State of Connecticut
State Board of Mental Health and Addiction Services
February 19, 2025
Microsoft Teams Meeting

Present online: Chmn. John Hamilton, Rebecca Allen, Jennifer Buckley, Thomas Burr, Sharon Castelli, Angela Duhaime, Allison Fulton, Holly Hackett, Pamela Maute, Giovanna Mozzo, Allyson Nadeau, Denise Paley, Manuel Paris

DMHAS Staff: Commr. Navarretta, Deputy Commr. Harrington, Jose Crego, Cheryl Arora, Vinneth Carvalho, Krystin DeLucia, Marilyn Duran, Erin Leavitt-Smith, Chris McClure, Chandra Persaud, Ashley Rogers, Sarju Shah, Kelly Sinko, Elsa Ward, Stephanie Welch

Agenda Item 1: Welcome and Call to Order

The meeting was called to order at approximately 2:30 PM Chmn. John Hamilton

Agenda Item 2: Minutes of previous meeting review and action

The minutes from the January 15, 2025 meeting were reviewed and accepted.

Agenda Item 3: Commissioner's Update

Budget: Cheryl Arora provided an update. We are in the early stages of the whole budget process. Some of the highlights of the Governor's budget are baseline adjustments which are changes that provide funding for services. We have the COLA for the private providers 2.55% that began in FY24 is being moved from OPM to DMHAS. The budget funds provide additional funding to the 988 Suicide Hotline to allow us to chat text functionality 24/7. It funds the home and community-based services waivers, also known as the nursing home waiver or the mental health waiver. It provides funding for 30 placements in each year of the biennium. And we also have analyzation of a discharge and diversion program for community placement for discharges from Whiting and Connecticut Valley Hospital.

There are a couple reductions we have $1.25 million in FY26 and $3.5 million in FY27 to reduce DMHAS over time and reduce DMHAS staffing costs at the Office of the Commissioner. There is a reduction for state funded prevention activities of $1.7 million in each year. There's a reallocation that moves the cannabis prevention and regulatory services fund money into the general fund.

The governor has recommended pick up of two of our ARPA initiatives, the privately provided mobile crisis programs at $3 million annually and supportive housing placements at $125million annually. These would be picked up using opioid settlement funding.

And lastly, there are some changes you won't see in the DMHAS budget. They are either at OPM or DSS and these dollars are not intended solely for DMHAS, it would be for statewide initiatives, and we would receive some portion of these dollars. They are budgeted for 3% COLA increase for private providers starting January 1st, 2026 and then another 3% beginning July 1, 2026. That's annually $126 million. There is a reinvestment of revenue that's been generated by the SUV waiver into the continuum of services for individuals with substance use disorders. And on an annual basis $17.9 million. And lastly, in the DSS budget, we have an initiative to reestablish rate parity for behavioral health services between children and adults. Because there has been disparity currently and there's concern about a cliff when children age out into our system, we don't want them to lose access to their services.

Legislative:
We had four proposals, and they were all folded into one bill for DMHAS HB 6834 act concerning DMHAS recommendations regarding various provisions to mental health and addiction services statutes. The Public Health Committee has agreed to draft the proposals. 1.) Pre-Trial intervention program sustainability 2.) Reducing stigma through recovery-friendly language 3.) Technical fix required for compliance with federal settlement agreement 4.) Updated definition of "Opioid Drug".

The public hearing was on February 3rd, the Commissioner testified in front of the committee. The Attorney General's Office and the Department of Consumer Protection also submitted favorable written testimony. And also we received favorable testimony from the nonprofit alliance when it came to the PTIP and the reimbursement rates.

This is a long session. We have a part time legislature, so we have long sessions in the odd numbered years and short sessions in the even numbered years. In the long sessions is where they produce the biennial budget. This session will end in June. Our committee of cognizance is the Public Health Committee. But we also go in front of the Human Services, Judiciary, General Law, Public Safety and Appropriations committees. And our team does monitor all committees and all bills for any potential impact to our agency operations or the people we serve.

Some emerging themes that we have seen this year so far is a big reaction to change in federal leadership, fiscal guardrails, special education, Artificial Intelligence, energy affordability, prescription drug affordability, housing and homelessness as well as PNP priorities.

We will be giving our budget presentation on Friday at 2:00 PM, and the public hearing starts at 4:00. There are different committee bill deadlines that legislative committees must act on. so there's a *Proposed Bill* – a bill introduced by an individual legislator at the beginning of a session, not fully drafted. *Committee Bill* – can either vote to have proposed bills fully drafted to be considered at a public hearing. *Subject Matter public hearing* – committee votes to have a hearing on a proposed bill to learn more about the issue area. *Raised Bill* – a fully drafted bill introduced by a committee that is not based on a proposed bill. – ex: an act concerning mental health. *JF* – bills must be voted out of committee by this deadline if not then bills will die. *Important deadlines* – Public Health Committee raised bill deadline 2/19/25 and Public Health Committee JF deadline 4/02/25. Just because a bill doesn't move forward doesn't mean the concept is not still alive. There's always amendment processes, implementers, and ways bills can be amended.

Agency Update:
Some activities over the past month were:

- We have done two press conferences. One with the AG around retailers selling illegally imported nicotine products and our collaboration with them on investigations and the second one on the OSAC funding of the big housing recommendation that got passed. That was $58 million that was going to individuals who are at risk for overdose or who have opiate use disorder. We'll be providing a voucher and then wrap around services and potentially client supports to keep people housed in a housing first model.

- The state of Oregon reached out to us for input on our Alcohol and Drug Policy Council, which is always good news when other states are noticing what we're doing and how we're handling policy around substance use disorder and all the different areas, prevention, recovery, treatment, and criminal justice.
- We've kicked off another internal training on integrated care just to make those trainings available to our state operated staff so that we are co-occurring capable and have the tools to treat people with substance use and mental health disorders.
- We were also awarded as a department the 6th annual AG Award and my colleagues from prevention attended along with my colleagues from opiate services.
- We have regular meetings with the Office of the Governor around federal transitions.
- We also had our ADPC meeting yesterday which was well attended. We had a presentation from Gina Florenzano on the new regulations, the federal regulations around OTPs and our mobile vans that we will be rolling out soon. So we had an RFP for two mobile vans and that was awarded to APT Foundation and to CHR.
- We also had a presentation on SBIRT for adolescents.
- Commr. Jodi Hill-Lily and Commr. Navarretta presented at a National SUD Summit with a focus on how the two departments worked on captive and plans of safe care, which we now call Family Care Plans.
- We visited Casa Mas in New Haven to celebrate Black History Month.

Agenda Item 4: Quarterly Report – Whiting Forensic Hospital, Jose Crego, CEO

Doctor Zachary Lenane has now become the Dutcher Service Medical Director and Doctor Crystal Salcido is a new psychiatrist on Whiting Unit 1. Staffing continues to be tight at times, especially at weekends. Most of this is due to W/C and FMLA. However, we continue to maintain safe staffing levels. We have a hiring event coming up for over 25 front-line positions both full time and part time. Forensic LPNs completed the Forensic Conversion providing increased versatility in staff use.

Patient Updates: *Vocational opportunities*: Valley View Cafe regularly has added 8 Whiting patients to their full-time schedules there on Fridays. The boutique has also added five additional patients to work in the boutique here on campus as well, and we're also looking at spaces in the greenhouse come spring. The Glastonbury Hunt Club continues to be interested in working with more of our patients. Many who were there are now out on TL, so recruitment for a new group is underway. This is a job that pays minimum wage, a significant increase for our patients.

Religious services: We have found an Imam who will come onsite for services. We continue to look for a Rabbi who will provide services. These services will augment the services currently being provided by our own chaplain.

Programming: Staff are currently undergoing training for EMDR, IDDI, and DBT as we look to broaden the programming available to our patients. The occupational therapy sensory room is almost completed in the Whiting basement. This will provide a space for both education and recreational activities for patients within the Whiting building. The Psychology department is expanding the number of Cog Rem groups that are available in both buildings. And the units now have Hulu available for TV watching. This service is monitored by staff and used for educational and recreational activities.

Environmental: Work on all the Whiting building kitchens is ongoing. We also look forward to completing the work on Whiting Unit 5 modernization, which will serve as a swing space for work on other units. The swing space allows maintenance to go on without impacting patients or their programming. Wi-Fi is

coming to the campus, and the tablet project is on hold as the vendor is being sold. We are awaiting the completion of the sale before we have a quote for their services.

Agenda Item 5: Presentation – Oder Adult Services, Erin Leavitt-Smith

Older adult services is part of long term services and supports. *Nursing Home Diversion and Transition Program* is a program where we contract with four private nonprofits throughout the state. We cover the entire state. We have eight nurses and three case managers that are available to do consultations and trainings on a variety of different things. Program goals: We divert individuals from institutional level of care and that could be an inpatient psychiatric setting but for the most part it's nursing homes. Ensuring that nursing home placements for DMHAS clients are necessary, appropriate, and safe. Transitioning nursing home residents, with a serious mental illness, back to the community. Diverting individuals from emergency departments and avoiding unnecessary acute care hospitalizations. Consultations with CVH, community providers, medical personnel, state partner staff. We also do a lot of work with the mental health waiver and money followers the person.

The *Mental Health Waiver* is a Medicaid waiver that is overseen by CMS and DSS, our waiver is a bit different than some of the other DSS waivers in that DMHAS does the assessments and we determine who gets enrolled on the waiver with the other DSS waivers, except for DDS. It is a Medicaid program, so it is fee for service and what the program does it's a skill building program. We have intensive psychiatric rehabilitation. It takes place in the participants home or other community settings of their choice. We pay attention to both the medical and the psychiatric needs. There is a real emphasis on recovery and wellness. It's a person-centered planning process. The client or the participant participates in creating that plan, they pick who their providers are. To be eligible you must be 22 years or older, Medicaid eligible for Husky C, meet nursing home level of care, serious mental illness diagnosis, voluntarily agrees to be in the program, and can reside safely in the community.

We do a comprehensive psychosocial assessment, risk assess, and functional assessment. The nursing home level of care they must have three critical needs and or cognitive deficits. Most of our participants get recovery assistance services. The Community support program is case management. We have peer support supported employment. We have 12 assisted living facilities that have been credentialed. We have specialized medical equipment and assistive technology. We can do some home adaptation, putting in ramps for people, and redoing like a bathroom shower, and home delivered meals. We also have our waiver housing and living support services, so if someone is getting waiver services and needs a subsidy, we can provide a monthly housing subsidy if they meet the housing criteria. And we use the same housing criteria as our homeless housing and homeless services. We can pay for application fees, security deposits, and help with moving expenses. We can go in twice a year to do heavy cleaning as well.

Senior outreach and engagement. We are in all five of our regions. We have two case managers in each of those regions and we contract with private nonprofits in each of those regions. The mission is to outreach and engage at risk older adults 55 and older. People in the community that are not engaged or having difficulty engaging. They can make a referral to the senior outreach engagement program for behavioral health, substance abuse and we often deal with housing issues. We go out to the person's residence, to senior centers, community locations, and wherever we can meet with a person. The program does a lot with going to senior centers and going to senior affairs to get the word out there. They've done a lot of presentations with some of the triple A's.

60 W is a nursing home in Rocky Hill, and it's been around now for 14 years. It is a 95-bed nursing home for difficult to place clients because of their psychiatric history and or their criminal history. It is run by

Icare and has two units a secure unit and a long-term care unit. They must meet nursing home level of care. Anybody can make a referral, and these are on the DMHAS website. If you go to programs and services, all these programs are listed with the referral forms if anyone needs them. We meet monthly with 60 W to review all our referrals and help them decide who's next. There is a waiting list that is fairly new over the last couple of years, so we work in conjunction with 60 W and to assess everyone and then discuss admissions.

Agenda Item 6: New DMHAS Safety / De-escalation – Dr. Vinneth Carvalho and Ashley Rogers

DMHAS is committed to the safety of our patients, clients and staff. We decided to work with the staff and the different facilities to get feedback from them about how our current safety program is going. After receiving the feedback, the Commissioner tasked us with finding a new evidence-based safety program that will enhance the safety of all. So we developed a work group comprised of representatives from the different settings such as inpatient, outpatient forensics and so forth. We started looking at all the other Safety programs on the market and in doing so, we narrowed it down to about 7. We reached out to the vendors of these programs, and they reviewed with us their program highlights and so forth. We asked about any research safety that they had done on their program and what its safety for staff, patients or clients. We also looked at some of the challenges that some of these programs would have in adapting to our DMHAS system, whether it was the values of DMHAS, for example, or whether it was the learning management system whether it was compatible or not. After we went through that process, we narrowed down the selection to three programs and they had a few things in common. They were evidence based. They were able to demonstrate that they had successful outcomes in other places across the nation that had similar treatment environments. They were tiered, which means that they had training options for staff in various settings and they were compatible with our learning management system. They were also compliant with state, federal and regulatory and accreditation requirements.

We also looked at challenges and the first one was that it provided blended learning; another challenge is that any of these three programs we were going to select there would be an additional one day extra of training in comparison to what we have now. And lastly, that the mechanical restraints weren't given in these programs, but in any event, it would have to be taught separately because it's based on manufacturers guidelines.

So by the end of 2024, we were able to select a safety program, and then we presented it to the Commissioner and then the next step was to present it to the various stakeholders. We have chosen the Crisis Prevention Institute (CPI). CPI is a one of the global leaders in evidence-based de-escalation and crisis prevention training. It is used in a variety of areas such as in schools, corporate America, correctional settings and so forth. And here in the northeast CPI is used in a few hospitals around us.

A survey that was done in June of 2024 for about 273 unique customers who had started using the CPI were asked what areas of your organization you have noticed a change in CPI and 74% of them said there was increased staff confidence in preventing or reducing crisis situations. 50% said they had improved patient well-being, 48% said they reduced incidence of challenging or disruptive behavior and 38% said it was less than need for restraints and seclusions.

One of the things that also set CPI apart was that they do look at a risk stratification matrix. Essentially, the staff members receive training based on their level of risk. So that is why it is a tiered approach, which we found extremely helpful. Because CPI is a nationally used and recognized program, they do provide a blue card. That's just like ACPR certification. This is something that each staff member would be issued upon completion of the training. There is a flexibility with CPI to ensure that we are training

staff in the most feasible way possible. The other thing that really stood CP is stood out from others was that they provide a lot of training or specialty training topics focusing on some of our most vulnerable populations.

Some of the key takeaways from CPI training. So some of their self-protective and or any sort of re-straint skills they have to match the level of risk and making sure that we are using the least restrictive means possible. We want to be using de-escalation skills, evidence-based ones that work effectively so that we can avoid any sort of physical intervention with patients or clients. We want to make sure safety comes first for everybody. So they do have a one person hold but it's for low level situations to guide and support a person. It's not something that they stress or focus on, and they'll work with us to modify it or exclude any skills or holds that are just not conducive to our environment of care and that don't align with our regulations or state laws etcetera.

So some of the key differences are that CPI is an evidence based program, whereas our current program is not. There is a slight increase in training time with CPI, so that would be if everything's done in person, and we do not use the blended learning option which is certainly an option that is out there and would require a little bit of additional time to train our new hires as well as recertify current staff. There is that different level of restriction based on the situation to ensure that we're doing least restrictive means to ensure everyone's safety. It is used internationally. So that is a key difference, and they do provide that nationally recognized certification and because they do not teach any sort of mechanical restraints that would be currently included in our CSS training program, which is what we use now. That would just be added on to the program as an additional component.

Agenda Item 7: RBHAO Report – Giovanna Mozzo

Overall, the RBHAOs have been working on priority reports, conducting focus groups and are working on compiling local regional data to inform the report, which then goes to DMHAS and gets informed to the federal block grant. We continue to build a prevention workforce by training our staff. Most recently we sent them to dialogue education through global learning partners. We hosted a healthy outcomes from positive experiences workshop and the keynote speaker was Jerry Moe and we had over 70 attendees and it was very well received. So our mini grants have been sent out to our communities and we're re-ceiving those applications. We are continuing our efforts around the opioid crisis. We're preparing for Problem Gambling month, which is in March. There's a lot going on in that calendar month and we'll be sharing all those efforts with our community partners. Save the date April first, our alcohol prevention coordinators our are working on preparing for a statewide Alcohol Awareness conference. We recently had a cannabis coalition grantee meeting. We have several grantees in each of our regions that are go-ing to be working on cannabis prevention through our cannabis initiative through DMHAS, and lastly all our RBHAOs have various trainings. You are encouraged to go onto their agency websites and look for that specific information on trainings and workshops and other meetings.

Agenda Item 7: General Updates/Announcements

- CCAR - Rebecca Allen: We had to make a difficult decision, and we are going to be closing our three newest centers, the Recovery Community Center in Torrington, New London and Danbury. Unfortunately, we just don't have the original funding that came from federal money and we just don't have any way to move forward with those centers.

Adjournment: The meeting was adjourned at 4:00 P.M. The next meeting will be held on Wednesday, **March 19, 2025**, beginning at 2:30 PM.