fund school systems so that school staff can be better educated on the supports available to students with ID/DD and not just hand parents a packet with a referral to DDS and no explanation of what DDS is and the supports that may be available. Schools need enough educated staff to help families connect to the correct services by making initial contacts or providing instruction and guidance, not just referrals.

Nutrition: Improve access to nutritious food in all communities for individuals of all abilities. This goes beyond access to home delivered meals but extends to having housing options in neighborhoods where there are grocery stores and with fresh produce and foods that are not expired or processed ready-to-eat meals.

Quality of Care: (a) Staffing ratios in facilities must be increased to meet the physical and psychological needs of residents. (b) Engage in meaningful quality assurance (QA) measures. QA is not just checking boxes and paperwork but measures of how staff interact and engage consumers and make a positive impact on their quality of life. Staff need to develop relational supports. QA should also include monitoring from an independent worker who comes to assess how the staff is doing with engaging consumers, providing stimulus, employing opportunities for the consumer to engage in lifelong learning and making the individual's home feel like home.

Transportation: (a) Must be improved and available in all communities so that individuals can truly participate in society through employment and social activity and reduce isolation and geographic limitations. (b) Need options other than public transportation that may not be a viable option for individuals with certain mental or behavioral health issues.

Workforce Development:

- Recruitment and Retention – (1) State should develop incentives, such as higher pay and benefits, that attract qualified workers to the home care profession and allow consumers who self-direct with budgets high enough to provide raises and other incentives that will allow them to retain good workers once found. Also, workers with special experience and certifications should be allowed to earn more without affecting individual service hours. (2) Incentivize community health workers and parents or other individuals who currently, or in the past, provided informal supports to individuals to join the self-directed home care workforce. (3) Recruit workers from local communities to improve cultural competence and build communities of support and inclusion. (4) Address the need for both paid health care and unskilled care (e.g., companionship) to provide stimulation and increase psycho-social health outcomes. The group recommended exploring the following models (a) Social Prescribing and Cognitive Stimulation Therapy out of the UK; (b) CVS' current exploration of the benefits of social prescribing; and (c) Zero Isolation Project out of Quinnipiac (Dr. Nicholson).
- Hiring Process – (1) Need to reduce the amount of paperwork required for employers and employees or at least streamline it between programs and offer assistance with

completion; and (2) Reduce the time it takes to hire new staff so that qualified workers are not lost because of they cannot wait six – ten weeks for a start date.

- Registry – The State should develop one universal registry that can be used to find staff regardless of the agency and program a person is using. The registry should have the following features: (1) be accessible in multiple languages and formats; (2) include worker descriptions, including any special training, certifications and experience working with special populations (i.e., behavior management, ASL certified, bilingual etc.), and (3) workers who have been pre-qualified and cleared by the State and are "ready-to-hire" who can start immediately. This is especially important when a back-up is needed. There should be a pool of pre-qualified workers to choose. Same concept as substitute teachers.
- Training – Improved training is needed for PCAs and employers, especially regarding Electronic Visit Verification (EVV). The current EVV training is too long, not engaging or easily understandable and does not focus on the issues that PCAs and employers encounter in daily utilization. EVV training needs to be revised to be shorter, include more plain language and focused on the issues that are most likely to arise when utilized in the real world.

APPENDIX G.

State Long-Term Services and Supports Programs and Expenditures

SFY 2020 - 2021

I. **Overview of State Agencies Providing Long-Term Services and Supports**

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2021**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2021**

I. Overview of State Agencies Providing Long-Term Services and Supports

Department of Aging and Disability Services (ADS): ADS receives both federal and state dollars to provide a broad array of services, equipment and supports to individuals with disabilities and older adults that promote independent living, community participation, self-advocacy and employment. ADS implements these services and supports through a variety of programs. The Bureau of Rehabilitation Services (BRS) administers the Vocational Rehabilitation and Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended by Title IV of the Workforce Innovation and Opportunity Act. BRS services are provided to adults who have a mental or physical impairment that is an impediment to employment. Supports are individualized to each job seeker and may include services such as personal assistance for evaluation and training purposes. The Driver Training Program for Persons with Disabilities provides driver instruction for qualified permanent Connecticut residents who require specialized equipment to operate a motor vehicle. The BRS' Independent Living program provides comprehensive independent living services, through contracts with Connecticut's five community-based independent living centers. The Workers' Rehabilitation Program assists injured workers in a return to gainful employment in the most timely and cost effective manner possible while taking into account the needs of the individual. Deaf and Hard of Hearing Services (formerly the Commission on the Deaf and Hearing Impaired) works to advocate, strengthen and implement State policies affecting individuals who are deaf or hard of hearing. Services and supports include counseling services and assistance to persons who are deaf and hard of hearing and their families. The Bureau of Disability Determination Services is charged with deciding eligibility for the Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) programs. These programs provide cash benefits to individuals who are unable to maintain employment due to the severity of their disabilities. The Bureau of Education and Services for the Blind (BESB) offers a comprehensive array of services to improve the independent living skills of adults who are legally blind and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training and teaching to improve activities of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs. The Bureau on Aging, consisting of the State Unit on Aging (SUA) and the Long Term Care Ombudsman Program (LTCOP), ensures that Connecticut's older adults have access to the supportive services necessary to live with dignity, security, and independence. The Bureau is responsible for planning, developing, and administering a comprehensive and integrated service delivery system for older persons in Connecticut. The State Unit on Aging administers Older Americans Act programs for supportive services, in-home services, and congregate and home-delivered meals. It also administers programs that provide senior community

employment, health insurance counseling, and respite care for caregivers. The Long-Term Care Ombudsman Program provides individual advocacy to residents of skilled nursing facilities, residential care homes and assisted living facilities. The State Ombudsman also advocates for systemic changes in policy and legislation in order to protect the health, safety, welfare and rights of individuals who reside in those settings. The LTCOP and SUA work closely with the aging network partners to provide these services. Partners include Connecticut's five area agencies on aging, municipal agents for the elderly, senior centers, and many others who provide services to older adults.

Department of Social Services (DSS): DSS provides a broad range of services to people who are elderly or have disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers over 90 programs. By statute, it is the State agency responsible for administering a number of programs under federal legislation, including the Social Security Act (which includes Medicaid) and the Food Stamp Act. DSS administers the Connecticut Home Care Program for Elders (CHCPE), a portion of which is State-funded, the Connecticut Home Care Program for Adults with Disabilities that is also State-funded, and other programs such as the Personal Care Assistance (PCA) Waiver Program, the Acquired Brain Injury (ABI) Waiver Programs, the Katie Beckett Model Waiver Program, the Lifespan Autism Waiver, Money follows the Person, the Department of Developmental Services Home and Community Based Waiver Programs, the Department of Mental Health and Addiction Services Medicaid Waiver program, and the Connecticut AIDS Drug Assistance Program. DSS also received approval from the Centers for Medicare and Medicaid (CMS) for a 1915(i) State Plan Home and Community-Based Services option for individuals age 65 and older who are at risk of nursing home placement but not yet nursing facility level of care. In addition, DSS was approved by CMS to add the Community First Choice state plan option of home and community-based services to its array of options for community-based long-term services and supports.

Department of Developmental Services (DDS): DDS provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, and family support to approximately 17,229 persons with intellectual disabilities and their families. The mission of DDS is to partner with the individuals they support and their families, to support lifelong planning, and to join with others to create and promote meaningful opportunities for individuals to fully participate as valued members of their communities.

As of June 2021, 67.6 percent of those people eligible to receive services from DDS were living in their own or their family home, 25.2 percent lived in public or private community living arrangements or received 24-hour continuous residential supports in the community, 2.3 percent lived in community companion homes, 1.6 percent lived in campus settings and 1.6 percent were in skilled nursing facilities.

Department of Mental Health and Addictions Services (DMHAS): DMHAS serves as both the state's State Mental Health Authority (SMHA) and Single State Agency for addiction services (SSA). It is an independent State agency having statutory responsibility to promote and administer an integrated system of comprehensive behavioral health preventive, treatment, and rehabilitative services. The DMHAS mission is "to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective, and efficient mental health and addiction services that foster self-sufficiency, dignity, and respect." Its primary purpose is to assist persons with mental health and/or substance use disorders to recover and sustain their health through delivery of high-quality services that are person-centered, promote hope, attend to trauma, improve overall health, and are anchored to a recovery-oriented system of care that is culturally competent and rooted in evidence-based practices.

To this end, DMHAS operates, funds, and coordinates inpatient and community-based behavioral health services for adults (18 and older) with serious substance use and/or mental health conditions as well as provides programs for individuals with special needs (e.g., AIDS/HIV, gambling, substance abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the DCF system, and those involved with the criminal justice system) including persons with serious mental illness residing in nursing homes, military personnel and their families, and persons who are homeless. DMHAS is responsible for the State's behavioral health general funds and SAMHSA block grant allocations and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults. DMHAS directly operates two inpatient hospitals and contracts with community hospitals and one private psychiatric hospital for inpatient and ambulatory care. DMHAS-operated inpatient hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services. DMHAS administers the mental health service system through a network of 13 Local Mental Health Authorities (LMHAs) statewide, six State-operated and seven non-profits, along with over 90 affiliated nonprofit community-based organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. T hey develop, maintain, and manage a comprehensive system of mental health treatment, rehabilitative services, and recovery support for designated local service.

Department of Housing (DOH): The Department of Housing's mission is to ensure everyone has access to quality housing opportunities and options throughout Connecticut. It is committed to strengthening and revitalizing communities by promoting inclusive affordable housing opportunities. DOH seeks to eliminate homelessness and to catalyze the creation and preservation of quality, affordable housing to meet the needs of all individuals and families statewide.

DOH works in concert with municipal leaders, public agencies, community groups, local housing authorities, and other housing developers in the planning and development of

affordable homeownership and rental housing units, the preservation of existing multi-family housing developments, community revitalization and financial and other support for the state's most vulnerable residents through DOH's funding and technical support programs. As the State's lead agency for all matters relating to housing, DOH provides leadership for all aspects of policy and planning relating to the development, redevelopment, preservation, maintenance and improvement of housing serving very low, low, and moderate income individuals and families. DOH is also responsible for overseeing compliance with applicable statutes, regulations and financial assistance agreements for funded activities through long-term program compliance monitoring.

Department of Transportation (CTDOT): CTDOT provides subsidies to bus and paratransit systems throughout the state. Local bus systems in Hartford, New Haven, Stamford, Waterbury, New Britain, Meriden and Wallingford are owned by CTDOT and operated under the CTtransit brand name and account for about 80% of the annual statewide bus ridership. In non-CTtransit service areas, local transit districts assume operation of bus services and enter into transit operating assistance contracts with CTDOT to obtain funding from the State. The fixed-route bus system provides discounted (half-fare) rides to seniors and people with disabilities. If an individual has a disability that precludes him or her from using the fixed-route service, he or she can apply for ADA paratransit eligibility. Paratransit is a shared ride, advanced reservation, origin-to-destination service for persons with disabilities who are unable to use the public bus service because of their disability and is mandated by the Americans with Disabilities Act of 1990. ADA paratransit services are available to origins and destinations within ¾ mile of the local bus route and are operated during the same days and hours as the fixed-route service. In addition, CTDOT administers the Section 5310 grant program and the State Matching Grant program. Section 5310 is a Federal grant program intended to improve mobility for seniors and individuals with disabilities by removing barriers to transportation service and expanding mobility options. It is open to private nonprofit organizations, local governmental authorities and operators of public transportation for qualifying projects and funds both capital and operating expenses. The State Matching Grant program, also known as the Municipal Grant Program (MGP), allows municipalities to apply for a pre-set amount of operating funding (determined by formula) on an annual basis. The funding allows municipalities to provide new or expanded transportation services to seniors and people with disabilities and requires a local match.

The Department of Public Health (DPH): The mission of DPH is to protect and improve the health and safety of the people of Connecticut. DPH is the state's leader in public health policy and advocacy. The Department is a partner to local health departments for which it provides advocacy, training and certification, technical assistance, consultation, and specialty services such as risk assessment that are not available on the local level. Additionally, DPH establishes health priorities and evaluates the effectiveness of health initiatives. The agency also has regulatory functions which focus on the quality of services provided by licensed professionals, health care institutions,

laboratories, ambulances, and environmental health entities. Resources are also dedicated to epidemiology, vital statistics, health education, and surveillance.

Department of Children and Families (DCF): DCF provides a variety of community-based and institutional services for children and adolescents with disabilities and their parents. The department's mandates include Prevention, Child Protection, Juvenile Justice Services and Behavioral Health. Services are provided through contracted providers as well as State-operated facilities. DCF is part of the Behavioral Health Partnership, along with DSS and DMHAS, with the goal to provide access to a more complete, coordinated, and effective system of community-based behavioral health services and support.

Office of Health Strategy (OHA): The Office of Health Strategy (OHS) was created in 2017 and established in 2018 by a strong bipartisan effort of the CT General Assembly to forward high-quality, affordable, and accessible healthcare for all residents. The legislation re-organized existing State resources into one body, redeploying people and programs more efficiently, and centralizing health policymaking to advance the healthcare reform initiatives that will drive down healthcare costs; close Connecticut's deeply entrenched racial, economic, and gender health disparities, and undertake technology-driven modernization efforts throughout the system. OHS has a multitude of statutory and regulatory responsibilities including Health Systems Planning and the Certificate of Need program, the development of the state's Health Information Exchange, administering the All Payer Claims Database and Consumer Information Website, and initiatives to improve drug pricing transparency. The work of OHS is funded, in part, by tens of millions of dollars in federal grants that are secured through a competitive process, positioning Connecticut as a leader in healthcare policy reform.

In many national surveys, Connecticut is a top ten state for healthcare. In 2018, U.S. News Best States ranked Connecticut fourth highest for healthcare. This is a promising statistic, but Connecticut is also among the states with the highest cost and high cost growth in the country. OHS collaborates with a variety of experts, consumers, and provider stakeholder groups to examine and address the barriers in Connecticut's health system - cost, access, and outcomes. A healthy population creates value for employers, is necessary for a strong economy, and is key to a high quality of life.
Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. An Adult Care Facility, operated by DVA, is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, Alzheimer's and related dementia care, end of life care, palliative care, long-term care, rehabilitation, respite care, mental health and psychological counseling. The Residential Facility is certified by the Federal Department of Veterans Affairs. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

II. State Long-Term Services and Supports Programs in Connecticut – SFY 2021

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Independent Living (IL) Program	Provides comprehensive independent living services, including peer support, information and referral, advocacy, facilitated transition of youth to post-secondary life and independent living skills training.	Community-based, cross-disability, nonresidential, private nonprofit agencies	No eligibility requirements.	Total Participants 167 Age 0-5: 0 5-19: 1 20-24: 8 25-59:158 60 up: 0 Gender Female: 85 Male: 82 Race Am Ind/Alask: 0 Asian: 3 AA: 25 Hawaiian/PI: 0 White: 99 Hisp/Lat: 37 2 or more: 3 Unknown: 0 Disability Cognitive:0 Mental/Emot:0 Physical: 25 Hearing: 0 Vision: 72 Multiple: 68

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Other: 0
ADS	Independent Living- Older Individuals who are Blind (OIB)	Provides comprehensive independent living services, including adaptive aids and devices, and training in their use, to enable individuals who are blind to maintain independence in their residences and communities.	Services are provided directly by ADS staff in the residences and communities of the individual, and through third party low vision practitioners at their medical practices.	Age 55 or older and legally blind or significantly visually impaired.	Total Participants (FFY2020) 507 Age 55-59:43 60 up: 464 Gender Female: 337 Male: 170 Race Am Ind/Alask: 0 Asian: 2 AA: 62 Hawaiian/PI: 0 White: 412 Hisp/Lat: 29 2 or more: 2 Unknown: 0 Disability Totally Blind: 15 Legally Blind:478 Severe Visual Impairment:14

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	State Long-Term Care Ombudsman Program	RECEIVES and looks into complaints and assists residents in resolving problems. EDUCATES residents and families about their rights. EMPOWERS and supports residents and families to discuss concerns with nursing home staff. PROVIDES information regarding long-term care programs and services. ADVOCATES improvements in state and federal laws and regulations. REPRESENTS residents' interests before governmental agencies. IDENTIFIES and seeks to remedy gaps in facility, government, or community services. RESPECTS the privacy	Long-Term Care Communities - Nursing homes, residential care homes and assisted living communities.	A resident of a long-term care community.	About 28,000 in long-term care communities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		and confidentiality of residents.			
ADS	CHOICES	State Health Insurance assistance Program (SHIP), including Medicare Improvements for Patients & Provider Act services (MIPPA) Health insurance counseling Outreach Training Information & referral	Area Agencies on Aging CHOICES Volunteer Host Organization Locations-sites where CHOICES Team members provide counseling and outreach assistance Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Medicare-eligible beneficiaries, and their caregivers, Providers and individuals interested in serving as program volunteers Assistance for beneficiaries with low income or residing in rural communities Age 60 and over. Under 60 if Medicare eligible.	New Team Member Trainings: 2 New Team Members Trained and Certified: 68 Total number of Beneficiary Counseling Sessions: 23,322 Beneficiaries under age 65: 3,473 Beneficiaries over age 65: 14,857 Beneficiary age not collected: 3,374 Beneficiary income below 150% FPL: 8,248 English as a Primary Language: Yes 19,349 No 2,355 Beneficiary Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Male: 6,900 Female: 13,069 Other: 18 Not Collected: 1,717 Beneficiary Race American Indian or Alaskan Native: 21 Asian: 327 Black or African American: 1,524 Hispanic or Latino: 1,740 Native Hawaiian or Other Pacific Islander: 58 White: 13,169 Not Collected: 4,902 Medicare Part D, Medicare Advantage, & Medicare Supplement Plan comparisons and enrollment contacts: 14,091 Medicare Savings Program, Extra Help/Low Income Subsidy, & Medicaid Application Assistance contacts: 1,722 Outreach events: 208 Outreach contacts (attendees): 9,867

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	SMP – Senior Medicare Patrol	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	Total Participants Presentations – 110 Beneficiaries who attended presentations 1,732 Outreach events – 155 One-on-one individual interactions - 151
ADS	CT Partnership for Long-Term Care - Information & Education Program	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers Variety of public venues	Age 18-89	Total Participants Calls for information - 148 Individuals counseled - 148 Attended public forums 0 Age NA Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	Adult day care Care management Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emergency response system Short-term respite care Information and referral Support groups Cognitive training Self-directed care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	No age requirement. Alzheimer's or a related dementia. $44,725 income $ 118,905 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	<u>Total Participants</u> 709 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Supportive Services and Health and Wellness: Older Americans Act Title IIIB and Title IIID	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emergency response system Recreation services Respite care Transportation Medication monitoring Evidence-Based Health Promotion Programs	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	Total Participants 15,133 Age N/A Gender N/A Race/Ethnicity N/A
ADS	Elderly Nutrition Program: Older Americans Act Title IIIC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery. Other nutrition services such as education and counseling provided as appropriate.	Congregate meals: senior community cafes, congregate housing, restaurants, schools, churches Home delivered meals: residential homes	Age 60 and over and their spouses/ caregivers	Total Participants Congregate meals: 276,143 meals served to 11,860 participants Home delivered meals: 1,842,877 meals served to 12,218 participants 466 units of Nutritional counseling were provided to 353 unduplicated persons

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					*Nutrition Education = 4,152 Units *Federal reporting does not require the count of people for this service, only units. Totals reflect units for FFY 2020.
ADS	CT's National Family Caregiver Support Program: Older Americans Act Title lllE	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups Cognitive training Self-directed care	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over. Two or more ADL limitations. Children 18 yrs of age or younger for grandparent support.	Participants: Respite - 492 Supplemental services – 781 Counseling, support groups, training - 814 Caregivers caring for older adults - 1,294 Grandparents and kinship caregivers caring for children and persons 18-59 with disabilities - 154
ADS	Congregate Housing Services	Adult day care Care management Chore services Companion services	Congregate housing	Age 60 and over. Frail adults with temporary or	Total CHSP Participants served: 249 Age:

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system Transportation Medication monitoring Foot care		permanent disabilities.	62+ - 236 18-61 - 13 <u>Gender:</u> Female participants - 204 Male participants - 45 <u>Race/Ethnicity</u> White (non-Hispanic) participants served - 244 Hispanic participants - 3 Black/African American participants (non-Hispanic) - 1 American Indian/Alaskan Native participants - 0 Asian/Pacific Islander - 1
ADS	Senior Community Service Employment Program	Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over. Income not exceeding 125% of the federal poverty level.	<u>Total Participants</u> 59 <u>Age</u> 55-64: 38 65-74: 19 75+: 2 <u>Gender</u> male: 15 female: 44 <u>Race/Ethnicity</u> White - 23 Black/African American - 27 Hispanic - 3 Asian - 1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					American Indian - 4
ADS	Medicare Legal and Education Assistance Project	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	Total Participants 1,451 direct client assistance Age N/A Gender N/A Race/Ethnicity N/A
ADS	Evidenced-Based Health Program	Chronic Disease Self-Management Education Program (CDSME), Statewide Fall Prevention Program Tai Ji Quan, Moving for Better Balance (TJQMBB)	Agencies on Aging VNA's, hospitals Community centers, Senior Centers Health departments Municipal agencies		Total Participants CDSME - Due to the COVID-19 pandemic, CDSME programs were delivered telephonically with 150 course completers Tai Chi Moving for Better Balance – Due to the COVID-19 pandemic, participants attended classes either virtually or in person. **Total =** 276

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	No Wrong Door (Aging & Disability Resource Centers) with funding from ACL Grants	Assessment Assistance Advocacy Care Transitions Case Consultation Decision Support Follow-Up Information Options Counseling Benefits Employment Long Term Support; Referral Short Term Support	Agencies on Aging Centers for Independent Living Some hospitals Personal residences Other public places By phone	Any person across the lifespan who is a person with a disability, older adult caregiver or planning ahead for future long term care needs. Available statewide	Total Participants Total unduplicated consumers of ADRC Services = 614 Consumers: 483 Caregivers: 7 Families: 85 Agencies: 18 Other: 21 No trainings were provided because it was very difficult to transition from in-person to virtual training due to COVID-19. Other state agencies are also providing this training.
ADS	Prevention of Elder Abuse, Neglect and Exploitation	Strengthen and carry out programs or activities by raising awareness to prevent, detect, intervene, investigate and respond to elder abuse, neglect and exploitation. -support of multi-disciplinary teams directed at advocacy to curtail elder abuse - financial exploitation education and training - Coalition for Elder Justice in Connecticut	Agencies on Aging State agencies Law Enforcement Aging, legal, victims, and disability networks Medical and educational organizations For-profit and non-profit, public and private organizations	Age 60+ and persons with disabilities	Total Participants 586

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support Senior Supports Vehicle modifications Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination Assistive Technology Peer Support Shared Living Training and Counseling for Unpaid Caregivers	Personal residences Community living arrangement Community companion home Community day program site Community employment	Individuals over the age of three. Person with intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants As of June 2021 Comprehensive Waiver 5,181 Individual and Family Support Waiver 3,603 Employment and Supports Waiver 2,120 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DDS	Intermediate Care Facility for persons with Intellectual Disability(ICF/ID)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/ID	No age limit. Person with intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants in DDS operated ICF/IDs 271 Age 0-18: 0 19-54: 57 55-64: 83 65+: 131 Total Participants in privately operated ICF/IDs 336 Age 0-18: 0 19-54: 147 55-64: 110 65+: 79 Gender N/A Race/Ethnicity N/A
DMHAS	Mental Health Standard Case management-and Community Support (CSP)	Info & Referral Transportation Case management Skill-Building	Personal Residences RCH NF Shelters Supportive housing sites	Adults age 18 and over. Primary diagnosis of a psychiatric disorder;	Total Participants 1,111 Age 18-20 75 21-25 146

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
			Clubhouses	Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care. No private insurance to pay for comparable services.	26-34 134 35-44 136 45-54 202 55-64 262 65+ 142 Unknown 14 <u>Gender</u> Female 532 Male 575 Trans* 2 Unknown 2 <u>Race</u> Am Indian 5 Asian 100 Black 186 Multi-race 6 Hawaiian 4 Other 89 Unknown 69 White 652 <u>Ethnicity</u> Hispanic195 Non-Hispanic 825 Unknown 91
DMHAS	Mental Health Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more	<u>Total Participants</u> 1,292 <u>Age</u> 18-20 189 21-25 393 26-34 214 35-44 159

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		available 24/7.		intensive and restrictive services. No private insurance to pay for comparable services.	45-54 120 55-64 165 65+ 36 <u>Gender</u> Female 475 Male 817 <u>Race</u> Am Indian 11 Asian 16 Black 317 Multi-race 19 Hawaiian 6 Other 160 Unknown 35 White 728 <u>Ethnicity</u> Hispanic 247 Non-Hispanic 960 Unknown 85
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of	<u>Total Participants</u> 131 <u>Age</u> 18-20 7 21-25 16 26-34 38 35-44 28 45-54 28 55-64 12 65+ 0 <u>Gender</u>

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				safety; Symptomology/ behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual. No private insurance to pay for comparable services.	Female 80 Male 50 Unknown 1 <u>Race/</u> Am Indian 1 Asian 1 Black 14 Multi-race 0 Other 7 Unknown 4 White 104 <u>Ethnicity</u> Hispanic 10 Non-Hispanic 115 Unknown 6
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	<u>Total Participants</u> 30,626 <u>Age</u> 18-20 1,039 21-25 2,476 26-34 5.304 35-44 5,467 45-54 5,845 55- 64 6,674 65+ 3,529 Unknown 292 <u>Gender</u> Female 16,551 Male 14,038

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Trans* 9 Unknown 28 <u>Race</u> Am Indian 172 Asian 344 Black 4,322 Hawaiian 96 Multi-race 136 Other 4,525 Unknown 1,124 White 19,907 <u>Ethnicity</u> Hispanic 6,306 Non-Hispanic 22,843 Unknown 1,477
DMHAS	Methadone Maintenance				<u>Total Participants</u> 13,555 <u>Age</u> 18-20 30 21-25 394 26-34 3,385 35-44 3,981 45-54 2,969 55-64 2,266 65+ 591 Unknown 2 <u>Gender</u> Female 4,841 Male 8,702 Unknown 12

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Race Am Indian 49 Asian 72 Black 1,087 Hawaiian 20 Multi-race 34 Other 2,438 White 9,575 Unknown 280 Ethnicity Hispanic 3,324 Non-Hispanic 9,643 Unknown 588
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 236 Age 18-20 4 21-25 17 26-34 67 35-44 61 45-54 30 55-64 46 65+ 11 Unknown 0 Gender Female 77 Male 159 Race Am Indian 0

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Asian 7 Black 46 Multi-race 4 Other 23 White 149 Unknown 7 <u>Ethnicity</u> Hispanic 31 Non-Hispanic 190 Unknown 15
DMHAS	Mental Health Residential - Supervised Apartments	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness. No private insurance to pay for comparable services.	Total Participants 805 Age 18-20 56 21-25 139 26-34 174 35-44 140 45-54 135 55-64 127 65+ 28 Unknown 6 Gender Female 278 Male 526 Trans* 0 Unknown 1 Race Am Indian 2 Asian 10 Black 207

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Multi-race 7 Other 92 Unknown 21 White 466 Ethnicity Hispanic 126 Non-Hispanic 626 Unknown 53
DMHAS	Social Rehabilitation	Independent living and community reintegration skill development.	Community setting	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	Total Participants 5,690 Age 18-20 57 21-25 254 26-34 732 35-44 919 45-54 1,338 55-64 1,780 65+ 573 Unknown 37 Gender Female 2,395 Male 3,287 Trans* 1 Unknown 7 Race Am Indian 49 Asian 54 Black 1,536 Hawaiian 9 Multi-race 31

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Other 644 Unknown 140 White 3,227 <u>Ethnicity</u> Hispanic 915 Non-Hispanic 4,541 Unknown 234
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care. No private insurance to pay for comparable services.	<u>Total Participants</u> 645 <u>Age</u> 18-20 13 21-25 51 26-34 168 35-44 172 45-54 132 55-64 91 65+ 18 <u>Gender</u> Female 184 Male 461 Trans* 0 Unknown 0 <u>Race</u> Am Indian 2 Asian 1 Black 156 Hawaiian 2 Multi-race 5 Other 81 Unknown 20

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					White 378 Ethnicity Hispanic 109 Non-Hispanic 497 Unknown 39
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others. No private insurance to pay for comparable services.	Total Participants 7,137 Age 18-20 457 21-25 752 26-34 1,387 35-44 1,256 45-54 1,063 55-64 1,143 65+ 771 Unknown 308 Gender Female 3,291 Male 3,830 Trans* 6 Unknown 10 Race Am Indian 19 Asian 72

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Black 1,287 Hawaiian 7 Multi-race 7 Other 810 Unknown 1,315 White 3,576 <u>Ethnicity</u> Hispanic 1,136 Non-Hispanic 4,456 Unknown 1,545
DMHAS	MH Residential Support	Case management to assist people in independent housing	Community settings and people's homes	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 624 Age 18 – 20 9 21 – 25 29 26 – 34 99 35 – 44 116 45 – 54 131 55 – 64 184 65+ 56 Unknown 0 Gender Female 225 Male 399 Transgender 0 Race Am Indian 2 Asian 5 Black 202 Multi race 6

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Hawaiian 1 Other 59 Unknown 4 White 345 Ethnicity Hispanic 77 Non-Hispanic 525 Unknown 22
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	<u>Total Participants</u> 835 <u>Age</u> 18-20 25 21-25 88 26-34 184 35-44 165 45-54 125 55-64 152 65+ 91 Unknown 5 <u>Gender</u> Female 241 Male 593 Unknown 1 <u>Race</u> Am Indian 1 Asian 18 Black 256 Multi-race 6 Other 74 Unknown 39

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					White 439 Ethnicity Hispanic 109 Non-Hispanic 666 Unknown 60
DMHAS	Substance Abuse Residential - Long-Term Care (3.3)	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development Up to 6 months	Structured recovery environment	Adults age 18 and over with significant problems with behavior and functioning in major life activities due to substance abuse.	Total Participants 174 Age 18 – 20 0 21-25 5 26-34 48 35-44 48 45-54 42 55-64 31 65+ 0 Gender Female 40 Male 134 Race Am Indian 0 Asian 1 Black 17 Other 9 White 138 Unknown 9 Hawaiian 0 Multiracial 0 Ethnicity

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Hispanic 18 Non-Hispanic 140 Unknown 16
DOH	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail. One ADL minimum. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,052 residents Age 65+: 1009 Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	Total Participants 4,595 units in 57 communities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DOH	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,983 units Age 0-64: 1,218 65+: 657 Gender N/A Race/Ethnicity N/A
DOH	811 PRA	Federal Financial Assistance to make rents affordable to extremely low income (ELI) non-elderly disabled.	Personal residences	Extremely Low Income (ELI) under the age of 62 and disabled.	Total Participants 12 Gender N/A Race/Ethnicity N/A
DOT	Local Bus Services	Transportation	Community	Open to the public, inclusive of seniors and people with a qualifying disability.	Total Participants 33,503,701 (SFY 2020 Passenger Trips) Age N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Gender N/A Race/Ethnicity N/A
DOT	ADA Paratransit Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	Total Participants 839,780 (SFY 2020 Passenger Trips) Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DOT	State Matching Grant Program	Demand Responsive Transportation to Seniors and People with Disabilities	Municipality applies for funds and provides matching funds	Seniors and people with disabilities of all ages.	Total Participants 80+ recipients, inclusive of municipalities that pool funding together for regional coordinated Dial-a-Ride service via local transit districts. Age N/A Gender N/A Race/Ethnicity N/A
DOT	Section 5310 Federal Grant Program	Transportation related services that go beyond traditional public transportation services and the Americans with Disabilities Act (ADA) complementary paratransit services.	Services must be derived from a locally-coordinated public transit human services transportation plan.	Seniors and people with disabilities of all ages	Total Participants 100+ recipients that provide service statewide, with over 500,000 trips provided. Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies Homemaker Home Health Agencies	Institutions identified under CGS 19a-490. Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Connecticut Home Care Program for Elders (CHCPE)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Home Delivered Meals MH counseling Minor home modifications Nursing services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Managed Residential Communities (Assisted Living) Alzheimer's units within Assisted Living Communities	Age 65 and over. Must have at least one critical need (bathing, dressing, toileting, transferring, eating/ feeding, meal preparation, medication administration). Medicaid Waiver income limit = $2250/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. Medicaid 1915(i) income limit = 150% of FPL, $1,518/month. Medicaid asset limit = indiv. $1,600. State funded income limit = no limit. State funded asset limit = Indiv $37,080/ couple $49,440 (one or both receiving services)	Total Participants Total – 13,395 Waiver – 12,612 State –1,942 1915i- 311 Age 65-84: 60% 85+: 40% Gender male: 26% female: 74% Race/Ethnicity – A - Asian 10% B - Black 28% C - Caucasian 48% N - Native American 6% O - Other 9%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	CT Home care Program for adults with Disabilities (CHCPD)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	<u>Total Participants</u> 70 <u>Age</u> Under 50: 16% 50-64: 84% <u>Gender</u> <u>N/A</u> <u>Race/Ethnicity</u> N/A
DSS	Personal Care Assistance Waiver	Care Management Independent Support Broker Adult Family Living	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise	<u>Total Participants</u> 1,022 <u>Age</u> Under 50: 51% Over 50: 49%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				require nursing facility care. Capable of self-direction. Medicaid income limit = 300% of SSI . Income in excess of 200% FPL applied to care.	<u>Gender</u> Male: 47% Female: 53% <u>Race/Ethnicity</u> N/A
DSS	Home and Community Supports Waiver for Persons with Autism	Clinical Behavioral Support Service Community Mentor Individual Goods and Services Personal Emergency Response System Social Skills Group Specialized Driving Assessment Live In Companion Respite Assistive Technology	Personal Residences	<u>Functional Eligibility</u>: Self-care, Understanding and use of language, Learning Mobility Self-direction, or Capacity for independent living. The functional impairments must have been diagnosed before age 22 and be expected to continue indefinitely.	<u>Total Participants</u> 123 <u>Age</u> 50-70 -11 49-30 – 29 29- 20 – 67 20 & under - 16 <u>Gender</u> Female: 10% Male: 79% Transgender: 1% <u>Race/Ethnicity</u> Black – 8% Caucasian – 79% Hispanic – 5% Other – 8% (Asian, Pacific Islander)

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Acquired Brain Injury Waivers (ABI + ABI II)	Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living	Personal care residence Group residence	Age 18-64. Brain injury that is not a result of a developmental disability or degenerative condition. Dysfunction is not primarily the result of a mental illness. Would otherwise be institutionalized. Medicaid income limit = Less than 200% FPL. Medicaid asset limit = Individual $1,600	Total Participants 568 Age 18-49: 45% 50+: 55% Gender Male: 66% Female: 34% Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 22 years old (those who are over age 22 as of 12/31/11 have the option to remain on the waiver) Would otherwise require care in a nursing home ICF/ID or chronic disease hospital. Medicaid income limit = $1,692. 300% of SSI? Medicaid asset limit = $1,000. $1,600? Income of parent or spouse not counted.	Total Participants 328 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Community First Choice	Personal care assistance Worker's Compensation Home delivered meals Support and Planning coach Health Coach-nurse/PT/OT/ST Assistive technology Environmental modifications Transitional services	Personal Residences	At Institutional Level of care: 1. Supervision or cueing ≥ 3 ADLs + need factor 2. Hands-on ≥ 3 ADLs 3. Hands-on ≥ 2 ADLs +need factor 4. A cognitive impairment which requires daily supervision to	Total Participants Grand Total: 5319 W/Waiver: 2441 CFC w/out waiver: 2878 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				prevent harm Living in a community setting Choosing to self-direct and manage an individual budget Active on Husky Medicaid	
DSS	Money Follows the Person	Transition Services Housing Services Peer Support Services Addiction & Substance Abuse Services and Supports Informal Caregiver's Support	Personal Residences	Title 19 Active (pays the last day) Institutionalized at least 90 consecutive days Approved Plan of Care Returning to Qualified housing Approved Transition plan	Total Participants 459 (only those enrolled in MFP) Age N/A Gender N/A Race/Ethnicity N/A
DVA	Veterans' Health Care Services	Licensed Chronic Disease Hospital provides continuous professional comprehensive healthcare services	John L. Levitow Healthcare Center (onsite)	Veterans as defined by CGS 27-103 who served honorably, are residents of Connecticut, and have a chronic disease/illness.	Average Monthly Census 84 Total Participants 101 Age

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care Mental health and Psychological counseling			18-61: 9 62+: 92 <u>Gender</u> 3 Female, 98 Male <u>Race/Ethnicity</u> Caucasian: 87 Hispanic: 2 Black: 11 Other: 1
DVA	Residential and Rehabilitative Services	Provides domiciliary level of care to facilitate rehabilitation and return to independent living including: Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	<u>Average Monthly Census</u> 110 <u>Total Participants</u> 135 <u>Age</u> 18-61: 44 62+: 91 <u>Gender</u> 7 Female, 128 Male <u>Race/Ethnicity</u> Caucasian: 95 Hispanic: 9 Black: 29 Other: 2

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2021

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
ADS	Independent Living (IL) Program	$798,851	$612,972			$185,251	$628
ADS	Independent Living – Older Individuals who are Blind (OIB)	$487,271	$44,847			$442,329	$95
ADS	CHOICES	$935,359	$423,177			$512,182	
ADS	SMP – Senior Medicare Patrol	$264,089				$264,089	
ADS	CT Partnership for LTC - Information & Education Program	$0				$0	
ADS	Statewide Respite Care Program and Alzheimer's Aide Program (for persons with Alzheimer's or related dementia)	$1,982,539	$1,982,539				
ADS	Supportive Services and Administration	$4,165,927	$153,273		$2,993,410	$870,774	
ADS	Health and Wellness						

Printed: 11/6/2023 3:21 PM - Connecticut - OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	(Title IIID)	$190,814	$4,789		$190,814		
ADS	Elderly Nutrition Program (Title IIIC and NSIP)	$17,960,034	$3,035,746		$8,284,557	$6,783,411	
ADS	CT's National Family Caregiver Support Program (Title IIIE)	$2,005,897			$1,873,436	$132,461	
ADS	Congregate Housing Services	$542,167	$134,230			$407,937	
ADS	Senior Community Service Employment Program	$912,697				$912,697	
ADS	Medicare Legal and Education Assistance Project	$277,606	$277,606				
ADS	Elderly Health Promotion	$84,560	$84,560				
ADS	Evidenced Based Health Program:	$50,000					$50,000

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	Fall Prevention						
ADS	No Wrong Door: Aging & Disability Resource Centers	$329,743				$329,743	
ADS	Prevention of Elder Abuse, Neglect and Exploitation	$518,072			$133,230	$384,842	
ADS	Long-Term Care Ombudsman Program	$1,812,009	$1,461,904		$175,947	$174,158 (Title VII)	
DSS	Connecticut Home Care Program (CHCPE)	$478,450,956	$31,872,007 (includes CHCPD expenditures)	$446,578,949			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$1,884,657	$1,884,657 (Included in CHCPE expenditures)	NA			
DSS	Personal Care Assistance Waiver	$3,804,837	NA	$3,804,837			

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Acquired Brain Injury Waiver (ABI)	$42,056,370	NA	$42,056,370			
DSS	ABI II	$23,953,019	NA	$23,953,019			
DSS	Katie Beckett Model Waiver	$72,928	NA	$72,928			
DSS	Autism Waiver	$1,477,893	NA	$1,477,893			
DSS	Community First Choice	$159,610,161	NA	$159,610,161			
DSS	Money Follows the Person	$34,175,006	NA	$34,175,006			
DDS	Home and Community Based Services Waivers	$1,241,540,000		$1,241,540,000			

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$171,440,000		$171,440,000 Does not include private ICF/IDs which are funded by DSS			
DMHAS	Case Management	$41,230,467	$36,737,056	$111,205	$0	$2,859,927	$1,522,279
DMHAS	Assertive Community Treatment	$23,969,151	$23,638,329	$178,508	$0	$16,468	$135,846
DMHAS	Home and Community Based Services Waivers	$16,023,882	$0	$16,023,882	$0	$0	$0
DMHAS	MH Intensive Outpatient	$456,854	$26,139	$0	$0	$15,819	$414,896
DMHAS	MH Outpatient Therapy	$93,383,394	$66,907,243	$5,887,836	$0	$3,318,595	$17,269,720

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Residential Group Home	$41,034,567	$30,014,527	$5,681,947	$0	$771,314	$4,566,779
DMHAS	MH Supervised Housing	$57,326,447	$53,205,549	$0	$0	$157,845	$3,963,053
DMHAS	MH Supported Housing	$44,118,461	$23,405,838	$ 0	$0	$19,883,297	$829,326
DMHAS	MH Psychosocial Rehabilitation	$19,473,549	$17,934,545	$0	$0	$811,823	$727,181
DMHAS	Crisis Stabilization	$11,005,932	$10,493,168	$0	$0	$430,814	$81,950
DMHAS	Mobile Crisis Services	$12,843,062	$11,369,243	$13,625	$0	$1,066,188	$394,006
DMHAS	Long Term Psychiatric Hospitalization	$167,055,394	$165,918,837	$0	$0	$1,136,557	$0

Page 53 of 76

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Substance Abuse Residential Long Term Care	$3,330,876	$1,577,642	$0	$0	$219,148	$1,534,086
DMHAS	Substance Abuse Residential Long Term Treatment	$18,573,881	$12,196,906	$0	$0	$4,581,703	$1,795,271
DMHAS	Substance Abuse Residential Transitional / Halfway House	$1,647,685	$1,044,679	$0	$0	$152,115	$450,891
DOH	Congregate Operating Subsidy Program	$9,434,641	$8,823,041			$611,600	
DOH	Elderly Rental Registry and Counseling	$1,011,170	$1,011,170				
DOH	Elderly Rental Assistance Program	$1,935,625	$1,935,625				

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOH	811 PRA	$746,851	$0			$746,851	
DOT	Local Bus Services	$246,773,279 SFY 2020 Data	$205,745,356 SFY 2020 Data			$1,849,699 SFY 2020 Data	$27,737,582 (Fare Revenue) $7,137,118 (Other Revenue) $437,425 (Other Subsidies) $3,866,098 (Local) SFY 2020 Data
DOT	ADA Paratransit Services	$41,189,111 SFY 2020 Data	$39,230,209 SFY 2020 Data				$1,738,188 (Fare Revenue) $197,753 (Other Revenue) $22,961 (Local) SFY 2020 Data
DOT	State Matching Grant Program	$8,778,660 SFY 2020 Data	$4,389,330 SFY 2020 Data				$4,389,330 (Local) SFY 2020 Data

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOT	Section 5301 Program	$4,688,113 Data projections for FFY 2019 Award Cycle (most recent)	$590,439 Data projections for FFY 2019 Award Cycle (most recent)			$3,261,248 Data projections for FFY 2019 Award Cycle (most recent)	$836,426 Data projections for FFY 2019 Award Cycle (most recent)
DVA	Veterans' Health Care Services	$13,264,997	$10,634,280			$539,547	$2,091,171
DVA	Residential and Rehabilitative Services	$3,382,368	$1,110,848			$1,472,327	$799,193

Environmental Factors and Plan

18. 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 condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[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 smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[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 abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

---

[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 Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: 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**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery 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 misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ◉ Yes ○ No

d) Does the state have an established FEP program? ◉ Yes ○ No

Does the state have an established CHRP program? ◉ Yes ○ No

e) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The CT Suicide Prevention Plan 2025 (Plan 2025-www.preventsuicidect.org) was released September 2020 by the CT Suicide Advisory Board (CTSAB), the single state-level advisory board in CT that addresses suicide prevention, intervention and response across the lifespan. 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 grants (New 2022-24); SAMHSA-Garrett Lee Smith Grants (New 2023-28), CDC-CT Violent Death Reporting System, CDC-CT Suicide Prevention Initiative). Many subcommittees lead efforts to reduce suicides and attempts including: the CT Zero Suicide Learning Community and Committee on Clinical Workforce Development; Reducing Access to Lethal Means; Data To Action; Intervention and Postvention Planning and Response; 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, data monitoring and CTSAB members. Examples of recent successes include the new grant initiatives noted above; 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; ongoing posting of Lifeline signage at data-driven sites where people have made attempts-bridges, overpasses, railway stations, parking areas; 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 and the addition of the Gizmo elementary curriculum on the AMCHP Innovation Hub (www.gizmo4mentalhealth.org); 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; addition of a new QPR Gatekeeper Master Trainer in CT; ongoing suicide prevention and postvention response planning trainings; and expanded joint 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 Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

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 4 Statewide Urgent Crisis Care Centers to both alleviate emergency department overflow and assist suicidal children & youth. Additionally, Intensive Transitional Case Managers were established during the peak of the crisis to assist youth and their families through the transition of an inpatient hospital stay to the community. A similar model will be used within the Care Coordination service. Lastly, youth Mobile Crisis provides bridging services for youth discharging from inpatient care and awaiting an appropriate outpatient level of care.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

DMHAS is the recipient of the FY 2022 Cooperative Agreements for States and Territories to Build Local 988 Capacity, and the Supplement (4/30/22-4/29/24) to serve the lifespan. DMHAS also just received the NOA for 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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- 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.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. 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?

N/A

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. As result of this collaboration, a statewide hybrid conference is planned for October 27, 2023 to highlight the progress in expanding access to care and provide overall education regarding substance use disorders, MOUD and the need to build collaborative relationships.

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) will continue its participation in and support of 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.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION

Office of the Commissioner

Ned Lamont
Governor

Angel Quiros
Commissioner

July 14, 2023

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 FFY 2024-2025 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services Block Grant application. The Department of Correction (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 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 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 DOC Health Services staff, DOC Parole and Community 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

Phone: 860.692.7482 ◆ Fax: 860.692.7483
24 Wolcott Hill Road ◆ Wethersfield, Connecticut 06109
Website: www.ct.gov/doc

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.

The DOC looks 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.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Angel Quiros
Commissioner
Connecticut Department of Correction

AQ:yl

Phone: 860.692.7482 ◆ Fax: 860.692.7483
24 Wolcott Hill Road ◆ Wethersfield, Connecticut 06109
Website: www.ct.gov/doc

July 14, 2023

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 FFY 2024-2025 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services 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
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

July 18, 2023

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 FFY 2024-2025 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 and assist with the development and promotion of messaging that behavioral health is health;
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

Phone: (860) 509-7101 • Fax: (860) 509-7111
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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 14, 2023

Nancy Navarretta, M.A., LPC,
NCC Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor,
Hartford, CT 06134

Vannessa Dorantes, LMSW
Commissioner
Department of Children and
Families
505 Hudson Street, Hartford,
CT 06106

Dear Commissioners,

I am pleased to provide a letter of support for Connecticut's FFY 2024-2025 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-occurring mental health and substance use disorders.

Phone: (860) 424-5008 • Fax: (860) 424-5057
TTY: 1-800-842-4524
E-mail: Commis.DSS@ct.gov
Hartford, Connecticut 06105-3730
www.ct.gov/dss

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

State of Connecticut
Department of Aging and Disability Services

July 17, 2023

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 FFY 2024-2025 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
Aging and Disability Services

55 FARMINGTON AVENUE • 12TH FLOOR, HARTFORD, CT 06105-3725
Phone: (860) 424-5055 Information: 1-800-537-2549 Fax: (860) 424-4850

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Vannessa L. Dorantes
Commissioner

Ned Lamont
Governor

July 13, 2023

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 2024-2025 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services Block Grant application. The Department of Children and Families (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 the 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 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.*

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,

Vannessa Dorantes, LMSW

Commissioner

CT Department of Children and Families

STATE OF CONNECTICUT

www.ct.gov/dcf
An Equal Opportunity Employer

State of Connecticut
Department of Developmental Services

Ned Lamont
Governor

Jordan A. Scheff
Commissioner

Elisa F. Velardo
Deputy Commissioner

July 24th, 2023

Vannessa Dorantes, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Dorantes,

I am pleased to provide a letter of support for Connecticut's FY2024-2025 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

Phone: 860 418-6000 ◆ TDD 860 418-6079 ◆ Fax: 860 418-6001
460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

NED LAMONT
GOVERNOR

NANCY NAVARRETTA, MA, LPC, NCC
COMMISSIONER

July 25, 2023

Vannessa Dorantes
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Dorantes,

On behalf of Department of Mental Health and Addiction Services (DMHAS), I am pleased to provide a letter of support for Connecticut's FY 2024-2025 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 2024-2025 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, NCC
Commissioner

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 18, 2023

Nancy Navarretta, M.A., LPC, NCC, Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor, Hartford, CT 06134

Vannessa Dorantes, 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 2024-2025 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-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
Commissioner, Department of Social Services

Phone: (860) 424-5008 • Fax: (860) 424-5057
TTY: 1-800-842-4524
E-mail: Commis.DSS@ct.gov
Hartford, Connecticut 06105-3730
www.ct.gov/dss

State of Connecticut
JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR
COURT SUPPORT SERVICES DIVISION
455 Winding Brook Drive, Glastonbury, CT 06033

July 25, 2023

The Honorable Nancy Navarretta, M.A., LPC, NCC
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor, Hartford, CT 06134

Vannessa Dorantes, LMSW
Commissioner
Department of Children and Families
505 Hudson Street, 10th Floor, Hartford, CT 06106

Dear Commissioners,

I am pleased to provide a letter of support for Connecticut's FY 2024-25 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 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.

Telephone: (860) 368-3800 | Fax: (860) 368-4351 | E-mail: Gary.Roberge@jud.ct.gov

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
Judicial Branch
Court Support Services Division

STATE OF CONNECTICUT
STATE BOARD OF EDUCATION

July 26, 2023

Vannessa Dorantes, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Dorantes:

On behalf of Connecticut State Department of Education (CSDE), I am pleased to provide a letter of support for Connecticut's FY 2024-2025 Community Mental Health Services 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 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.

CSDE, in partnership with DCF and the Court Support Services Division (CSSD) of the Judicial Branch will continue to work collaboratively on school-based diversion of children by ensuring supports for students experiencing and at risk for 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 for Connecticut's children and families,

We look forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Sincerely,

Charlene M. Russell-Tucker
Commissioner of Education

cc: Sinthia Sone-Moyano, Deputy Commissioner

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

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

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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

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

The Adult 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, the Planning Council was surveyed to identify strengths, gaps, and needs within the behavioral health system. The data from this survey was utilized alongside data from the regional prioritization process (discussed further in our response to question 2) to identify priority areas and to inform the allocation planning process. The state allocation plans for both the Mental Health Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant were reviewed with the planning council to highlight areas of new or increased investment. Presentations were provided to the planning council to identify the specific projects and initiatives that are being developed to address areas they identified as needs or gaps within the behavioral health services system, and their feedback was sought in these presentations to help inform implementation. Lastly, the FFY24-25 combined state plan was shared with the planning council for their review and feedback.

The Children's Behavioral Health Advisory Committee (CBHAC) is also directly involved in planning and allocation processes related to children's mental health and is an important part of Connecticut's planning efforts. During CBHAC meetings, the various state partners including the Department of Children and Families (DCF), Department of Mental Health and Addiction Services (DMHAS) Young Adult Services, State Department of Education, and others present state updates and gather feedback from CBHAC members. CBHAC meetings held throughout the year include time for review of the MHBG. CBHAC meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan. Of note, the Department has used CBHAC meetings to share updates and seek feedback from CBHAC related to the various initiatives related to children's mental health that were implemented including the Urban Trauma Network, the Urgent Crisis Centers, and the expansion of Mobile Crisis to 24/7.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse 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.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

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

5. 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 Adult Behavioral Health Planning Council include: to review the combined SABG/MHBG application/plan provided by DMHAS and to submit any recommendations for modifications of those plans; to serve as advocates for adults with DMI and children with SED and their families, as well as others with behavioral health problems; to monitor, review, and evaluate, at least annually, the allocation and adequacy of behavioral health services in Connecticut.

Adult Behavioral Health 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.

The duties of the Children's Behavioral Health Advisory Committee (CBHAC) are similar to that of the adult council and include the specific duty to “promote and enhance the provision of behavioral health services for all children” in Connecticut. The CBHAC serves as the state’s Children’s Mental Health Planning Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that it will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state’s System of Care for children and families.

The 30 member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, five members appointed by the leadership of the General Assembly, as well as fifteen members appointed by the commissioner of DCF. The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. “At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child.” In addition, a parent is to serve as co-chair of the CBHAC/CMHPC. CBHAC meetings held throughout the year include time for review of the MHBG. Meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Council does not include membership from State Marketplace agency or State Agency on Aging

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, February 3, 2023

Attendance: Aleece Kelly, Alexandrino Rivera, Amanda Knef, Amy Hilario, Andrea Richardson, Ann Petitti, April Mayo, Benita Toussiant, Beresford Wilson, Brenetta Henry, Briannali Rivera, Cara Manzari, Carolyn Westerholm, Celeste, Constance Capacchione, Damaris (Dami) Cox, Dana Bossio, Daniela Giordano, Deb Kelleher, Donaicis Alers, Donald Vail, Donyale Pina, Doriana Vicedomini, Dorothy Cimmino, Dr. Alice Farrell, Dr. Maria W. Cruz, Dr. Marie Spivey, Drew Lavallee, Eleanor Trapasso, Ellender Mathis, Elsa Cordova, Erica Aldieri, Erica Charles, Falinda King, Gabrielle Hall, Ivette Diana, Jackie Cook, Jean Alberghini, Jennifer Abbatemarco, Jenny Bridges, Jess Greenwood, Judith Eisenberg, Jules Calabro, Julie DeMarco, Karen Delane, Kassandrah Banks, Katie Johnson, Keisha Martin-Velez, Kelly Waterhouse, Kim Tanguay, Kimberly Torres-Bacon, Kristin Graham, Kymani Scarlett, Lindsay Kyle, Lisa Girard, Lois Berkowitz, Lyne Landry, M. Alex Geertsma, Maria Brereton, Mary Pike, Maureen O'Neil-Davis, Megan Thibault, Morgan Leary, Nan Arnstein, Patricia Card (Interpreter), Patricia Gaylord, Patrick McCormack, Penny Lemery, Paul Guerrero, Quiana Mayo, Rebekah Behan, Renee Wright, Ronnie Vollano, Sabina Griffith, Sabra Mayo, Samantha Inniss, Sandra, Sebastian Spencer, Sheila Figueroa, Shi-maine Holmes, Solai Demorest, Stacey Kabasakalian, Tania Santana, Tarsha, Taylor Ford, Tim Cunningham, Tim Marshall, Wanda Roman, Xavier Williams, Yvette Young, zz 1203----343, zz 1203----492, zz 1203----782, zz 1860----813

Welcome and Introductions

- Meeting began at 10:02 am
- CBHAC's mission, purpose and priority areas were reviewed

CBHAC Committee Members Monthly Recap (January 2023)

- December 2022 meeting minutes were approved
- Discussion with State Departments about bringing more data into regular meetings
- State Department members that were present will be going back to their agencies and trying to see how that request can be fulfilled
- CBHAC Bylaws revisions continued
- Small CBHAC subcommittee met in between meetings to complete the final draft and that was sent out to members for review

Review of 2022 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

Agency Updates

1. DMHAS - Jenn Abbatemarco

- During last month's meeting we spoke about the human trafficking initiative as part of the Human Trafficking Awareness. Stephanie Rivera is the DMHAS lead and potentially can present at CBHAC in June
- CBHAC leadership will help connect those interested in joining the Human Trafficking workgroup that is collaborating with DCF that will be taking place this year
- The group will be working to raise awareness across our teams around human trafficking on how to better identify and screen individuals who may have experienced that or be vulnerable to experience that and then integrating some interventions into the treatment models that are currently offered
- DMHAS has partnered with Rise B group at Advocacy Unlimited to put together a Young Adult Leadership

- About 80 participants came together last Friday, 01/27/23 all young adults experiencing mental health issues and in different stages of recovery
- They spent the morning with a woman named Julia Tenenbaum, who is a young adult who raises awareness around mental health and social justice. She also has a book if anyone is interested
- In the afternoon the young adults participated in experientially based workshops such as mindfulness, meditation and journaling
- The RFP for a Dialectical Behavior Therapy (DBT) residential program for young adults has been selected for the right to negotiate. Updates will become available as they come up

2. Department of Education – no report

3. Department of Juvenile Justice Services – Kelly Orts for Carmen Hernandez

- The request for proposal (RFP) for linking youth to natural communities is out and on the judicial website
- It will close on February 14th, 2023. If any community organizations are interested in applying they can find information on how to do that by visiting the website
- A current contract for Multi-Systematic Therapy (MST) will be ending shortly and will not be rebuilt next year. Instead will be working with DCF, who will be putting out the RFP directly Court Support Services Division (CSSD) will continue to contribute and work with DCF on the MST contract
- Judicial Branch is currently hiring for a Director of Diversity, Equity and Inclusion
- **Q**: What are the ages of the youth to be served by the LYNC RFP? **A**: Ages is 12-17 years old.
- **Q**: Is the MST RFP that DCF is putting out the same dollar amount as it was with CSSD? **A**: The understanding is that it will be the full rate of procurement.

4. Department of Social Services – Donaicis Alers/Morgan Leary

- DSS continues to plan for the unwinding of the public health emergency. We have a designated date of May 11.
- Morgan Leary from Medical Eligibility Units/Program Oversight and Grants Administration Division presented on the Public Health Emergency Unwinding and what it means
- During the public health emergency, many states were offered the opportunity to offer some expanded assistance to the residents of our state
- Now that the public health emergency is coming to an end we're using the term unwinding, as those changes start to return to pre pandemic levels of operation
- The federal government signed the Consolidated Appropriations Act at the end of last year so that the individuals who were extended on Medicaid and CHIP during the public health emergency, even if they were no longer eligible, are going to have the opportunity to do a renewal to determine what they might be eligible, and that's going to be a 12 month process
- More information on this can be found on website www.ct.gov/php
- **Q**: What is the Department of Social Services position going to be regarding continuing telehealth reimbursement for Medicaid clients? **A**: At this time the department is working on the telehealth information to be rolled out to providers and members

5. Department of Children and Families – Tim Marshall for Bethany Zorba

- All four of the urgent crisis centers have been contracted and a go live date is being worked out
- The goal is to open within the next 30 to 45 days and be fully accepting families and youth
- The sub-acute crisis stabilization that are the one to 14 day bed units are going to be accompanying and supporting those for urgent crisis centers
- When the RFP was released there were not sufficient interest so DCF has been engaging providers with the possibly of providing that service in two parts of the state. Two providers are in contract negotiations but that will take some time
- the child serving mobile crisis system has changed to now service 24 hours, seven days a week, 365 days a year as of January 1, 2023

- **Q**: Are the contracts actually completed and signed for the urgent care clinics? What are the barriers? Does the department have an estimated timeline for when you think you can get providers on board for that? **A**: The UCC contracts have been fully executed and implementation and hiring has been occurring the live date has not been decided. Barriers are physical plant operations as well as the sub-acute crisis stabilizations not being fully on board yet

6. Office of Early Childhood- Ashley McAuliffe

- The Office of Early Childhood has made an official announcement that the CARE for Kids program is going to begin enrollment management of the current waitlist starting on March 1
- It is only going to affect new families or applicants to the CARE for Kids system for more information visit the CARE 4 Kids website or contact Office of Early Childhood
- There's also been a lot of talk among providers in childcare and home visiting and Birth to Three regarding the home test kits for COVID. The expiration dates have been extended and links to are being shared in case people need more information
- OEC has updated their tree telephone line. Callers can choose English or Spanish and they are routed to a live person for further assistance
- OEC office and telephone hours are from 8:30-4pm Monday through Friday
- The universal nurse home visiting program is a pilot program in collaboration with DSS, Department of Public Health and the Office of Health strategies
- The pilot is in the Bridgeport and Bridgeport Hospital is working with another provider to provide universal nurse home visitation to all families who deliver at Bridgeport Hospital or St Vincent's Hospital
- The staff of those programs are currently undergoing family connects international training, which is the evidence based home visiting model that is being utilized

Monthly Presentation- Aleece Kelly from CHDI
(see handouts)

Community Announcements
-none reported

Next meeting: March 03, 2023

Voting Member Minutes

- Unanimous approval of recent revisions to CBHAC bylaws document
- Review of new voting member application. Approval of new voting member as a provider with contingency status, as individual needs to attend several more CBHAC meetings.
- Discussion of legislative appointment openings and desire to fill positions. Goal of September of 2023 to fill these appointed positions. List of voting members to be disseminated to all voting members.
- Some discussion about local community collaboratives and increasing engagement throughout the system. Plan for additional discussion and potential action related to engagement.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, January 6, 2023

Attendance: Abigail Pepin, Agata Raszczyk-Lawska, Alexandrino Rivera, Allyson Nadeau, Amanda Knef, Amy Hilario, Ann Petitti, Benita Toussaint, Beresford Wilson, Bethany Zorba, Briannali Rivera, Candice Capotorto, Carmen Hernandez, Chlo-Anne Bobrowski, Constance Capacchione, Crystal Williams, Cynthia Renner, Daniela Giordano, Danielle Verderame, Darrin McCalla, De Popkin, Dona Ditrio, Donald Vail, Dorothy Cimmino, DPina, Dr. Alice Farrell, Drew Lavallee, Elaine Agard (CHR CC), Ellender Mathis, Erica Aldieri, Frank e. Otter, Gabrielle Hall, GuerreV1, Holly H. KTP Admin, Celeste Flores, Isabel Gonillo, Jackie Cook, Jacquese C. Patterson, Jeana Bracey, Jennifer Abbatemarco, Jess Greenwood, Jo Hawke, Jules Calabro, Karen Delane, Karina Ordonez-Abad, Kassandrah Banks, khurdle, Kim Tanguay, Kristin Graham, Kymani Scarlett, Latasha Thomas, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Lois Berkowitz, Lyne Landry, M. Alex Geertsma, Maguena Deslandes, Mai Kader, Maria Brereton, Maureen O'Neil-Davis, Megan's Iphone, Melanie Wilde-Lane, Michael Wynne, Ms. Caldwell, Nan Arnstein, Nicole Szilagyi, Paula Patton, Penny Lemery, Paul Guerrero, Quiana Mayo, Rebekah Behan, Renee Wright, Ronnie Vollano, Rosemary Angulo Interpreter, Sabina Griffith, Sabra Mayo, Sam Galloway, Sam Taylor, Sandra Rivera, Sebastian Spencer, Sheila Figueroa, Shereffia Francis, Shi-maine Holmes, Solai's Demorest, Stacey Kabasakalian, Susan Rubino, Tammy MFCCC, Tania Santana, Tarsha, Taylor Ford, Tim Cunningham, Victoria O'Neil, Wanda Roman, Xavier Williams, Yolanda Stinson, Yvette Young, Zenaida Mora, Zosh Flammia, and seven phone numbers

Welcome and Introductions

- Meeting began at 10:03 am
- CBHAC's mission, purpose and priority areas were reviewed

CBHAC Committee Members Monthly Recap (December 2022)

- November 2022 meeting minutes were approved
- Members are in the process of updating CBHAC Bylaws to be more reflective of the work they are currently doing and how they move forward

Review of 2022 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

Agency Updates

1. **DMHAS - Jenn Abbatemarco**
    - DMHAS is seeing a growing number of young people between 18 and 25 in need of focused treatment surrounding significant histories of trauma particularly early childhood trauma
    - A request for proposal (RFP) was posted for a DBT intensive residential treatment program and a program was selected and that is now in the negotiation phase
    - January is Human Trafficking Awareness Month and we are working closely with our state agency partner Department of Children and Families (DCF) on several initiatives over this next year related to human trafficking
    - Two priority areas are expanding awareness and providing training to our staff within the department to develop a curriculum to implement with vulnerable youth
    - Individuals who are survivors of human trafficking historically are individuals who have faced discrimination, people of color, indigenous communities, people who identify as LGBTQ people struggling with chronic mental health issues, substance use trauma, unstable housing and poverty
    - There is a workgroup made up of members across the department from different divisions

- We will be rolling out expanded human trafficking specific training to our staff and will be looking at how to integrate screening and assessment tools into our intake assessments
- It is a gap we have identified in terms of our ability to identify individuals who may be victims of human trafficking and to get them the support that they need
- **Q**: Has it ever been considered that youth with trauma not have an inpatient stay that is locked down instead have more of an outpatient IOP so they are not traumatized again? **A**: There are individuals that go to Solnit but separate from that process we support young people in the community and there are not locked treatment settings
- A request for data on initiatives to be shared at CBHAC on resources that are in the community, because our priorities as a committee is to you know, have access to care, and we want to know about that care and how we can bring this back to our local communities and address that to support the State Departments' efforts
- **Q**: Where in the state is the DBT residential program going to be located? **A**: Southwestern part of the state

2. Department of Education – Cho-Ann Bobrowski

- That SDE provided superintendents with an excellent resource document for students, families. It contains information for educational safety, mental health and food security resources, technology resources, 211 as well as the 988 information
- It was distributed in English, Spanish, Portuguese, Haitian
- The distribution also fulfills a legislative requirement that schools have this resource and includes the DCF WRAP CT services so that they can distribute to families in September and April
- They were also distributed to students who attend health classes in high schools and is available on our website
- The $5 million ARPA grant fund for school mental health workers is to assist local regional, school districts and risks in hiring and retaining additional school social workers, school psychologists, school counselors, marriage and family counselors and school nurses
- During the month of December, applications were reviewed and a grantee should be announced soon
- In addition to this grant we will also be opening an application through our electronic grant management system for $15 million to include more roles for mental health workers such as trauma specialists, behavioral tech technicians, board certified behavioral analyst and licensed professional counselors
- The Hill behavioral health pilot grant is to supplement the existing efforts of schools at a district level
- Seven school districts are involved in this pilot and it helps them look at their own strengths and weaknesses by using a SHAPE assessment and identify any gaps and determined specific priorities show that they can support the mental health needs of the students
- There will be a summer grant opportunity opening probably in March or April to support, hire and retain mental health workers not only available for local or regional but will also be open to community based organizations and private schools
- **Q**: What are the seven school districts? **A**: New Hartford, Manchester Chaplin. Griswold, Highland charter, Norwalk and Killingly.

3. Department of Juvenile Justice Services – Carmen Hernandez

- RFP (Request for Proposal) for linking youth to natural communities went out last Friday, 12/30/22
- If there are any community agencies that are interested in getting more information or even bidding for this program they can find the necessary information on the judicial branch website https://www.jud.ct.gov/external/news/busopp/Default.htm

- You can also you can register there as well to receive notifications of all of our bid process or any programs
- We have a pre bidders conference for that particular program scheduled for January 10 at 9:30 via teams and I believe that you can find the link on the on the website
- CSSD also in the process of reviewing proposals and awarding an agency the transitional living residential program
- The region staff secure residential treatment program is also in the process of being awarded
- This program will be implementing dialectical behavior therapy for those youth in our residential programs
- Working on a new memorandum of agreement (MOA) with the Department of Mental Health and Addiction Services (DMHAS) to identify kids in the juvenile justice system early in the process so when they turn 18 there will already be services in place for them
- **Q**: Where will the staff secure residential treatment programs be located? **A**: Hartford, Bridgeport, Waterbury and Hamden
- **Q**: Are the facilities in Hartford and Bridgeport detention centers? **A**: Yes, they are housed there.
- **Q**: What are the differences between the locations compared to the detention centers in the state? **A**: The Waterbury center is run by Connecticut Junior Republic (CJR) the one in Hamden, Connecticut Partners in Action (CPA) they are staff secure versus the Bridgeport and Hartford where each room is locked
- A request was made for CSSD to come back to CBHAC and talk more specifically about the programs and who is directing them
- **Q**: Are there other MOAs with the other agencies that also potentially get involved with kids once they turn 18? **A**: Yes, we have MOAs with almost every other state agency

4. **Department of Social Services – no report**

5. **Department of Children and Families – Bethany Zorba**
   - The department has been working on some goals in reference to adoption and reunification
   - Pandemic did impact things related to both of these issues for families for example having children returned home because the courts were shut down for a long time
   - A very sensitive subject for many people is a need for permanency for children and some families have had to put children up for adoption
   - There have been 1150 children who have been adopted this year. Either adopted or through a transfer of guardianship to either other family members or persons known to the child and over 400 children have been reunified with their families
   - The department is very proud of the fact that we're keeping kids out of foster care, or keeping children with people that are known to them
   - **A**: How many children were removed in the same time period? What is the racial and ethnic breakdown of those children? **Q**: Information will be provided in the CBHAC notes.
   -
6. **Office of Early Childhood- no report**

Monthly Presentation- *CT Association School Based Health Centers by Dr. Melanie Wilde-Lane*

- **Q**: Are the school-based health center staff employees of the school? **A**: There are two types, we have parent organizations who hire and employ the school-based health center staff but may not be the host of the SBHC but some parent organizations are also the host so they could hire board of education staff
- **Q**: Which schools in the state are the school-based health centers located? **A**: There is a mapping tool on our website because there are approximately 230 centers that offer medical and mental health and 200 that offer only dental
- We've also done an are in the process of doing an Educating Practices school based health center learning module with Connecticut children's

- **Q**: This service does not replace the child's regular pediatrician? **A**: We collaborate with the child's professional medical or mental health provider.

Community Announcements

- None reported

Next meeting: February 03, 2023 10:00 a.m.

Voting Member Meeting 11am-12pm

1. Approval of minutes from previous month
2. Additional conversation carried over from 10am meeting re: data from state agencies. Planning for several presentations in next 6 months.
3. Additional CBHAC bylaws discussion. Small sub-committee formed and will meet in several weeks to finalize a draft for voting in February.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, April 14, 2023

Attendance: Adrianna Ramirez CTFSN, Alex Sargent, Alexandrino Rivera, Amy Marracino, Andre Gibbs, Arianna Alcorn, Benita Toussaint, Brenetta Henry, Briannali Rivera, Candida Mendoza (interpreter), Cara Manzari, Carmen Hernandez, Carmen Teresa Rosario, Catherine (?), Chlo-Anne Bobrowski, Christina Ghio, Crystal Williams, Cynthia Petronio-Vazquez, Damaris (Dami) Cox, Daniela Giordano, De Popkin, Deb Kelleher, Diana Perry, Donald Vail, Dr. Alice Farrell, Dr. Marie Spivey, Drew Lavallee, Ellender Mathis, Erica Garcia-Young, Falinda King, Frank Brady, Graciela Davila/ Graciella CT, Isabel Gonillo, James B, Judith Eisenberg, Jules Calabro, Karina CC, Kelly Waterhouse, Kymani Scarlett, Latasha Thomas, Lisa Palazzo, Lois Berkowitz, Lyne Landry, M. Alex Geertsma, Maguena Deslandes, Mai Kader, Mary Hryniewicz, Megan Thibault, Melissa Coan-Kremmel, Mike Garrett, Mikhela Hull, Nan Arnstein, Pam Williams, Paula Patton, Penny Lemery, Quiana Mayo, Renee Toper, Ronnie Vollano, Sabina Griffith, Sabra Mayo, Sandra Rivera, Sebastian Spencer, Shalamiesha Gilbert, Shi-maine Holmes, Solai Demorest, Sonia, Stacey Kabasakalian, Stephney Springer, Tania Santana, Tarsha, Theresa Andriulli, Tim Cunningham, T Nunez, V.Thaxter, Wanda Roman, Xavier Williams, Yolanda Stinson, Yvette Cortez, Yvonne Pallotto and eight phone numbers

Welcome and Introductions

- Meeting began at 10:02 am
- CBHAC's mission and purpose were reviewed

Review of 2023 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

March Voting Membership Business

- Approval of February minutes.
- Discussion of annual report recommendations and need for review over the coming months. Questions will also go out to Community Collaboratives.
- Discussion of upcoming changes to CBHAC invite. Zoom link will be updated. We thank FAVOR, Inc. for their technical support going forward. Update emails will be sent through CBHAC email list.

State Department Updates

1. **Department of Mental Health and addition Services (DMHAS) – Amy Marracino for Jenn Abbatemarco**
    - **a.** Expanding First Episode Psychosis (FEP) program in collaboration with Yale Specialized Treatment Early in Psychosis (STEP) program and Department of Children and Families (DCF). Developing statewide plan for FEP services. STEP has been internationally recognized for recent onset schizophrenia and early intervention programming. Goal to have early detection, assessment, and evaluation coordinators, one for each DMHAS region. Component of this program will include training, education, assessment, training for family members, and working with treatment providers for clinical trainings and consultation.
        - **i.** Q: Is outreach being done to juvenile justice system? A: will bring this to next workgroup meeting
        - **ii.** Q: Outreach to families? A: please share any ideas with Amy/DMHAS Amy.Marracino@ct.gov

iii. Idea: connect with school Parent Teacher Organization (PTO) meetings to reach parents
iv. Q: At what age can child be diagnosed? Early psychosis usually shows up later, not PreK, earliest usually early adolescence.

b. TurningPointCT website managed by Positive Directions. Looking for teens and young adults to share their voice for podcasts, articles, videos.
   i. April themes: alcohol, earth day and ecosystem awareness, autism awareness, national poetry month, stress awareness month, humor month, nutrition and wellness.
   ii. April podcasts: Connection between mental and physical health. why mental health terminology matters

2. Department of Education (SDE) – Chlo-Anne Bobrowski

a. Supporting Social and Emotional learning (SEL): SDE did scan of state regarding SEL. Recommendations for systems approach. Schools are starting to recognize that this is part of supporting student learning. Pilots include 7 school districts with significant investment, to work with Child Health and Development Institute (CHDI) and researchers from UConn and Yale, to conduct School Health Assessment and Performance Evaluation SHAPE assessments, thus reviewing strength and weaknesses, identify areas for potential growth, reviewing resources, supporting schools to provide assistance to students.
b. Behavioral Health pilot: school mental health worker grant, 23 recipients to increase staffing for social workers, psychologists, counselors. School Mental Health specialist grant still open until 4/20. American Rescue Plan Act (ARPA) mental health support, $8 million: mental health staff for summer programs and camps. This funding is pretty flexible of how camps can use them.
c. Regional Education Services Centers (RESC) trauma coordinators in each of SDE regions for training for schools. For information on how to contact your Regional Trauma Coordinator, or about UPLIFT: A Trauma-Informed Care Training Program for Schools, please visit this link: https://www.rescalliance.org/uplift
d. Noted that most of these programs come from funds that are ARPA, and thus one-time funds, and that the goal is to make sure this work gets sustained after these initial funds conclude.
e. Q: back orders on medications including Attention Deficit Hyperactivity Disorder (ADHD) medications. Are there programs for emergency and bridging time with other supports or services? C: Suggestions to look for alternative medications. Also noting hesitation by pediatricians to prescribe medications etc. and reiterated need to involve pediatric providers in identification of and connecting to supports

3. Department of Social Services (DSS) – Yvonne Pallotto

a. Telehalth guidance: bulletin with new guidance came out in March (2023/18), for beyond May 11th when public health emergency officially ends.
https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_18.pdf&URI=Bulletins/pb23_18.pdf
Telehealth services will be reimbursed at same rate as in-person services, for both audio-visual service and audio-services only. Written consent required for client/patient. Other rules continue to apply such as medical necessity etc. See CTDSS.map for more information.
b. Unwinding of public health emergency: 'Update Us so we can Update You' campaign. During next 12-18 months, monthly redeterminations will start up again on rolling basis for HUSKY members. Renewal notices have been going out and will continue to go out on rolling basis, via mail, email and phone calls for some more high-risk Medicaid

members. The federal government announced that the emergency declarations will end on May 11, 2023.

c. Covid 19 testing will continue beyond 5/11. Opioid Use Disorder treatment will not be affected.

d. Q: Concerns from parents on some codes, such as allowing for only one session/week Applied Behavior Analysis (ABA) services via telehealth. A: Can talk offline about this including where to submit written comments stating need for more frequent visits.

4. Department of Children and Families (DCF) – Yvette Cortez

a. DCF's role in FEP program, see DMHAS update above: children starting at age 16 with first episode psychosis, can also benefit, and helping with Mental Health Block Grant FEP spending and getting input from this group, including Yale and Carelon. Using algorithms to identify people to outreach to, for potentially more support also through STEP or other treatment providers, including based on medications prescribed

b. Question re: equitability also addressed by identifying youth who have Medicaid and include demographics

c. CBHAC Priorities: pediatric and behavioral health integration: working with Dr. Rogers from CT Children's Medical Center on offering trainings for pediatricians

d. Access to comprehensive array of services and support and Disparities and access to culturally appropriate care: funding some Culturally and Linguistically Appropriate Services (CLAS) work, and pushing in every single conversation if we are looking through the diversity lens: race, ethnicity, gender, language etc. Are people at table who represent the community? CBHAC is great example of diversity of people at table and bringing questions and ideas to bear.

e. When writing Mental Health Block Grant, also looking at identified gaps in services. This includes crisis services, such as new urgent care centers, which are on delay a bit partly due to facility permitting and other issues. Hope to have these services available in next couple of months.
Mobile Crisis was expanded to 24/7/365.

f. Q/suggestion: for FEP work, should be looking to earlier than 16 years of age, more like 13. A: based on research of brain development has been decided to start in later teen years as episodes of psychosis earlier are usually connected to other mental health diagnoses. And, supports and service as early as possible is critical, not matter what issue or diagnosis. Need to collaborate with providers such as pediatric primary care providers.

g. PRIME Psychosis Prodrome Research Clinic at Yale includes younger ages (ages 12 – 25) and also to prevent psychosis from developing in first place

h. Comment/question: don't have measures at earlier ages for later more serious mental health issues. Screenings in pediatric offices don't often lead to connection to services. Trying to figure out what causes that gap and how to address it. Also noted Medicaid Oversight Council (MAPOC) meeting later that day and Carelon presentation on behavioral health services.

i. During presentations with pediatricians, gap of information, understanding of the local mental health services available becomes apparent. Staff has shared Connecting to Care resources including website and regional resource lists, Access Mental Health and other resources. Acknowledged that more work needs to be done for this integration. We will have a more in-depth conversation about this topic.

j. Q: for children in Spanish speaking community, diagnosis of autism early in life and then later switched to psychosis and schizophrenia. A: acknowledging existing inequities in diagnosis and services based on race, ethnic and language etc. Not sure but may also apply to this particular situation of autism and psychosis.

k. Q: Are trainings available for early identification of children's needs? A: working with pediatric providers but also in education setting with schools, also as it relates to other needs impacting ability to learn and mental health such as access to nutritious food.

5. **Office of Early Childhood (OEC) – no report**

6. **Department of Juvenile Justice Services (CSSD) – presentation instead of update**

Monthly Presentation: Judicial Branch Court Support Services Division (CSSD) (see handouts)

Community Announcements

Next meeting: May 5th, 2023

Voting Member Minutes

Voting members did not have time meet.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, October 14, 2022

Attendance:
Abigail Pepin, Allyson Nadeau, Amanda Knef, Andre Gibbs, Aneta Szczpiorski, Antonia Edwards, Benita Toussaint, Beresford Wilson, Bethany Zorba, Brenetta Henry, Briannali Rivera, Cara Manzari, Carmen Teresa Rosario, Carol Campbell, Carolyn Westerholm, Celeste, Constance Capacchione, Cynthia Ratchelous, Daniela Giordano, Danielle Verderame, Darrin McCalla, Deb Kelleher, Diana Perry, Donaicis Alers, Donald Vail, Dorothy Cimmino, Dr. Marie Spivey, Drew Lavallee, Ellender Mathis, Elsa Cordova, Erica Aldieri, Erica Charles Davy, Esbeidy (interpreter), Gabrielle Hall, Glory Teix, GuerreV1, Isabel Gonillo, Ivette Diana, James Bethea, Jean Alberghini, Jeana Bracey, Jennifer Abbatemarco, Jennifer Foss, Jo Hawke, Judith Eisenberg, Jules Calabro, Julie DeMarco, Karen Delane, Katie Johnson, Keisha Martin-Velez, Kristin Graham, Kymani Scarlett, Latasha Thomas, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Lois Berkowitz, Luz Villfane, M. Alex Geertsma, Maguena Deslandes, Mai Kader, Maria, Maria Feliciano, Mary Sirochman, Maureen O'Neil-Davis (Family Forward), Michael Wynne, Ms. Caldwell, Nan Arnstein, Nicole Szilagyi, Patricia Gaylord, Penny Lemery, Paige Trevethan, Quiana Mayo, Rebecca Rowe, Rebekah Behan, Renee Wright, Ronnie Vollano, Sadie Witherspoon, Sabra Mayo, Sam Galloway, Sam Taylor, Sandra Rivera, Sara Carey, Sarah Kirchmann, Sebastian Spencer, Sheila Figueroa, Shereffia Francis, Shi-maine Holmes, Solai Demorest, Stacey Kabasakalian, Tania Santana, Tanja Larsen, Wanda Roman, Xavier Williams, Yvette Young, Zosh Flammia, and six phone numbers

Welcome and Introductions
- Meeting began at 10:02 a.m.
- CBHAC Mission and Purpose reviewed
- CT Association of School Based Health Centers presentation was postponed.

Review of 2022 Priority Areas
1. Pediatric primary care and behavioral health care integration
2. Disparities and access to culturally appropriate care
3. Access to comprehensive array of services and supports

Voting Membership Updates
- 6 vacant slots to be filled (4 parent, 2 provider)
- Plan to offer orientation morning of scheduled CBHAC meetings
- Goal to fill vacant positions by end of 2022, and monitor vacancies regularly moving forward
- Voting member engagement plan and regular meetings (updating member application, reviewing bylaws, supporting annual recommendations to DCF commissioner, etc.)
- If you are a voting member, you should have received separate communication about these updates and new structure. Starting today, voting members will join a breakout room after general business concludes to take care of voting member business. State Department representatives are voting members.

Agency Updates
1. **DMHAS – Jennifer Abbatemarco**
    - Commissioner Nancy Navaretta is committed to access to care as a priority area. September was National Recovery month, continued into October, also honored by being out in the community for public awareness regarding Narcan including handing out about 45,000 Narcan kits. Young adults particularly impacted by opioids. Outreach and engagement around Narcan and dangers of Fentanyl includes connections to treatment if needed.
    - Thoughtfully and strategically include young adult (YA) and youth voices into services also by collaborating with Youth Group National. Effort started with DMHAS staff and survey on agency/unit readiness on actively incorporating youth/YA into decision making

etc. New Central Advisory Board, with 20-30 members over half being YA, to work on how to better incorporate youth voice into policy as well as program changes at the treatment level. Will continue to report out as we move forward.

- Q & A: Are there YA of color, different ethnic backgrounds and representing other diversity aspects on the new advisory board? Ratio of African American and Hispanic youth on advisory board? Indigenous youth? Statewide breakout? A: There are YA of color, also representing rural and urban and suburban areas. Will get these different breakdowns at next meeting.
- Q: Looking for apprenticeships for people to get communities more involved, and for partnerships? A: Can connect via email Bethany.Zorba@ct.gov A: please also connect with local Community Collaboratives www.connectingtocarect.org/collaboratives/

2. Department of Education – no report due to no representative in attendance

3. **CT Judicial Branch, Court Support Services Division – Carmen Hernandez**

- Congregate CARE regions programs is out to bid. If anyone is interested, please go to the website to find out more information and apply www.jud.ct.gov/cssd/

4. Department of Social Services – Donaicis Alers

- Prior Authorizations for most outpatient services has been lifted for HUSKY members
- Q: only outpatient services? A: currently yes, but working on psychiatric evaluations as well
- Q: Does it apply for foster care kids also? A: Applies to all providers providing outpatient services
- Q: Having trouble with referral from one doctor to another. Does it apply? A: no, referral from doctor to doctor is different than and separate from prior authorization for specific number of units of treatment.
- Q: Are regional DSS offices open? A: Will get an answer.

5. Department of Children and Families – Bethany Zorba

- DCF Commissioner Vanessa Dorantes was on TODAY Show talking about racial justice and reduction of kids in care, exiting decades long consent decree, and vision for the department Link to Today Show's segment with Commissioner Dorantes https://twitter.com/CTDCF/status/1580226511000391685
- Statewide racial justice workgroup: bimonthly meetings with some family member participation. If there is interested in additional families joining, we can connect you. Bethany.Zorba@ct.gov Change in practice in development regarding department's response to racist situations when this occurs, including support for individual/s impacted and reparations.
- At CBHAC November meeting, DCF legislative liaison Vincent Russo will review the numerous recent legislative changes.
- Q: the workgroup mentioned, was that the health plan implementation advisory board? A: no, this is the department's specific racial justice workgroup
- Q: For children and youth 18 years of age, do they have a plan when they get out of the system? Concerned that they're getting into drugs, prostitution. A: When youth age out and have continued mental health concerns, usual referral to DMHAS services, young adult services. Once youth turn 18, services are voluntary. If in foster care, youth can receive services through age 21 if they chose to, including housing etc. We can have future presentation on this.
- Concern: foster care and opioid addiction. Q: Where are resources/monies going from new legislations passed? Example of Solnit staff shortages and functioning "like a holding

tank for kids." A: Services that were funded through legislation includes lengthy process of putting services out to bid, then contracting process, overall often 4-6 months process. Vinnie Russo will review passed legislation at next month's meeting. Offer to CBHAC attendees to submit questions to CBHAC co-chairs or Bethany to share with Vinnie.
- Related comment to question of how funding is being used: Can we utilize funds to build out respite services? A: developing behavioral health urgent care and subacute program to divert from emergency departments. Additional funds for care coordination respite funds. We can get more details. We can research more specific Solnit questions.
- Q: what type of compensation are families getting for racial justice workgroup participation? A: Can ask, but don't think there is financial compensation.
- Comment/Q: not adequate placements for higher levels of care to meet kids needs A: previous department focus on making sure kids are not in residential care that don't need that level of care, thus great reduction in this service level. May see some increase there. This is also coupled with concerns about some of these monies being time limited to next two years or so, and how to sustain services beyond that.

6. **Office of Early Childhood – no report**
    - Bethany will also connect with other state departments

CBHAC Business

- Review of slides on reginal resource lists, websites, social media platforms, mobile crisis, suicide prevention resources. For opportunities to connect with and get involved with systems of care/networks of care on local and regional level, please reach out to Network of Care Managers (Beacon Health Options) and Family Systems Managers (FAVOR, Inc.) and have your voice heard.
- Connect with co-chairs Gabrielle Hall gabrielle.hall@beaconhealthoptions.com or Nan Arnstein narnstein@creativeartsdm.org with any ideas, follow up questions etc. Please add "CBHAC Follow-Up" in the email subject line.
- Note: voting members were requested to stay on for member business via going into a breakout room. Family members were requested to stay on to ensure attendance was noted for stipends via FAVOR, Inc. staff.

Next meeting: November 4, 2022

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, November 4, 2022

Attendance: Alexandrino Rivera, Amy Hilario, Andre Gibbs, Andrea Goetz, Andrew Lavallee, Ann Petitti, Antonia Edwards, Benita Toussiant, Bethany Zorba, Briannali Rivera, Cara Manzari, Carmen Hernandez, Carmen Teresa Rosario, Cindy Crusto, Constance Capacchione, Damaris (Dami) Cox, Daniela Giordano, Danielle Verderame, Darrin McCalla, Donaicis Alers, Donald Vail, Doriana Vicedomini, Dorothy Cimmino, Dr. Marie Spivey, Elana, Eleanor Farrell, Elsa Cordova, Erica Aldieri, Erica Charles, Frank Gregory, Gabrielle Hall, GalaxyPhone, GuerreV1, iCeleste (Celeste Flores), Jacquese C. Patterson, James Bethea, Jennifer Abbatemarco, Jennifer Foss, Jenny Bridges, Jo Hawke, JoShanda Guerrier, Judith Eisenberg, Jules Calabro, Kelli Price, Kristin Graham, Kymani Scarlett, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Liz Rember, Lois Berkowitz, Lyne Landry, M. Alex Geertsma, Mai Kader, Maria Dezi, Maria Feliciano, Mary Hryniewicz, Mary Pike, Maureen O'Neil-Davis, Melissa Kremmel, Nan Arnstein, Nicole Szilagyi, Patricia Gaylord, Penny Lemery, pguerrero, ptrevethan, Quiana Mayo, Rebekah Behan, Ronnie Vollano, Sabina Griffith, Sabra Mayo, Sam Galloway, Sandra Rivera, Sara Carey, Sarah Kirchmann, Sebastian Spencer, Shereffia Francis, Shi-maine Holmes, Solai's Demorest, Stephney Springer, Susan Rubino, Tania Santana, Tarsha, Tim Cunningham, Tim Marshall, Vinn Russo, Wanda Roman, Xavier Williams, Yrama Lopez-Interpreter, Yvette Young, 1203----343, zz 1203----492, zz 1860----273, zz203----782

Welcome and Introductions

- Meeting began 10:06 a.m.
- Reviewed CBHAC mission, purpose and priority areas
- Review of meeting structure: new member orientation will take place before the meeting, presentations, state department updates and announcements from 10-11. Then CBHAC voting members will join breakout room for business meeting 11-12 p.m.
- There are currently six vacant CBHAC member slots available contact co-chairs Gabrielle Hall or Nan Arnstein for further information
- During last meeting's CBHAC, voting members reviewed the membership application that will be available in a fillable Microsoft Word document. Members also reviewing and providing feedback for the annual report.

Review of 2022 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

Agency Updates

1. **DMHAS - Jenn Abbatemarco**

- Update on social media campaign around mental health resources and 988. In the process of choosing a vendor. Goal of the campaign is to outreach to underserved/underrepresented groups in CT.
- DMHAS working with DCF to develop messaging around safe environments for children due to the proliferation of fentanyl
- F/U from a question last month: Of 15 young adults who have been partnering and developing youth led, youth driven advisory councils in all of the young adult services programs statewide, seven identify as black, four identify as Hispanic and four identify as white, non-Hispanic. DMHAS realized there was no category that represented indigenous. This has been added to the form moving forward.

2. **Department of Education - no update**
3. **Department of Juvenile Justice Services – Carmen Hernandez- present but no update**
4. **Department of Social Services – Donaicis Alers**

- DSS is currently moving the process along for the post public health emergency and they are asking all Husky members to update their information as they will be disseminating redetermination paperwork which was not required during the public health emergency.
- Individuals that have Husky A, Husky B, or Husky D must update their information via access health website and those members that have Husky C must update their information via DSS website

5. **Department of Children and Families – Bethany Zorba- updates given during presentation**

6. **Office of Early Childhood- no update**

Monthly Presentation by Vincent Russo and Dr. Frank Gregory, DCF Legislative Update (see handout)

- **Q**: This would undoubtable increase current mental health workers workload; will the funding support a higher level of income for current and/or new hires to support this initiative? **A:** There are many grants that can be used to hire additional specialists. DSS continues to work with the federal government and DCF trying to see if we get some additional increases through them for reimbursement purposes that could help offset some of those additional costs
- **Q**: What is being done about the current crisis with mental health facilities with our youth in extreme crisis? where have the previous funds been spent to combat the issues? **A:** In the emergency departments we have established care coordinators and intensive treatment coordination through several providers to help families and kids find access outside of the hospital. We are in the process now of starting up our urgent crisis centers and our stabilization centers.

- **Q**: Where will the Urgent Crisis Centers be located? **A**: Hartford, New Haven, Waterbury and in the East. They will be open 24/7.

- **Q**: How does Family First Act objectives and its reimbursement funding model tie in or inform the latest DCF goals and budget? **A**: There is a lot of overlap but there are also distinctions. Families First in general provides supports and services in a preventive way to families so that services can be secured without coming into the child welfare system.

Community Announcements- none

Next meeting: December 02, 2022 10:00 a.m.

Voting Member Meeting Minutes

Agenda

1. Approval of minutes from October-**completed**
   Moving forward, voting member meeting summary will be included with regular meeting minutes.
2. Voting for new members-**one application received and reviewed with group. Completed.**
   Zoom voting poll will be used moving forward so members can vote anonymously.
3. Annual report comments, feedback, and sharing with legislators.-**completed**
   No additional feedback at this time.
4. Priorities-**completed**
   Discussion related to annual voting on top three priority areas. Further discussion at December main meeting.

5. Bylaws
   Group will receive the bylaws again via email and further discussion is planned for December voting member meeting.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, December 2, 2022

Attendance: Abigail Pepin, Adrianna Ramirez, Alexandrino Rivera, Alice DeMeo, Amanda Knef, Amy Marracino, Andre Gibbs, Andrea Richardson, Ann Petitti, Antonia Edwards, Benita Toussaint, Beresford Wilson, Bonilla Tamara, Briannali Rivera, Cara Manzari, Carmen Hernandez, Carmen Teresa Rosario, Chlo-Anne Bobrowski, Constance Capacchione, Dana Bossio, Daniela Giordano, Danielle Verderame, Darrin McCalla, Doriana Vicedomini, Dorothy Cimmino, DPina, Drew Lavallee, Ellender Mathis, Erica Charles Davy, Frank e. Otter, Gabrielle Hall, Ginny, iCeleste (Celeste Flores), Jacquese C. Patterson, Jeana Bracey, Jenny Bridges, Jess Greenwood, Jo Hawke, Judith Eisenberg, Jules Calabro, Julie DeMarco, Karen Delane, Kassandrah Banks, Keisha Martin-Velez, Kristin Graham, Kymani Scarlett, Linda, Lindsay Kyle, Lisa Girard, Lisa Palazzo, Llina Hilario, Lois Berkowitz, Lyne Landry, M. Alex Geertsma, Mai Kader, Maria Feliciano, Mary Sirochman, Melanie Wilde-Lane, Nan Arnstein, Neva Caldwell, Penny Lemery, pguerrero, ptrevethan, Quiana Mayo, Rachael Guthrie, Rebekah Behan, Sam Galloway, Sandra Rivera, Sarah Hornberger, Sebastian Spencer, Sheila Figueroa, Shereffia Francis, Shi-maine Holmes, Solai's Demorest, Susan Rubino, Tamara Olicoeur, Tania Santana, Tanja Larsen, Tarsha, Taylor Ford, Theresa Andriulli, Tim Cunningham, Tyrone Calloway, Wanda Roman, Xavier Williams, Yolanda Stinson, and three numbers

Welcome and Introductions

- Meeting began at 10:03 a.m.
- CBHAC Mission, purpose and priority areas were reviewed
- During November's meeting CBHAC members discussed to include voting member summary in minutes that was sent to distribution list
- Congratulations to new CBHAC member Yolanda Stinson
- There are still some member vacancies: two providers and three family member slots
- If anyone is interested forward an email to Gabrielle Hall or Nan Arnstein subject line CBHAC application and they will forward application to you
- Discussed the annual report and the report was completed and submitted to the DCF Commissioner Duran
- Discussed annual voting on the top three priority areas
- During this month's meeting members plan to review the bylaws and make updates

Review of 2022 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

Agency Updates

1. **DMHAS – Amy Marracino**
    - A Request For Proposal for a Dialectical Behavior Therapy (DBT) residential program for young adults has been put out by DMHAS
    - This would be the first specialized program that will be focusing on DBT for young adults and really help young adults with very significant trauma histories and significant related challenges
    - There is a new agency working with EA Sports called Affinity eSports located in the Newtown area it was developed by Mark Kilpatrick
    - He's developed this organization that allows children, adolescents and young adults, who are involved with video gaming to help them engage in that activity in a very positive pro social way
    - Groups are offered on site to really teach them how to engage through video games in a positive way, they do a lot of team building activities
    - DMHAS has also established a new partnership with the Connecticut Association of Schools, the Connecticut interscholastic Athletic Conference to provide mental health and substance use resources to high school students, athletic directors, parents and coaches

- This partnership is going to help increase access to critical resources to help with both preventing and responding to youth mental health and substance use issues which I know has been so incredibly prevalent
- DHMAS has been involved in something called sequential intercept, model mapping
- It is a collaboration of our departments forensic division partnered with our young adult services division and partnered with our CEO of Southwest Connecticut mental health center to work with the Fairfield Police Department
- It involves stakeholders from a number of disciplines and providers from state and local mental health addiction resources, hospitals, criminal justice and parole
- The collaborative working on a two day workshop with the Fairfield Police Department looking at individuals who have been arrested, adjudicated and released while experiencing co-occurring mental health and substance disorders
- The goal of analyzing the process was to identify gaps and services, both short and long term care to look at ways to problem solve around these issues and reducing recidivism, reducing suicides and death by overdose by making sure that individuals are getting their basic needs met to prevent bad outcomes

2. **Department of Education – Chlo-Anne Bobrowski, Education Manager for health and family services with the Department of Education**
   - This is the final year of the five year grant from SAMHSA for three school districts regarding Project AWARE (Naugatuck Windham, and Middletown) have received funding in assessing their strengths and weaknesses in their behavioral health and screening for the students
   - It includes staff training so they can perform screenings for students. The data that is collected is looks for number of resources available in order to connect students to outside community based organizations and provide any kind of behavioral health services within the district
   - An additional program developed based on the lessons learned from Project AWARE we are launching a behavioral health pilot that is going to include seven different districts
   - Department of Education received $5 million for a school mental health worker grant. There were 92 applications
   - There is an updated NARCAN guidance as of December that was distributed to the superintendent, superintendents and LEAs for the storage and administration of NARCAN in all schools, which includes elementary, middle and high school
   - We want to thank the regional behavioral action organizations for their assistance with this update
   - **Q**: What towns were involved the Project Aware? there was no announcement in Hartford? **A:** Project AWARE was not in Hartford it was a pilot program in three small districts (Naugatuck Windham, and Middletown)
   - **Q**: It is going to be expanded to other districts now that the pilot program is over? **A**: Yes to seven more school districts.

3. **Department of Juvenile Justice Services – Carmen Hernandez**
   - Effective January 2023, delinquency cases that are referred to the juvenile court will be screened to assess the client's risk to recidivate (risk for them to be re-arrested)
   - The results of this screen will be used to determine whether the case will be directed to the community for services in the community, or if they will be handled administratively with the juvenile probation officer or if they're going to go in front of a judge and be handled judicially
   - This process is known as a risk based case handling
   - Cases coming into the courts will be screened by a probation officer who will administer a validated script tool or assessment called the Prospective Risk Evaluation for delinquency in Connecticut
   - The new is intended to ensure that the clients with the highest risk to recidivate will receive intensive services from the court and

- Those that have lower risk to recidivate will be the services addressed in the community rather than that the youth coming into the court system
- CSSD is also hoping that using the validated tool will lower the potential impact of bias or on decision making
- **Q**: Is everyone going to be participating in this assessment? **A**: Only those that are arrested and have to go into court will be assessed and it's only done by probation officers
- **Q**: Can you tell me what CSSD or what the judicial branch has done to enhance the community based services that children will be referred to? **A:** Those community-based services are not funded by CSSD and the reason why we divert kids to those existing programs is so that they do not have to come into the court programs and be in the system. This is all pre-adjudication.

4. Department of Social Services – Donaicis Alers- no update

5. Department of Children and Families – Alice Demeo for Bethany Zorba- no updates

6. Office of Early Childhood- Rachel Guthrie for Ashley McAuliffe

- The Universal Home Visiting program contractor was selected after a competitive RFP process. Bridgeport Hospital in conjunction with many other community partners will be implementing the family connects international model for Connecticut universal nurse home visiting pilot program
- Hoping to begin serving families in the first half of 2023 as they move through mode requirements
- Sparkler application available in English and Spanish. This application helps to support health early childhood development through tracking tools that monitor children's social emotional, cognitive communication, physical development
- That includes the Ages and Stages questionnaires, and it also supplies families and home visiting providers with activities that help the parents and caregivers support their children's development
- In 2020 is when the Connecticut home visiting system piloted the sparkler application and at that time, it was only piloted to five Connecticut communities which included Stanford, Danbury, Manchester, Manchester Bristol and New Haven
- Things were learned and in October 2021 sparkler became available for all children and families in CT at no cost
- At the end of 2021, there were 6820 children enrolled in the sparkler application, which was an increase of 2009 from December of 2020. Additionally, 89% of families engaged and played in the sparkler activities and rated them and said that their children had been playing with them and that they were appropriate for their children's age and they enjoyed doing it
- The Birth to Three program continues to accept referrals to determine if the child is eligible to receive specific services to help with the growth and development in all area
- OEC continues to partner with natural touch which is a doula service, to train home visitors to become doula certified themselves
- Implementing a new learning management system called Canvas. We are currently in the developmental stage to ensure professional development opportunities are available to children, care providers birth to three providers, home visiting providers and many others
- OEC previously received the preschool development grant funding also known as PDG funding and intends to pursue additional funding that has come out to continue innovative work in the early childhood

Monthly Presentation (none)

CBHAC Voting Member Summary from November

- Talked about the priority areas and system transformation
- Priority areas need to stay the same for a minimum of three years as they go through a legislation process and that takes time

- As we are restructuring and building see back in this virtual platform and since the pandemic we are building our membership
- CBHAC members who are legislatively appointed to contact their legislators and make sure there's strong communication back and forth after each meeting
- CBHAC will be tracking some data specific to the priority areas/goals to share in the future
- CBHAC members are willing to be peers to other families that may be interested in joining

Community Announcements

- People who need more information or want to learn how to get involved can also reach out to their regional NOC managers from Beacon and their regional FSMs from FAVOR

Next meeting: January 6, 2023

December Voting Member Meeting

- Approved November meeting minutes
- Review of CBHAC bylaws document. Some discussion of specific sections needing editing. Plan to review further in the next few months.
- Will enable Zoom live transcript feature for upcoming meetings.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, May 5, 2023

Attendance:

Welcome and Introductions

- Meeting began at 10:04 am
- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022 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 2023)

Agency Updates

1. **DMHAS - Jenn Abbatemarco (not present but update to be included in minutes)** partnering with TurningPointCT for Mental Health Awareness month. Self-care and mental health wellbeing will be the themes of focus. Educational podcasts and social media videos will be available throughout the month which can be accessed via the TurningPointCT.org website (this relates to Priority Area #3). Additionally, DMHAS, along with other state agencies, will be participating in the CT Equity Study. This equity study will focus on key challenges and opportunities to improve equity, existing equity initiatives in the agency, organizational culture and equity, communication and relationships with stakeholders, and data collection/analysis/reporting. DMHAS YAS has been one of the programs identified to participate in this study (this fits under Priority Area #2).

2. **Department of Education – Chlo Ann B.**
   - The 2nd round of school mental health worker grant has concluded ($15 million grant and we had 109 applications); will fund 60 recipients and announcements will be made at end of May.
   - The summer mental health worker grant available for camps, private schools ($8 million grant) is being published via an electronic management system in the upcoming weeks
   - Partnering with The Right Alliance to seek a $1.2 million grant for risk trauma coordinators
   - On 5/10 SDE members along will participating on a SEL (Social Emotional Learning) listening tour in select districts which includes Stafford Springs, and three schools with our Connecticut technical schools

3. **Department of Juvenile Justice Services –no representative**

4. **Department of Social Services – Donaicis Alers**
   - May 12 is official unwinding day for all COVID-19 pandemic
   - A bulletin has been created and will address location of provider and member rendering telehealth services
   - The bulletin will be accompanied by Frequently Asked Questions and TSS maps website information

5. **Department of Children and Families –Bethany Zorba**
   - Partnering with the Judicial Branch to support CHDI in hosting the evidence based practice conference on May 25, 2023
   - This year's theme is Rebuilding Children's Behavioral Health through Innovation

- Registration still open but for the wait list at this time; link is in the chat
- Bethany working with new Supervisor Dr. Stephanie Bozak

6. **Office of Early Childhood-no report**

Monthly Presentation- RESC (Regional Educational Service Centers) Diana Perry & Tianna Hill from LEARN
(see handouts)

- **Q:** Is it mandatory for school districts to participate? **A:** It is voluntary currently no state mandate
- **Q:** Is this initiative taking into account the spiritual component of trauma informed care? **A**: Not specifically but it is a part of that culture, gender, and other historical issues embedded into every module
- Participants were encouraged to reach out directly with to Learn on ideas on how to be more inclusive of other components such as the spiritual example to assist with development
- **Q**: How many schools in Connecticut have taken up this opportunity? **A**: Approximately 13-14 districts have contacted them with questions
- **Q**: How can individuals get involved? **A**: By participating in presentations and there will be a train the trainer program. If anyone is interested fill out an intake form that was shared in the chat
- **Q**: Who will be helping providers, school personnel individuals on how to deal with secondary trauma? **A**: Leadership orientation is part of the program and the centers will be offering that support

2nd presentation- Urban Trauma Provider Network presented by Emmanuel Silva Sosa (see handouts)

- **Q**: Does this program help youth who get involved with juvenile/criminal justice system? **A**: The program is focused with training clinicians at the moment but it is great idea for the future

Community Announcements
-none reported

<u>Voting Member Meeting</u>

Voting mbrs: 12 total

- Review of mbr application and vote. Orientation needed for two new members. Goal to complete by June meeting
- July-keep meeting as scheduled, possibly have shorter meeting. Voting mbrs can still meet. Gab away. Will reconsider for future years taking July off
- Review of orientation. Questions to members about subcommittees and membership. What should the focus be now in the short term? Build membership or restart subcommittees? Need to consider DEI in voting membership makeup. Chairs and DCF will review the list, roles, and need for legislative appointees. Should group look at areas/regions/towns represented to make sure there is equal representation?

Next meeting: June 02, 2023

Comité Asesor en Salud Conductual Infantil (CBHAC)
Acta - Viernes, 07 de julio de 2023

Asistencia:

Bienvenida y presentaciones

- La reunión comenzó a las 10:05 a. m.
- 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 2023

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 (junio de 2023)

- Ver las diapositivas de PowerPoint

Actualizaciones de las agencias

1. **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS, por sus siglas en inglés) - Jenn Abbatemarco**
   - Se ha presentado una solicitud de propuesta (RFP, por sus siglas en inglés) para un Centro de tratamiento para una estabilización rápida (RSTC, por sus siglas en inglés) para un centro de 23 horas y se busca ubicarlo en Bridgeport o New Haven. Esto es para ayudar con el acceso a la atención, ofreciendo un mayor acceso al tratamiento de salud mental y de consumo de sustancias.
   - El programa estatal para el tratamiento del primer episodio de psicosis (STEP, por sus siglas en inglés) en colaboración con Yale y el Departamento de Niños y Familias se está expandiendo, y hemos podido comenzar a contratar coordinadores de evaluación y detección temprana
   - P: ¿Qué está haciendo el DMHAS para abordar las desigualdades en sistemas y servicios? R: En términos del STEP, estamos haciendo este lanzamiento para todas las regiones; proveedores solo asegúrense de que las personas estén al tanto de los servicios que se brindan allí para recibir comentarios sobre las áreas que podríamos estar pasando por alto a fin de mejorar este recurso.

2. **Departamento de Educación – Chlo-Ann B. (no hay informe)**

3. **Departamento de Servicios de Justicia de Menores - Barbara Lanza**
   - La División de Servicios de Apoyo Judicial (CSSD, por sus siglas en inglés) aún está trabajando en el presupuesto, por lo que no hay actualizaciones al respecto
   - A partir de julio, los agentes de libertad condicional para adultos y menores ahora llevarán naloxona a todas las visitas domiciliarias
   - Prevemos que el programa residencial intermedio para mujeres adolescentes estará abierto a partir del 1 de septiembre. Se adjudicó el contrato a Community Solutions Incorporated y actualmente están renovando su edificio, así como reclutando, contratando y capacitando personal
   - El programa, anteriormente conocido como Track Therapeutic respite and Assessment Center (un centro con ocho camas para chicos), ahora tiene un proveedor de servicios diferente llamado Community diversion and respite centers. Dispondrá de 14 camas para chicos en lugar de 8 gestionadas por CJR
   - P: ¿Dónde están ubicados los programas residenciales para chicas? R: Plainville, Connecticut
   - P: ¿Por qué el personal llevará naloxona a las visitas domiciliarias? R: Es una medida de precaución para salvar potencialmente la vida de una persona, ya que hace unas semanas una

persona en uno de nuestros programas residenciales sufrió una sobredosis y fue salvada por otra que tenía naloxona

4. **Departamento de Servicios Sociales - Donaicis Alers**
   - Nuestro contrato de transporte médico no de emergencia (NEMT, por sus siglas en inglés) se ha extendido hasta el 3/1/2024
   - Los servicios dentales de Husky se están ampliando de dos maneras: ofreciendo servicios bucodentales y cobertura para niños indocumentados de 12 años, para que reciban servicios dentales en virtud de ese patrocinador
   - P: ¿Por qué se sigue prorrogando el contrato de Veyo cuando hay quejas y no ha pasado a audiencia pública? R: Veyo fue comprada el verano pasado por NPM y ahora está haciendo una transición a los servicios de transporte médico. Su plataforma es mucho más grande y puede proporcionar más servicios que comenzarán en marzo.
   - Comentario del público: Se pidió que las actas de las reuniones no fueran depuradas y que reflejaran la preocupación del público. Hubo muchos comentarios de que el público está realmente preocupado por la falta de responsabilidad de Veyo y la compra por parte de NPM sin una solicitud de propuesta, comentarios o aportes del público, ya que afecta a aquellos que tienen que depender del servicio y no han podido utilizarlo debido a los muchos problemas que tienen
   - P: ¿Habrá participación pública en la solicitud de propuestas para emergencias no médicas? R: Sí, ese es el objetivo
   - Comentario del público: Tiene que haber más representación de los conductores en el contrato de transporte médico. También hay un gran problema con el reembolso del kilometraje a los familiares o amigos que transportan a otras personas a citas médicas. El proceso está estropeado y no funciona ni tiene sentido en términos de acceso, especialmente para los que viven en comunidades rurales. El Consejo de Medicaid debería tomarse muy en serio estas preocupaciones, ya que proceden directamente de los consumidores del CBHAC.
   - P: ¿Puede venir el agente de transporte médico y hacer una presentación para que conozcan las barreras y los desafíos? R: Se compartió información en el chat sobre dónde encontrar información sobre NEMT. El CBHAC considerará si una presentación tiene sentido en el CBHAC o compartirá las oportunidades existentes de defensa de NEMT con el grupo del CBHAC.
5. **Departamento de Niños y Familias –Stephanie Bozak**
   - Dos Centros de crisis urgentes (UCC, por sus siglas en inglés) abiertos: Wellmore de 6 a. m. a 10 p. m., de lunes a viernes, y Child and Family Agency (CFA) abierto de 8 a. m. a 4 p. m. El Village for Families and Children abrirá el 10 de julio y su horario previsto es de 7 a. m. a 11 p. m.
   - P: ¿Cómo están funcionando hasta ahora los UCC? R: Muy pocos clientes porque acaban de abrir, pero van bien
   - P: ¿Hay datos que reflejen cómo se está apoyando a los niños bajo el cuidado del DCF en términos de educación? ¿Se están abordando las desigualdades para disminuir la brecha? R: El DCF le pidió a la persona que hizo esta pregunta que enviara un correo electrónico para conectarla con el Administrador del DCF sobre nuestros Apoyos Educativos para responder esto.
   - Comentario del público: El CBHAC u otro cuerpo legislativo debería prestar atención a que el DCF no quiere continuar financiando más que con los fondos de la Ley del Plan de Rescate Estadounidense (ARPA, por sus siglas en inglés) para continuar financiando Child First. Este programa es un programa crucial para los padres que sufren depresión con niños pequeños y es una vergüenza que como estado dejemos que este programa se desperdicie. A las agencias que recibieron los fondos de ARPA se les ha dicho que los fondos se han agotado.
   - Según el DCF, actualmente el DCF está utilizando los fondos de ARPA para financiar los programas Child First que fueron contratados previamente a través de la OEC. Una vez que los fondos de ARPA se consumen, sin embargo, el presupuesto del Estado no continúa financiando

estos equipos de Child First, aunque los equipos originalmente contratados de Child First a través del DCF permanecerán intactos.

6. **Oficina de la Primera Infancia- Lindsey Brennan (presente pero las actualizaciones se compartieron después de la reunión por falta de tiempo)**
    - La OEC pasó el mes de junio cerrando el año fiscal
    - La OEC sigue dirigiendo los esfuerzos del Panel selecto, y muchos grupos de trabajo celebran reuniones semanales, así como sesiones periódicas de audiencias para recabar opiniones a medida que el panel elabora recomendaciones.
    - El campamento de verano Sparkler ha comenzado para las familias de visitas domiciliarias. Funciona semanalmente hasta finales de agosto (8 semanas). El campamento se centra en cuentos populares e historias de narradores y actividades.

Presentaciones mensuales - CHDI
(ver folletos)

Anuncios a la comunidad-ninguno

Reunión de miembros con derecho a voto (no habrá reunión por falta de tiempo)

Próxima reunión: 1 de septiembre.

Children's Behavioral Health Advisory Committee (CBHAC)
Minutes – Friday, June 02, 2023

Attendance: (Filled in after minutes translated to Spanish)

Welcome and Introductions

- Meeting began at 10:03 am
- CBHAC's mission, purpose and priority areas were reviewed

Review of 2022 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 2023)

- A new parent member was voting in
- Discussed upcoming meetings and schedule
- No August CBHAC meeting
- Ongoing discussions around voting membership and current vacancies
- If you are interested in being a voting member reach out to Gabrielle Hall or Nan Arnstein and they will send application form

Agency Updates

1. **DMHAS - Jenn Abbatemarco (see presentation section for update)**

2. **Department of Education – Chlo Ann B. (no report)**

3. **Department of Juvenile Justice Services – Barbara Lanza**

   - End of fiscal year- finalizing budgets and sending out agreements for new fiscal year
   - A community-based programs was recently awarded the Link program (linking youth to natural communities). We awarded 11 contracts across the state through that RFP
   - July 1st start date for the Multi-systemic therapy New MST contract provider. Working in collaboration with DCF
   - MST contract is ending June 30. With CSSD, DCF has put out an RFP (request for proposal)
   - We also have awarded our FEAR program which is our adolescent female intermediate residential program. Awarded to Community Solutions Incorporated in Plainville and will begin to accept referrals in September
   - Q: Are there any type of programs being put in place for youth? A: There is a motor vehicle diversion program which is located within the link program.
   - Q: Is there any data listed on race and ethnicity as far as these groups that being referred to these link programs? A: Yes.

4. **Department of Social Services – Donaicis Alers/ S. Williams**
   - Still going through the pandemic unwinding process
   - Updated telehealth information on the www.ct.gov/dss
   - DSS working on the provision of services at school based health centers more information to come

5. **Department of Children and Families –Stephanie Bozak**

- DCF is working with all four agencies contracted for the Urgent Crisis Centers (UCCs)
- Each agency has a slightly different timeline of when they might open but there is a ribbon cutting that is scheduled for Wellmore this month
- Connecticut received data which showed that our 988 calls have a 94% answer rate putting us in top three states which also relates to the mobile crisis response times
- The department is also working with Urban Trauma LLC, to train clinicians with an anticipation that they're going to be start taking clients towards the end of this month

6. Office of Early Childhood- Lindsey Brennan

- The Universal Home Visiting contract has been signed with Bridgeport Hospital and staff are starting to go through the family connects training. Once that training is complete, then they will be able to start seeing clients, no official start date.
- Home Visiting is continuing to work through the Medicaid process to help expand the services to more children and families
- Working with social finance to create a customized referral document that can be filled out during the WIC appointment and then be sent to OEC for follow up with the families
- Deciding which would be the best region to pilot this referral process and then first Sparkler so we're going to be releasing an RFP request for proposals for up to 20 communities to receive funding to help implement the Sparkler tool and assessments with their families and programs

Monthly Presentation- DMHAS - Jenn Abbatemarco & Amy Messina
(see handouts)

- What type of supports are given to young adults when they are in housing? A: It depends on what they need at the time of discharge but they will work with a transition team
- A comment was made that some young adults may fall through the cracks and they will need someone closely supporting them
- Young adults are followed in any type of a supervised housing situation and the level of care, really focuses on life skills development to prepare for independent living at both the six month and 12 month

Community Announcements

- The Consumer Youth and Family Advisory Council is going to be sending out a save the date for the 8th annual iCan conference. Currently looking for sponsors
- Family forward advocacy Connecticut is hosting its fourth parent resiliency workshop this Saturday 06/03/2023 from 10am to 12 at the Berlin Peck Memorial Library. Presentation by Dr. Laura Langston and Attorney Lisa Vincent
- The Hartford Public Library on Main Street is undergoing renovations but people can go to the one on Albany Ave and Blue Hills Ave to get help with the citizenship and/or the summer programs

Voting member meeting 11am-12pm

- Review of voting members and plan to fill legislative appointment vacancies through legislators. DCF to support and letters will go out to legislators re: current appointments and vacancies.
- For all legislative appointees, meeting minutes will be emailed to the legislators and appointees will be copied moving forward. Annual report will also be shared.
- Some discussion around a recommendation for the annual report related to collaboration across state departments when creating new programs and services.
- Voting members agreed presentations not necessary every month. This will allow time for voting member business. Information can be shared via CBHAC email distribution if

not through presentations. Will continue to seek input from attendees about relevant presentation topics.

Next meeting: July 7, 2023

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	March 30, 2023 | 2:00 – 3:30 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Elsa Ward, Allison Nadeau, Allison Fulton, Frank Gregory, Pam Mautte, Michaela Fissel, Angela Duhaime	
Staff Present:	Kyle Barrette, Chrishaun Jackson, Liz Feder, Erika Echeverria, Sarju Shah	
AGENDA ITEM:		**ACTION**
New Chair Appointment	Angela Duhaime, Executive Director of SERAC, appointed as the Adult Behavioral Health Planning Council Chair	
Block Grant Update: Kyle Barrette, Block Grant State Planner	The Combined Block Grant application is due by September 1, 2023. This will include a full assessment of the strengths, capacity, gaps, and needs of the overall behavioral health system, which will be reviewed by the Planning Council and submitted to SAMHSA. The assessment will inform DMHAS plans for the block grants. We plan to have the RBHAO regional priority reports and the statewide synthesis report from CPES to present and discuss at the next Planning Council meeting. We plan to create a survey for council members to participate in that asks about the gaps and needs across our system, so that Council member voices can be included in the gaps/needs assessment submitted as part of the block grant application. ▪ **Allison Fulton** suggested to pull questions from the guidance document that the RBHAOs are using to complete their regional priority reports. These questions are related to mental health, substance misuse, and problem gambling. ▪ **Michaela Fissel** voiced her opinion regarding nonprofit organizations who may rarely be involved in the process and that this would be a chance to hear "their" voice. SAMHSA requires that states identify priority areas to work on as part of the application. These areas are identified through goals/objectives that are developed around each of the priority populations of the BG *(see attached power point)*. Planning Council to review discuss goals/objectives during next Planning Council meeting.	Kyle will forward resources from SAMHSA with regards to definitions/language (SMI, etc.) Kyle will prepare and draft survey based on the regional priority report guidance document and send to Planning Council members for review/edits/comments.

Block Grant Budget Update: Kyle Barrette, Block Grant State Planner	The presidents proposed budget for fiscal year 2024 was released in March. The proposed budget significantly increases federal funding for both the mental health and substance abuse block grants by about $700 million for each block grant. Although there is the potential for the presidents proposed budget to be passed, based on previous years experience the increases to state block grant allocations are likely be much smaller than what is proposed. New initiatives/changes to the Block Grants are included in the President's proposed budget: ▪ The **Substance Abuse Block Grant** will be renamed to the **Substance Use Prevention, Treatment, and Recovery Block Grant (SUPTRS).** ▪ A new set aside of 10% for recovery support services *(see attached power point).* ▪ A new set aside of 10% for mental health prevention/early intervention programming Kyle opened floor for discussion regarding needs that Planning Council members are seeing that could be addressed with increases to block grant funding. ➢ **Substance Use related needs?** ▪ More resources made available to Social Emotional Learning (SEL), or enhancing what is already available ▪ Holistic approaches to stress/addiction/wellness (more non-clinical and wellness programming/staffing) ▪ Family/Parenting support groups (MH/SU awareness/education, social activities) ▪ Alternative recovery methods ▪ Trauma informed supports/initiatives (as a MH/SU Prevention strategy) ▪ Other types of pro social supports ▪ Targeted recovery resources for young adults ▪ Enhance services for young adults ➢ **Mental Health related needs?** ▪ Education regarding serious mental illness (how to define, verbiage, etc.) ▪ Michaela Fissel raised concern related to the use of the term serious mental illness to categorize or label individuals and requested to participate in the crafting of the education and language to be used	
DMHAS Update: Elsa Ward, Director, Office of Recovery Community Affairs	<u>Elsa Ward</u> ▪ State working towards have a single Peer certification process. An advisory committee working on this recently had their final meeting and is currently preparing recommendations for DMHAS regarding the certification. Subject matter expert	

Erika Echeverria, BHPM, Evidence Based Practices Division Sarju Shah, Director, Prevention and Health Promotion Divsion	committee is now meeting to finalize questions that will be included in the exam used for the certification process. Elsa noted that SAMHSA has recently released their own Peer Certification process and can be used to inform Connecticut's process. ▪ Currently conducting outreach to providers and stakeholders throughout the state and has the goal of reaching all parts of the state. If groups/providers are interested in meeting with the Office of Recovery Community Affairs, Elsa requested that they reach out to her directly. ▪ Elsa provided an overview of the calls that her office has been receiving and shared that she mostly receives calls from families who have a family member with active substance use and who are looking for resources and supports. Elsa noted that more family supports would be helpful for these families (groups, education, etc.). ▪ The DMHAS webpage for the Office of Community Affairs has recently been updated to include new information and initiatives (https://portal.ct.gov/DMHAS/Divisions/Divisions/Recovery-Community-Affairs) <u>Erika Echeverria:</u> ▪ There has been an increase in the call volume for 988 and the percentage of calls answered in an average of 4 seconds is at 98%. We continue to have conversations to explore text and chat services for 988. The governor's budget has proposed $2.2 million for fiscal year 2024 and $3.1 million for fiscal year 2025 to support 988. o Council members raised questions regarding whether data was being collected on calls to 988 and what were the common reasons people were calling. Erika noted that DMHAS/United Way are collecting data on the types of calls being received, demographics, and the needs individuals are presenting with. o Council members asked if any data on 988 calls could be shared with the RBHAOs. ▪ Mobile Crisis teams are working to expand their hours to 24/7. Some teams are already there but DMHAS is hoping to have all teams operating 24/7 by September 21st 2023. ▪ DMHAS is currently planning to add crisis stabilization units and peer respite programs to the Crisis Continuum of Care in Connecticut. <u>Sarju Shah:</u>	Erika will look into what data she may be able to share with the RBHAOs regarding 988 calls

	▪ The Prevention division is currently working with the RBHAOs to get the regional priority reports drafted by April with the hopes of sharing with DMHAS and the Planning Council in June. ▪ In 2021, the Prevention Division was identified as the team that would be supporting cannabis prevention activities for DMHAS. The Prevention Division has partnered with the Alcohol and Drug Policy Council and developed a cannabis workgroup. We have also developed the "Be in the No" education and awareness campaign. The goal is to educate and inform about the legal use of cannabis as well as prevention messages. The campaign can be found on https://beintheknowct.org/. Prevention Division planning to distribute lock bags to provide safe storage for cannabis through the mobile clearinghouse. ▪ DMHAS received $6.25 million from Samsung for the Partnerships for Success grant which focuses on reducing underage drinking. The RFP process has been completed and is currently going through negotiations with hopes of starting in April. The 12 communities with high focus for this grant are East Windsor, Bolton, Stamford, South Windsor, East Haven, Ansonia, Derby, Ashford, Brooklyn, Chaplin, Southbury, and Thomaston. ▪ The Prevention Division has partnered with the State Education Resource Center (SERC) to develop a prevention, education and advocacy resource library with the goal to provide prevention materials and evidence based curriculum to K-12 students. SERC is currently moving to Waterbury where the library will be located.	
New Programs/ Services Initiatives: Kyle Barrette, Block Grant State Planner	Brief updates provided on the following initiatives (see attached PowerPoint) ▪ Transit Homeless Outreach Program (Transit HOP) ▪ Access MH for Moms (https://www.accessmhct.com/) ▪ First Episode Psychosis (Project 169)	
2023 Meeting Planning: Council	Question was raised regarding whether to increase future meetings to 2 hours. Some council members were in support. No members voiced opposition. Council discussed continued efforts to expand membership. A pamphlet has been created that explains the Planning Council for individuals interested in joining.	Kyle will increase future meetings to 2 hours Kyle to resend Planning Council pamphlet

		Council members to send agenda items to Kyle and Angela ahead of next meeting.
Next Meeting:	June 8, 2023 | 2:00 – 4:00 pm	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	June 8, 2023 | 2:00 – 3:30 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Angela Duhaime, Michaela Fissel, Chlo-Anne Bobrowski, Allison Fulton, Kathy Flaherty, Jennifer Abbatemarco, Laura Watson, Pamela Maute, Allyson Nadeau, Ellen Econs	
Staff Present:	Kyle Barrette, Sarju Shan, Dana Begin, Jennifer Sussman, Elizabeth Feder, Elsa Ward	
AGENDA ITEM:		**ACTION**
Regional Prioritization Results: Jennifer Sussman, Center for Prevention Evaluation and Statistics (CPES)	Jennifer Sussman presented aggregate findings from the DMHAS Regional Prioritization Reports complete by the RBHAOs. Jennifer highlighted the top priorities for mental health, substance use, prevention, and problem gambling as identified through the regional prioritization process. This is a data driven report of the RBHO's work and the BG process which entails both the DMHAS and RBHO's planning and defining regional priorities and making recommendations. Power Point attached	CPES will present aggregate findings from the Regional Prioritization reports at next ADPC meeting, to further disseminate findings and recommendations
Planning Council Survey Results: Kyle Barrette, DMHAS Angela Duhaime, Chair	Kyle Barrrette and Angela Duhaime presented findings from the behavioral health needs survey completed by planning council members. The survey was conducted to provide the council with specific input into the behavioral health needs assessment process and to inform planning efforts for the Mental Health Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant. The information from the survey will be incorporated into the behavioral health needs assessment, along with the regional prioritization results, as part of the biennial combined block grant application. Power Point attached	DMHAS will incorporate survey findings within the behavioral health needs assessment currently being prepared
Overview of Serious Mental Illness: Kyle Barrette, DMHAS	Based on previous questions from Planning Council members regarding Serious Mental Illness (SMI), Kyle Barrette presented on the history and definition of the term SMI. The Center for Mental Health Services initially developed the definition of Serious Mental Illness as a way to both identify the target population for the Mental Health Block Grant and to allocate funding to states. The current definition for SMI is someone over the age of 18 who currently has or had within the past year, a diagnosable mental behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major activities, including basic daily living and instrumental living. Kyle provided an overview of the most common diagnoses associated with SMI.	

	Power Point attached.	
Internalized Stigma and Illness Identity: Michaela Fissel, Advocacy Unlimited	As a follow-up to the presentation on SMI, Michaela Fissel presented on illness identity and internalized stigma. Michaela presented experiential knowledge and research showing that diagnostic terminology such as SMI, and the association or categorization of individuals using these terms, can contribute to negative societal perceptions regarding mental health and contribute to negative self-beliefs among individuals. Michael presented on the importance and impact of the language we use related to Mental Health, and the importance of updating current language to be less stigmatizing and more person centered.	Michaela will present and lead a discussion on alternative language at the next Planning Council meeting.
Block Grant Update: Kyle Barrette, DMHAS	Kyle discussed the current work block grant work taking place. Kyle noted that the combined block grant application will be released by SAMHSA in July and is due September 1, 2023. The plan is to have the draft application completed and open for public comment and planning council review by August 17, 2023.	
DMHAS Update: Sarju Shah, Director, Prevention and Health Promotion Division, DMHAS Elsa Ward, Director, Office of Recovery Community Affairs, DMHAS Dana Begin, Director, Evidence Based Practices Division, DMHAS	**<u>Sarju Shah – Prevention Update</u>:** The Prevention Division was awarded a Partnership for Success Grant (related to alcohol prevention), and the RFP has been completed. This award is $6.25 million for over 5 years. The Prevention Division has also been awarded additional funding for Prescription Drug Overdose, and the Garrett Lee Smith Campus Suicide Prevention Grant, totaling $7 million for over the next 5 years. Sarju also introduced Prevention Division staff to the Council to help build connections and provide an overview of the Division's work. • Denique Whitmore Lewis was introduced as a new Prevention Division staff member and the new lead for cannabis prevention related activities; • Andrea Duarte handles mental health promotion, works with our RBHAO's, and works with 988; • Kelly Edwards supports the opioid prevention work, and work related to young adults; • Stephanie Welch leads the discretionary funds, Partnership for Success, PCC, and alcohol related activities **<u>Elsa Ward – Office of Recover Community Affairs Update:</u>** The office is currently working with stakeholders on finalizing the Peer Certification language and process for the state. **<u>Dana Begin – Evidence Based Practices Update:</u>**	

	DMHAS was recently informed of a funding opportunity from SAMHSA for continued support for 988. Connecticut is eligible for $2.25 million each year for the next 3 years.	
Meeting Planning: Angela Duhaime, Chair	Angela led a discussion on meeting planning for the rest of the 2023 planning council meeting series. Angela requested suggestions for future presentations and agenda items be sent to her and Kyle Barrette. Angela discussed the need to change the date of the next planning council meeting so that the combined block grant application can be reviewed with the council. Angela proposed August 17 and 24 as potential dates and the council voted to change the date of the next meeting to August 17, 2023.	Kyle to change calendar invite for next planning council meeting to August 17, 2023
Next Meeting:	August 17, 2023 | 2:00 – 3:30 pm	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	September 8, 2022 | 2:00 – 4:00 PM	
Location:	Teams	
Attendance		
Members Present:	Peter Tolisano (DDS), Chlo-Anne Bobrowski (SDE), Bill Halsey (DSS), Laura Watson (DOH), Allyson Nadeau, Kathy Flaherty, Maureen O'Neil-Davis, Ellen Econs, Jennifer Abbatemarco, Pamela Mautte, Allison Fulton, Lori Fedewa	
Staff Present:	Kyle Barrette, Chrishaun Jackson, Elsa Ward, Dana Begin, Kim Karanda, Shelly Nolan	
AGENDA ITEM:		**ACTION**
FFY23 Block Grant Application: Kyle Barrette	Kyle presented on the FFY23 Block Grant application and provided overview of allocation. This was a "mini" application. The next full biannual application will be prepared over the course of next year for submission in August of 2023. The application will include analysis of statewide and regional gaps/needs. This will be presented to the council early in 2023 for feedback and comments from the Planning Council.	**Link to block grant application sent by email to members**
Legislative update: Kyle Barrette	Kyle discussed legislative "wish list" being compiled by DMHAS Chief of Staff Chris McClure who is taking over the role of legislative liaison from Mary Kate Mason who recently retired. Kyle noted that any legislative ideas/recommendations from Planning Council members can be included.	**Planning Council members to send ideas/recommendations to Kyle Barrette**
988/Crisis Response Update: Dana Begin	Dana Begin, Director of Evidence Base Practices, presented on the rollout of 988 in Connecticut. New federal legislation requires states to establish a three digit suicide and crisis lifeline. This was formerly known as the National Suicide Prevention Lifeline, which will continue to operate through the new 988 line. United Way serves as the call center for 988 as well as other crisis response and resource hotlines in the state. All of these numbers will continue in operation and there will be no wrong number for people to call. Calls to all numbers, including 988 will be triaged to most appropriate staff and resources. DMHAS continues to conduct media campaigns to raise awareness about 988. Dana noted that any questions about 988 can be forwarded to her at dana.begin@ct.gov.	

Recovery System Update: Kyle Barrette	Elsa Ward, Director of the Office of Recovery and Community Affairs, presented on the work of her Office. The office continues to promote recovery and the different pathways to recovery. Elsa requested that any community partners or council members interested in recovery can reach out to her to discuss potential ways of working together. Elsa noted that she was been conducting visits to providers throughout the state and has the goal of visiting all CT PNP providers by the end of 2023. Elsa discussed upcoming mental health awareness month and noted that providers can reach out to her to collaborate for any events they are holding and so that DMHAS can help raise awareness about the events through social media. Elsa discussed upcoming trainings on integrated healing being led by New Life II, a faith-based organization based out of New Britain. These trainings will target community members and stakeholders, to understand how integrated healing can support individuals in recovery. Elsa noted that she is working to redesign the website for the Office of Recovery Community Affairs.	
Presentation: ACCESS Mental Health for Moms CT: Shelly Nolan	Shelly Nolan, director of Women's Services, provided a presentation on a new block grant funded initiative, ACCESS Mental Health CT for Moms (https://www.accessmhct.com/moms/). This program is a collaboration between DMHAS, Beacon Health Options, and Yale, and seeks to improve maternal health outcomes and reduce postpartum fatalities related to mental health and/or substance use disorder. Through the program, primary care physicians and other medical staff who are caring for pregnant and parenting women can receive direct consultation to better support and care for patients that are experiencing mental health and or Substance Use challenges. The program provides medical providers with real-time consultation related to psychopharmacology and counseling recommendations, with the intention of maintaining and improving the mothers existing care.	**Presentation slides will be sent to council members**
Presentation: Project 169: Vinod Srihari	Vinod Srihari, Professor of Psychiatry (Yale) presented on the work of the STEP clinic that provides specialized treatment to individuals with First-Episode Psychosis, as well as a new campaign to expand treatment resources for First-Episode Psychosis to new regions of the state and reduce the duration of untreated psychosis, through a partnership with DMHAS. Vinod provided background information around efforts to reduce the high burden of illness early in the course of schizophrenia spectrum disorder and the development of the treatment approach used within the STEP clinic. Vinod shared information on the developed of web-based platform to collect and share data related to first-episode psychosis, and provide information on how providers and stakeholders can become involved with the campaign.	**Presentation slides will be sent to council members**
Expanding Planning Council Membership: Kyle Barrette	Kyle raised discussion about how to increase and expand planning council membership. Kyle sought feedback on recruitment efforts and recommendations for potential new	**Continue discussion at next meeting. New member**

	members. Kyle noted that is able to reach out to any potential new members to provide orientation on the planning council and answer any questions.	**recommendations to be sent to Kyle through email.**
Next Meeting:	November, 10, 2022 | 2:00 – 4:00 PM	

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	November 10, 2022 | 2:00 – 4:00 PM	
Location:	Teams	
Members Present:	Peter Tolisano, Jennifer Abbatemarco, Allison Fulton, Ellen Econs, Pamela Mautte, Maureen O'Neil-Davis, Bill Halsey, Laura Watson, Kathy Flaherty, Mui Mui Hin-McCormick	
Staff Present:	Kyle Barrette, Chrishaun Jackson, Elsa Ward, Dana Begin, Kim Karanda, Molly Machado	
AGENDA ITEM:		**ACTION**
FFY23 Block Grant updates: Kyle Barrette, Director of EQMI (DMHAS)	DMHAS is currently reviewing the FY23 federal budget being considered in congress to identify the proposed increases to the block grants. The proposed budget includes an overall increase of $150 million to the Mental Health Block Grant and an increase of $50 million to the Substance Abuse Block Grant. However, state level allocations will not be calculated until the budget is passed. A vote on federal budget is scheduled for December 15th but there may be another continuing resolution at this time. *(Proposed Budget attached)* The combined biennial block grant application is due October 1, 2023. This block grant application involves a full assessment of the behavioral health services system in CT, as well as identification of gaps and needs across the system. The Regional Behavioral Health Action Organizations are currently preparing regional priority reports that will help to identify gaps and needs across the service system. Once these reports are prepared, these will be presented to the Planning Council for their review/feedback.	
DMHAS Updates: Elsa Ward, Director of Community Recover Affairs (DMHAS) Dana Begin, Director of Evidence Based Practices (DMHAS)	Elsa Ward presented on two new projects that are currently being supported by the COVID-19 Supplemental Block Grant. 1. **New Life II,** located in New Britain CT, is the first Black/BIPOC run faith-based recovery organization in the state. They were awarded funds to train community members and stakeholders in integrated healing. Through this initiative they will conduct 5 trainings (each with 15 people maximum) targeting the New Britain community. Interested residents of New Britain (or stakeholders working in New Britain) can reach out to Elsa for more information about the trainings. 2. **Advocacy Unlimited (AU)** is a peer run non-profit organization based in Connecticut that provides education, advocacy and support through non-clinical and holistic engagement. AU was awarded funds to conduct two training series. The trainings,	

	titled "Alternatives to Suicide" and "Breath, Body, and Meditation Management Program (BBM)" provide resources to individuals to help manage their emotions and symptoms. Dana Begin provided updates on the statewide crisis services system. 1. DMHAS has received additional funding for statewide **Mobile Crisis Teams** to expand to 24/7 operations and DMHAS is working with providers to scale up their services to 24 hours a day. The teams are working hard to recruit new staff to scale up services and welcome referrals from community providers. 2. As of July 2022, **988** was officially launched in CT. This three digit crisis hotline will not replace any existing hotlines in CT and all calls will be routed to the same call center where they will be triaged and handed off to the most appropriate call specialists. The National Suicide Prevention Lifeline (1.800.273.TALK) will continue to be in existence. United Way, which operates the statewide call center, has reported a significant increase in the number of individuals calling 988 since the launch. Additional funding from SAMHSA has been awarded to the state of Connecticut for the 988 grant. This additional funding will be used to help support the Chat and Text services for 988. 3. There have been discussions with the local LMHA's and CEO's around the Crisis Continuum. There are three components to this crisis care system: someone to call, someone to respond, and somewhere to go. DMMHAS has been looking to expand our continuum of care services around "somewhere to go" for individuals in crisis. DMHAS is in discussion with our LMHA's and CEO's on how to expand these services and exploring the development of crisis stabilization units as an alternative to emergency departments.	
New Programs/Services/Initiatives: Kim Karanda, Director of Statewide Services (DMHAS) Mollie Machado, Behavioral Health Program Manager (DMHAS)	Kim Karanda and Mollie Machado presented on the **Transit Homeless Outreach Program (Transit HOP).** This program is a partnership between DMHAS and the Department of Transportation (DOT) which came about as a way to engage and support individuals experiencing homelessness and/or substance use or mental health disorders who regularly ride the Fastrack or spend time at one of its stations. Through this program, 2.5 FTE Outreach Workers will canvas, provide referrals, and provide education to people at various DOT and CT Transit locations around the state. Outreach has begun in Hartford and New Britain train stations and Fastrak locations. Outreach workers are providing educational information, harm reduction supplies, linkages to emergency shelters, and linkages to substance use and mental health treatment programs.	Kyle to send out PPT presentation

Membership discussion: Kyle Barrette, Director of EQMI (DMHAS)	Kyle Barrette brought up discussion about how to expand membership of the planning council. Kyle shared draft informational document that provide an overview of the planning council and answers to common questions. This document is intended to be disseminated to individuals who may be interested in joining the planning council. Earlier this year the Planning Council narrowed its focus to mental health to reduce overlap with other state advisory/advocacy bodies working on substance use. However, this has limited the scope of the council and created some challenges in recruiting members who are interested in advocacy related to behavioral health more broadly or substance use specifically. As such, DMHAS proposed to expand the planning council back to a behavioral health focus (Adult Behavioral Health Planning Council).	Members to review draft document and provide feedback by 11/18/2022. Kyle to finalize document and disseminate to council members, for dissemination to stakeholders and interested parties. Expand focus of planning council to behavioral health and update name of council to Adult Behavioral Health Planning Council.
Planning for 2023: Open Discussion	Kyle Barrette opened discussion on priorities and potential topics for 2023 Planning Council meetings. ▪ Expand membership of Planning Council and identify new Planning Council Chair ▪ Review results of regional prioritization reports completed by the RBHAOs ▪ Identify/review block grant priorities/goals for biennial application	DMHAS staff and Planning Council members will outreach to individuals with potential interest in joining the council. Planning council members to submit ideas for meeting/presentation topics to Kyle Barrette
Next Meeting:	March 9th, 2023 2:00-4:00pm	Kyle to send out calendar invites for 2023 Planning Council meetings

August 21, 2023

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,

I am pleased to provide a letter of support for Connecticut's FFY 2024-2025 combined Community Mental Health Services and Substance Use Prevention, Treatment and Recovery Services Block Grant application. The FFY 2024-2025 combined application and plan was presented to the Behavioral Health Planning Council (BHPC) during its August meeting, including an opportunity for discussion and recommendations. A web-based link to the application and plan were emailed to council members to provide an opportunity for further review and comment.

The BHPC has reviewed the state's application/plan and has been routinely updated on all block grant activities as part of the agenda for each planning council meeting. Updates have included information regarding new block grant funded programs and initiatives within the state's behavioral health system, budget updates, technical assistance opportunities, and an overview of all block grant plans, proposals, and reports.

The BHPC looks forward to continuing its collaboration with the Department of Mental Health and Addiction Services (DMHAS) to advocate for behavioral health needs of Connecticut residents.

Sincerely,

Angela Rae Duhaime

Angela Duhaime, MA
Behavioral Health Planning Council Chair

CHILDREN'S BEHAVIORAL HEALTH ADVISORY COMMITTEE

The Honorable Vannessa Dorantes, MA
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

July 26, 2023

Dear Commissioner Dorantes:

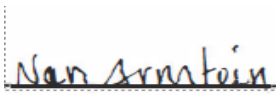
Within the past year, The Children's Behavioral Health Advisory Committee (CBHAC) has met consistently to continue exploring opportunities to enhance our child serving behavioral health system and support the evolving needs of children and families in CT. We are in the process of re-establishing and building up our voting member body and a major highlight recently is the revision of CBHAC bylaws in early 2023. With a renewed focus on the member-supported top priority areas of pediatric primary care and behavioral health care integration, disparities in access to culturally appropriate care, and access to a comprehensive array of services and supports, there is optimism about the upcoming year and additional opportunities to build upon strengths in our state and address needs and gaps.

CBHAC has been routinely updated on all block grant related activities through DCF. Updates include information on technical assistance opportunities, SAMHSA initiatives, webinars, budget changes, and progress with respect to block grant requirements, revisions, and deadlines.

CBHAC supports Connecticut's FY 2023-2024 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application and plan. The Block Grant application/plan was presented to CBHAC during its June 2022 meeting, including an opportunity for discussion and recommendations. The September 2023 CBHAC meeting will include additional discussion about the application and plan. Comments and recommendations on the block grant application/plan have been included in the application/plan as required by SAMHSA.

CBHAC looks forward to continuing collaboration with DCF to serve the behavioral health needs of the children and families of Connecticut.

Sincerely,



Nan Arnstein
Child Council Co-Chair

Gabrielle Hall
Child Council Co-Chair

Adult Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Thursday, August 17, 2023, | 2:00 – 3:30 PM	
Location:	Teams	
Members Present:	Allyson Nadeau, Michaela Fissel, Angela Duhaime, Peter Tolisano, Dana Begin, Jennifer Abbatemarco, Maria Feliciano, Pamela Mautte, Lori Fedewa, Laura Watson	
Staff Present:	Kyle Barrette, Elizabeth Feder, Denique Weidema-Lewis, Andrea Duarte, Elsa Ward	
AGENDA ITEM:		**ACTION**
Block Grant Update: Kyle Barrette,	Kyle provided updates on the combined MHBG and SUPTRSBG application and plan. Kyle provided an overview of the various sections of the application. Kyle identified the priority areas identified in the application and reviewed the specific projects and initiatives that DMHAS is planning to implement with block grant funding to address the needs and recommendations identified through the regional prioritization process and planning council survey. Kyle identified the period that the combined application will be open for public comment and discussed how to submit comments and recommendations. **Feedback:** Regarding plans for a statewide initiative to expand First-Episode Psychosis services (P169), Michael Fissel noted the importance of including groups like CT Hearing Voices network in planning/implementation efforts and to think about supportive resources in the state that may not be mainstream but can support individuals who may be experiencing early symptoms. Dana Begin noted that a list of regional resources for early psychosis is currently being compiled and DMHAS will work to include resources/organizations mentioned by Michaela. *Power Point attached	**Kyle will email planning council members the link to view and comment on the block grant application**
Advocacy Unlimited Presentation: Michael Fissel, Advocacy Unlimited	Michaela Fissel presented on the importance and impact of language as it pertains to behavioral health. Michaela provided an overview of existing literature highlighting the impact of language on self-beliefs and behavioral health outcomes and engaged the council in discussion on alternate language use that aligns with recovery orientation and person-centered care.	Michaela will provide presentation slides and information on an additional upcoming training

	*Power Point Presentation attached	
Membership Discussion: Angela Duhaime (Chair)	Angela discussed the establishment of membership recruitment/development as an ongoing agenda item that will be included for all meetings moving forward, to brainstorm recruitment strategies and outline groups/communities/populations that the council should seek membership from. Angela noted that if members identify individuals who may be interested in joining the planning council, they can send this information to her and Kyle Barrette.	Include standing agenda item related to membership recruitment/development
DMHAS Update: Andrea Duarte, DMHAS Prevention Division Elsa Ward, Director, Office of Recovery Community Affairs Dana Begin, Director, Evidence Based Practices Division	**Prevention** - Andrea noted that there are new adult mental health plan resources under the Gizmo initiative for Adult Mental Health (trusted adult and caregivers companion guide) available on the website at gizmo4.org. **Recovery System** - Elsa Ward provided updates regarding various Recovery month activities that her office is work to implement, including a media campaign for celebrating recovery. For this campaign, individuals in Recovery across the state are recording brief one-minute videos that discuss their story of recovery. These will be brough together and made available through social media platforms. Elsa noted that if planning council members are aware of anyone who would like to create a video, they can contact her and she can help the person to create their video. **Crisis Response System** – No updates at this time	Andrea to share link to Gizmo resources.
Adjournment: Angela Duhaime (Chair)	Next meeting will be Tuesday November 9th. Members can send agenda items and presentation ideas to Angela and Kyle.	

Environmental Factors and Plan

Advisory Council Members

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

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

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Donaicis Alers	State Employees			
Nan Arnstein	Others (Advocates who are not State employees or providers)			
Peggy Ayer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Dana Begin	State Employees			
Chlo-Ann Bobrowski	State Employees			
Stephanie Bozak	State Employees			
Eileen Bronko	Parents of children with SED			
Burns Craig	State Employees			
Erica Charles Davy	Parents of children with SED			
Angela Duhaime	Others (Advocates who are not State employees or providers)			
Ellen Econs	State Employees			
Antonia Edwards	Parents of children with SED			
Lori Fedewa	Others (Advocates who are not State employees or providers)			
Maria Feliciano	Others (Advocates who are not State employees or providers)			
Michaela Fissel	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathy Flaherty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Allison Fulton	Others (Advocates who are not State employees or providers)			
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			
Mui Mui Hin-McCormick	Providers			
Lindsay Kyle	Providers			
Lynne Landry	Providers			
Pam Mautte	Providers			
Sabra Mayo	Parents of children with SED			
George McDonald	Parents of children with SED			
Allyson Nadeau	Others (Advocates who are not State employees or providers)			
Maureen O'Neill-Davis	Parents of children with SED			
Yolanda Stinson	Parents of children with SED			
Peter Tolisano	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.
OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:
William Halsey is a representative from the CT Department of Social Services which serves as both the state Medicaid agency and as the state Social Services agency. WebBGAS does not allow states to choose multiple state agency types when entering planning council members so we are clarifying that William Halsey serves as the representative for both of these state agency types.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	0	
Parents of children with SED	12	
Vacancies (individual & family members)	4	
Others (Advocates who are not State employees or providers)	6	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**25**	**58.14%**
State Employees	10	
Providers	8	
Vacancies	0	
Total State Employees & Providers	**18**	**41.86%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**43**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

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 2023 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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

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

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

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

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

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

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

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

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

Future years are subject to authorizing language in appropriations bills.

End Notes

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

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

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

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

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

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

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

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

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

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

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Connecticut does not use SUBG funding for SSPs

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Connecticut does not use SUBG funding to support SSPs