

# Connecticut

## UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022  
(generated on 08/12/2019 1.04.12 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 2020

End Year 2021

#### State SAPT DUNS Number

Number 103626086

Expiration Date

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

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

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

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

Mailing Address P.O. Box 341431 410 Capitol Avenue

City Hartford

Zip Code 06134

Telephone 860-418-6676

Fax 860-418-6691

Email Address Miriam.Delphin-Rittmon@ct.gov

#### State CMHS DUNS Number

Number 103626086

Expiration Date

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

#### II. Contact Person for the CMHS Grantee of the Block Grant

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

NOT FINAL

Mailing Address 410 Capitol Ave  
City Hartford  
Zip Code 06134  
Telephone (860) 418-8650  
Fax 860-418-6691  
Email Address Miriam.Delphin-Rittmon@ct.gov

**III. Third Party Administrator of Mental Health Services**

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

**V. Date Submitted**

Submission Date

Revision Date

**VI. Contact Person Responsible for Application Submission**

First Name Susan

Last Name Bouffard

Telephone 860-418-6993

Fax 860-418-6896

Email Address susan.bouffard@ct.gov

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**Footnotes:**

## State Information

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

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U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
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 as required by  
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 as authorized by  
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 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

| <b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>  |  |                                  |
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| Section  | Title  | Chapter                          |
| Section 1921   | Formula Grants to States   | <a href="#">42 USC § 300x-21</a> |
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

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

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

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



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

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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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.
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- 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).
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  17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
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  19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

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

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

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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<sup>1</sup>: Ned Lamont

Title: Governor

Date Signed: 7/30/19

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**

## State Information

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

#### Fiscal Year 2020

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  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

| <b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>  |   |                                  |
|--|---|----------------------------------|
| Section  | Title   | Chapter                          |
| Section 1911   | Formula Grants to States  | <a href="#">42 USC § 300x</a>    |
| Section 1912   | State Plan for Comprehensive Community Mental Health Services for Certain Individuals | <a href="#">42 USC § 300x-1</a>  |
| Section 1913   | Certain Agreements  | <a href="#">42 USC § 300x-2</a>  |
| Section 1914   | State Mental Health Planning Council  | <a href="#">42 USC § 300x-3</a>  |
| Section 1915   | Additional Provisions   | <a href="#">42 USC § 300x-4</a>  |
| Section 1916   | Restrictions on Use of Payments   | <a href="#">42 USC § 300x-5</a>  |
| Section 1917   | Application for Grant   | <a href="#">42 USC § 300x-6</a>  |
| <b>Title XIX, Part B, Subpart III of the Public Health Service Act</b> |   |                                  |
| Section 1941   | Opportunity for Public Comment on State Plans   | <a href="#">42 USC § 300x-51</a> |
| Section 1942   | Requirement of Reports and Audits by States   | <a href="#">42 USC § 300x-52</a> |
| Section 1943   | Additional Requirements   | <a href="#">42 USC § 300x-53</a> |
| Section 1946   | Prohibition Regarding Receipt of Funds  | <a href="#">42 USC § 300x-56</a> |
| Section 1947   | Nondiscrimination   | <a href="#">42 USC § 300x-57</a> |
| Section 1953   | Continuation of Certain Programs  | <a href="#">42 USC § 300x-63</a> |
| Section 1955   | Services Provided by Nongovernmental Organizations                                    | <a href="#">42 USC § 300x-65</a> |
| Section 1956   | Services for Individuals with Co-Occurring Disorders                                  | <a href="#">42 USC § 300x-66</a> |

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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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<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**

## State Information

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

#### Fiscal Year 2020

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  
 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 Grants to States  | 42 USC § 300x    |
| Section 1912  | State Plan for Comprehensive Community Mental Health Services for Certain Individuals | 42 USC § 300x-1  |
| Section 1913  | Certain Agreements  | 42 USC § 300x-2  |
| Section 1914  | State Mental Health Planning Council  | 42 USC § 300x-3  |
| Section 1915  | Additional Provisions   | 42 USC § 300x-4  |
| Section 1916  | Restrictions on Use of Payments   | 42 USC § 300x-5  |
| Section 1917  | Application for Grant   | 42 USC § 300x-6  |
| Title XIX, Part B, Subpart III of the Public Health Service Act |   |                  |
| Section 1941  | Opportunity for Public Comment on State Plans   | 42 USC § 300x-51 |
| Section 1942  | Requirement of Reports and Audits by States   | 42 USC § 300x-52 |
| Section 1943  | Additional Requirements   | 42 USC § 300x-53 |
| Section 1946  | Prohibition Regarding Receipt of Funds  | 42 USC § 300x-56 |
| Section 1947  | Nondiscrimination   | 42 USC § 300x-57 |
| Section 1953  | Continuation of Certain Programs  | 42 USC § 300x-63 |
| Section 1955  | Services Provided by Nongovernmental Organizations                                    | 42 USC § 300x-65 |
| Section 1956  | Services for Individuals with Co-Occurring Disorders                                  | 42 USC § 300x-66 |

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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 Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
  13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
  14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
  15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
  16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
  17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
  18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
  19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

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

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

### 2. Certification Regarding Drug-Free Workplace Requirements

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

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

### 3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

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

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

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

### **HHS Assurances of Compliance (HHS 690)**

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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



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

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

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

Signature of CEO or Designee<sup>1</sup>: Ned Lamont

Title: Governor

Date Signed: 7/30/19

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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

**Footnotes:**



## State Information

### Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

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Name

Title

Organization

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Signature:

Date:

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

**Footnotes:**

## Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, 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. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

**Footnotes:**

NOT FINAL

**State of Connecticut  
Combined MHBG/SABG Block Grant Application/Plan  
Federal Fiscal Year 2020-2021**

**Adult Services**

**Introduction**

The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) prepared the State of Connecticut FFY 2020-2021 combined block grant application and plan. DCF contributed only to the development of the Community Mental Health Services Block Grant (MHBG), as Connecticut has a consolidated child welfare agency. Both the Substance Abuse Prevention and Treatment (SABG) and MHBG components were developed in close collaboration with Connecticut's State Behavioral Health Planning Council (BHPC) which encompasses both mental health and substance use.

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

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

During state fiscal year (SFY) 2018, DMHAS provided and/or funded behavioral health services to over 105,000 individuals, through its inpatient, outpatient, and recovery support programs. Over 100,000 persons were recipients of prevention and health promotion activities in the Institute of Medicine (IOM) categories of selected and indicated, while over a million persons were potential target recipients of some form of universal prevention efforts conducted within the state.

**Behavioral Health Assessment and Plan**

**Overview**

## Connecticut Demographic Data

Connecticut is a small state with a net land area of 4,842 square miles and an average of 738 people per square mile. It has a total population of 3,572,665 according to the U.S. Census Bureau Quick Facts – as of July 1, 2018, which represents less than a 1% decrease from the 2015 census figure. Major population areas are Bridgeport, Hartford, New Haven, Stamford, and Waterbury. Of the 169 incorporated towns/cities in Connecticut, 68 are designated as rural, based on the Office of Rural Health definition (census less than 10,000 **and** population density of 500 or less people per square mile.) The total rural population of Connecticut based on the most recent Connecticut Rural Health Report, is 326,132. There is no county government. State agencies provide health and human services statewide or at the regional level with various regional geographic configurations.

According to the July 1, 2018 U.S. Census Bureau estimates, Connecticut’s racial composition is as follows:

- 80.3% White/Caucasian
- 11.9% Black/African American
- 4.8% Asian
- 0.5% American Indian/Alaska Native
- 0.1% Native Hawaiian/Other Pacific Islander
- 2.4% Two or more races

Hispanic/Latinos comprise 16.1% of the total population of Connecticut.

There was less than a 1% population decline from 2015 to 2018. Connecticut’s population continues to age as 16.8% of its residents are age 65 or older (up 1% from 2015). There was a small increase in the percentage of Hispanic/Latino residents (from 15.4% to 16.1%) and a slight decrease in the percentage of white/Caucasian residents (from 80.8% to 80.3%). Just over 14% (14.2%) of residents were foreign born and in 22.1% of households, a language other than English is spoken (for persons 5+). Connecticut is a well-educated state with 90.2% having at least a high school diploma and 38.4% with at least a Bachelor’s Degree. The median household income is over \$73,781, but 9.6% are people in poverty. There are 180,111 persons identified as veterans or 5% of the Connecticut population.

## DMHAS Organizational Structure

### Overview

DMHAS’ **mission** is “to promote the overall health and wellness of persons with behavioral health needs through an integrated network of holistic, comprehensive, effective and efficient services and supports that foster dignity, respect and self-sufficiency in those we serve.” DMHAS’ **core values** are: affording all persons dignity and respect; treating all persons with equity and fairness; and leading with a sense of urgency and accountability. For more information *about DMHAS*:

<https://www.ct.gov/dmhas/cwp/view.asp?a=2899&q=334082>

DMHAS is Connecticut’s Stat Mental Health Authority (SMHA) and Single State Agency (SSA), and is a member of the Governor’s Cabinet. It is an independent state agency having statutory responsibility to promote and administer comprehensive behavioral health preventive and treatment services. DMHAS operates, funds and coordinates inpatient and community-based behavioral health services for adults

(18 and older) having substance use and/or psychiatric disorders. DMHAS is responsible for the state's behavioral health general funds, MHBG and SABG allocations, and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults.

While the department's prevention services are available to Connecticut citizens of all ages, DMHAS' mandate is to treat **adults** with psychiatric and/or substance use disorders that lack the financial means to obtain such services on their own. DMHAS also provides programs for individuals with special needs (e.g., AIDS/HIV, problem gamblers, substance using pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the DCF service system, those involved with the criminal justice system) as well as persons with serious mental illness (SMI) residing in nursing homes, military personnel and their families, and persons who are homeless.

DMHAS directly operates Connecticut Valley Hospital (CVH) which provides an inpatient level of care for those with serious psychiatric conditions and medically managed detoxification and residential rehabilitation services for those with substance use disorders (SUD). DMHAS contracts with two private psychiatric hospitals (Natchaug and St. Vincent) for acute and intermediate inpatient services. Inpatient psychiatric beds are also located at four of the state's LMHAs, namely, Connecticut Mental Health Center (CMHC), Capitol Region Mental Health Center (CRMHC), Greater Bridgeport Community Mental Health Center (GBCMHC) and the Southeastern Mental Health Authority (SMHA). Community addiction treatment services are delivered by a vast network of private nonprofit providers and programs across all levels of care.

DMHAS directly operates the mental health service system for persons with SMI at the regional and local level through a network of state-operated and state-funded community services and supports. Included in this network are thirteen LMHAs statewide, six DMHAS-operated and seven DMHAS-funded, along with over ninety affiliated private 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. LMHAs develop, maintain, and manage a comprehensive system of mental health treatment, recovery support, and rehabilitative services for designated local service areas known as "catchment areas".

DMHAS' prevention and health promotion services are delivered through close collaboration with the five RBHAOs covering the state. The department works directly with communities including schools, workplaces, and neighborhoods to nurture supportive and safe environments in support of drug-free lives.

## **Service Delivery System – Mental Health**

### **Psychiatric Inpatient Services**

DMHAS currently provides acute psychiatric inpatient services to adults at three state-operated facilities including Connecticut Valley Hospital (CVH), Greater Bridgeport Mental Health Center (GBMHC), and Connecticut Mental Health Center (CMHC). In addition to these state hospitals, DMHAS operates two LMHA facilities that manage subacute beds, including Southeastern Connecticut Mental Health Authority (SMHA) and Capitol Region Mental Health Center (CRMHC). In concert with DMHAS' overall approach to illness management, the inpatient facilities provide a variety of skills-based and recovery-oriented interventions focused on reducing acute psychiatric symptoms and improving level of functioning for adults who are gravely disabled by mental illness. The ultimate goal of inpatient care is to enable the person with SMI to live in the most integrated setting. All DMHAS inpatient facilities provide

therapeutic programs designed to meet the treatment needs of adults in the most cost-effective manner possible. Specialty services provided include Geriatrics, Traumatic/Acquired Brain Injury, Cognitive Rehabilitation, Co-Occurring, Dialectical Behavior Therapy and Forensic Services.

The Whiting Forensic Hospital (WFH), located on the campus of CVH, operates 232 beds. WFH became a separate state-operated facility in the spring of 2018. Services are provided to individuals who are admitted under the following categories:

- Psychiatric Security Review Board (PSRB) commitment
- Criminal court order for restoration to competency to stand trial
- Civil commitment (voluntary or involuntary)
- Transfer from the Department of Correction (during period of incarceration or at end of sentence)

The Young Adult Services Program expanded capacity as part of the consolidation of the former Cedar Ridge Hospital to the CVH campus in 2010. At the same time, a co-occurring inpatient unit was established at the GBMHC facility. Additionally, DMHAS, in collaboration with the state's Medicaid Authority (Department of Social Services – DSS), procured intermediate duration acute beds in the community for individuals in need of this level of care.

### **Contracted Inpatient Services**

Comprehensive, hospital-based psychiatric services are those clinical and medical activities and interventions necessary for the stabilization of the individual's psychiatric or co-occurring psychiatric and substance use disorder, including, at a minimum, thorough psychiatric and substance use evaluations, and medication evaluation and management. DMHAS contracts with two private psychiatric hospitals (Natchaug and St. Vincent) for acute and intermediate inpatient services. The department uses a statewide utilization management/review process with a dedicated staff person and input from the DMHAS Medical Director.

## **Forensic Services**

### **Community Forensic Services**

The Division of Forensic Services (DFS) was established to implement and coordinate specialty 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. Forensic services are directed at efforts 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 DFS span the continuum of the criminal justice system from pre-arrest to end of sentence after incarceration and return to the community.

#### **I. Pre-Booking Diversion DMHAS Crisis Intervention Team (CIT)**

CIT is a pre-arrest diversion program for police, in collaboration with mental health professionals, to divert individuals at the time of initial contact with law enforcement. The CIT program trains police officers to interact in a constructive manner with individuals having psychiatric disorders. It is now under the supervision of the Mobile Crisis Clinical Manager.



The DMHAS CIT program was established in 2004 in collaboration with the National Alliance on Mental Illness – CT (NAMI-CT), local police departments, and the Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE). It was implemented with federal funds and is now entirely state funded. The DMHAS program expands on the Memphis, Tennessee CIT model by funding positions for clinicians, from DMHAS-funded LMHAs, who are trained and designated to work in collaboration with police departments. This critical link between mental health professionals and law enforcement allows for immediate and follow-up engagement and linking individuals to treatment and other needed services.

### **Forensic Outreach and Engagement (FOE; Hartford, New Haven)**

Engagement Specialists (ES), employed by local substance use service agencies, provide services in a Harm Reduction model to persons with addictions who are justice involved or at risk of justice involvement. The ESs work to engage clients by providing assistance based on the clients' priorities. FOE accepts referrals from the police departments of people diverted from arrest and from the police and others of people who need this assistance. FOE is based on the Law Enforcement Assisted Diversion (LEAD) model, but since it utilizes a wider range of referral sources than traditional LEAD, the name of the program is different.

## **II. Post-Booking Diversion**

All criminal courts in CT are state-operated and the state made a policy decision to avoid specific courts or dockets for the mental health population and, instead, provide behavioral health jail diversion programming in all criminal courts.

### **Jail Diversion/Court Liaison Program (JD; statewide)**

Clinicians in all 20 arraignment courts screen adult defendants with mental illness, including SMI and co-occurring conditions, and can offer community treatment options in lieu of jail while the case proceeds through the court process. JD makes referrals for services, monitors compliance, and reports compliance to court.

### **Woman's Jail Diversion (JDW; New Britain, Bristol, New Haven)**

JDW offers a full range of services to women with trauma sequelae, most with substance abuse, who are at risk of incarceration pretrial or at risk of violation while on parole/probation. Services include clinical, medication, community support, limited temporary housing, and client supports.

### **Jail Diversion Veterans (JDVets; Norwich, New London, Middletown)**

JDVets targets veterans of the Iraq and Afghanistan wars as well as older veterans and those active in the military who have current criminal charges. The program can offer community treatment options in lieu of jail while the case proceeds through the court process. JDVets refers clients for clinical services and specialized veteran's services, monitors compliance, and reports compliance to court. The program provides consultation to JD staff statewide.

### **Jail Diversion Substance Abuse (JDSA; Hartford)**

JDSA targets adults with substance dependence in need of immediate admission to residential detox and/or intensive residential treatment on the day of arraignment or rapid admission to IOP. JDSA offers intensive case management, sober house rent, other transitional housing options, client supports, monitors compliance, and reports compliance to court.

#### **Alternative Drug Intervention (ADI; New Haven)**

The ADI program offers full services to male pretrial defendants with substance dependence in New Haven court (women go into the JD Women's program). Services include clinical, medication, case management, and client supports.

#### **Pretrial Intervention Program (PTIP; statewide)**

Per state statute, the PTIP program provides: 1) evaluations for placement recommendation for "first-offender" DUI and drug possession cases and 2) Alcohol Education groups, Drug Education groups, or referral to substance abuse treatment programs.

### **III. Re-entry DOC-DMHAS Referral Process (statewide)**

All discharging sentenced inmates with SMI are referred to the DMHAS Division of Forensic Services and assigned to an LMHA for discharge planning and engagement. Some of these individuals are admitted to CORP.

#### **Connecticut Offender Re-entry Program (CORP; 5 sites; 4 prisons)**

CORP provides pre-release (6-18 months) engagement, discharge planning, and twice weekly skills groups in DOC by LMHA staff for sentenced inmates with SMI. Also provided are post-release support, temporary housing, and client supports.

#### **Transitional Case Management (TCM; 4 sites; 5 prisons)**

TCM offers pre-release (3-4 months) engagement and discharge planning in DOC by PNPs and post-release outpatient substance abuse treatment, case management, and temporary housing for sentenced men with substance dependence.

### **IV. Programs That Serve Multiple Points In The Criminal Justice System Community Recovery Engagement Support and Treatment (CREST; New Haven)**

The CREST program is a day reporting center for adults with SMI under court/probation/parole/PSRB supervision. Services include case management and skills groups, as well as clinical services provided by the LMHA.

#### **Sierra Center Pretrial Transitional Residential Program (New Haven)**

DFS funds 9 beds and CSSD funds 14 beds for pretrial defendants with SMI statewide who are released from jail. The Sierra center provides skill-building, programming and intensive supervision. The LMHA provides clinical services and case management. Most clients also attend CREST.

### **Advanced Supervision and Intervention Support Team (ASIST; 9 sites)**

ASIST combines AIC supervision with clinical support (LMHAs and PNPs) and case management for adults with moderate-serious mental illness under court/probation/parole supervision. ASIST is collaboratively funded/managed by DMHAS, CSSD, and DOC. Some temporary housing and client supports are provided.

### **Forensic Supportive Housing (FSH; 3 sites)**

FSH offers permanent supportive housing services with Rental Assistance Program (RAP) certificates for Division of Forensic Services clients with SMI and patients with SMI discharging from state psychiatric beds at risk of incarceration. It includes temporary housing, temporary rental assistance before RAP is granted, and client supports.

### **Forensic Housing Assistance Fund (FHAF)**

FHAF uses funds in the Housing Assistance Fund (HAF) that are allocated for clients of DFS programs. The program provides temporary funds to help clients with SMI secure permanent housing prior to receipt of a permanent rental subsidy. It subsidizes rents and provides a no-interest loan for security deposit for an apartment and utilities.

### **Forensic Transitional Housing**

Transitional housing beds are provided in multiple locations so that homelessness is not a barrier for adults who are diverted or re-entering the community.

## **Community-based Treatment Services**

The department's **Community Services Division (CSD)** has direct responsibility for overseeing most DMHAS contracted services, which includes funded Local Mental Health Authorities (LMHAs) for behavioral health services as well as all funded community nonprofit addiction service providers. CSD activities include:

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

CSD provides oversight to the seven private nonprofit contracted LMHAs and ensures they receive information regarding department policies and system initiatives. CSD provides a consistent approach in its collaboration with LMHAs to operationalize fiscal, administrative, and clinical responsibilities, as well as DMHAS initiatives, at the local level. CSD monitors the activities of the LMHAs in allocating resources

among programs and facilities in response to system needs providing a link between LMHAs and DMHAS' Office of the Commissioner. This organizational structure recognizes variations in local needs and provides the essential framework for achieving DMHAS' objectives and operations. The six state-operated LMHAs report directly to the DMHAS Assistant to the Commissioner, and some state-operated programs are including in CSD monitoring activities for a statewide perspective (e.g., ACT, CSP). CSD Regional Staff coordinates 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 practitioners
- Private nonprofit mental health providers not funded by DMHAS
- DOC for prison inmates
- Board of Pardons and Paroles for persons paroled into the community
- JB-CSSD for probationers
- Federally Qualified Health Centers, Health Maintenance Organizations, and primary care physicians
- U.S. Department of Veterans' Affairs, including inpatient psychiatric beds, and outpatient and counseling services at two VA medical centers, six community-based outpatient clinics and four Veterans' Centers
- Volunteer-run, peer supported services and self-help groups

### **Mobile Emergency Crisis Services**

Mobile Emergency Crisis Services are defined as mobile, readily accessible, rapid response, short term services for individuals eighteen (18) or older and their families experiencing episodes of acute behavioral health crises. These services are delivered with appropriate safety measures in safe settings through the Local Mental Health Authority (LMHA) and one other community agency through the use of mobile emergency crisis teams. Mobile emergency crisis services provide concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, stabilize psychiatric symptoms, behavioral, and situational problems, and whenever possible, avert the need for hospitalization. Mobile emergency crisis services focus on evaluation, stabilization and supports and activities may include: assessment, evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further continuous care and assistance as

required. Mobile emergency crisis clinicians collaborate with and assist local police officers to de-escalate crises and provide diversion to alternative settings rather than incarcerations. DMHAS has implemented the Crisis Intervention Team (CIT) model, a best practice designed to promote safety for persons in crisis, the community, and the police officers who respond to crisis calls. The CIT trained clinicians work collaboratively with police departments and, when available, respond to crisis calls with the police.

### **Crisis Respite Services**

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

### **Outpatient Services**

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

### **Group Homes**

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

### **Intensive Residential Mental Health Treatment**

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

### **Supervised Housing**

Supervised housing is a set of recovery-oriented services provided 24/7 by on-site staff. Staff provides individuals with assistance in all areas of daily living, community integration, education assistance and counseling, management of personal financial resources and budgeting, referrals to all necessary services, meal preparation, improving communication skills, and use of leisure time. Other services include case management and, as needed, housing assistance from the housing resource coordinator to aid individuals in finding, obtaining, and keeping safe affordable housing.

### **Supportive Housing**

Supportive housing combines affordable housing, most often through a rental subsidy, with intensive yet flexible support services. These services focus on housing-based case management or assisting the tenant reintegrate into the community by teaching him/her the basic skills of tenancy. Supportive Housing has proven to reduce higher cost institutional services, such as homeless shelters, inpatient psychiatric and physical hospitalizations, as well as readmission into the criminal justice system. Connecticut has created over 2000 units of Supportive Housing in the past 10 years through the establishment of the Interagency Committee on Supportive Housing to address the needs of the homeless population in the state.

### **Community Support Services**

Support services provided in the community are designed to assist persons with serious mental illness to function as independently and self-sufficiently as possible to enhance their chances of successful community placement. Peer staff draw on their experiences with SMI and co-occurring disorders to further facilitate recovery and community participation of the individuals served.

### **Assertive Community Treatment (ACT)**

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

### **Community Support Programs (CSP)**

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

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

## **Mental Health 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.

### **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.

### **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, jails or other community locations where their services are needed. The Peer Bridgers develop relationships with community resources and supports and function as liaisons for the program participants, including providing transportation. The Peer Bridgers provide long-term support for persons with SPMI to function optimally in the community.

### **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 – 21 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 – 21 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 the care of DCF.

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 – 21 year old clients are discharged to supportive community settings.

### **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.

### **Supported Employment and Education Services**



Employment and educational services are integral to DMHAS' goal of offering a recovery-oriented system of care for persons in recovery who experience behavioral health conditions. DMHAS has put protocols in place to insure that consumers have both the necessary opportunities and supports to become involved in employment and education activities that have been shown to promote recovery and facilitate successful community integration. DMHAS funds 33 agencies that provide a broad menu of employment and education services. In 2016, DMHAS had to reduce the supported employment contract due to reductions in state funding. Current contracts focus DMHAS funding on Individual Placement and Support (IPS) evidence-based supported employment and preferred employment practices as well as emerging supported education best practices. DMHAS uses a modified version of the SAMHSA Supported Education toolkit to deliver supported education services. The DMHAS employment systems manager conducts fidelity reviews every two years at each site to insure ongoing quality improvement. Extensive feedback is offered along with technical assistance and training to any and all providers who need or request assistance with program/staff capacity building. DMHAS continues extensive collaboration with the Department of Rehabilitation Services (DORS), Connecticut's Vocational Rehabilitation Agency. DMHAS and DORS jointly fund a manager that works to bridge our complementary employment services at the state and local levels. With the award of a new 5-year SAMHSA grant to deliver Supported Employment services to underserved populations, and in efforts to expand employment services, DMHAS has contracted with two additional providers to deliver modified IPS supported employment services serving the Hispanic population in the greater Hartford area and persons with criminal justice involvement in the greater New Haven area.

## Continuum of Substance Use Treatment Services

### Overview

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

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

transportation, employment services and relapse prevention. In addition, supports provided include telephone peer support and Recovery Centers. Mutual help organizations, e.g., 12-step programs, provide a supportive network, which encourages individuals in their efforts to maintain a substance-free lifestyle in the community.

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

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

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

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

Members of these priority populations will receive care based on what is recommended for them as determined by assessment combined with their preferences. Pregnant women are given priority access to treatment and will receive prenatal care directly by the provider or through referral. Pregnant women and women with dependent children have specialized “Women and Children’s” programs available along with supportive services. Persons with opioid use disorders who inject drugs can access MAT which has expanded services to meet needs resulting from the current opioid epidemic. Services are available for persons with TB and HIV/AIDS including screening, counseling, treatment and referrals for care and the data for both these populations reflect a trend of decreasing numbers of new infections.

## **Detoxification Services**

### **Medically Managed Detoxification (4.2)**

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

### **Medically Monitored (Residential) Detoxification (3.7D)**

Medically monitored detoxification is provided in a residential facility licensed by the Department of Public Health (DPH) to offer residential detoxification and evaluation; it involves treatment of substance use dependence when 24-hour medical and nursing oversight is required. Comprehensive evaluations and withdrawal management are provided as well as short-term counseling, connections to treatment,

and referrals to other supports. These programs are increasingly using methadone, buprenorphine, and naltrexone to start people on long-term use of these medications for OUD.

### **Residential Rehabilitation Services**

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

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

#### **Intensive Residential Rehabilitation (3.7)**

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

#### **Intermediate/Long-Term Residential (3.5)**

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

#### **Long-Term Residential Care (3.3)**

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

#### **Transitional/Halfway House (3.1)**

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

## **Ambulatory (Outpatient) Services**

### **Intensive Outpatient Services**

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

### **Veterans Recovery Center (VRC) at Fellowship House**

A collaborative effort between DMHAS and the Connecticut Department of Veterans' Affairs (DVA) is the Veterans Recovery Center providing outpatient and an optional four-week intensive outpatient (required 12 hours per week) programs for veterans. Services provided by DMHAS include relapse prevention, 12-step groups, anger management groups, and meditation classes. The Fellowship House is located on the grounds of the DVA under the auspices of DMHAS. The program is designed to assist and support veterans with substance use disorders to achieve their recovery goals. The VRC interfaces with other services on the DVA grounds, including educational and vocational referrals, employment counseling and job placement assistance.

### **Standard Outpatient**

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

### **Medication Assisted Treatment**

#### *Methadone Maintenance*

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

#### *Buprenorphine and Naltrexone Maintenance*

Buprenorphine maintenance is a non-residential, medically necessary service provided in a state-operated facility, or in a facility licensed by DPH to offer medically necessary chemical maintenance treatment. Buprenorphine maintenance involves regularly scheduled administration of Buprenorphine,

prescribed at individual dosages, and usually includes adjunct clinical/counseling services. More frequent clinical contacts are provided if indicated in the individual's recovery plan. Medical and nursing supervision are provided. In response to the opioid crisis, DMHAS has applied for and received SAMHSA grant funds which have allowed it to expand buprenorphine and naltrexone access by assisting prescribers in its facilities with obtaining the DATA waiver to prescribe, providing guidelines for infrastructure development related to buprenorphine prescribing, and hiring recovery coaches to assist in the process.

#### *Ambulatory Detoxification*

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

### **Substance Use Support Services**

#### **Shelter**

Shelter services provide short-term housing to individuals who are homeless and assistance in connecting them with stable housing and clinical 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.

### **Evidence-Based and Best Practices**

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

#### **Assertive Community Treatment (ACT)**

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

#### **Integrated Treatment for Individuals with Co-Occurring Disorders**

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

#### **Dialectical Behavior Therapy (DBT)**

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

### **Supported Employment (SE)**

Using the Individual Placement and Support (IPS) model, SE is implemented in thirty programs throughout the state. This evidence-based model is described in contract language as the scope of work. Fidelity reviews continue to support high fidelity implementation. DMHAS continues to participate in the international supported employment collaborative convened by Westat. In fall 2014, DMHAS was awarded a 5-year SAMHSA Supported Employment grant to strengthen and expand SE services across the state, particularly for Latinos and individuals with criminal justice involvement.

### **Supported Education**

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

### **Supportive Housing**

Supportive Housing continues with high quality fidelity monitoring and implementation.

### **Trauma-Informed and Trauma-Specific Services**

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

### **Medication Assisted Treatment (MAT)**

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

### **Other Evidence Based Practices (EBPs)**

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

### **Alternative Services**

DMHAS has an integrative Medicine Committee at Connecticut Valley Hospital as well as a statewide committee. The first annual conference was held in December 2016. There is increased emphasis in this area relative to the opioid crisis (e.g., alternative pain management strategies). A webpage was created



on the DMHAS website documenting the committee's work and information on this topic:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=580236>.

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

### **EBP Governance Committee**

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

The EBP Division created a series of webpages on the DMHAS website that describe different EBPs and various publications available to help implement the practices. This is a valuable resource for providers, consumers and families: <http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912>.

## **Targeted Services and Populations**

### **Trauma Services**

Trauma responsiveness 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/printed-training-catalog>.

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 get two free staff training slots for each trauma event. The cost for DMHAS-funded participants is subsidized by DMHAS funding.

- The Trauma and Gender (TAG) Learning Collaborative bimonthly meeting is co-chaired by DMHAS and the CWC and promotes best practices in trauma-informed and gender-responsive behavioral healthcare in Connecticut by providing recommendations, tools, trainings, national/local experts and networking opportunities to **all** DMHAS funded and operated agencies.
- The Women's Services Practice Improvement Collaborative (WSPIC) is a partnership of the CWC, DMHAS and women's specialty service providers. The collaborative meets bi-monthly and offers all women's services providers with an opportunity to learn from each other in a collaborative environment. Expert speakers are brought in to enhance learning and provide education on evidence based practices, new DMHAS initiatives and current trends related to women's healthcare. Recent topics include implementation of "One Key Question" curriculum, breastfeeding, maternal and infant attachment, Child Abuse Prevention and Treatment Act (CAPTA), education services and housing. Additionally, a case study is presented each month, by a treatment provider, and feedback and resources are provided by the group to enhance clinical practice.
- The Consortium publishes a *Trauma Matters* newsletter quarterly which is widely distributed: [www.womensconsortium.org/trauma-matters](http://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/trauma-services-directory>
- The DMHAS Trauma webpage: <https://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335292>

## Women's Services

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

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

- Primary health care and prenatal care;
- Primary pediatric care including immunizations for children of women in treatment;
- Mental health services, including evaluation, treatment, and medication prescribing and monitoring;
- Linkages to coordinate and integrate support services with substance use services and prenatal services;
- Non-emergency transportation to medical and social services for pregnancy-related care;

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

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

All priority access calls are routed to the centralized phone number at the Department’s Administrative Service Organization’s (Advanced Behavioral Health – ABH) where calls are tracked and care coordination monitored. If ABH cannot obtain timely treatment placement for the women, the DMHAS Women’s Administrator and/or her designee are contacted to ensure timely access to care or to have interim services arranged. ABH produces quarterly reports that include the number of calls received and the outcome of the request. Bringing the process of earlier identification, treatment engagement and access together in one place has enhanced the previous referral system and provides a greater level of accountability regarding priority access to care for pregnant and parenting women.

**Women’s Specialty Services**

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

**67 Bed Capacity - PPW SU residences**

| <b>Agency</b>       | <b>Residential Program</b>   | <b>Location</b> |
|---------------------|------------------------------|-----------------|
| Liberation Programs | Families in Recovery Program | Norwalk         |
| Connection, Inc.    | Hallie House                 | Middletown      |

|                            |                            |           |
|----------------------------|----------------------------|-----------|
| Connection, Inc.           | Mother's Retreat           | Groton    |
| APT Foundation             | Amethyst House             | New Haven |
| Community Health Resources | New Life                   | Putnam    |
| InterCommunity             | Coventry House             | Hartford  |
| Wellmore Behavioral Health | Women & Children's Program | Waterbury |

### Women's Outpatient Services

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

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

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

### 15 Women's Recovery Navigators statewide – 3 per region

| Women's REACH Program Agency            | Locations Served                              |
|---|---|
| CASA, Inc.                              | Region 1 (Bridgeport, Norwalk & Stamford)     |
| The Connection, Inc                     | Region 2 (Middletown, Meriden & New Haven)    |
| Advanced Behavioral Health              | Region 3 (Norwich, New London & Willimantic)  |
| The Village for Families & Children     | Region 4 (Hartford, New Britain & Manchester) |
| The McCall Center for Behavioral Health | Region 5 (Danbury, Waterbury & Torrington)    |

### Key Interagency Collaborations

#### CT Keeping Infants Drug-free (CT KID)

This initiative is funded by DMHAS and DCF. The mission of CT KID is to improve the capacity of professionals to diagnose, treat and prevent prenatal substance exposure, including Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD), and through education, policy, and increase coordination of services that engage and support families impacted by substance use. In 2015, the **NAS/FASD Statewide Coordinator** position was established. The SEI coordinator is tasked with

implementing the five year strategic plan developed by DMHAS and DCF while determining ongoing mutual priorities with project partners related to screening and assessment, engagement and retention in treatment, and data and information sharing.

#### **CT Women and Opioids Workgroup (CT-WOW)**

This workgroup was created in 2016 following an invitational symposium sponsored by the US DHHS, Office of Women's Health. The interagency workgroup has established partnerships and a strategic plan to address the Child Abuse Protection and Treatment Act (CAPTA) which requires the notification by healthcare settings of substance exposed infants to DCF, incorporation of reproductive health education for women with substance use disorders and further investigation of evidence-based practices for pain management for women with substance use disorders. **\*In April 2019, DMHAS will sponsor a full-day conference entitled "The Opioid Crisis: Supporting Women & Families."**

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

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

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

#### **Every Woman Connecticut (EWCT)**

Every Woman Connecticut is an initiative that focuses on addressing improvements in care for individuals of childbearing age, recognizing that physical, emotional, and social health are vital to overall wellbeing. A primary intervention promoted by EWCT is **"One Key Question® (OKQ)."** DMHAS has plans to provide training and implementation of this curriculum, in partnership with March of Dimes, throughout our service system in the coming year. To date, 5 of the 7 women and children's Substance Use Residential programs have received OKQ training.

#### **Two-Generation Interventions (2 Gen)**

The Department has partnered with sister agencies in the adoption of a two-generation focus in the PPW programs by creating programming and interventions that support a women's role as caregiver and as an integral component of the family unit. One such intervention is the partnering of DMHAS' Pregnant and Parenting Women Substance Use residences with the Office of Early Childhood/Early Head Start. Early Head Start has been offered to all women and children in the PPW residential programs since 2015 to provide access to comprehensive services and support for all low-income children. Each program has developed a memorandum of agreement with a local Early Head Start provider and several

had the opportunity to participate in Infant Mental Health and Circle of Security Training to help women and children improve attachment, recover from trauma and understand the interaction of these topics within the parent-child relationship and family system.

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

### **State Health Improvement Plan (SHIP)**

The SHIP initiative addresses the category of mental health and substance use disorders by seeking to improve overall health across the lifespan through access to quality behavioral health services that include screening, early intervention, prevention and treatment as well as reducing non-medical use of pain relievers. In the area of Maternal, Infant and Child Health, work is being directed toward optimizing the health and well-being of women, infants and families with a focus on disparate populations.

### **Child Abuse Prevention and Treatment Act (CAPTA) Stakeholder Group**

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

### **Young Adult Services**

Early intervention with young adults experiencing behavioral health problems can reduce the likelihood of future disability, increase the potential for productive adulthood, and avoid life-long service costs and other adverse consequences. The Young Adult Services (YAS) division at DMHAS continues to focus on meeting the needs of youth transitioning out of the DCF system into the DMHAS adult treatment system. Young adults transferring from DCF exhibit extremely complex psychiatric issues, significant neurocognitive deficits and impairments in functional life domains. As a result, the youth being referred require services and supports that create a supportive, safe, and structured environment that allows them to learn the skills that they need in order for them to transition to a more independent living situation.

In an effort to provide these levels of care that are age and developmentally appropriate and trauma-informed, DMHAS YAS not only focuses on the clinical aspects of care, but also the practical aspect of skill development and basic needs for quality of life. In addition, YAS continues to identify programs and initiate projects to support the treatment and recovery needs of these high risk youth and young adults. YAS has also established peer mentoring and youth advisory services for youth and continues to provide training and support on the inclusion of families in the person-centered planning process as well as expanding programming that emphasizes employment skills and employment opportunities in youth businesses.

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

"Be Proud Be Responsible" (BPBR) continues to be implemented as a prevention initiative that uses an evidence-based curriculum designed to give young people the knowledge and skills they need to reduce their risk of HIV and other sexually transmitted diseases. The course offers this sensitive material in a safe and engaging manner that young adults can relate to while it educates them about sexual behavior, risk factors, and prophylactic strategies.

### **Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) Services**

Intervening early with mental illness improves outcomes over both the short and long-term. Unfortunately, for many young people, the path to receiving appropriate services has not been smooth or efficient. Connecticut's system of services for ESMI has evolved in recent years, in part due to the establishment of the 10% set-aside, and includes the following components:

Beacon First Episode Program – the Department of Children and Families (DCF) contracted with Beacon Health Options using 10% set-aside funds with the goal of mining Medicaid claims data for identification and referral of members with early psychosis. Potential members are identified through two mechanisms:

- Criteria based claims methodology in which the member was not diagnosed with a psychotic disorder nor filled a prescription for an antipsychotic in the period looking back from 6 to 24 months from the current point in time AND has been diagnosed with a psychotic disorder and filled a prescription for an antipsychotic within the past 6 months.
- Real time identification by Beacon staff noting members with a first inpatient hospitalization/treatment episode for psychotic symptoms OR a member displaying signs/symptoms of what appears to be a first episode psychosis.

The Beacon FEP Intensive Case Manager (ICM) assesses the eligibility of real-time referrals as they are reported by Beacon staff and reviews the claims-identified members' data monthly to determine appropriateness for inclusion in the FEP program. The FEP ICM assesses whether those meeting criteria for FEP are already connected to services or not. If they are not yet connected to services, the FEP ICM attempts to engage the member and/ or their caregiver so that connections to services are made.

PRIME Clinic – The Prevention through Risk Identification, Management and Education (PRIME) clinic is a Psychosis Prodrome Research Clinic for persons ages 12 – 40 whose thoughts, feelings and/or experiences have changed in a way that is cause for concern and may indicate the presence of a serious mental illness. Schizophrenia and other Psychotic disorders are often preceded by prodromal changes which may last days to years before the onset of the illness. The longer the duration of untreated psychosis (DUP), the greater the likelihood of dysfunction for the individual over their lifetime. The PRIME clinic offers:

- free clinical evaluation and assessment

- supportive counseling
- follow along monitoring
- clinical treatment with medications
- neuropsychological testing
- MRI (magnetic resonance imaging) evaluations
- Community education
- Free treatment
- Collaboration with community providers and schools

Specialized Treatment in Early Psychosis (STEP) Program – The STEP program is based at the Community Mental Health Center (CMHC) in New Haven, Connecticut and operates as a collaboration between the state Department of Mental Health and Addiction Services (DMHAS) and Yale University Department of Psychiatry. It receives some of the 10% set-aside FEP funds. STEP serves the 10 towns comprising the Greater New Haven area for persons 16 – 35 using a phase-specific model and offering free comprehensive clinical care to patients and families including:

- Comprehensive clinical evaluation and regular outcome assessments
- Medication management
- Individual and group therapy
- Family education and support
- Social cognition and skills
- Rehabilitation (education and employment)

Potential Program – The Potential Program is based in Hartford, Connecticut and is a collaboration of Hartford Hospital and the Institute of Living. A recipient of some of the 10% set-aside FEP funds, it serves young people across Connecticut (except for the Greater New Haven area). Potential offers specialized and less intensive services within its young adult program for persons in the early stage of psychotic illness, including outreach and vocational services as well as:

- Individual and group psychotherapy
- Medication management
- Family education and support
- Cognitive remediation

### **Military Personnel and their Families**

DMHAS' Military Support Program (MSP) was established in 2007 by Connecticut General Statute and is unique in the United States. The MSP is funded by DMHAS and operated by Advanced Behavioral Health (ABH). Each year, hundreds of service members, veterans, and their families have accessed counseling services through MSP for issues such as depression, anxiety, sleep difficulties, substance use disorders, trauma, marital/family issues, and children/adolescent struggles related to a parent's deployment. Assistance is provided in the form of information and referral to outpatient counseling for service members from Operations Enduring Freedom (OEF), Iraqi Freedom (OIF) and New Dawn (OND); National Guard/Reserve members; and their families, broadly defined to include spouses, children, siblings, parents, cousins, grandparents, and significant others. All veterans with post-9/11 military service and their family members are eligible. Counseling services are confidential and available locally.

A toll free number (866-251-2913) reaches the MSP call center operated by ABH. The call center is open weekdays from 8:30 am to 5:00 pm. The MSP will provide:



- **Outreach** through involvement in the Yellow Ribbon Reintegration Program and the Embedded Clinical Program
- **Intensive Community Case Management** to assist military members and their families with obtaining timely and appropriate services and supports
- **Referral** to local confidential counseling services using service member's insurance plans or to other free or affordable community resources
- **Follow up** through case management until a connection with resources is established

MSP services are provided at no cost to the military member and their family. For those with private insurance, the MSP staff will access the service member's providers, formulate a list of local providers, and call the providers to ensure that they have openings and are familiar with military life issues. Follow up calls are made to ensure that service members find a good match with a counselor. For those without insurance, the MSP will provide free, intensive case management to assist the service member to access state-funded outpatient services or a provider participating in a no-fee community program such as "Give-an-hour". Service members and their families are also assisted with determining eligibility for insurance and applying for coverage.

MSP staff assesses the caller's overall needs and identify resources to meet those needs. MSP staff participates in statewide and community coordinating committees that work to identify and resolve unmet needs of service members and their families. MSP partners with the Connecticut Army National Guard (CTARNG) Behavioral Health, National Guard Service Member and Family Support Center, Vet Centers and VA Healthcare System to maximize access to existing services.

The Embedded Clinician services of the MSP provides deployment health education to service members and their families and serves as a key point of contact for behavioral health services. Embedded Clinicians are licensed behavioral health professionals assigned to specific National Guard Units who attend one drill day a month. The Embedded Clinician program is unique in that no other state in the country established a program that embeds civilian clinicians with National Guard Units at the Company level.

DMHAS Forensics Division operates a jail diversion program for veterans in Connecticut.

### **Persons with Mental Illness who are Homeless**

In an effort to decrease the number of homeless individuals with SMI, or with co-occurring substance use disorders, DMHAS established Homeless Outreach and Engagement Teams. These teams provide outreach, assessment, engagement, and case management services to homeless individuals. The department is a recipient of federal formula funds from Projects for Assistance in Transition from Homelessness (PATH) that serves persons with SMI or who are dually diagnosed with SMI and a co-occurring substance use disorder that are homeless or at risk of becoming homeless. The Homeless Outreach Teams are scattered across the state in urban, suburban, and rural settings. In addition to these Homeless Outreach Teams, DMHAS worked to create a network of social service and rental subsidy providers to produce approximately 4000 units of permanent supportive housing. These units include housing subsidies with case management services and are dedicated to individuals who are experiencing homelessness and have a mental health or co-occurring substance use disorder with the goal of stabilizing the individual in the community.

### **Persons involved in Criminal Justice System (see Forensic Services Division)**

In Connecticut, the Department of Correction (DOC) operates all jails, prisons and Adult Parole. Bail Services and Adult Probation are administered by the Court Support Services Division (CSSD) of the Judicial Branch. Law enforcement is operated by local police and state police.

While DMHAS does not provide behavioral health services in correctional facilities, it implemented all programs for criminal justice involved persons in collaboration with police, courts, DOC, probation, parole, Board of Pardons and Paroles and continues to operate the programs with these collaborations. DMHAS participates in multiple standing and ad hoc state level committees and commissions that address criminal justice policy and programming. DMHAS chairs a monthly meeting with DOC custody, program, and mental health staff, Parole, Probation, and LMHAS to address system barriers and plan for release coordination of inmates with serious mental illness.

The DMHAS Division of Forensic Services manages a variety of community programs for adults where close collaboration with the criminal justice system is needed to maximize diversion and successful re-entry. Services range from the Crisis Intervention Team program for police to divert individuals at the time of initial contact with law enforcement, to an array of court-based jail diversion (JD) and specialty diversion programs in lieu of incarceration, to coordinating arrangements for continuing behavioral health care for those with an anticipated DOC release, including appointments, expedited Medicaid eligibility, identification papers, etc.

The 2011 State of Connecticut Re-entry Strategy outlines the process of connecting released inmates to community services. The plan is available at:

[http://www.ct.gov/opm/lib/opm/cjppd/cjcjpac/20110215\\_reentry\\_riskassessmentstrategy.pdf](http://www.ct.gov/opm/lib/opm/cjppd/cjcjpac/20110215_reentry_riskassessmentstrategy.pdf).

### **Rural/Older Adults/Nursing Homes/Medicaid Home/MFP**

#### **Persons who live in Rural Areas**

The Connecticut Office of Rural Health (CT-ORH) has defined “rural” as a census of less than 10,000 and a population density of 500 people or less per square mile; as adopted by the CT-ORH Advisory Board November 2014. Using this algorithm, the rural population for the state is estimated at 326,132<sup>1</sup>. The total rural population currently represents 9.1% of the state’s overall population. In general, rural residents tend to be aged 65 years and older, excepting the southwestern region which has more people aged less than 20 years. Each county has some town within its borders that meet the definition of “rural”, although the vast majority of these are within the Eastern and Northwestern portions of the state.

DMHAS continues to examine the need, accessibility and availability of behavioral health services in rural areas. Past efforts to develop local systems of care has taken into account issues such as lack of transportation. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices. The federally funded State Opioid Response (SOR) and State Targeted Response to the Opioid Crisis (STR) grants have increased capacity for MAT services and recovery supports provided by agencies serving rural communities across the state. Newly funded services include Recovery Coaches, located at 13 hospital emergency departments, many of which serve patients

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<sup>1</sup> Connecticut Office of Rural Health, “An Assessment of Connecticut Rural Health: Overview, Obstacles and Opportunities”, 2015. Retrieved from <  
[http://www.ruralhealthct.org/assets/CT\\_Office\\_of\\_Rural\\_Health\\_Rural%20Assessment\\_2015.pdf](http://www.ruralhealthct.org/assets/CT_Office_of_Rural_Health_Rural%20Assessment_2015.pdf)>.

from nearby rural towns. Additionally, the SOR grant has supported Naloxone training and distribution events and mini-grants for a minimum of 75 community coalitions for opioid awareness and prevention activities.

DMHAS has been a member of the Office of Rural Health (ORH) steering committee for more than 5 years. Connecticut's ORH is a member of the Alcohol and Drug Policy Council (ADPC).

### **Persons with Disabilities and Older Adults**

In 2011, the DMHAS Commissioner issued a departmental policy statement, *Accessibility to Services, Programs, Facilities and Activities*, which outlines the requirements of facilities in regard to their responsibilities pursuant to Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. All state-operated and contracted agencies are required to meet these requirements. The policy can be found at: <http://www.ct.gov/dmhas/lib/dmhas/policies/Chapter2.20.pdf>

### **Services for Older Adult Population**

As one in four older adults has a significant mental health disorder, this population requires focused attention and resources. Older adults with mental illness are at increased risk for receiving inadequate and inappropriate care. Without adequate treatment, mental health disorders in older persons are associated with significant disability and impairment, including compromised quality of life, cognitive impairment, increased caregiver stress, increased mortality and poor health outcomes. Older adults with mental health problems also have higher emergency department utilization and cost of healthcare services in general. As the baby boomer generation ages, it is estimated that by the year 2030, the number of older adults with major psychiatric illness will reach 15 million nationwide. In fact, in Connecticut, the general population is expected to increase by 9%, while the population age 65 and older is expected to increase by 35%. Proportionately, Connecticut is the fifth oldest state in the nation.

DMHAS' Long Term Services and Supports (LTSS) unit continues to broaden its statewide partnerships with providers of services to older adults. The LTSS Clinical Director attends the Office of Policy and Management's Long Term Care Planning Committee and co-chairs the Older Adult Workgroup with staff from the State Unit on Aging (part of the Department of Rehabilitation Services – DORS). The Older Adult Workgroup is comprised of public and private providers of services to older adults. The Workgroup continues to operationalize recommendations from the statewide assets mapping project completed in 2016 in conjunction with the University of Connecticut Center on Aging. One such recommendation was education to older adult service providers regarding the unique needs of older adults. This resulted in a full day conference in March 2019 titled *Successful Aging: The Intersection of Physical and Behavioral Health* where 200 people attended. Part of the afternoon session was dedicated on strengthening or re-establishing regional multi-disciplinary teams (MTeams) across the state by having regional breakout groups and expanding participants in the process. To date, MTeams are occurring in all but one region with planning for the final group currently in process.

DMHAS LTSS currently manages the Senior Outreach and Engagement Program that services older adults with substance use disorders and mental health needs. In 2017, DMHAS reconfigured their Senior Outreach Program and posted a Request for Proposals (RFP) for the new program. Awards were made to one private nonprofit agency in each of the 5 DMHAS regions with a start date of January 2018. The program provides services in a person-centered, strengths-based, culturally sensitive manner that reduces substance misuse, stabilizes behavioral health symptoms and improves quality of life, while

assisting older adults remain integrated in the community in the least restrictive setting possible. The program complements existing DMHAS programs that focus on diverting older adults from long term care and developing home and community based services to assist older adults with “aging in place.”

Another program that assesses for appropriate level of care is the Nursing Home Diversion and Transition Program (NHDTP). Through collaboration with DMHAS-funded agencies, the NHDTP was established with two 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. Nurse Clinicians, and Case Managers, funded by DMHAS, at private non-profit agencies work directly with a wide range of community providers, nursing home staff, and hospital discharge planners to establish appropriate levels of care for clients. There is also ongoing collaboration with the state's Money Follows the Person Demonstration Project and the Medicaid Home and Community-based Mental Health Waiver (MHW). The NHDTP Individuals who may not meet criteria for the waiver, or may not want wrap-around waiver services, may be served by the DMHAS NHDTP.

### **Screening for Nursing Homes and Long-Term Care**

A statewide needs assessment of Connecticut citizens regarding long-term care services found that approximately 25% of the respondents reported symptoms of depression. Additionally, persons with psychiatric disabilities reported difficulty accessing mental health services. To address these issues, the final Long-Term Care report to the General Assembly stressed the importance of state agency collaboration.

In February 2010, DSS contracted with a national vendor, ASCEND, to manage Connecticut's Pre-admission Screening Resident Review (PASRR) Program. In collaboration with DSS, DMHAS continues to work closely with ASCEND, to divert people from nursing homes and find more appropriate community placements. All clients with mental health issues are screened prior to admission to nursing homes.

A schedule of quarterly conference calls with DMHAS, ASCEND and DSS was established to discuss issues, referrals and trends noted by managers overseeing the contract. This enables managers to address systems issues with the provider network to ensure clients are appropriately referred and screened for nursing home admission.

### **Medicaid Home and Community-Based Services, Mental Health Waiver**

In September 2008, Connecticut was approved for a Mental Health Home and Community-Based Waiver to return clients to their communities who are currently receiving services in a nursing home. This also allows clients with mental illness in nursing homes to participate in the Federal Money Follows the Person (MFP) demonstration grant. Both of these rebalancing programs started in 2009 with the goal of discharging clients from nursing homes under a cost cap. Since April 2009, under the Mental Health HCBS Waiver, approximately 1500 clients were discharged or diverted from Nursing Homes into the community with the Mental Health Waiver Supports. The unique services of the Mental Health Waiver focus on psychiatric rehabilitation and recovery. The services are designed to help clients achieve the maximum independent functioning and recovery within their communities.

DMHAS service recipients have access to financial choice in self-directed care through the Mental Health Waiver. The Community Support Clinician, under contract or staffed by DMHAS, provides information to the waiver participant to support efforts to direct their own services. Individuals directing their own services are referred to the fiscal intermediary to provide employer-related services. The fiscal

intermediary coordinates multiple activities related to Recovery Assistant (RA) and Overnight Recovery Assistant (ORA) services such as recruitment, maintaining a registry of service providers, providing enrollment packets, performing background checks, providing information and training materials to assist in employment and training of workers, facilitating meetings with the participant and the staff providing RA and ORA services, managing, on a monthly basis, all invoices for RA and ORA against the amount of services authorized in a participants Recovery Plan, and developing fiscal accounting and expenditure reports.

### **Money Follows the Person (MFP) Demonstration Grant**

Both DSS (the State Medicaid Agency) and DMHAS have been involved in determining how many clients with psychiatric disorders are currently residing in Connecticut nursing homes. People eligible for DMHAS services are referred to the appropriate community provider. Through collaborative processes and in conjunction with the Mental Health Waiver, DMHAS and DSS MFP Demonstration Grant staff work to effectively discharge clients back into the community in a clinically sound manner. DMHAS MFP staff utilize the Universal Assessment that all other waivers use to screen participants to determine an appropriate recovery plan. DMHAS is an active member of the MFP Steering Committee, which is comprised of a coalition of cross-agency staff that addresses improved discharge planning regarding entitlements, housing, and other services. DMHAS also sits on the Long-Term Care Planning Committee and the MFP Quality Improvement Committee.

### **Problem Gambling Services (PGS)**

DMHAS provides individual, family, group, peer recovery support, medication, case management and financial counseling for persons 18 and older with problem or disordered gambling and other persons affected by gambling (e.g. family member, spouse, and significant other) through the Bettor Choice Gambling Treatment Programs offered at 16 locations state wide. The Problem Gambling Services (PGS) webpages offer direct links to these programs as well as brief videos highlighting individual and family journeys through the challenges of gambling disorder and the positive impacts of recovery, fact sheets on a number of problem gambling topics (teens and gambling, gambling and older adults, gambling and the criminal justice system, gambling and primary care, video gaming, etc.). The webpages also link to online training opportunities for DMHAS employees and DMHAS funded agencies (Introduction to Integrating Gambling and Problem Gambling into substance use and mental health; Working with people presenting gambling problems and financial issues in behavioral health settings; and Family Therapy with problem gamblers and their family members). A confidential help line, which connects the caller to the Connecticut Council on Problem Gambling (CCPG), a private nonprofit DMHAS funded agency, is available and posted on the DMHAS website. DMHAS continually evaluates and seeks to improve the Problem Gambling Helpline through collaborative efforts with CCPG, which also oversees a "live chat" option. Finally, there are several resources for clinicians on treating gambling disorder and materials for the general public to learn more about this hidden addiction.

PGS is currently working on the DiGI Initiative (Disordered Gambling Integration Initiative) which seeks to integrate problem gambling services into existing behavioral health programs. The initiative includes incorporating problem gambling into agencies through policy/procedure, protocols, staff development, materials and programming. At participating agencies:

- All staff would receive training and onsite support from PGS, including identifying key staff members who are working towards obtaining gambling-specific credentials;
- All clients would be screened and assessed, as indicated;

- Programs would provide problem gambling interventions, including psychoeducation.

PGS is involved in prevention efforts including:

- Statewide Gambling Awareness Prevention Initiative: in which Regional Gambling Awareness Teams comprised of prevention/treatment professionals and other community stakeholders work to raise awareness;
- Asian American Pacific Islander (AAPI) Ambassador Program: is a collaboration between PGS, CCPG and AAPI community stakeholders to raise awareness about gambling in AAPI communities using the Community Conversations model;
- Congregational/Community Assistance Program (CAP): provides 6 hour training sessions to organizations (e.g., faith based, businesses) throughout the state to raise awareness of the impact of addictions, including gambling, and suicide;
- Youth Peer Leadership and Gambling Awareness Media Project: Youth-produced gambling awareness media through PGS' partner, Capital Regional Education Council (CREC).

### Prevention Services

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

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

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

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

**Training and Technical Assistance Services Center** – provides training workshops that focus on prevention skills development, application of these skills, mental health promotion, and violence and

substance use prevention. They also assess the workforce training needs and ensure that trainings align with Prevention Certification.

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

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

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

Direct service programs include:

- **Local Prevention Councils (LPCs)** - Through the RBHAOs, all 169 cities/towns throughout Connecticut receive mini grants to support local, municipal-based alcohol, tobacco and other drug (ATOD) use prevention councils. The intent of this grant program is to facilitate the development and/or implementation of ATOD use prevention initiatives at the local level with the support of the chief elected officials. The specific goals of LPCs are to increase public awareness of ATOD prevention and stimulate the development and implementation of local prevention activities primarily focused on youth. Funds have been used to leverage more resources and can be used to support activities to increase awareness of opioid problems in this region.
- **CT SPF Coalitions (CSC)** - The 12 community-based programs/coalitions implement evidence based strategies to prevent underage drinking using the Strategic Prevention Framework (SPF) 5 Step process. The CSC programs use the SPF 5 Step process to address other priority substances such as marijuana and Prescription Drug abuse.
- Under the oversight of the CT Clearinghouse, a **Statewide Healthy Campus Coalition** is comprised of Connecticut colleges and universities who participate in, and occasionally receive funds for activities to address the reduction of ATOD use and abuse amongst their student populations.

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

## **Other DMHAS Programs**

### **TB and HIV**

DMHAS set-aside providers ensure that all persons admitted are informed of and offered infectious disease services, including TB screening, in a timely manner. DMHAS continues to offer technical assistance as needed to treatment programs that assure appropriate identification, treatment, and/or referral for those individuals identified as infected with TB and/or HIV.

The HIV/TB Services Administrator monitors DMHAS providers for compliance with infectious disease protocols, which provide for the identification of affected clients. CSD Regional Teams complete randomized chart reviews as part of their routine monitoring activities.

On October 1, 2016, DPH changed their practice of providing ppd solution for TB screening, prompted in part by very low numbers of Connecticut residents being found positive for active TB, even among populations previously considered at risk. This change aligned with CDC's efforts to revise guidelines/practices based on data that included the involvement of the Connecticut TB Control Officer, Lynn Sosa, M.D. of the Connecticut DPH. These changes necessitated a response by DMHAS as some providers had been receiving ppd solution directly from DPH without charge. Since federal law requires substance use treatment programs receiving SABG funds to make TB services available, DMHAS consulted with the Connecticut state TB Control Officer (Lynn Sosa) and the SAMHSA CSAT Project officer (Lisa Creatura) to resolve the situation. The resolution involved the introduction of a screening questionnaire. Those clients identified as at risk by the questionnaire have a ppd and those with a positive ppd result are referred for further services as indicated. Each affected program has a choice to either purchase ppd solution and conduct this screening at their facility or refer such clients to a community health center. A meeting was held with the affected providers, the DMHAS HIV/TB Services Administrator, the Block Grant State Planner and the DPH TB Control Officer to review the practice changes. At that meeting, the DPH TB Control Officer presented the most up to date evidence on TB and specifically, Connecticut data, including the very small number of active cases (including among PWID) and identified high-risk groups in our state as refugees from other countries or persons exposed to such refugees.

Connecticut has not been an HIV "designated" state for several years. According to the CDC HIV Surveillance Report, the 2017 rate for Connecticut was 7.4, well below the threshold. As a result of not being an HIV designated state, block grant funds are no longer used for HIV early intervention services.

Providers were directed by DMHAS to implement "opt-out testing" in 2011. This was based upon the CDC recommendations for "opt-out testing" for HIV/AIDS and the subsequent passage of Connecticut's own revisions to the state's HIV testing consent law (effective date – July 1, 2009). If an individual does opt out, they do receive the pre-test counseling to inform them of the risks if they are HIV positive. In the past, many people did not want to participate in what they considered "probing" pre-test counseling, which carried a stigma of its own, but are now more willing to be tested as part of other routine medical examinations. Feedback from providers indicates that opt-out testing has increased the numbers of people being tested. Providers continue to provide risk reduction counseling, family/partner



support, referrals to partner notification services, nutritional counseling, and, in some cases, alternative therapy such as acupuncture. All clients tested also receive post-test counseling services.

### **Charitable Choice**

Monitoring of the charitable choice requirement is by exception, i.e., the Community Services Division regional managers follow up on any complaints received. Beginning in state fiscal year 2012, DMHAS added contract language specifying the requirements of 42 CFR Part 54 and 54a prohibiting the use of SABG funds to support inherently religious activities in treatment services. Annually, DMHAS sends a notice to providers reminding them of the Charitable Choice requirements. In addition, faith-based providers post documents pertaining to the rights of clients to treatment services free of proselytizing and the right to seek referrals to alternative providers if the client objects to the religious nature of the provider. The department continues to explore additional options for enhancing provider awareness of the Charitable Choice regulation, especially the client's freedom not to engage in religious activities and their right to receive services from an alternative provider.

### **Services for Deaf/Deaf-Blind/Hard of Hearing (DHOH)**

The DMHAS Deaf/Deaf-Blind/Hard of Hearing (DHOH) office is part of the Office of Multicultural Health Equity (OMHE). All DMHAS state-operated facilities have a designated contact person that is educated and trained to accommodate the communication needs of persons who are DHOH. DMHAS offers DHOH services to clients/patients/companions/visitors of state-operated facilities and programs such that equal access to recovery-oriented, person-centered, culturally appropriate and linguistically accessible mental health and substance use services through an interpreter at no cost are provided. In addition, DMHAS offers vocational/employment services through a staff employment systems manager to assist DHOH individuals in finding employment.

There is a HOTLINE for Deaf/Deaf-Blind/Hard of Hearing persons in need of mental health assistance which can be accessed by texting the word "deaf" to 741-741. Also, in August 2018, Connecticut launched the statewide *Text 911* capability which allows persons who are DHOH or who have a speech disability and are in need of emergency services to text their emergency to 911.

### **Office of Multicultural Health Equity (OMHE)**

The Office of Multicultural Affairs (OMA) was established in 1997 to enhance the delivery of DMHAS mental health and substance use services for all individuals from diverse backgrounds, including, but not limited to such differences as race, ethnicity, age, gender, sexual orientation, spiritual background, and physical or mental status. Key goals of the OMA were to increase cultural competence at the direct care, organizational, and system levels and to identify and eliminate disparities through increased policy, program, and system development and design.

OMA is now the Office of Multicultural Health Equity (OMHE). The focus continues to be on the infusion of cultural competency and the identification and elimination of disparities. The current Strategic Plan from 2019 seeks to further imbed cultural competency within the DMHAS infrastructure and to enhance in-depth understanding of cultural factors and forces to analyze health disparities. Goals of the Strategic Plan include:

**Goal # 1: standardized data collection(demographics) and reporting throughout our system -**

Enhancing the DMHAS data collection system to include key demographic and cultural variables in all state-operated programs utilizing a new data collection tool for admissions that collects information on gender, race, ethnicity, preferred language, gender identity, sexual orientation, and vision and hearing problems.

**Goal # 2: CLAS Standards / Language Access** - Ensuring the implementation of Culturally and Linguistically Appropriate Services (CLAS) standards focusing on language access to be in compliance with federal law and to eliminate health disparities.

**Goal # 3: Training on Diversity and Inclusion to build and strengthen relationships, reduce disparities, provide resources, and engage clients and staff** - Providing training and technical assistance in implementing CLAS standards throughout the DMHAS service system.

**Goal # 4: Standard Operations for MCACs** - Ensuring the diversity of member representatives on the Multicultural Advisory Council (MCAC) reflects the stakeholder groups and the continuity of MCAC work at the local and state wide levels.

**Goal # 5: BHH Health Integration** – To see the intersectionality along gender and condition, to reduce disparities and to determine area of disparity and possible solutions that DMHAS will address.

Through the implementation of the Strategic Plan, DMHAS seeks to use linkages with other state agencies to further develop regional, cultural and recovery resources. It also provides the department opportunities to explore ways to implement cultural best and promising practices throughout the DMHAS system of services and supports, including the use of peer training for system change developed through collaboration with the Yale Program for Recovery and Community Health (PRCH).

DMHAS introduced a Connecticut Health Foundation funded initiative in collaboration with PRCH to develop and test a cultural competence system change intervention that uses consumers telling their stories to develop an understanding of the impact of bias and stigma on treatment and delivery of services. This ongoing effort, called *Recovery Speaks*, involves persons in recovery from substance use and mental health conditions sharing their success stories at different DMHAS and community sites.

DMHAS continues to work on its Health Disparities Initiative with support of its academic partners from Yale University. OMHE, in collaboration with Yale researchers, is continuing work to use both quantitative and qualitative methods to determine if the department’s implementation of multicultural policies, initiatives, and expectations have impacted disparities in state-operated inpatient services, utilize findings from disparities research to inform system interventions, use findings from evaluations of OMHE training programs to determine effectiveness of the training programs, and continue dissemination of disparities work with presentations and training curricula.

## **DMHAS Administrative Units**

### **Human Resources**

The DMHAS Human Resource Division (HRD) is responsible for providing a full range of human resource services to approximately 3,400 bargaining unit, confidential, and managerial employees at all locations throughout the state. HRD consists of several divisions that include: Employment Services, Facility Operations; Labor Relations; Loss Prevention; Payroll and Benefits; and the CORE Unit. The division provides quality, cost-effective, responsible and customer driven human resource services in order to support the department’s mission, goals, and strategic initiatives. In particular, HRD has established goals for filling registered nurse and licensed clinical social worker positions through its recruitment and retention activities and in response to a very challenging job market, the HRD has hired clinical recruiter

with a track record of hiring psychiatrists, physicians and executive level mental health professionals. In addition, other recruitment activities include student internships and other recruitment initiatives that attract qualified and competent applicants. These activities also include marketing opportunities and partnerships with social work and nursing schools as viable recruitment sources. The upward career mobility, educational leave, tuition reimbursement, and other educational benefit programs are offered in support of current employees who wish to pursue academic degrees in nursing, and other healthcare related disciplines.

### **Office of Workforce Development**

Through the DMHAS Office of Workforce Development, the department provides training to staff from both state operated and private nonprofit agencies funded by DMHAS. Free Instructor-led and self-directed, web-based training offers courses on a variety of behavioral health care topics including LGBT issues, working with veterans, evidence based practices and working with diverse populations. The division offers multiple courses related to mental health, substance use, and co-occurring disorders treatment. These include trainings related to evidence-based practices, including Cognitive Behavioral Therapy and Motivational Interviewing. The division offers three course catalogs a year and trainings are offered for free to staff at both DMHAS-operated and DMHAS-funded agencies.

### **Patient Confidentiality and Privacy**

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

- Overseeing the implementation of the DMHAS Compliance Plan by working with each facility and assessing risk areas;
- Analyzing the laws and regulations pertinent to the DMHAS health care environment;
- Consulting with the Attorney General's Office regarding interpretation of state and federal laws and actions, including possible infractions;
- 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;
- Consulting with Human Resources on establishing goals and objectives for employees;
- Encouraging manager and employees to report fraud or other improprieties without fear of retaliation;
- Training and educating new employees and existing employees through workshops, web-based training, and seminars;
- Conducting unauthorized PHI disclosure analysis to determine breach status;
- Supporting the DMHAS facilities in privacy investigations and researching complaints; and
- Responding and documenting "Alert Line" inquiries and/or problems and issues.

The Agency Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities, including but not limited to, patient records, billing records,

contract agreements, etc. This authority allows the Agency Compliance Officer to monitor agency controls as well as detect and intervene with potential compliance issues across the DMHAS state system of care.

### **Evaluation, Quality Management and Improvement**

The mission of the Evaluation, Quality Management and Improvement (EQMI) Division is to serve as the primary information and data resource center for DMHAS with regard to services provided and people served. WITS serves as the data system for the state-operated programs and DDaP serves as the data system for the private nonprofit programs. Together this data is maintained at the Enterprise Data Warehouse (EDW).

Major functions of EQMI include:

- Development, reporting and analysis of performance measures for services operated and funded by DMHAS
- Regular reports and analysis of DMHAS system performance, service utilization and trends
- Development, oversight, and analysis of the DMHAS consumer survey
- Administration of federal block grants
- Coordination of planning and priority setting activities

EQMI produces an array of routine reports including:

- Required federal data submission (e.g., TEDS, URS)
- Triennial report of substance use service activity in the state as required by the legislature
- An annual Consumer Satisfaction Report based on use of the MHSIP
- An annual Statistical Report on the numbers and demographic characteristics of clients served in the DMHAS system
- Quarterly “dashboard” data at the provider and program level as well as aggregated by level of care state wide reflecting admissions, discharges, and other activities performed by that level of care demonstrating trends and comparing the data to state averages or thresholds
- An annual Continuous Quality Improvement (CQI) plan that includes a focus on a DMHAS data-informed high priority issue (e.g., the opioid epidemic)

Most of the reports produced by EQMI are posted on the DMHAS website and can be accessed by the public. EQMI also collects, analyzes and reports on critical incidents, use of restraint and seclusion, DMHAS services by region and other data as requested or as circumstances dictate.

### **Research and Evaluation of Services**

The DMHAS Research Division was created over two decades ago through a unique arrangement with the University of Connecticut. Research Division staff are hired through UCONN and considered faculty and professional staff at the School of Social Work, but collectively serve as a DMHAS unit. As such, the DMHAS Research Division is a nationally recognized leader among state mental health and substance abuse agencies in services and applied research. DMHAS researchers, sometimes with partners at the University of Connecticut, Yale University, Dartmouth College, Brandeis University, Duke University, the Mount Sinai School of Medicine and others, have investigated many issues of policy relevance in the mental health and addictions fields. In addition to responding to the research needs of DMHAS and other state agencies such as the Department of Correction and the Office of Early Childhood, the

Research Division has received millions of dollars in federal funds to research such areas as supportive housing, homeless families, criminal justice diversion, co-occurring mental health and substance abuse disorders, consumer-operated services, trauma-informed care, mental health service quality indicators, substance abuse treatment outcomes, the needs of veterans, the concerns of young adults, and implementation science. DMHAS continues to conduct research to understand the processes underlying mental illness and addictive disorders, and to evaluate new techniques to respond to them. Research conducted in Connecticut informs decision-makers at both local and national levels about the effectiveness of treatment, prevention, and community-based interventions. Study findings are also reported in professional journals and at national conferences.

### **Recovery Services**

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

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

### **Connecticut Community for Addiction Recovery (CCAR)**

CCAR operates three recovery community centers (Bridgeport, Windham and Hartford) which offer a place to go and spend time with others in recovery from substance use, participate in 12-step meetings, and participate in other group activities. CCAR operates a Telephone Recovery Support program in which persons in recovery call others early in their recovery who have requested the support. Assistance may also be provided in the form of transportation to self-help support meetings, information about available resources, etc. CCAR initiated a new program in March 2017 which involves hospital EDs contacting a CCAR-trained Recovery Coach when they have a patient present with a substance-related issue (such as an overdose). The Recovery Coach attempts to engage the patient and get them to take the next step toward recovery. This initiative now includes 13 hospital EDs and in the coming year will include 21 hospital Emergency Departments. Expansion of CCAR recovery centers into two additional areas in the state (New Haven and Manchester) are underway.

## DMHAS Advisory Bodies

In determining the need for mental health services and the allocation of resources, the Commissioner and her Executive Group confer with and rely upon the viewpoints and recommendations of many constituency and stakeholder groups across the state. This includes the Board of Mental Health and Addiction Services, a 40-member advisory group consisting of gubernatorial appointees, Regional Behavioral Health Action Organizations (RBHAOs), consumers/individuals in recovery, family members, providers and advocates. Concerning matters of importance regarding the MHBG, the state's Adult Behavioral Health Planning Council plays a critical role, reporting its recommendations to the SBMHAS and the Commissioner.

The five RBHAOs, which were preceded statutorily by five Regional Mental Health Boards and thirteen Regional Action Councils, play a fundamental role in planning, prevention and advocacy efforts. RBHAOs work with local Catchment Area Councils (CACs) and local communities (organized into the Connecticut Prevention Network) to ensure grassroots involvement. Through regular contact with persons in recovery and with private and public providers of services, RBHAO members monitor ongoing services and assess the need for services. Through these efforts, they identify service gaps and deficiencies. Evaluations of the service system have factored into DMHAS' decisions to increase funding where service needs were identified, as well as to reduce or eliminate funding where programs were not effectively serving consumers. Members of RBHAOs are selected to represent all constituent groups – consumers of services, family members of consumers, municipalities, as well as private and public providers of services. RBHAOs examine issues from the varied perspectives of these constituent groups. In that role, they also touch upon a variety of concerns related to behavioral health including stigma/discrimination, primary health and wellness, public safety, criminal justice, education, housing and employment.

In addition, DMHAS actively collaborates and supports a number of consumer/persons in recovery advocacy groups, including the National Association on Mental Illness - Connecticut, Connecticut Community for Addiction Recovery (CCAR), and Advocacy Unlimited (AU).

## **Children's plan Step I**

**Asses the strengths and needs of the service system to address the specific populations. Include a discussion of the current service system's attention to the priority population children with SED.**

### **Section I State Information**

#### **Overview**

##### **Connecticut**

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

While approximately 10% of Connecticut (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 2018, CT Medicaid paid for 2,320 youth inpatient psychiatric stays, for a total number of 27,262 inpatient days; and 195 psychiatric residential treatment facilities (PRTF) admissions for a total number of 33,909 days. In addition, there were over 14,000 behavioral health emergency department (ED) visits. In 2017, CT experienced 3 suicides per 100,000 youth. With lifetime prevalence of schizophrenia spectrum disorders at 1 percent, an estimated 600 CT emerging adults annually need evidence-informed early psychosis services.

#### **The Department of Children and Families (DCF)**

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

DCF, established under Section 17a-2 of the Connecticut General Statutes, is one of the nation's few agencies to offer child protection, behavioral health and prevention services. This comprehensive approach enables DCF to offer quality services regardless

of how a child's problems arise. Whether children and youth are abused and/or neglected, or have emotional, mental health or substance abuse issues, the Department can respond to these children and youth in a way that draws upon community and state resources to help.

DCF recognizes the importance of family and strives to support children and youth in their homes and communities. When this is not possible, a placement that meets the child's individualized needs in the least restrictive setting is pursued. When services are provided out of the child's home, whether in foster care, residential treatment or other facilities, they are designed to return children safely and permanently back to the community.

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

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

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

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

## **Behavioral Health Assessment and Plan – Children's Services**

### **Organizational Structure - State Level (DCF)**

The Department has four mandated areas which include child welfare, children's behavioral health, education and prevention. In addition to the operated facilities, the Department consists of a Central Office and fourteen 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 took into account the work and recommendations of the policy committees established at the Governor's Policy Summit.

DCF's newly appointed Commissioner Vanessa 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. Development is ongoing with Phase 1 focused on getting mostly external input to develop a high-level agency vision & strategic goals, a top-level organizational structure and an executive team.

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

DCF Strategic Goals:

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

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

our sister agencies to join together and support and serve the families in Connecticut in an efficient and effective way.

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

#### Organizational Values

The strategy is about what DCF aims to do, but it is just as important to set the aspiration for how DCF will work to achieve its goals. To this end, it is important that agency's 3200 staff members work with purposeful pride and passion for practice, and people.

This means:

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

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

#### **Role of the State Mental Health Agency for Children: Connecticut Department of Children and Families**

##### **Statutory Authority:**

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

### **Children's Behavioral Health Plan:**

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

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

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

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

Since 2015, DCF continues to implement the behavioral health/mental health plan, in partnership with eleven other state agencies, numerous private agencies and children and families of Connecticut. Central to the development of the CT Children's Behavioral Health Plan is ongoing feedback from consumers and providers across the

state. The Department and all of the state partners benefits from the courage of families who share their stories and offer valuable feedback to what is working well and where improvements are needed. The feedback sessions are held annually and have continued involving over 300 adults and youth. These sessions are essential in allowing us to continuously examine the service system and make necessary adjustments and improvements.

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

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

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

In the coming two years CT hopes to fully examine the service system and the funding in real time rather than retrospectively. Such examination is critical to better inform

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

**Children's Mental Health Oversight:**

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

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

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

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

variety of sectors and professions, including attorneys, a physician, psychiatrist and community providers.

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

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

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

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

membership, at least one of which is a parent of a child with serious emotional disturbance.

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

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

### **State Agency Collaborations**

The Commissioners from DCF and the Department of Mental Health and Addiction Services (DMHAS), Department of Developmental Services (DDS), the Connecticut Judicial Branch, Court Support Services Division (CSSD), Department of Social Services (DSS), Department of Public Health (DPH), State Department of Education (SDE) and others meet and dialogue routinely and share in a number of joint activities,

Memorandum of Understanding (MOUs) and shared projects regarding cross-cutting mental health issues of importance to each of the agencies. Some of these activities, MOUs and projects include the following:

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

### **Administrative Service Organization Partnership**

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



primary care providers such as pediatricians and provide co-occurring mental health and substance use services when necessary.

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

### **Licensing Mental Health and Related Services**

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

### **Credentialing Mental Health and Related Services**

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

- Reviewing background information that is submitted with the individual's application including criminal records, child protective service registry and sex offender registry

- Reviewing the Federal Office of the Inspector General’s website registry of professional healthcare providers and entities excluded from participation in federal healthcare programs
- Receiving and recording complaints regarding provider service quality and performance
- Conducting quality site visits for all After School programs to assure the program is offered in a safe and secure setting

### **Mental Health Services Oversight**

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

### **Description of the State Mental Health Service System for Children:**

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

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

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

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

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

### **Cultural and Linguistic Competence**

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

The DCF Division of Multicultural Affairs is charged with developing, implementing, and sustaining diversity initiatives and policies designed to meet these needs. DCF has been focused on the issue of racial justice for many years. Its formal journey began in 2005 as a participant in the national Breakthrough Series Collaborative focused on disproportionality and disparities sponsored by Casey Family Programs. After a series of leadership and organizational changes, the Department renewed its focus on these issues in 2011 by bringing in the People’s Institute for Survival and Beyond. This resulted in two external consultants (Heidi Brooks and Jen Agosti) being contracted in February 2012. This facilitation continues with both statewide and regional specific support.

The shifts in racial, ethnic, linguistic, religious, special needs, disability, and gender orientation diversity in Connecticut have required that the Department develop approaches and skills that will enable its staff and all service providers to effectively work with people from diverse backgrounds. Training initiatives and case practices for DCF staff are focused on: cultural awareness, knowledge acquisition and skills development. Cultural awareness includes a process of self-exploration that results in a

clear understanding of the worldview that directs interactions with children and families who are different than the staff providing services for them. Knowledge acquisition, includes an expectation that staff are to be thoroughly familiar with the language of multiculturalism and culturally competent practices. Skills development includes trainings focused on what are, and how to apply multi-culturally competent practices, and ongoing self-assessments

All DCF contracts with service providers require the delivery of culturally competent services and supports. Quality assurance mechanisms are in place to review and assure the delivery of culturally competent services by providers. The following is an example of DCF contract language:

***“The Contractor shall administer, manage and deliver a culturally responsive and competent program. This shall, at a minimum, be evidenced by equity and parity in access to services, consumer satisfaction, and outcomes for clients served, regardless of race, ethnicity, language, religion, gender, sexual orientation, economic status and/or disability. Policies, practices and quality improvement activities shall be informed by the needs and demographics of the community served or to be served by the program. The Contractor shall include access, consumer satisfaction and outcomes as elements of its program review and monitoring.”***

***“The Contractor shall recruit, hire and retain a professional and paraprofessional staff that is culturally and linguistically diverse. Staff development to support cross-cultural competency shall occur both pre- and in-service. Furthermore, as a means to facilitate culturally competent service delivery, issues of diversity and multiculturalism shall be included in treatment/service planning, discharge planning, case reviews, grand rounds, analysis and review of program data, and staff supervision.”***

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

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

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

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

**Access to Services:**

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

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

The DCF flexible funding:

- Supports the wraparound child and family team meeting process and are tied to an objective in a child’s Individualized Plan of Care. These may include a variety of non-traditional and unique services, supports or care.
- Supports families with children who have significant behavioral health needs. Assists the child and family in achieving the therapeutic goals outlined in the Plan of Care (POC).
- Helps children remain in their home and community; and achieve the highest level of functioning and life satisfaction possible as its ultimate goal.

- Must be the payer of last resort. In the case of funding for clinical services that would otherwise be reimbursed by third parties - Medicaid, private insurance, etc.

**Diverse Mental Health Service Array:**

A wide range of over ninety clinical and non-traditional services, programs and rehabilitative supports are available across the state, including services to address trauma and co-occurring disorders. (Please refer to the Connecticut Service Array on pages 20-41 for details of DCF services.)

The continuum of services provided by DCF is characterized by: Data driven planning and decision making; a balance of promotion, prevention, early intervention and treatment services; attention to the child's development and the developmental appropriateness of interactions and interventions; and collaboration across a broad range of formal and informal systems and sectors to develop comprehensive strategies and effective mental health services.

The Department uses a structured process to review strengths of the service array, identify service gaps, needs and challenges; contract management and oversight issues; performance; and service system expectations and outcomes. The use of Results Based Accountability (RBA) reports for DCF's contracted services are a central component. This structure is a primary vehicle for how the Department assesses ongoing service needs in line with the Connecticut budget process.

The working group consists of representatives from the following:

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

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

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

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

(For a full description of the Evidence Based Practices (EBPs) see pages 34-38) 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 570 trainings and reached over 13,000 individuals. We have also offered 19 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 multi-disciplinary Team ensuring that the victims are afforded all the resources needed to maximize prosecutions while ensuring the youth and their families are provided the appropriate mental health and medical services required.

### **Organizational Structure – Community Level**

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

### **Community Based Services versus Congregate Care Services**



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

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

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

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

- The Department currently has 3,868 children in placement under age 18.
- As of 7/1/19, 7.7% of all children in care (regardless of age), or 6.4% of those under age 18 are in congregate care.

- From 7/1/17 to 7/1/19, the percent of children in state care with relative/kin increased from 40.5% to 43.6%.
- 

With regards to the number of children and youth placed outside of Connecticut in congregate care programs, 337 children and youth were placed outside the state in congregate care on July 1, 2010 compared to 9 on July 1, 2019.

## **Connecticut Children’s Behavioral Health Service Array**

### **DCF Community Based Services for Children, Youth and Families**

#### **Prevention & Early Identification/Intervention Services**

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

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

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

**The Child Abuse Centers of Excellence** - this service including board certified Child Abuse Pediatricians 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.

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

**Community Support for Families** - This service engages families who have received a Family Assessment Response from DCF and helps connect them to concrete, traditional and non-traditional supports and services in their community. This collaborative approach and partnership, places the family in the lead role of its own service delivery. The provider assists the family in developing solutions, identifying community resources and supports, and promotes permanent connections for the family with an array of supports and resources within their community.

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

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

**Early Childhood Consultation Partnership (ECCP)/Mental Health Consultation to Childcare** - The ECCP provides statewide mental health consultation program to pre-schools, Head Start, and service providers funded by DCF. The service is designed to meet the social/emotional needs of children birth to five by offering support, education

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

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

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

**Fatherhood Engagement Services (FES)** – In late FY2019, the Department contracted with 6 private agencies to offer this service across the state. FES provides intensive outreach, case management services and 24/7 Dad© group programming to fathers involved with an open DCF case. The service works to engage fathers in case planning and in achieving more timely permanency.

**Intensive Care Coordination (ICC)** - ICC serves children and youth, ages 10-18, with serious behavioral or mental health needs returning to their home or community from congregate care or other restrictive treatment settings (emergency departments/in-patient hospitals, residential treatment, etc.) or who are at risk of removal from home or their community. The ICC employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence-based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the administrative level, the ICC program, assists DCF in developing local and regional networks of care, which has included the CONNECT federal System of Care grant activities.

**Juvenile Review Board (JRB)** - This service creates community-based Juvenile Review Boards, panels composed of community volunteers, who recommend services and supports to be implemented as a diversion from the juvenile justice system, first time misdemeanor or Class D Felony offenders and other qualifying children and youth under the Families with Service Needs (FWSN) statutes. The service allows for the collaboration among community service providers and interested adults, empowering them to take responsibility for the well-being of the youth in their community. Referrals primarily come from schools and local police.

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

### **Child, Youth and Family Evaluations**

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

**The Child Abuse Centers of Excellence** - this service including board certified Child Abuse Pediatricians 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.

**Intermediate Evaluation for Youth** - This service provides a comprehensive and multidisciplinary outpatient assessment and treatment plan development for children and youth. The primary assessment tool includes full intelligence testing, personality assessment, substance abuse screening, home visit and family assessment, and

evaluation of educational problems and/or learning disability with a report completed within 28 days.

**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 is compiled by the multidisciplinary team and written report provided for each child referred for service. Referral(s) to a specialized service are made as indicated by the findings

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

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

**Be Responsible Be Proud** - This service is designed to provide statewide sexual health education for youth involved with the child welfare & juvenile justice system or, to youth who have specialized behavioral, emotional or academic needs.

**Community Based Life Skills** - The target population served by this program is DCF-committed youth, ages 15 and older, residing in community-based foster homes. The intervention provides youth with a set of skills necessary to assist in their transition from DCF care towards self-sufficiency utilizing a DCF-approved curriculum with experiential learning approaches.

**Community Transition Program** - This service is provided in conjunction with the Norwich Area Office and does assessment and care planning for children/youth who are transitioning from out-of-home levels of care to the community. Services are also provided to keep children/youth who are in the community from being placed in out-of-home care.

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

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

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

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

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

**Intimate Partner Violence (IPV-FAIR)** – The goal of the service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. This four (4) to six (6) month service provides a supportive service array of assessments, 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. The Fathers for Change Promising Practice Model will also be offered through the IPV-FAIR Service. This service will offer intervention to fathers of children under age 10 who have been an offender of intimate partner violence and have co-occurring substance use issues. Safety planning will be at the center of the IPV-FAIR service provision.

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

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

**One-on-One Mentoring** - This service recruits, trains and supervises individual mentors, who are then matched for a minimum of one year with a male or female youth ages 14 through 21. DCF makes the referrals and provides on-going training and group activities for the mentor/mentee pair. Mentors are screened and trained and, once matched with a youth, receive supervision at least once a month. There is on-going training of mentors and occasional group activities for the mentor/mentee pairs.

**Parent Program (St. Josephs)** - This service provides both the General Parenting Program (GPP) and the Dads Are the Difference Program (DAD) for parents involved with DCF. Both programs offer parenting classes and help families connect to needed resources/supports in the community as a means to strengthen families that are at risk of child abuse and neglect by providing parenting education and support.

**Parent & Youth Training and Support** - The Parent and Youth Training and Support program will deliver training and support to primary caregivers of children with behavioral health and other special needs and to youth with disabilities or those returning from juvenile justice programs or facilities funded by DCF.

**Parenting Class** - This service provides parenting education and skill building in English, Spanish and or Portuguese to parents in the Greater Danbury area of the state.

**Permanency Placement Services Program (PPSP)** - This is a permanency placement program dedicated to DCF-committed children to support placement through adoption



or guardianship. Services include: Completion of documents to legally free a child for adoption through juvenile court; recruitment, screening, home studies and evaluations; pre- and post-adoption, guardianship placement planning and finalization services or reunification services with biological parents. A written service agreement, mutually developed between DCF and the provider, is made prior to the commencement of services, and includes the type(s) of service(s) to be provided and time to be spent on each service.

**Prison Transportation** – This service provides bi-weekly transportation for children and youth so they can visit their mothers or guardians who are in prison at York Correctional Institution for Woman. Children/youth in DCF custody are given priority. The service includes toys, books and other forms of entertainment for children to use during travel time. Social work support is available for children who experience emotional difficulty on the way to, during and/or returning from the visits with their mother or guardians.

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

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

Reunification Readiness Assessment uses a standardized assessment tool to develop service plan. Therapeutic Family Time is made available for families and assists the provider in assessment by using the Visit Coaching model. This component provides feedback and recommendations to the Department regarding the family's readiness for reunification

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

Therapeutic Family Time – Uses the Visit Coaching Model, uses the Keys to Interactive Parenting Scale (KIPS), an evidence based tool to effectively measure parent child

interaction and parenting behaviors, preserves and restores parent/child attachment and facilitates permanency planning and emphasizes a continuity of relationships.

**School-Based Diversion Initiative (SBDI)** - Funded by the Connecticut Judicial Branch, DCF and the CT Department of Education, 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. Secondly, SBDI seeks to reduce the number of youth who are expelled or receive out of school suspension when these students can be held accountable while remaining in school.

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

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

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

**Supportive Housing for Families** - This service provides subsidized housing and intensive case management services to DCF families statewide whose inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a

network of services in the following areas: Economic, social, and health. Housing is secured in conjunction with the family and use of a Section VIII voucher from the Department of Social Services (DSS).

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

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

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

**Work To Learn Youth Program** - This youth educational/vocational program provides supportive services to assist youth and young adults, ages 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 may also take part in an on-site, youth-run businesses providing an additional opportunity to utilize and strengthen their skill set.

**Zero to Three – Safe Babies** – The Zero to three Safe Babies Project, provides coordination of services to parents and children younger than 36 months in order to speed reunification or facilitate another permanency goal. The children involved in the program have been placed outside of their home for the first time via court order. The service coordination involves facilitating communication and cooperation among a “zero

to three team" of stakeholders (e.g. court services, infant mental health, protective services, developmental screening) and the parent(s) to develop and expedite a case specific plan of action toward reunification.

### **Mental Health Treatment Services**

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

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

**Enhanced Care Clinics (ECC's)** - Connecticut established Enhanced Care Clinics (ECC's), which are specially designated mental health and substance abuse clinics that serve adults and/or children. The ECC's provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other routine outpatient services for Medicaid members. The overall goal of the Enhanced Care Clinics initiative is to provide adults and children who are seeking behavioral health services and supports with improved timeliness of access to behavioral health care as well as improved quality of care. ECC's must also be able to meet special requirements starting with access and the ability to see clients in a timely fashion depending on their level of urgency.

Currently under this model, ECC's must adhere to the following access standards: The capability to see clients with emergent needs within two hours of arrival at the clinic, the capability to see clients with urgent needs within two days of initial contact, the capability to see clients with routine needs within two weeks of initial contact. Following an initial face-to-face clinical evaluation those clients who are determined to be clinically appropriate to receive outpatient services must be offered a follow-up appointment within 2 weeks of the initial evaluation. ECC's must also provide extended coverage outside of normal business hours. Evidence of collaboration and coordination with primary care providers around medication management and general

medical issues as well as screening, evaluation and treatment of co-occurring mental health and substance use disorders are additional requirement of all ECCs.

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

**Intensive Family Preservation (IFP)** - IFP provides 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. If indicated, families are linked to other therapeutic interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.

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

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

**Juvenile Sexual Treatment (JOTLAB)** - Juveniles Opting for Treatment to Learn Appropriate Behavior is a comprehensive community-based rehabilitative, specialized extended day treatment program that serves adjudicated and non-adjudicated male and female youth ages 8-17, who have engaged in inappropriate and abusive sexual

behaviors. Services include: A comprehensive clinical evaluation, bi-weekly individual psychotherapy, monthly family/caretaker counseling, twice weekly psycho-educational therapy groups as well as twice weekly social skill building groups.

**Multidimensional Family Therapy (MDFT)** - This service provides intensive home-based clinical interventions for children ages 11-18 exhibiting significant behavioral health issues and who are at imminent risk of removal from their home or 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 specifically address any issues 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) Consultation and Evaluation** - This service provides program development, training, clinical and programmatic consultation to MDFT providers statewide which integrate the standards and practices consistent with MDFT requirements and quality improvement programming. Additionally, this service provides program development, training and clinical consultation for the Family Substance Abuse Treatment Services (FSATS) teams serving youth who are criminally involved. .

**Multi-systemic Therapy: Consultation and Evaluation** - This service provides for clinical consultation to state-wide Court Support Services Division (CSSD) and DCF funded 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.

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

**New Haven Trauma Coalition** - The New Haven Trauma Network is a collaboration headed by the Clifford Beers Clinic which has four components: (1) Care Coordination;

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

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

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

### **Substance Abuse Treatment Services**

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

Blending three (3) evidence-based models, ATM works with youth who are or maybe using opioid drugs by providing comprehensive services to address this use and promote their on-going recovery. ATM offers a continuum of services for the youth and his/her family, including Multidimensional Family Therapy (MDFT), access to Medicated Assisted Treatment (MAT) if needed, & Recovery Management Check-ups and Support (RMCS) following the completion of the MDFT services.

Recovery Management Check-ups and Support (RMCS) provides ongoing recovery support and assessment for youth and their families after MDFT services end. Recovery Support Workers (specially trained case managers) facilitate involvement with pro-recovery peers and activities, monitor return to use and other concerns, assertively link youth and families to services as needed, and promote positive family relationships. RMCS lasts for up to 12 months following a 7-8 month course of MDFT. Recovery support sessions for youth and families take place weekly for the first 90 days, with the frequency decreasing or increasing for the remaining time depending on the needs of the youth as determined by the MDFT treatment team. Sessions may take place in person, in the community, over the phone, and by text messaging as permitted by the provider sites responsible for RMCS implementation.

**Family Based Recovery** - This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance abuse. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy.

**Project SAFE** - This is a statewide program that provides priority access to substance abuse evaluations, outreach and engagement and outpatient substance abuse treatment to parent/caregivers who are involved in an open DCF case. Additional services include assisting families to gain access to mental health, medical, social, educational, vocational, housing and other services essential to meeting basic human needs.

### **Evidence Based Treatment Programs**

**Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC)** - This service is an evidence-based substance abuse outpatient treatment program for substance-using adolescent's 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.



**Care Coordination** - This evidence based service provides high fidelity "Wraparound" care through the use of the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths, ages 0-18, 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 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. Twenty-five percent (25%) of the services are provided to youth involved with DCF Juvenile Service - Parole. 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)** – This is an evidence based comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. 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.

**Multi-systemic Therapy (MST)** - This service, using a national evidence-based treatment model, provides intensive home-based services to children who are returning or have returned from a residential level of care or are at imminent risk of removal due to mental health issues. Following 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. This service promotes change in the natural environments such as the home, school and community. Interventions with families promote the parent's capacity to monitor and intervene positively with their child and/or youth. The clinical supervisor and therapists have daily contact with each family served including providing 24 hour a day, 7 day a week access. Average length of service is 3-5 months per family.

**Multi-systemic Therapy - Building Stronger Families** - Using a national evidence-based treatment model, intensive family and community based treatment is provided to families that are active DCF cases due to the physical abuse and/or neglect of a child in the family and abuse of or dependence upon marijuana and/or 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.

**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, a 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)** - This is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

**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.

**Wrap Around New Haven** – Funded by a CMS Innovative Health Grant this initiative delivers evidence-based, culturally-appropriate, integrated medical, behavioral health, and community-based services coordinated by a multidisciplinary Wraparound Team. The Team collaboratively identifies high-need families in New Haven with complex medical and behavioral health care needs, integrates services across multiple health care institutions (e.g., hospital, community health clinic, mental health clinic, and two school based health clinics) reducing care fragmentation that places families at risk for poor care, poor outcomes, and excessive health care costs.

### Crisis Services

**EMPS – Mobile Crisis Services** - EMPS is a mobile crisis intervention for children experiencing behavioral health or psychiatric emergencies. The service is delivered through a face-to-face mobile response to the child's home, school or other location preferred by the family. In rare situations the intervention can be delivered telephonically, or in rare situations through a telephonic intervention, if appropriate.

**EMPS - 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 EMPS 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, EMPS contracted service providers, and other entities as determined by DCF.

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

## **DCF Congregate Care Services for Children, Youth and Families**

### **Mental Health Treatment Services**

**Career Enhancement Training** - This service is a training program, known as, Manufacturing in Motion. It is designed to develop job-related learning opportunities in a collaboration between Goodwin College and Touchstone School staff and faculty. These learning experiences will complement the formal academic program by adding career building skills and vocational education. The content of this career enhancement training will focus on areas such as customer service, office support, and personal finance, computer-aided design, manufacturing principles, allied health opportunities and career skills.

**Federal Preparing Adolescents for Self-Sufficiency (PASS)** - This service is a group home/congregate-care behavioral health treatment setting for youth. A PASS Group Home provides an environment that fosters individualized maximum outcomes in the areas of education, vocation, employability, independent living skills, health and mental health, community connections, and permanent connections.

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

**Specialized Group Home with Behavioral Health and Support Services** - This group home is staffed 24 hour, 7 days a week and is located within the community. It serves multiple youth and young adults, ages 16 through 21, with serious emotional disturbance and their families through the provision of comprehensive, coordinated care and clinical treatment by specially-trained staff.

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

### **Substance Abuse Treatment Services**

Multidimensional Family Therapy (MDFT) Group Home.

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

**Residential Substance Abuse Treatment - Children's Center of Hamden** - This service provides brief residential substance abuse treatment for male and female adolescents, ages 12-17 involved with juvenile or adult court.

### **Crisis Services**

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

**Short-Term Family Integrated Treatment (S-FIT):** This is a short-term residential treatment option providing crisis stabilization and assessment, with rapid reintegration and transition back home. The primary goal of the program is to: Stabilize the child,

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

### **DCF Behavioral Health System Strengths**

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

#### **System of Trauma-Informed Care**

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

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

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

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

DCF has taken a number of steps in building a system of trauma informed care. Beginning in 2007, DCF utilized a combination of DCF state funds, Mental Health Block Grant funds and a federal grant from the Administration for Children and Families to partner with a coordinating center, the Child Health and Development Institute (CHDI) to disseminate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in community-based children's outpatient clinics across Connecticut. This is an evidence based practice for children and youth ages 4 through 21 and their caregivers who have experienced a significant traumatic event and are experiencing chronic symptoms related to the trauma exposure. TF-CBT is a time limited intervention, which usually lasts five to six months and involves outpatient sessions with both the child and caregiver. There are currently over 35 clinics in Connecticut, over 72 total sites and an additional 88 clinicians were trained this year to bring the total to 888 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



works to ensure that children and youth with less overt “developmental” trauma are identified and receive effective and comprehensive trauma treatment services.

Last year 516 children received a MATCH intervention. An additional 5 agencies were trained in MATCH this past year, bringing the total to 15 agencies statewide. An additional 27 clinicians were trained this year, bringing the total number of clinicians trained to 141.

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. Seventeen school districts and over 46 schools are offering CBITS across the state. To date, 806 students have received treatment in school and 90% 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 EMPS Mobile Crisis Service that DCF funds and oversees has staff trained in trauma principles and conducting trauma screening. This infuses trauma informed care in the state’s crisis intervention. DCF has also been involved in providing pediatric primary care providers, school personnel and police with training on identifying and responding to child and youth trauma.

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

### **Infant Mental Health**

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

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

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

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

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

### **Family/Caregiver Involvement**

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

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

### **Collaboration Within and Across Agencies and Systems**

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

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

Husky A and B are the cornerstone of Connecticut's health care infrastructure for children, parents, and pregnant women whose income are near or under 185% of the Federal Poverty line.

CT continues to directly reimburse providers for health care but utilizes a private, not-for-profit contractor (Community Health Network of Connecticut) as the Administrative Service organization (ASO), to provide administrative support functions, such as assisting families in accessing healthcare, conducting outreach to enroll providers, and tracking utilization of and access to services.

Connecticut continues its relationship with Value Options as the ASO for behavioral health services for adults and children with Medicaid. Value Options is an integral part of the Connecticut Behavioral Health Partnership (CTBHP) with DCF, Department of Social Service, and (state Medicaid dept.) Department of Mental Health and Addiction Services, and a legislative oversight committee that provides for a systems-of-care, data-informed and innovative approach to behavioral health care for children and youth in Connecticut.

In 2018, CT Medicaid paid for 2,324 youth inpatient psychiatric stays, for a total number of 27,262 inpatient days; and 195 psychiatric residential treatment facilities (PRTF) admissions for a total number of 33,909 days. In addition, there were over 14,000 behavioral health emergency department (ED) visits. In 2017, CT experienced 3 suicides per 100,000 youth.

Medicaid provides health insurance for 357,525 low income children in Connecticut. The youth Medicaid membership has remained stable by age group—mostly 3-12 year olds (55.4%), followed by 13-17 year olds (25.9%) and 0-2 year olds (18.7%). Gender demographics have also been stable over the past four years, with slightly more male (51.5%) than female (48.9%) youth members. 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 3.1%

## Planning Steps

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

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and 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.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). 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 should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>16</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

<sup>16</sup> <http://www.healthypeople.gov/2020/default.aspx>

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

#### Footnotes:

NOT FINAL

**2020-2021 Combined Block Grant  
Behavioral Health Needs Assessment**

The behavioral health needs assessment for Connecticut is based on a variety of quantitative and qualitative data sources including the National Survey on Drug Use and Health (NSDUH) 2017 as well as the Connecticut State Report based on the 2016 and 2017 NSDUH Reports; the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Report for FY 2018; the 2015 Connecticut Behavioral Health Barometer; The DMHAS Statewide Priority Setting Report conducted in 2019; DMHAS Enterprise Data Warehouse (EDW) data; data from the Connecticut Office of the Chief Medical Examiner (OCME); and US Census Data.

**Prevalence and Treated Prevalence**

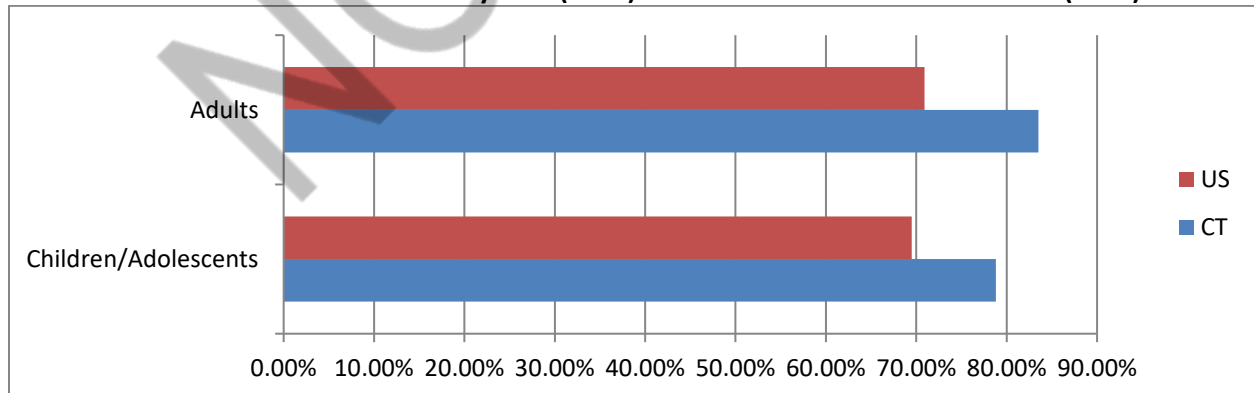
**Mental Health**

**Any Mental Illness (AMI)**

In SFY 2018, the DMHAS Annual Statistical Report, which reflects services provided by DMHAS funded and operated programs, reported more than 54,000 persons served in mental health programs only. Seventy-two percent of clients had a single mental health program admission. Nearly equal percentages of males and females received DMHAS mental health services. Most clients served were White/Caucasian (61%), followed by Black/African American (18%) and “Other” (14%). Twenty-one percent of clients served in DMHAS mental health programs were of Hispanic/Latino origin. Comparing percentages receiving mental health services to state population percentages, White/Caucasian clients were underrepresented (comprising 68% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 16% of the state population, respectively). The average age of clients receiving mental health services was 45.8 years ( $\pm$  15.4).

Of special interest to DMHAS, mental health consumers served in the public mental health system in Connecticut in 2014 reported improved functioning at rates greater than the national average.

**Mental Health Consumers in CT and the US Reporting Improved Functioning from Treatment in the Public Mental Health System (2014) – CT Behavioral Health Barometer (2015)**



**Any Mental Illness in the Past Year (NSDUH 2016 – 2017)**

|                    | <b>Age 18+</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|----------------|
| <b>U.S.</b>        | 18.6%          | 23.9%               | 17.7%          |
| <b>Northeast</b>   | 18.0%          | 24.1%               | 17.0%          |
| <b>Connecticut</b> | 18.2%          | 25.6%               | 17.0%          |

Connecticut residents had similar percentages for any mental illness for all ages except young adults (18 – 25) where it slightly higher than both the U.S. and Northeast percentages. On a positive note, higher percentages across age groups in Connecticut were recipients of mental health services in the past year compared to northeast and US figures.

**Received Mental Health Service in the Past Year (NSDUH 2016 – 2017)**

|                    | <b>Age 18+</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|----------------|
| <b>U.S.</b>        | 14.6%          | 13.9%               | 14.7%          |
| <b>Northeast</b>   | 15.7%          | 15.2%               | 15.7%          |
| <b>Connecticut</b> | 16.6%          | 18.4%               | 16.3%          |

According to the Connecticut Behavioral Health Barometer (2015), about 214,000 adults with AMI each year from 2010 to 2014 (47.5%), received mental health treatment/counseling which was similar to but greater than the national average of 42.7%.

**Serious Mental Illness (SMI)**

Data from the Annual Statistical Report SFY 2018 reveals that more than half of the clients served (62%) in the DMHAS system met criteria for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, major depression, and PTSD.

**Serious Mental Illness in the Past Year (NSDUH 2016 – 2017)**

|                    | <b>Age 18+</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|----------------|
| <b>U.S.</b>        | 4.4%           | 6.7%                | 4.0%           |
| <b>Northeast</b>   | 4.2%           | 6.6%                | 3.8%           |
| <b>Connecticut</b> | 4.2%           | 7.4%                | 3.6%           |

Connecticut residents had lower percentages of serious mental illness for all ages except young adults (18 – 25) where it was slightly above both the U.S. and Northeast percentages.

**Depression**

Connecticut percentages for depression were similar to the national and regional estimates for all age categories except those ages 18 – 25 where it was slightly higher.

**Major Depressive Episode in the Past Year (NSDUH 2016 – 2017)**

|                    | <b>Age 18+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 6.9%           | 13.0%               | 12.0%               | 6.1%           |
| <b>Northeast</b>   | 6.8%           | 12.1%               | 11.8%               | 6.0%           |
| <b>Connecticut</b> | 7.0%           | 13.2%               | 13.1%               | 6.0%           |

Data from the Annual Statistical Report indicated 17% of clients had depressive disorders and 12% had bipolar and related disorders, together accounting for nearly a third of all diagnoses treated.

The Behavioral Health Barometer – 2015 for Connecticut reported past year treatment for Major Depressive Episode (MDE) in adolescents based on annual averages from 2007-14 was 52.3% which was higher than the national average of 38.1%. This reflects MDE treatment for Connecticut adolescents at about 11,000 annually.

**Suicide/Suicidal Thoughts**

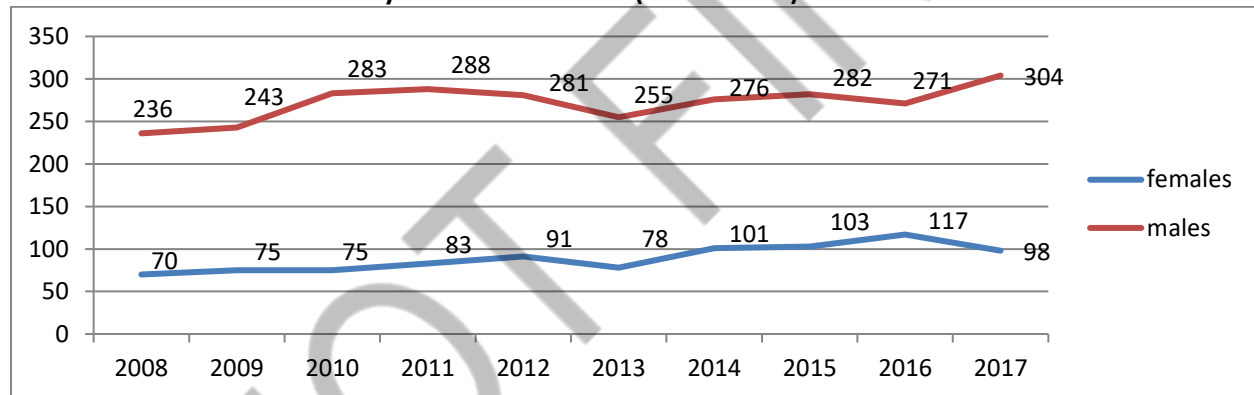
Connecticut rates for serious suicidal thoughts for all age categories are similar to national and regional estimates.

**Serious Thoughts of Suicide in the Past Year (NSDUH 2016 – 2017)**

|                    | Age 18+ | Ages 18 - 25 | Age 26+ |
|--------------------|---------|--------------|---------|
| <b>U.S.</b>        | 4.2%    | 9.6%         | 3.3%    |
| <b>Northeast</b>   | 4.0%    | 9.5%         | 3.1%    |
| <b>Connecticut</b> | 4.1%    | 10.0%        | 3.1%    |

Examining suicides over the past decade (as seen in the graph above) reflects a gradual rising trend for both sexes until the paths diverge in 2017 with a decrease for females and an increase for males. Males continue to outpace females at a rate of about 3:1.

**Suicides by Sex in Connecticut (2008 – 2017) from OCME data**



**Substance Use**

Over 57,000 persons were treated in substance use programs only by DMHAS based on the Annual Statistical Report for FY 2018. Seventy percent of clients had a single substance use program admission. More than twice as many males (68%) as females (31%) received DMHAS substance use services. Most clients served were White/Caucasian (63%), followed by “Other” (16%), and Black/African American (14%). Twenty-two percent of clients served in DMHAS substance use programs were of Hispanic/Latino origin. Comparing percentages receiving substance use services to state population percentages, White/Caucasian clients were underrepresented (comprising 68% of the population), while Black/African American and persons of Hispanic/Latino origin were overrepresented (comprising 12% and 16% of the state population, respectively). The average age of clients receiving substance use services was 38.9 years ( $\pm 12.8$ ).

**Alcohol**

Connecticut residents of all ages continue to consume alcohol and to binge use alcohol at higher percentages than national and regional estimates.

**Alcohol Use in the Past Month (NSDUH 2016 – 2017)**

|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 51.2%          | 9.5%                | 56.7%               | 55.2%          |
| <b>Northeast</b>   | 56.4%          | 10.6%               | 63.2%               | 60.3%          |
| <b>Connecticut</b> | 60.2%          | 11.4%               | 67.0%               | 64.7%          |

**Binge Alcohol Use in the Past Month (NSDUH 2016 – 2017)**

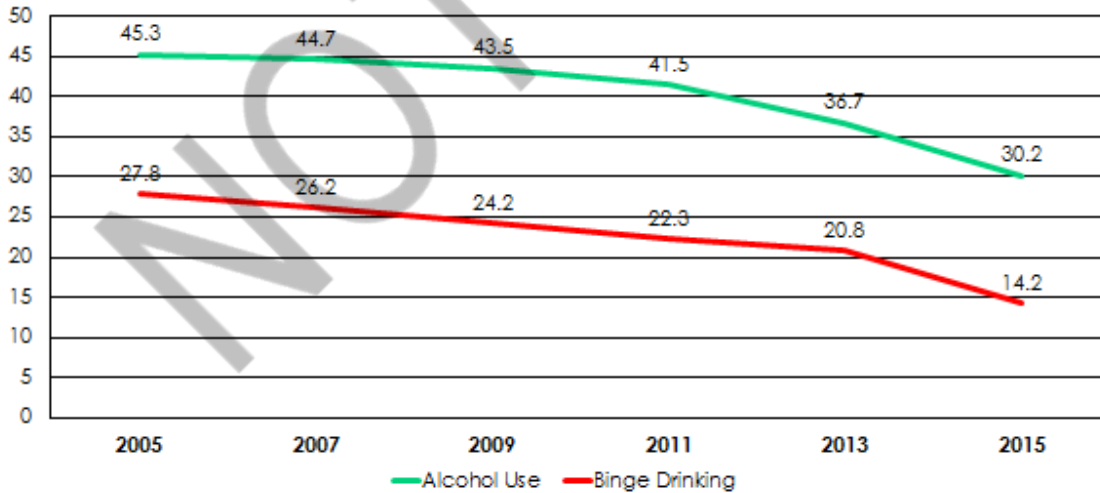
|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 24.4%          | 5.1%                | 37.6%               | 24.5%          |
| <b>Northeast</b>   | 26.5%          | 5.8%                | 43.7%               | 25.9%          |
| <b>Connecticut</b> | 28.3%          | 6.4%                | 47.0%               | 27.8%          |

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

|                    | <b>Alcohol Use in the Past Month</b> | <b>Binge Alcohol Use in Past Month</b> |
|--------------------|--------------------------------------|--|
| <b>U.S.</b>        | 19.5%                                | 12.0%                                  |
| <b>Northeast</b>   | 22.9%                                | 14.9%                                  |
| <b>Connecticut</b> | 23.9%                                | 15.8%                                  |

However, as the chart below indicates, overall trends of underage alcohol use and binge alcohol use have been declining in the state for over a decade.

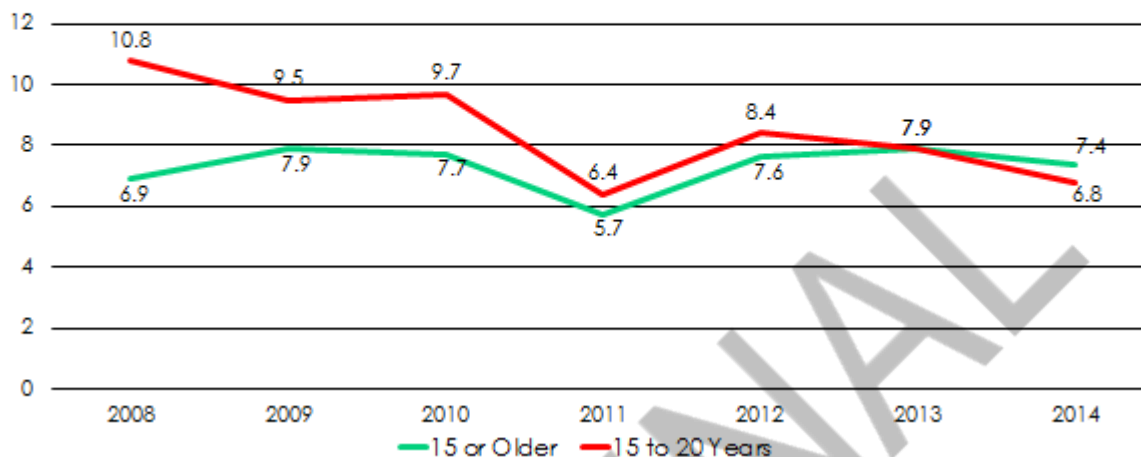
**PERCENT OF HIGH SCHOOL STUDENTS REPORTING PAST 30-DAY ALCOHOL USE AND BINGE DRINKING: YRBS, CONNECTICUT, 2005-2015**



Alcohol-related motor vehicle accidents have likewise declined in recent years.



## ALCOHOL-RELATED MOTOR VEHICLE ACCIDENTS PER 10,000 POPULATION AGED 15 TO 20 YEARS OLD VS. POPULATION AGED 15 OR OLDER: CT, 2008-2014

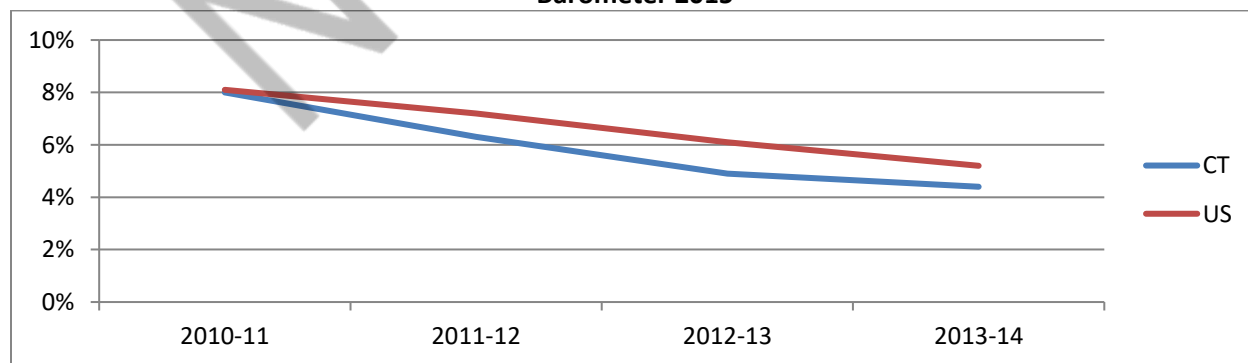


For those admitted to DMHAS substance use programs in 2018, alcohol was identified as the drug of choice in 37% of cases. Small numbers of persons received treatment for alcohol abuse/dependence in Connecticut (7.1%) based on 2010-14 Behavioral Health Barometer data from 2015, but this is similar to the national average of 7.3%. This reflects about 16,000 persons receiving treatment for alcohol abuse/dependence in Connecticut annually.

### Cigarettes

With the exception of 18 – 25 year olds, Connecticut residents smoke cigarettes less than the regional or national estimates; and the numbers have been declining for some time.

Past Month Cigarette Use among Adolescents - (2010-11 to 2013-14) – CT Behavioral Health Barometer 2015



**Cigarette Use in the Past Month (NSDUH 2016 – 2017)**

|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 18.5%          | 3.3%                | 22.9%               | 19.5%          |
| <b>Northeast</b>   | 17.5%          | 2.9%                | 22.4%               | 18.3%          |
| <b>Connecticut</b> | 16.8%          | 2.5%                | 23.7%               | 17.4%          |

**E-Cigarettes/Electronic Nicotine Delivery Systems (ENDS)**

In recent years, Connecticut has passed laws related to the use of e-cigarettes/electronic nicotine delivery systems (ENDS) for minors, including:

- Prohibiting minors from buying or possessing e-cigarettes/ENDS in public
- Prohibiting anyone from selling, giving, or delivering e-cigarettes/ENDS to minors
- Restricting use of e-cigarettes/ENDS in public places, like restaurants, universities, health care facilities, airports, hotels, etc.
- Requiring dealers and manufacturers of e-cigarettes/ENDS to register with the Department of Consumer Protection

These legislative steps were taken in response to the dramatic rise in use of e-cigarettes/ENDS. According to the CDC, recent increases in the use of e-cigarettes/ENDS are what is driving the increase in tobacco product use among youth. They report that 5% of middle school students and 21% of high school students have used e-cigarettes/ENDS in the last 30 days. The Connecticut Department of Public Health Youth Tobacco Survey results, collected during the spring of 2017, found 10% of 9<sup>th</sup> graders and 20% of 12<sup>th</sup> graders reported current use of e-cigarettes/ENDS. Unfortunately, most of the students surveyed believed there was no or little risk associated with use of these devices.

**Illicit Substances**

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

**Illicit Drug Use in the Past Month (NSDUH 2016 – 2017)**

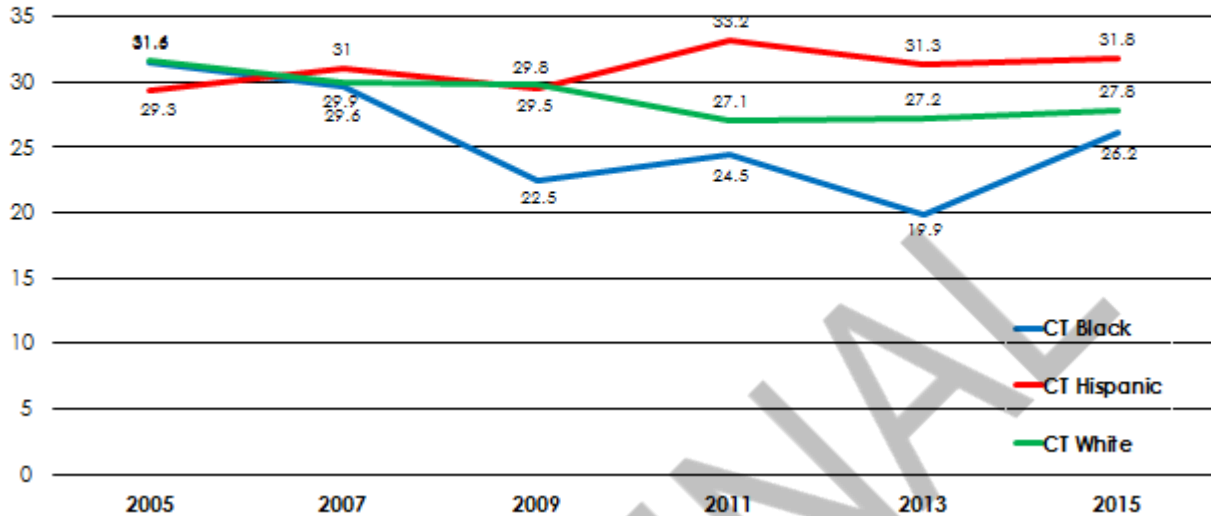
|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 10.9%          | 7.9%                | 23.7%               | 9.2%           |
| <b>Northeast</b>   | 11.6%          | 8.1%                | 27.1%               | 9.5%           |
| <b>Connecticut</b> | 12.3%          | 9.6%                | 32.7%               | 9.3%           |

Illicit drug use percentages for Connecticut exceed both the national and regional estimates. Subtracting out marijuana use is informative as it reveals that most of the illicit drug use is accounted for by marijuana. The remainder of the illicit drug use is generally within the national and regional range with the exception of young adults 18 – 25.

**Illicit Drug Use Other than Marijuana in the Past Month (NSDUH 2016 – 2017)**

|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 3.4%           | 2.4%                | 7.1%                | 2.9%           |
| <b>Northeast</b>   | 3.4%           | 2.1%                | 7.7%                | 2.9%           |
| <b>Connecticut</b> | 3.7%           | 2.3%                | 9.3%                | 3.0%           |

## PERCENT OF CONNECTICUT HIGH SCHOOL STUDENTS OFFERED/SOLD/GIVEN AN ILLEGAL DRUG ON SCHOOL PROPERTY: YRBS, 2005-2015



Past year illicit drug abuse/dependence among persons 12+ has been remarkably stable in recent years, according to data from the Connecticut Behavioral Health Barometer -2015, varying only within 0.4% for both Connecticut and the nation (from 2.5% to 2.9%).

Past year treatment for illicit drug abuse/dependence among persons 12+ in Connecticut based on annual averages from 2007-14 revealed that 20.1% received treatment which is much greater than the national average of 13.9%. This means that about 18,000 persons each year in Connecticut receive treatment for illicit drug abuse/dependence.

### Marijuana

As noted above, marijuana continues to be the primary illicit drug used in the state. With neighboring states legalizing recreational marijuana use, perceptions of risk associated with smoking marijuana monthly continue to decline and use continues to rise.

#### Marijuana Use in the Past Month (NSDUH 2016 – 2017)

|                    | Age 12+ | Ages 12 - 17 | Ages 18 - 25 | Age 26+ |
|--------------------|---------|--------------|--------------|---------|
| <b>U.S.</b>        | 9.2%    | 6.5%         | 21.5%        | 7.6%    |
| <b>Northeast</b>   | 9.8%    | 6.8%         | 24.9%        | 7.8%    |
| <b>Connecticut</b> | 10.6%   | 7.9%         | 30.4%        | 7.7%    |

Percentages for Connecticut and the northeast for monthly marijuana use exceed the national average for all age categories except adults 26+. In concert with greater use is less perceived risk from smoking marijuana which is less than the national and regional percentages across the board. Eleven percent of persons admitted to substance use services in FY 2018 identified marijuana/hashish/THC as their drug of choice.

**Perception of Great Risk from Smoking Marijuana Once a Month (NSDUH 2016 – 2017)**

|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 26.9%          | 25.8%               | 12.9%               | 29.4%          |
| <b>Northeast</b>   | 25.3%          | 25.3%               | 11.8%               | 27.5%          |
| <b>Connecticut</b> | 22.0%          | 22.4%               | 10.4%               | 23.9%          |

**Heroin**

The opioid crisis, which has taken a heavy toll on the northeast, appears at this point to have peaked. The 2016-2017 data presented below, however, reflects the prior rise in heroin use, but does not reflect the illicitly manufactured fentanyl which overtook heroin as the primary opioid involved in overdose deaths in the state.

**Heroin Use in the Past Year (NSDUH 2016 – 2017)**

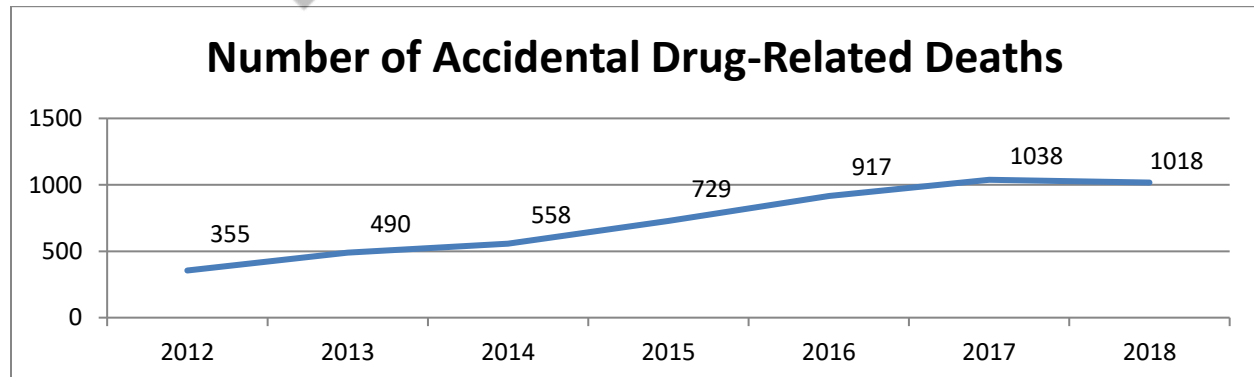
|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 0.3%           | .05%                | 0.6%                | 0.3%           |
| <b>Northeast</b>   | 0.5%           | .05%                | 0.8%                | 0.4%           |
| <b>Connecticut</b> | 0.7%           | .06%                | 1.3%                | 0.7%           |

For persons admitted to substance use programs in FY 2018, the Annual Statistical Report noted that 36% identified heroin as the primary drug of choice.

In calendar year 2018, Connecticut’s Office of the Chief Medical Examiner (OCME) reported a total of 1018 accidental drug-related deaths, 93% of which involved opioids. Nationally, per the CDC, about 66% of fatal overdoses involve opioids. This means that nearly every death in Connecticut involves an opioid and for the majority of cases, that means the involvement of illicitly manufactured fentanyl. In fact, 74% of fatal overdoses involved fentanyl/fentanyl analogues, 38% involved heroin, and 14% involved prescription opioids. In addition, most fatal overdoses involved other substances in addition to opioids, primarily cocaine (32%), benzodiazepines (27%) and/or alcohol (26%).

The typical fatal overdose victim in Connecticut in 2018 was a non-Hispanic white male between the ages of 30 and 59 who was using fentanyl and other substances and on the day he overdosed, so did two other people in our state.

Despite these disturbing statistics, for the first time since 2012, the total number of accidental drug-related deaths in Connecticut decreased from calendar year 2017 to 2018, suggesting perhaps, that the epidemic may have peaked.



### Pain Reliever Misuse

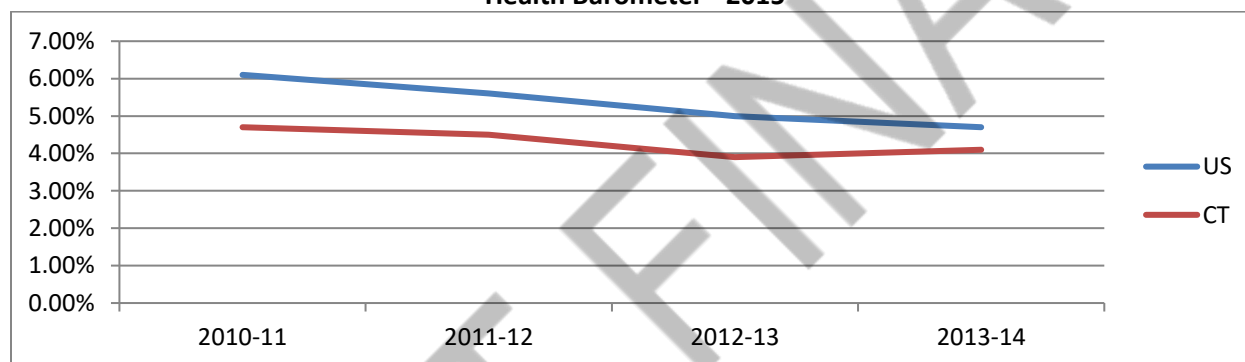
Percentages related to misuse of prescription opioids are similar to the national percentages, but greater than for the northeast region. Only 4% of persons admitted for substance use services in FY 2018 reported “other opiates” as their primary drug of choice.

**Pain Reliever Misuse in the Past Year (NSDUH 2016 – 2017)**

|                    | Age 12+ | Ages 12 - 17 | Ages 18 - 25 | Age 26+ |
|--------------------|---------|--------------|--------------|---------|
| <b>U.S.</b>        | 4.2%    | 3.3%         | 7.1%         | 3.8%    |
| <b>Northeast</b>   | 3.8%    | 2.6%         | 6.6%         | 3.4%    |
| <b>Connecticut</b> | 4.2%    | 3.2%         | 7.5%         | 3.8%    |

Examining the trend over time of nonmedical use of pain relievers among adolescents from 2010-11 to 2013-14 finds percentages declining for both Connecticut and the nation.

**Past Year Nonmedical Use of Pain Relievers among Adolescents (2010-11 to 2013-14) – CT Behavioral Health Barometer - 2015**



### Stimulants

In Connecticut, use of stimulants, especially cocaine, has been increasing since 2012, and in 2018 there were 21 cases of methamphetamine found in fatal overdose data. In response to this finding, DMHAS has modified its CQI plan to include monitoring of stimulant use as an adjunct to the primary opioid crisis. The increase in cocaine use is reflected in the table below.

**Cocaine Use in the Past Year (NSDUH 2016 – 2017)**

|                    | Age 12+ | Ages 12 - 17 | Ages 18 - 25 | Age 26+ |
|--------------------|---------|--------------|--------------|---------|
| <b>U.S.</b>        | 2.0%    | 0.5%         | 5.9%         | 1.6%    |
| <b>Northeast</b>   | 2.3%    | 0.5%         | 6.7%         | 1.9%    |
| <b>Connecticut</b> | 2.7%    | 0.6%         | 8.4%         | 2.1%    |

Based on the Annual Statistical Report FY 2018, 7% of admissions to substance use services were for a primary cocaine problem.

However, the rise in methamphetamine use as detected in accidental drug-related deaths in the state is not reflected in the following table, perhaps as the increase is too recent.

**Methamphetamine Use in the Past Year (NSDUH 2016 – 2017)**

|                    | <b>Age 12+</b> | <b>Ages 12 - 17</b> | <b>Ages 18 - 25</b> | <b>Age 26+</b> |
|--------------------|----------------|---------------------|---------------------|----------------|
| <b>U.S.</b>        | 0.6%           | 0.2%                | 0.9%                | 0.6%           |
| <b>Northeast</b>   | 0.3%           | 0.1%                | 0.5%                | 0.3%           |
| <b>Connecticut</b> | 0.3%           | 0.1%                | 0.5%                | 0.3%           |

**Co-Occurring Mental Health and Substance Use**

Nearly one-third (32%) of the persons treated by DMHAS in FY 2018 had both a mental health (SMI) and substance use diagnosis. Nearly 7,000 persons (6,947) received services from both mental health and substance use programs during the same fiscal year. These clients were more male (60.5%) than female (39.5%). Sixty-two percent were white/Caucasian, 19% were black/African American and 14% were “other”. Twenty percent were Hispanic/Latino. Compared to the U.S. Census Bureau data, white/Caucasian persons were underrepresented (comprising 68% of the population), while Black/African American and Hispanic/Latino were overrepresented (comprising 12% and 16% of the state population, respectively) in treatment. The average age of persons receiving both mental health and substance use services was 41.9 years ( $\pm$  12.2).

**Persons Served in DMHAS Programs**

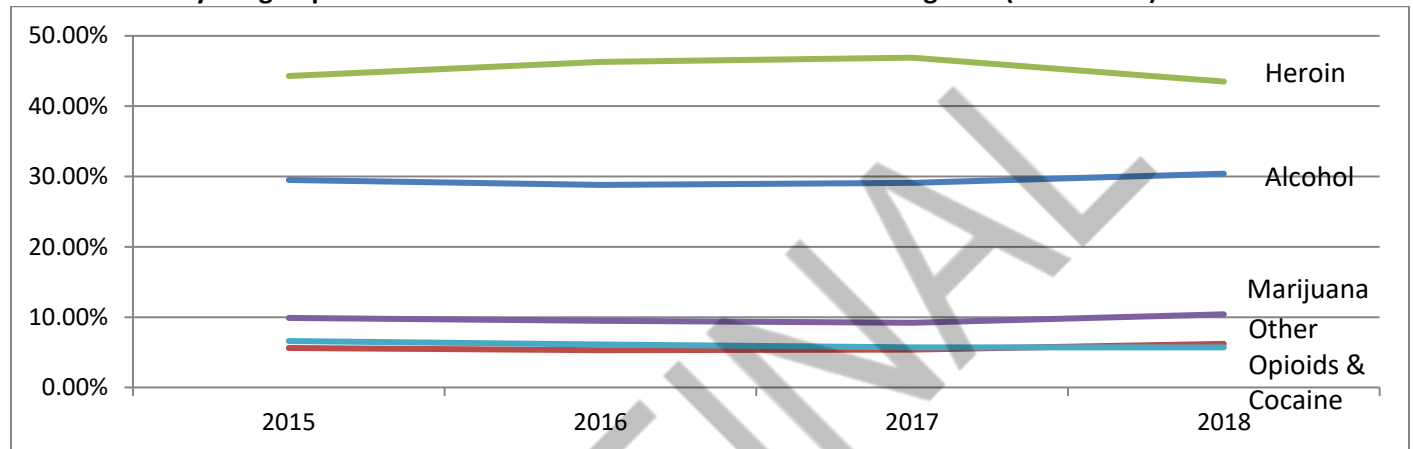
The following data is from the FY 18 Annual Statistical Report available at: <https://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreport2018.pdf>. During SFY 18 (July 1, 2017 – June 30, 2018), DMHAS served a total of 105,540 people; 57,501 were treated in substance use programs and 54,986 were treated in mental health programs. These totals include 6,947 co-occurring clients who received services from both mental health and substance use treatment services, but are included as a separate category in the demographic table below. An almost equal number of males and females received mental health services, while more than twice as many males than females participated in substance use services. Most clients were White/Caucasian (62%), followed by Black/African American (16%), and Other Race (15%). Twenty-one percent of DMHAS clients were of Hispanic/Latino ethnicity, primarily of Puerto Rican origin (12%). Younger clients were more likely to receive substance use services (average age 38.9 years) while older clients were more likely to receive mental health services (average age 45.8 years). The most utilized level of care was Outpatient with 99% of mental health clients and 91% of substance use clients received these services. For mental health clients, Outpatient services include standard outpatient (64%), Case Management (15%), Crisis Services (12%), and Social Rehabilitation (11%). For substance use clients, Outpatient services include Pre-Trial Intervention (34%), standard Outpatient (36%), and Medication Assisted Treatment (27%). Residential services were the next most utilized, with 4% 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 5% of substance use clients. Some clients participated in more than one level of care during the fiscal year. Young Adult Services (YAS) serve clients 18 – 25 with a history of involvement in the Department of Children and Families (DCF) and major mental health problems. Of the DMHAS population 18 – 25 treated during the fiscal year, 8.6% or 1,194 received specialized YAS services.

Substance-related and addictive disorders were the most frequently diagnosed condition among those receiving services from DMHAS at 44%. The largest mental health category diagnosed outside of substances was Depressive Disorders (17%), followed by Schizophrenia Spectrum and Other Psychotic Disorders (12%) and Bipolar and Related Disorders (10%). Over 60% of the clients met criteria for SMI (serious mental illness) with a diagnosis that included one or more of the following: schizophrenia (and related disorders), bipolar (and related disorders), major depression, and PTSD. Two out of three clients

(69%) meet criteria for a substance use disorder. One-third of clients (33%) meet criteria for a co-occurring disorder (both SMI and a substance use diagnosis).

Among admissions to substance use programs, heroin (44%) was the most frequently reported primary drug. Combining Heroin with other opioid drugs accounted for the primary drug in 49% of all substance use admissions. Alcohol was reported as the primary drug in 30% of admissions; Marijuana/Hashish/THC in 10% of admissions; and Cocaine in 6% of the admissions.

**Primary Drug Reported at Admission to DMHAS Substance Use Programs (2015 -2018)**



**Demographics of Clients Served**

|                                  | Substance Use |               | Mental Health |               | Both         |               | Total          |               |
|----------------------------------|---------------|---------------|---------------|---------------|--------------|---------------|----------------|---------------|
|                                  | N             | %             | N             | %             | N            | %             | N              | %             |
| <b>Gender</b>                    |               |               |               |               |              |               |                |               |
| Female                           | 15,791        | 31.2%         | 24,102        | 50.2%         | 2,744        | 39.5%         | 42,637         | 40.4%         |
| Male                             | 34,309        | 67.9%         | 23,883        | 49.7%         | 4,201        | 60.5%         | 62,393         | 59.1%         |
| Transgender                      | 2             | 0.0%          | 20            | 0.0%          | -            | -             | 22             | 0.0%          |
| Unknown                          | 452           | 0.9%          | 34            | 0.1%          | 2            | 0.0%          | 488            | 0.5%          |
| <b>Total</b>                     | <b>50,554</b> | <b>100.0%</b> | <b>48,039</b> | <b>100.0%</b> | <b>6,947</b> | <b>100.0%</b> | <b>105,540</b> | <b>100.0%</b> |
|                                  | Substance Use |               | Mental Health |               | Both         |               | Total          |               |
|                                  | N             | %             | N             | %             | N            | %             | N              | %             |
| <b>Race</b>                      |               |               |               |               |              |               |                |               |
| American Indian/Alaska Native    | 222           | 0.4%          | 272           | 0.6%          | 46           | 0.7%          | 540            | 0.5%          |
| Asian                            | 349           | 0.7%          | 575           | 1.2%          | 25           | 0.4%          | 949            | 0.9%          |
| Black/African American           | 6,925         | 13.7%         | 8,703         | 18.1%         | 1,310        | 18.9%         | 16,938         | 16.0%         |
| Native Hawaiian/Pacific Islander | 123           | 0.2%          | 116           | 0.2%          | 11           | 0.2%          | 250            | 0.2%          |
| White/Caucasian                  | 31,965        | 63.2%         | 29,324        | 61.0%         | 4,328        | 62.3%         | 65,617         | 62.2%         |
| More than one                    | 433           | 0.9%          | 242           | 0.5%          | 41           | 0.6%          | 716            | 0.7%          |

|                         |                      |          |                      |          |             |          |              |          |
|-------------------------|----------------------|----------|----------------------|----------|-------------|----------|--------------|----------|
| race                    |                      |          |                      |          |             |          |              |          |
| Unknown                 | 2,575                | 5.1%     | 2,171                | 4.5%     | 183         | 2.6%     | 4,929        | 4.7%     |
| Other                   | 7,962                | 15.7%    | 6,636                | 13.8%    | 1,003       | 14.4%    | 15,601       | 14.8%    |
| Total                   | 50,554               | 100.0%   | 48,039               | 100.0%   | 6,947       | 100.0%   | 105,540      | 100.0%   |
|                         | <b>Substance Use</b> |          | <b>Mental Health</b> |          | <b>Both</b> |          | <b>Total</b> |          |
|                         | <b>N</b>             | <b>%</b> | <b>N</b>             | <b>%</b> | <b>N</b>    | <b>%</b> | <b>N</b>     | <b>%</b> |
| <b>Ethnicity</b>        |                      |          |                      |          |             |          |              |          |
| Hispanic-Cuban          | 108                  | 0.2%     | 78                   | 0.2%     | 17          | 0.2%     | 203          | 0.2%     |
| Hispanic – Mexican      | 402                  | 0.8%     | 212                  | 0.4%     | 32          | 0.5%     | 646          | 0.6%     |
| Hispanic-Other          | 4,281                | 8.5%     | 4,004                | 8.3%     | 476         | 6.9%     | 8,761        | 8.3%     |
| Hispanic – Puerto Rican | 6,196                | 12.3%    | 5,578                | 11.6%    | 876         | 12.6%    | 12,650       | 12.0%    |
| All Hispanics           | 10,987               | 21.8%    | 9,872                | 20.5%    | 1,401       | 20.2%    | 22,260       | 21.1%    |
|                         |                      |          |                      |          |             |          |              |          |
| Non-Hispanics           | 35,048               | 69.3%    | 35,175               | 73.2%    | 5,179       | 74.6%    | 75,402       | 71.4%    |
| Unknown                 | 4,519                | 8.9%     | 2,992                | 6.2%     | 367         | 5.3%     | 7,878        | 7.5%     |
| Total                   | 50,554               | 100.0%   | 48,039               | 100.0%   | 6,947       | 100.0%   | 105,540      | 100.0%   |
|                         | <b>Substance Use</b> |          | <b>Mental Health</b> |          | <b>Both</b> |          | <b>Total</b> |          |
|                         | <b>N</b>             | <b>%</b> | <b>N</b>             | <b>%</b> | <b>N</b>    | <b>%</b> | <b>N</b>     | <b>%</b> |
| <b>Age</b>              |                      |          |                      |          |             |          |              |          |
| 18 – 25                 | 7,368                | 14.6%    | 5,544                | 11.5%    | 594         | 8.6%     | 13,506       | 12.8%    |
| 26 – 34                 | 14,775               | 29.2%    | 7,988                | 16.6%    | 1,731       | 24.9%    | 24,494       | 23.2%    |
| 35 – 44                 | 11,236               | 22.2%    | 7,880                | 16.4%    | 1,627       | 23.4%    | 20,743       | 19.7%    |
| 45 – 54                 | 9,001                | 17.8%    | 10,339               | 21.5%    | 1,700       | 24.5%    | 21,040       | 19.9%    |
| 55 – 64                 | 5,773                | 11.4%    | 10,820               | 22.5%    | 1,141       | 16.4%    | 17,734       | 16.8%    |
| 65+                     | 1,410                | 2.8%     | 4,945                | 10.3%    | 154         | 2.2%     | 6,509        | 6.2%     |
| Unknown                 | 991                  | 2.0%     | 523                  | 1.1%     | -           | 0.0%     | 1,514        | 1.4%     |
| Total                   | 50,554               | 100.0%   | 48,039               | 100.0%   | 6,947       | 100.0%   | 105,540      | 100.0%   |

### Workforce Development and Shortages

According to the HRSA Fact Sheet 2018 for Connecticut, the state is short 43 Primary Care Providers and 34 Mental Health Professionals. HRSA designated Medically Underserved Areas (MUA) and Populations (MUP) data follows.

| <b>Medically Underserved Areas in Connecticut (HRSA 2018)</b> |              |                        |
|---|--------------|------------------------|
| <b>from highest to lowest need</b>                            |              |                        |
| <b>Location</b>   | <b>Score</b> | <b>Rural/Non-Rural</b> |
| New Haven (Governor Service Area)                             | 0.0          | Non-rural              |
| Windham (Governor Service Area)                               | 0.0          | Rural                  |
| Hartford Service Area   | 39.1         | Non-rural              |
| Hartford Service Area   | 46.8         | Non-rural              |
| New London Service Area                                       | 47.7         | Non-rural              |
| New Haven Service Area  | 52.2         | Non-rural              |



| Middlesex Service Area  | 52.5   | Non-rural                                    |
|---|--|--|
| New London Service Area   | 54.4   | Non-rural                                    |
| Fairfield Service Area  | 54.6   | Non-rural                                    |
| Central Bristol Service Area  | 56.8   | Non-rural                                    |
| South end Stamford Service Area   | 58.3   | Non-rural                                    |
| Fairfield Service Area  | 59.6   | Non-rural                                    |
| New Haven Service Area  | 59.6   | Non-rural                                    |
| New Haven Service Area  | 59.8   | Non-rural                                    |
| New Haven Service Area  | 59.8   | Non-rural                                    |
| New Haven Service Area  | 59.8   | Non-rural                                    |
| Central Waterbury Service Area  | 59.8   | Non-rural                                    |
| Hartford Service Area   | 60.2   | Non-rural                                    |
| Hartford Service Area   | 60.9   | Non-rural                                    |
| <b>Medically Underserved Populations – Low Income (HRSA 2018)</b>                         |  |  |
| <b>From highest to lowest need</b>  |  |  |
| Central Torrington Service Area   | 41.1   | Rural  |
| Northcentral New Britain Service Area   | 41.6   | Non-rural                                    |
| South Norwalk Service Area  | 46.8   | Non-rural                                    |
| West Haven Service Area   | 47.1   | Non-rural                                    |
| Rockville Service Area  | 47.8   | Non-rural                                    |
| East Hartford Service Area  | 47.9   | Non-rural                                    |
| Norwich Service Area  | 50.9   | Non-rural                                    |
| Danbury Service Area  | 52.9   | Non-rural                                    |
| Southeast Windham Service Area  | 56.1   | Non-rural                                    |
| Central Waterbury Service Area  | 59.8   | Non-rural                                    |
| West Stratford Service Area   | 62.5   | Non-rural                                    |
| <b>Low Income Population with Health Professional Shortage – Primary Care (HRSA 2018)</b> |  |  |
| <b>From highest to lowest need</b>  |  |  |
| <b>Location</b>   | <b>Health Professional Shortage Area Score</b> | <b>Health Professional Shortage Area FTE</b> |
| Bridgeport  | 18   | 0  |
| Hartford  | 16   | 0  |
| Bristol Service Area  | 15   | 0  |
| Central Meriden   | 15   | 0  |
| New Haven/West Haven  | 15   | 0  |
| New London  | 15   | 0.35   |
| Town of Windham   | 15   | 0  |
| Ansonia   | 14   | 0  |
| East Hartford   | 14   | 0  |
| Norwich   | 14   | 0  |
| Torrington  | 14   | 0  |
| Central Norwalk   | 13   | 0  |
| Mansfield   | 13   | 0  |
| Middletown Service Area   | 13   | 0  |
| Waterbury   | 13   | 0  |
| Danbury   | 12   | 0  |

|  |  |  |
|--|--|--|
| Groton   | 12   | 0  |
| Northwest Enfield  | 12   | 0  |
| Putnam Service Area  | 12   | 0  |
| South end Stamford   | 12   | 0  |
| Stratford  | 10   | 0  |
| <b>Geographic or Low Income Area with Health Professional Shortage – Mental Health (HRSA 2018)</b> |  |  |
| <b>From highest to lowest need</b>   |  |  |
| <b>Location</b>  | <b>Health Professional Shortage Area Score</b> | <b>Health Professional Shortage Area FTE</b> |
| Low Income Hartford  | 19   | 0  |
| Low Income Bridgeport  | 17   | 0  |
| Low Income New Haven/West Haven  | 17   | 0  |
| Region 3 (Eastern Connecticut)   | 16   | 6.77   |
| Middlesex County   | 16   | 1.88   |
| Litchfield County  | 13   | 1.76   |
| Low Income Danbury   | 11   | 0  |
| Low Income South end Stamford  | 10   | 0  |

### 2018/19 Statewide Priority Setting Process

DMHAS is committed to supporting a comprehensive, unified planning process across its state-operated and funded mental health and substance use services at local, regional, and state levels. The purpose of this planning process is to develop an integrated and ongoing method to: 1) determine unmet mental health and substance use treatment and prevention needs; 2) gain broad stakeholder (persons with lived experience, advocates, family members, providers, and others) input on service priorities and needs; and 3) monitor ongoing efforts that result in better decision-making, service delivery, and policy-making. A description of the entire priority setting process for 2018/19 follows.

#### Background:

This was the first year implementing a revised priority setting process. Transitioning from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) to integrated Regional Behavioral Health Action Organizations (RBHAOs) meant changes were also indicated for the Priority Setting Process. Formerly separate survey processes were reorganized into a unified activity comprehensively assessing the entire DMHAS behavioral health service system. The final agreed upon process involved months of planning with representatives from the RBHAOs, the DMHAS Prevention Division, the DMHAS Block Grant State Planner, the State Epidemiological Outcomes Workgroup (SEOW) and University of Connecticut Health Center's (UHC) Center for Prevention Evaluation and Statistics (CPES). 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

- **Completion of regional reports** inclusive of all the elements above into a structured format along with strengths, identified needs/gaps/barriers, and recommendations

**Priorities:**

Based on the 5 regional reports, the top 3 priorities were:

1. Mental health conditions
2. Alcohol use
3. Non-medical use of prescription drugs

1. **Mental Health Conditions**: A broad ranging topic, but the focus of concern expressed by the regions was the increase in anxiety and depression in young people

2. **Alcohol Use**: Prior to the opioid epidemic, alcohol was the substance of greatest concern and the primary reason for most substance use treatment admissions to DMHAS. With so much attention focused on the opioid crisis and its associated consequences, attention was diverted from the most commonly used and abused substance – alcohol. A number of regional reports remarked on the need to return focus to substances and issues other than opioids.

3. **Non-medical Use of Prescription Drugs (NMUPD)**: Because of the known association between prescription opioid misuse and heroin/fentanyl use which has fueled our current opioid epidemic, much scrutiny has been given to prescription opioids. However, the regions expressed concern over the lack of attention to threats posed by benzodiazepines and stimulants which are also frequently prescribed and abused, but largely ignored.

**Emerging Issues:**

The most notable emerging issue was vaping. The percentage of high school students that have tried vaping and concerns about the addictiveness of both nicotine and marijuana are raising alarm. Advertising that promotes vaping as a cessation strategy is questioned. The dramatic rise in vaping has afforded little opportunity for data collection.

**Strengths:** Many strengths, assets and resources were identified in the regional reports. They have been grouped together by topic in this section.

*The Continuum of Care* – DMHAS has a broad treatment continuum with many behavioral health providers representing all levels of care along with several system of care collaboratives. Specific improvement in the quality of the mobile crisis team response was noted.

*Recovery Supports* – DMHAS has committed to developing and maintaining recovery supports which are widely available. There are dozens of free support groups, trained peers in recovery, recovery coaches in emergency departments and outpatient centers, family support groups, warm lines staffed by people in recovery, along with specific recovery support groups too numerous to name. In addition, the Connecticut Community for Addiction Recovery (CCAR) offers telephone recovery support, support groups and recovery coach training. Advocacy Unlimited (AU) offers Toivo, peer bridgers, recovery university, and hearing voices network. Finally, there are 12-step meetings specific for Spanish speakers, teens, medical professionals, etc.

*Access* – Greater access to services has been made possible by expansion of satellite offices, open access appointments, more MAT and IOP groups, the CT Addictions.com bed availability site, the 1-800 access

line, Beacon Health Options' MAT locator map, and some hospitals providing better access at their Emergency Departments (EDs). The Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) model is being utilized. Also, some vans are providing mobile outreach and Medication Assisted Treatment (MAT).

*Integration* – Integration of behavioral health with overall health and wellness focused activities has become more common. Some LMHAs have established medical clinics on site or have close collaborative relationships with nearby primary care providers. Some providers have become certified FQHCs themselves. Some providers are starting to screen for conditions beyond their usual range using SBIRT. More LMHAs now offer MAT. Usual naloxone training has been combined with QPR suicide prevention training.

*Wellness* – Similar to integration efforts mentioned in the above paragraph, a number of providers are expanding their focus toward health and wellness, in particular clubhouses, the Chrysalis Center, and LPCs were noted. Some schools are now addressing mental health wellness and mindfulness.

*Schools* – Enhancements promoting mental health have been added at a number of individual schools. These include designating “Zen Dens” or rooms meant to provide an opportunity for students to de-stress; school-based health services; schools contracting for in-school support; inclusion of social-emotional programming into the curriculum; receipt of suicide-prevention funds; and use of EMPS through 211 for students in need. AmeriCorps, VISTA Corps and Prevention Corps service members are working with some school districts to provide faculty education, identify and deliver curriculum enhancements and provide resources and support information to students and others at health and wellness events. Some regions have Therapeutic Alternative Schools as options.

*Grassroots/Community efforts* – There are a number of task forces, coalitions and grassroots organizations actively working to forward behavioral health issues. There's been greater involvement on the part of communities and providers, some of which have chosen to apply for, and been awarded, grants, including grants for communities to address underage drinking and/or non-medical use of prescription drugs. Communities have supported medication drop boxes and take-back days. Community health improvement projects of local hospitals include behavioral health goals and a number of hospitals participate or host Community Care Teams (CCTs) or navigators working to improve outcomes for persons with behavioral health issues who are homeless or frequent visitors to EDs. There have been community collaborations for youth and juvenile justice. The 211 info line is an asset as are stakeholder partners including LPCs and CACs.

*Law Enforcement* – Improved communication and interactions between first responders and behavioral health providers was noted along with the perception that first responders are more accepting of trainings such as Mental Health First Aid (MHFA) and Crisis Intervention Team (CIT). In addition, there is the sense that because of these efforts, there is reduced stigma/shame and greater willingness to respond to behavioral health crises. More municipalities are initiating diversion strategies from arrest to treatment with HOPE or HOPE-like models.

*Suicide* – The Connecticut Suicide Advisory Board (CTSAB) is the coordinating body for most suicide prevention activities statewide. Other strengths of the system include the Statewide Suicide Network of Care, *Gizmo's Pawesome Guide to Mental Health Curriculum* educational campaign, and the One Word, One Voice, One Life campaign. Suicide prevention and awareness have been implemented in a number

of school districts. There are QPR and CONNECT trainers available to provide suicide prevention training regionally.

*Opioid Epidemic* – The focus on the opioid epidemic has also brought increased attention to mental health issues and suicide. There are a multiplicity of medication drop boxes and promotion of take back events. Many naloxone training sessions and distribution have occurred across the state. The Change the Script and the Live Loud campaigns to raise awareness have been well received. The state has a number of stationary and mobile specialized syringe services (SSPs) funded by DPH. Connecticut has been the recipient of millions in federal grants to fund interventions to respond to the opioid crisis. At this point, many first responders, pharmacies, libraries, schools, hospital EDs, and others are armed with naloxone. There is a Narcan NOW app and DPH’s NORA (Naloxone and Opioid Response App) which handily cover all the critical information needed and can be downloaded to a mobile phone. Other strengths related to this topic include the involvement of New England HIDTA (High Intensity Drug Trafficking Area), mandatory use of the state’s prescription drug monitoring program; and expansion of MAT to LMHAs, hospitals, substance use programs, health centers and other locations.

*Children/Youth/Adolescents* – Specialized services for younger persons in need of behavioral health services include The Center for Child and Adolescent Treatment Services, which is an IOP helping adolescents, teenagers and their families; the Connecticut Institute for Communities offers a comprehensive array of primary care and behavioral health services for all ages; Multi-Dimensional Family Therapy (MDFT) is offered at Wheeler for at risk youth; summer camps for special needs youth are available; there are 2 specialized first episode psychosis (FEP) programs in the state; and more wrap around and in-home service options for children are available.

*Problem Gambling* – There are Bettor Choice providers to treat problem gambling along with gambling awareness teams, gambling awareness events, youth led gambling awareness conferences, and the ambassador pilot program designed to address problem gambling concerns specific to the Asian American/Pacific Islander community.

**Needs:** The identified needs/gaps/barriers are also organized by topic.

*The Continuum of Care* – There is a lack of “one stop shopping” such that the entire family, regardless of their ages or behavioral health needs, could be provided treatment and support services at one location. Ideally, if behavioral health interventions are provided early, before situations escalate and become emergencies, the outcomes would be better. Calls made to mobile crisis, however, can result in long delays, including children waiting at EDs without other options. There are two FEP programs in Connecticut, meaning not all regions have a local FEP program. More of the following were identified as needed: respite, long term addiction treatment, and inpatient rehabilitation beds; outpatient and intensive outpatient services; and specialized services for adolescents, adults with autism, persons with co-occurring conditions, and LGBTQI persons.

*Recovery Supports* – The sentiment was expressed that more support services were needed, rather than treatment per se. Recovery supports needed included case management, community support services, and the following specialized support groups: SMART Recovery groups for those 25 and older, women with postpartum depression, persons with co-occurring conditions, those with suicidal ideation, and those facilitating groups. Akin to recovery coaches in the ED for substance use issues was the proposal to have peer support specialists in the ED to assist patients with mental health issues. Job opportunities

for Peer Support Specialists were noted as lacking. Young adults were described as needing more life skills training.

*Access* - It remains a challenge to navigate the behavioral health system for those who are unfamiliar with it and there is a lack of services on demand. In rural areas, and for those who are disabled/home bound, there are fewer service options combined with limited transportation and the need for more satellite offices, telehealth and mobile options to address the shortage. Warm hand offs are needed when persons are transitioning between levels of care.

Access is also limited by the shortage of behavioral health providers, especially prescribers, and insurance barriers, such as high copays and deductibles, Medicare obstacles for accessing services by older adults, and high staff turnover.

*Integration* – greater communication and coordination are needed and better collaboration among state agencies, namely DPH, DMHAS, DCF and law enforcement. Further integration of behavioral health and primary care was advocated for along with police initiatives in behavioral health and increased involvement of local officials, especially with regard to the opioid crisis. It was noted that MHFA and YMHA still haven't happened in some schools and communities while stigma still persists. More early screening using SBIRT and ASBIRT are needed.

*Schools* – There is a lack of current and evidence-based curricula related to behavioral health education in the schools as well as a lack of inclusion of problem gambling prevention and education on brain health and the media.

*Opioid epidemic* – One region noted it has only one methadone clinic for the entire area. Some of the private and private nonprofit programs that offer methadone only accept cash and don't provide the necessary adjunct services. Some MAT clinics can't seem to hire qualified staff and some staff members aren't well informed or supportive of MAT.

*Other substance use issues* – LGBTQI persons and their use of methamphetamine need specialized services. Vaping needs to have primary prevention services focused on it for both nicotine and marijuana use and it needs to be designated as a substance use disorder. There is a sense that some persons aren't fully detoxified from alcohol before being discharged. There are no specific adolescent detox beds.

*Safe affordable housing* – There continues to be a lack of safe affordable housing options, especially for persons with behavioral health conditions. Not all sober homes are credentialed and the quality of sober homes and halfway houses varies considerably.

## **Recommendations:**

Prevention of substance use –

- Provide training and supports for youth compliance inspections, including point of sale identification checks to prevent under 21 purchases of tobacco and alcohol
- Raise awareness and provide education to decrease access to and availability of alcohol, heroin and prescription drugs, especially for 14 – 25 year olds, 65+ year olds and LGBTQI
- Compare perceived risk and use rates for vaping in 2019 and identify effective strategies for outreach and education about the dangers for youth

- Continue efforts to decrease opioid overdose deaths through promotion of prevention/treatment/recovery activities for opioid use disorder with a focus on high risk communities
- Provide stable and adequate funding to support education, training and capacity building
- Increase parental perception of risk of alcohol and ENDS (electronic nicotine delivery systems) use through education
- Schools need to adopt firm policies and procedures in response to ENDS use
- Raise awareness about benzodiazepine and cocaine use and misuse
- Support legislation to require blister packaging of medications to prevent diversion
- Develop a comprehensive plan to address the potential legalization of marijuana
- Address the pro-social community beliefs and behaviors regarding marijuana

#### Treatment of Substance use –

- Increase available resources: long term programs, detox beds, drug/alcohol counselors, DMHAS-funded MAT providers, individual therapy services, inpatient/residential rehab, transitional levels of care, and outpatient/intensive outpatient
- Ensure substance use providers are co-occurring disorder treatment capable
- Continue to develop and advertise other effective approaches for providing treatment on an outpatient basis (in-home, sober housing, mobile, MAT induction in hospitals and correctional settings) so people don't overdose while waiting for treatment
- Explore options for mobile and telehealth for those in rural areas with limited transportation
- Address the stigma associated with EAP and professional consequences
- More ENDS cessation programs are needed and ENDS promoted as a cessation tool should be challenged
- N-O-T youth cessation doesn't include vaping so under 18 cessation options are limited
- Marijuana use ignored or overlooked when persons are in treatment for other substances
- MAT not available at all programs in the region
- Lack of alternative pain management options
- Police departments need more clinical support

#### Recovery from Substance Use –

- Support efforts to ensure safe and affordable sober homes and study access to qualified sober housing
- Review the function of access line and recommend improvements
- Expand recovery coaches to community-based settings and police/fire departments
- Increase recovery supports, especially services for youth and young adults and options other than faith-based AA
- Support establishing recovery-friendly communities using SOR mini-grant funding to LPCs and coalitions
- Decrease stigma
- Lack of options for step down services

#### Prevention/Promotion of mental health issues –

- Assist in compiling local data about suicide and self-injury
- Support legislation to ensure social-emotional curriculum and positive school climate for k-12

- Local workforce training/education to build capacity; target awareness/education for 14 – 25 and LGBTQI populations
- Region 4 school surveys don't include a measure for anxiety – adjust the 2019 survey
- Provide stable and adequate funding to support education, training and capacity building
- Stigma and lack of awareness continues
- Increased screen time for youth and adults leads to disconnection and poor relationship skills

#### Treatment of Mental health issues –

- Ensure mental health services providers are co-occurring disorder treatment capable
- Support recommendations of psychiatric workforce taskforce to address shortages of providers; there is a shortage of pediatric psychiatrists as well as Spanish – and Portuguese-speaking providers
- In region 1: Develop an FEP and consider converting a CSP to an ACT
- Increase co-occurring disorder treatment capacity; increase early screening
- Explore offering mobile and telehealth options for rural areas/transportation barriers
- Address gap of supported, supportive and residential housing. DMHAS will have to look for revenues in its state allocation for housing supports/services that aren't subject to federal requirements targeting a narrow definition of homelessness.
- More early identification services and access to placement especially for youth; increase parity
- Suicide-bed availability and psychiatric care for children/adolescents
- Access to care before it becomes acute (people must decompensate to the point of being unable to care for themselves before they receive care or only receive treatment once incarcerated)
- Increase workforce to match treatment demand
- Early identification and intervention services and crisis services not available equally across the region
- Current commitment criteria make it nearly impossible to be admitted involuntarily to a hospital for inpatient care
- Need more trauma-informed care
- Adults not aware of EMPS

#### Recovery from mental health issues –

- Develop peer respite programs throughout the state to decrease hospitalization
- Increase mental health recovery support groups
- Provide SPF training to region 4 CAC members to plan and implement strategies to address lack of affordable housing
- Support a continued role for CACs due to their necessity for vital consumer engagement and critical community monitoring role. DMHAS contracts are unclear about funding for CACs
- Recovery coaches in EDs for mental health
- Lack of access in rural areas – need telehealth
- Those who are less acute don't have enough treatment options
- Increasing community level housing supports for SMI would improve treatment/outcomes
- Advanced suicide prevention strategies such as community level saturation of evidence-based education (QPR or MHFA) would decrease risk and improve outcomes

#### Prevention of Problem Gambling –



- Keep offering training for community prevention specialists
- Provide education/awareness of problem gambling for older adults and targeted campaign for enlisted military/families (at the submarine base)
- Review the school survey questions on perceived risk and use rates for problem gambling to address the overlap between computer gaming, sports betting and gambling
- Continue conversations with key community informants about prevalence and strategies being used to address anxiety, vaping and problem gambling among youth and young adults
- Include computer gaming as a topic in all problem gambling training
- Raise awareness of risks
- Online gaming and sport betting are accessible and easily hidden

#### Treatment of Problem Gambling –

- Continue research to measure prevalence change and better understand impact of problem gambling on communities
- Lack of problem gambling treatment services in northeastern part of state
- Expand Disordered Gambling Integration Project (DigIn) in areas where gambling is expanding and increase promotion of the HelpLine in those same areas (East Windsor, Enfield and Windsor Locks)
- Increase awareness of problem gambling services
- Problem gambling associated with increased smoking and drinking

#### Recovery from Problem Gambling –

- Ensure problem gambling supports are available in multiple languages
- Increase access to gambling recovery support groups
- Engage leaders of Gamblers Anonymous to expand GA meetings in those areas where gambling is expanding (East Windsor, Enfield and Windsor Locks)
- Promote inclusion of problem gambling in Recovery Coach and Recovery Support Specialist training
- Lack of awareness of local recovery supports
- People with gambling disorders are at increased risk of suicide

#### Prevention of integrated behavioral health concerns –

- Integrate messaging about MH/SU/PG to fight stigma, raise awareness of how interrelated they are and promote wellness
- Develop videos, webinars, and digital toolkits to be disseminated statewide
- Invest in social media buys to reach a bigger audience
- Revisit SBIRT screening programs to integrate other conditions – consider using Region 1 tool
- Expand certified prevention specialist staffing at RBHAOs to enhance primary prevention of all behavioral health issues and the ability to provide local training
- Develop universal trauma screening for k-12 to address trauma at trauma-informed schools
- Integrate mental health/prevention/Strategic Prevention Framework (SPF) model
- Elicit feedback from Hartford Foundation Community Fund Advisory Committee

#### Treatment of Integrated behavioral health concerns –

- Remove eligibility barriers for co-occurring disorders clients to get treatment and expand capacity to treat behavioral health and physical co-morbidities
- Increase the number of bilingual/multilingual providers and staff cultural competence

- Conduct a statewide campaign to increase awareness of available treatment resources and physician understanding of MAT
- Improve Veyo or find another transportation service
- Incentivize providers to accept private insurance and Medicaid
- Remove siloes and integrate programs and structures
- First responders should have clinicians available to respond with them to triage and avoid ED revolving door
- Increase collaboration to address adult behavioral health issues (currently limited to opioid treatment or overdose prevention)

#### Recovery of integrated behavioral health concerns –

- Increase supportive housing services for the behavioral health population
- Increase case management resources across programs, ease restrictions so more people have access
- Revisit benefits policies and job programs to decrease employment barriers
- Conduct external evaluation of AU, CCAR and MH-America peer training programs to cross walk and develop best practices
- Support legislation to make peer support reimbursable
- Increase support for culturally competent recovery models

#### Other General Recommendations -

- Expand ADPC to include and address MH/PG
- Merge children and adult mobile crisis services
- Provide comprehensive treatment and “one stop shopping” to address entire family
- Ensure all relevant state agencies are represented on the BHPC
- Work creatively with housing providers to address need for affordable, supportive housing
- Coordinate suicide and opioid response across DMHAS/DCF/DPH
- Use DPH training materials for NORA and CPMRS (CT Prescription Monitoring and Reporting System) rather than separate materials
- Work with DOC and DMV to develop a legitimate alternative form of identification to better care for the undocumented
- Explore creating slots for case management from the General Fund (as done in Maryland) for high need individuals regardless of ability to pay
- Ensure information and websites are available in multiple languages
- Make use of video conferencing technology/webinars to decrease travel time
- Regionalize conferences/trainings to maximize participation
- Have a better coordinated system of all behavioral health issues in elementary/middle/high school

### **Consumer Satisfaction Survey Measures**

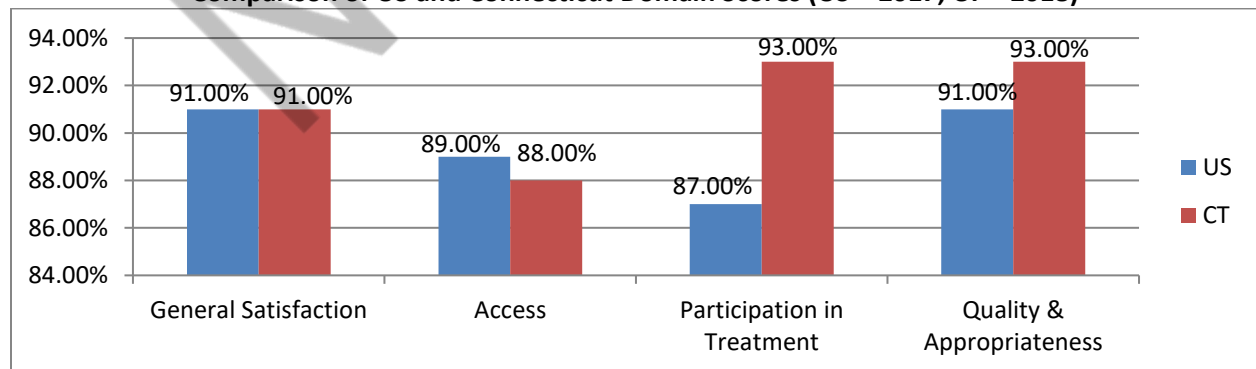
DMHAS conducts an annual consumer satisfaction survey in order to better understand consumers’ experiences with the public state-operated and community-funded service delivery system, as well as to use these data for quality improvement. The Consumer Survey has been administered annually since 2000,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

The survey is offered to consumers/individuals in recovery within the context of their treatment for behavioral health issues. Most levels of care are required to participate in the survey. State-operated and private nonprofit providers are required to collect and report results to the Office of the Commissioner, where the data is collated, analyzed and synthesized into an annual report. For FY 2018, over 23,000 surveys from 100 providers within the DMHAS behavioral health system were received. The FY 18 full report is at: <https://www.ct.gov/dmhas/lib/dmhas/consumersurvey/cs2018.pdf>.

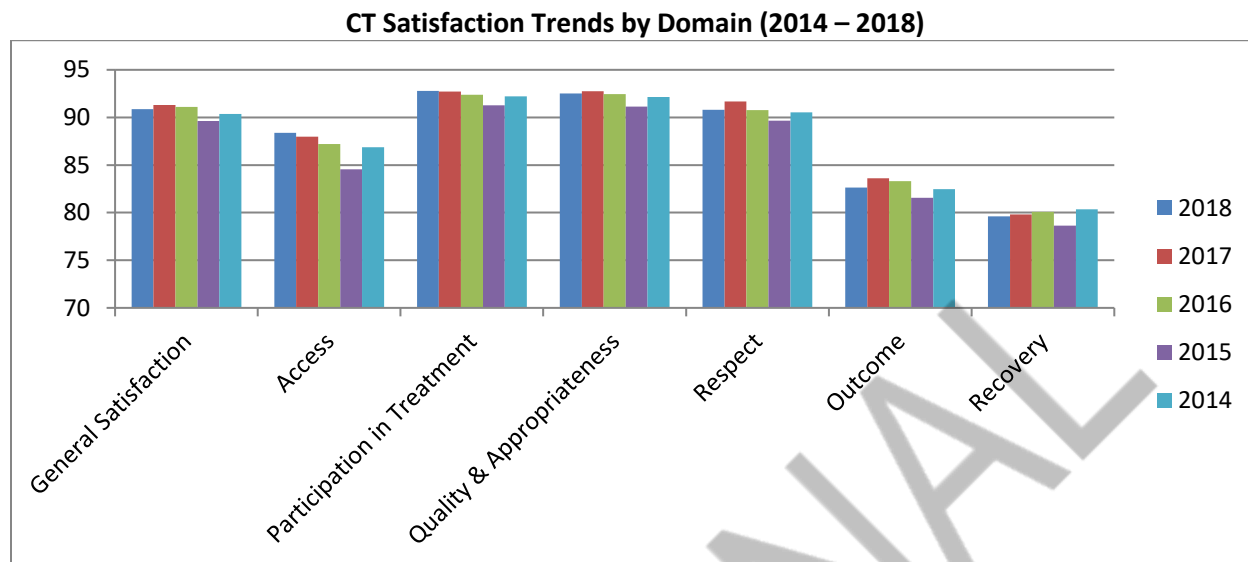
Since 2005, DMHAS has been utilizing a *Recovery Domain* that was added to the survey. The Recovery domain is comprised of five questions which assess perception of “recovery oriented services”. The recovery questions were developed in collaboration with the Yale Program for Recovery and Community Health. This addition provides DMHAS with valuable information regarding its success in implementing a recovery-oriented service system. DMHAS also uses an additional *Respect Domain* to collect information about perceived respect towards people in recovery. Two other instruments are included in the survey. The first is the WHOQOL-BREF Quality of Life instrument which is a widely used, standardized quality of life tool developed by the World Health Organization. This 26-item tool measures consumer satisfaction with the quality of the person’s life in physical, psychological, social and environmental domains. DMHAS received 1,800 QOL responses. The other tool added is the 8-question Health Outcomes Survey which includes items from the CDC’s Behavioral Risk Factor Surveillance System (BRFSS). These questions ask about body mass index (BMI), chronic health conditions, overall health from a physical and psychological perspective, and drinking habits. A total of 1,933 surveys were received on these Health Outcome Measures. The national emphasis on the integration of behavioral health and primary health care underscores the importance of these optional tools.

Of the 23,628 surveys returned, 25% were from outpatient programs, 6% from intensive outpatient, 14% from Medication Assisted Treatment programs, 8% from Case Management, 10% from residential programs, 9% from employment or social rehabilitation programs, and 28% from either other levels of care or from respondents who didn’t identify the program type. A comparison of consumer survey findings (2018) and national results (2017 CMHS Uniform Reporting System Output Tables) reveal that Connecticut respondents reported higher levels of satisfaction in all consumer satisfaction domains than the national averages with the exception of the Access domain where there was a 1% difference.

**Comparison of US and Connecticut Domain Scores (US – 2017; CT – 2018)**



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



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

- More clients in mental health programs reported satisfaction in the Access, Appropriateness, General Satisfaction and Respect domains while more clients in substance use programs reported satisfaction in the Outcome and Recovery domains.
- Across all programs, more women reported satisfaction with services in the Access, Appropriateness, General Satisfaction, Participation in Treatment and Respect domains while more men reported satisfaction in the Outcome and Recovery domains.
- Across all programs, white respondents were more satisfied than those in the Other Race category in the Appropriateness and Respect domains; Black respondents were more satisfied in the Outcome domain than other races and more satisfied in the Recovery domain than White respondents; and both Black and White respondents were more satisfied than those in the Other Race category in the Participation in Treatment domain.
- Across all programs, Non-Hispanic clients were more satisfied than Hispanics in the Participation in Treatment and Respect domains.
- In the General Satisfaction domain, older clients were more satisfied than younger clients.

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

Results on the QOL survey found that clients served in substance use programs reported a significantly better quality of life with respect to physical health, psychological factors, and social factors. Mental health clients reported a significantly better quality of life with respect to environmental factors. There

was no significant difference found for General QOL, although the score for substance use clients was slightly higher.

**Quality of Life Scores across DMHAS Subpopulations**

|                      | Physical Health | Psychological | Social | Environmental | General QOL |
|----------------------|-----------------|---------------|--------|---------------|-------------|
| <b>All Programs</b>  | 64.7            | 66.4          | 62.8   | 64.1          | 68.8        |
| <b>Substance Use</b> | 67.1            | 68.6          | 66.0   | 62.7          | 69.3        |
| <b>Mental Health</b> | 62.5            | 64.4          | 59.7   | 65.5          | 68.1        |

The QOL results also revealed that across all programs:

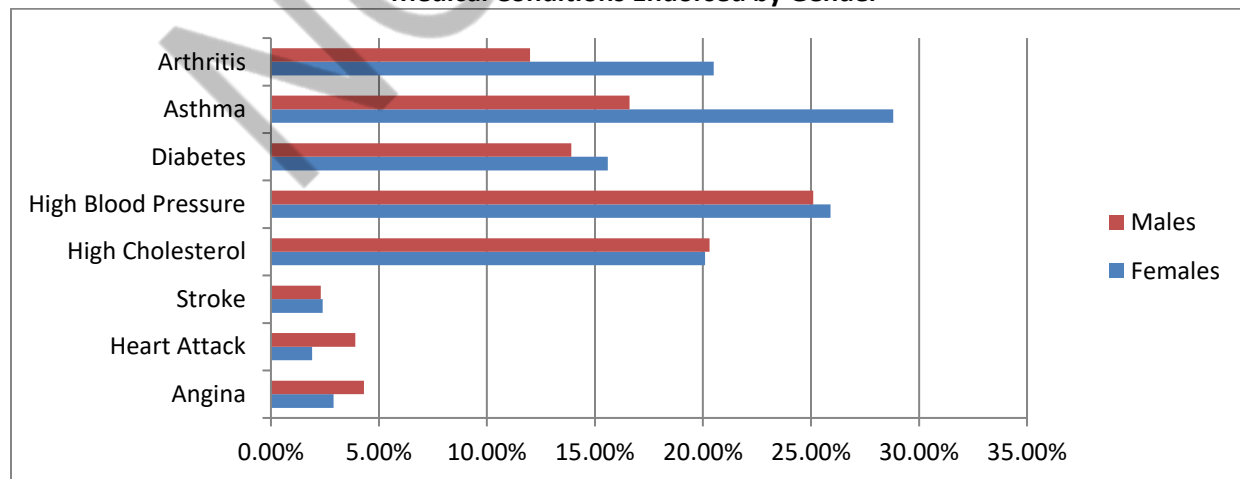
- Men reported better QOL than women in Physical Health, Psychological Factors, and General QOL
- Black respondents reported better QOL in Psychological Factors than White respondents
- White respondents reported better QOL in Environmental Factors than Other Races
- Non-Hispanic respondents reported better QOL in Environmental Factors than Hispanic respondents

As part of the FY 18 Consumer Satisfaction Survey process, DMHAS providers had the option to administer an 8-question Health Outcome Survey. The survey is available in English and Spanish. Body Mass Index (BMI), cardiovascular/respiratory/diabetes disease, overall health from physical and psychological perspectives, and smoking and drinking habits are all items. A total of 1,933 surveys were completed. Fifty-three percent of the responses were from clients in mental health programs and 45% were from clients in substance use programs. BMI could be calculated for 66.5% (1,286) of the respondents. The average BMI for clients was 32.2 (+8.7) with the women’s average at 32.4 (+8.0) and the men’s average at 32.1 (+8.6). According to the CDC, BMI categories for adults (ages 20 and older) indicate that all these averages reported fall into the Obese BMI category:

| Underweight BMI | Normal BMI   | Overweight BMI | Obese BMI |
|-----------------|--------------|----------------|-----------|
| < 18.5%         | 18.5 – 24.9% | 25.0 – 29.9%   | 30.0% +   |

Respondents endorsed the following list of medical conditions:

**Medical Conditions Endorsed by Gender**



Despite the medical conditions reported, clients rated their overall health as excellent/very good/good 69.2% and 30.8% reported their overall health as fair/poor.

NOT FINAL

## **Children's Plan Step II**

### ***Identify the unmet service needs and critical gaps within the current system***

Connecticut is the 29th most populated state with a total population of about 3,576,500, and about 761,795 or 21.3% 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 in need of mental health services in Connecticut. (20% may have behavioral health symptoms). Despite the strengths of the Connecticut system mentioned above, a number of families with children with SED, struggle to find support and treatment.

Families experience a number of barriers to treatment including at times a fragmented system in which access varies according to such factors as insurance status, involvement in child welfare or juvenile justice, race and ethnicity, language, and geographic location. In addition, the array of services lacks sufficient inclusion of supports for all children and families that promote nurturing relationships and environments that foster social, emotional, and behavioral wellness.

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.

The Connecticut legislation addressing the children's behavioral health system called for the development of a ***“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.

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 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 blue print to enhance Connecticut system of care.

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## Planning Steps

### Quality and Data Collection Readiness

#### Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?  
*Please indicate areas of technical assistance needed related to this section.*

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**Footnotes:**

NOT FINAL

## Quality and Data Collection Readiness

### 1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

DMHAS Adult Services: Connecticut Department of Mental Health and Addiction Services (DMHAS) allocates a portion of block grant funding to our sister agency, the Connecticut Department of Children and Families (DCF). DMHAS reports both mental health and substance use TEDS data. DMHAS has reported substance abuse (SA) TEDS for a number of years. The adult service system collects client level data for all funded or operated mental health or substance abuse services. In addition, a state statute in CT requires non-funded SA providers to report admissions and discharges to DMHAS. DMHAS does collect data at each of the levels described above: client, program, and provider.

DMHAS developed a data system to capture information from its private providers (DDaP) and uses a commercial system (WITS) to capture data from its state-run services. DDaP and WITS captures over 140 variables including NOMS, race and ethnicity, payor information, and contractually required performance measures. These data are then transferred for reporting purposes into an Enterprise Data Warehouse (EDW). DMHAS is able to provide quarterly report cards for all funded and operated programs. The report cards include information related to consumer satisfaction, data quality, service utilization, National Outcome Measures (NOMS), and other contractually specified performance measures.

DCF's Children's Services: Behavioral health providers contracted by DCF report client-level data into an internet-based system known as the DCF Provider Information Exchange (PIE). Each contracted service (referred to as a Program) has its own customized data collection model in which data includes specified outcomes.

Data is collected along a combination of points during service delivery, and for some programs, during and after service delivery. Data can be collected on all referrals to a given program, at intake and discharge, or periodically during the episode either at scheduled times for required Periodic Updates or on an as-needed basis for events called Activities.

Individual providers can choose to enter data into the system either directly through the website or through monthly batch uploads or automated web services data transfers from internal database systems. A collection of data quality, performance management, and outcome reports are built into the system, which also offers a data extraction utility for downloading customized datasets for additional analysis.

Access to the system is controlled through web-based security profiles, ensuring that users only have access to the data and information that their security profile allows. A wealth of training material is provided online in both written and short video formats, and a demonstration site is also available for training new users.

**2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.)**

DMHAS Adult Services: As indicated above, the adult information system only captures data from funded or operated mental health and substance abuse service providers. The exception is that DMHAS does collect information from non-funded licensed SA providers. Not all providers comply with this requirement, but most do. Additional behavioral health data is collected by the state's Medicaid Authority (Department of Social Services – DSS). That information is available to DMHAS through a memorandum of agreement. That agreement specifies that DMHAS can access Medicaid claims data.

DCF Children's Services: Programs that submit data into the PIE system include substance abuse, mental health, in-home services, care coordination, and a variety of other child welfare services. Future releases will include the addition of other such services, as well as services to support juvenile justice populations. All such programs are services contracted by CT DCF, but the clients receiving those services may or may not also be receiving other child welfare or juvenile justice services directly from the agency.

**3. Is the state currently able to collect and report on measures at the individual client level (that is, by client served, but not with client-identifying information)?**

DMHAS Adult Services: DMHAS is capable of providing data at the individual level and is currently reporting TEDS data for both mental health and substance abuse.

DCF Children's Services: The PIE system and the DCF SACWIS system currently under development will give Connecticut added ability to better capture the draft measures at the individual client level.

**4. If not, what changes will the state need to make to be able to collect and report on these measure?**

DMHAS Adult Services: DCF would need to significantly upgrade their data collection systems. Data is not maintained in the same manner as the adult system (by client, program provider, level of care, and services) and would require significant upgrade to the current systems in order to report TEDS data.

DCF Children's System: Currently DCF has an annual allocation for maintenance and small enhancements in the PIE system.

# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1  
**Priority Area:** To empower women, including PWWDC, to make informed choices around reproductive healthcare and to discuss their pregnancy intentions  
**Priority Type:** SAT  
**Population(s):** PWWDC

**Goal of the priority area:**

To ensure that women have access to accurate information about reproductive healthcare, contraception and optimal birth spacing as a component of their care

**Objective:**

To ensure that women with substance use or co-occurring disorders receive education about and are able to access contraception, medication assisted treatment, and other services/resources that address both their substance use and reproductive health needs

**Strategies to attain the objective:**

One Key Question (OKQ) is an evidence-based practice used to initiate conversations about reproductive health, optimal birth spacing, and preventing unintended pregnancy. The DMHAS Women's REACH (Recovery, Engagement, Access, Coaching, and Healing) Program was recently added to the continuum of care for PPW. REACH provides female recovery navigators (all REACH staff are women with lived experience) in each DMHAS region to provide community connections to treatment and recovery support services to women, in particular, those who are pregnant and/or parenting. All of the recovery navigators in the REACH program will be trained on OKQ and how to connect the women they work with to needed reproductive health services/resources.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Percent of recovery navigators working with substance using women in the community that are trained on One Key Question and connecting women to needed services/resources  
**Baseline Measurement:** NA  
**First-year target/outcome measurement:** 50% of the recovery navigators will be trained on One Key Question and connecting women to services/resources  
**Second-year target/outcome measurement:** 100% of recovery navigators will be trained on One Key Question and connecting women to services/resouces

**Data Source:**

The DMHAS Women's Services Director will maintain training logs for the recovery navigators

**Description of Data:**

Attendance list of recovery navigators who participate in the training

**Data issues/caveats that affect outcome measures::**

none anticipated

**Priority #:** 2  
**Priority Area:** Expand Medication Assisted Treatment (MAT) among PWID  
**Priority Type:** SAT  
**Population(s):** PWID

**Goal of the priority area:**

Successfully engage PWID in MAT and decrease the drop-out rate

**Objective:**

To increase the percentage of PWID that stay on MAT at least 30 days post-induction

**Strategies to attain the objective:**

DMHAS has made efforts to expand MAT options across the state. The department has arranged for Recovery Coaches in several hospital EDs and plans to arrange for Recovery Coaches at some of the state's methadone clinics to assist clients in their recovery. Additionally, DMHAS managers will conduct regular meetings with MAT providers to share data and discuss best practice engagement strategies.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** percent of MAT clients that continue in the program at least 30 days post-induction  
**Baseline Measurement:** 85.18%  
**First-year target/outcome measurement:** 86.0%  
**Second-year target/outcome measurement:** 86.5%

**Data Source:**

DMHAS data warehouse.

**Description of Data:**

DMHAS MAT providers: Outcome measures: MAT initiation: discharges within 30 days. The resulting value is subtracted from 100% to reflect the percent staying in MAT at least 30 days post-induction.

**Data issues/caveats that affect outcome measures::**

none anticipated

**Priority #:** 3  
**Priority Area:** Reduce infectious disease transmission through education  
**Priority Type:** SAT  
**Population(s):** TB

**Goal of the priority area:**

To provide training on Infectious Diseases: Current Trends and High Risk Populations, including TB, to substance use treatment staff

**Objective:**

All substance use treatment program infection control nurses will be provided the most current information on infectious diseases, including high risk populations and current trends, including TB

**Strategies to attain the objective:**

Infectious Disease content experts in Connecticut will be engaged to conduct presentations on current trends and high risk populations for substance use treatment staff. Infection control nurses will be expected to attend. Any infection control nurse unable to attend one of the scheduled presentations will meet in person with the DMHAS manager coordinating the training to review the material and ensure comprehension.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Attendance by the infection control nurses at the training  
**Baseline Measurement:** NA



**First-year target/outcome measurement:** 50% of the infection control nurses will attend the training

**Second-year target/outcome measurement:** 100% of the infection control nurses will attend the training

**Data Source:**

sign in sheets reflecting attendance

**Description of Data:**

The DMHAS manager responsible for coordinating the training will maintain sign on sheets for the training events.

**Data issues/caveats that affect outcome measures::**

none anticipated

**Priority #:** 4

**Priority Area:** Decreased hospitalization of persons with SMI by increased utilization of community-based levels of care

**Priority Type:** MHS

**Population(s):** SMI

**Goal of the priority area:**

To increase utilization of community-based alternatives to hospitalization for persons with SMI

**Objective:**

To automate real time availability of mental health community-based services and make them available to providers and the public

**Strategies to attain the objective:**

DMHAS will develop and implement a psychiatric bed registry program for respite, mental health intensive, group homes, supervised apartments, and transitional levels of care. Providers will be required to update bed availability in real time. The system will include links to the programs for additional information.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** utilization rates for the 5 community-based levels of care

**Baseline Measurement:** to be determined

**First-year target/outcome measurement:** implement the automated system and educate staff at the programs providing these levels of care in use of the system

**Second-year target/outcome measurement:** utilization rates for these 5 community-based levels of care will exceed the baseline rates

**Data Source:**

DMHAS administrative data

**Description of Data:**

utilization rates by level of care

**Data issues/caveats that affect outcome measures::**

none anticipated

**Priority #:** 5

**Priority Area:** Childhood Trauma

**Priority Type:** MHS

**Population(s):** SED

**Goal of the priority area:**

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

**Objective:**

1. Increase the number of mental health agencies in CT that provide the evidence based treatment utilizing MATCH, CBITS and TF-CBT 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.
2. Increasing the number of clinical staff trained in providing MATCH, CBITS and TF-CBT services to children, youth and their caregivers which will lead to an increase in children, youth and families served..

**Strategies to attain the objective:**

Strategies to attain the objective:

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** 3,000

**First-year target/outcome measurement:** 3,200

**Second-year target/outcome measurement:** 3300

**Data Source:**

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

**Description of Data:**

CHDI will provide data

**Data issues/caveats that affect outcome measures::**

None

**Indicator #:** 2

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

**Baseline Measurement:** Baseline of 300 clinicians trained

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

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

**Data Source:**

The Child Health and Development Institute of Connecticut (CHDI)

**Description of Data:**

Report of actual numbers

**Data issues/caveats that affect outcome measures::**

none

**Priority #:** 6  
**Priority Area:** ESMI Intervention  
**Priority Type:** MHS  
**Population(s):** ESMI

**Goal of the priority area:**

Earlier identification and intervention for those with ESMI

**Objective:**

Earlier identification using ESMI outreach worker and Medicaid Claims data of any psychotic disorders in young persons. Continued utilization of the states' 2 evidence based program, POTENTIAL and STEP.

**Strategies to attain the objective:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** The percentage of young persons identified with ESMI who agree to engage in treatment  
**Baseline Measurement:** 15% of young persons identified with ESMI will agree to engage in treatment.  
**First-year target/outcome measurement:** 18% of young persons identified with ESMI will agree to engage in treatment.  
**Second-year target/outcome measurement:** 20% of young persons identified with ESMI will agree to engage in treatment.

**Data Source:**

Beacon Health Options-ASO, POTENTIAL and STEP program

**Description of Data:**

Number of youth identified, referred and engaged in treatment

**Data issues/caveats that affect outcome measures::**

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

**Priority #:** 7  
**Priority Area:** Family Engagement  
**Priority Type:** MHS  
**Population(s):** SED

**Goal of the priority area:**

To increase family voice.

**Objective:**

To ensure that the voices, perspectives and input of family members are included in developing, planning, and overseeing the statewide children's behavioral health system while ensuring families have the tools to advocate for their children and system change.

**Strategies to attain the objective:**

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

**Annual Performance Indicators to measure goal success**

|   |  |
|---|--|
| <b>Indicator #:</b>                                       | 1  |
| <b>Indicator:</b>   | Increasing the number of families interfacing with the family system organization through support services, support groups, trainings, events and then participating in follow up activities |
| <b>Baseline Measurement:</b>                              | 5800 points of interface with families   |
| <b>First-year target/outcome measurement:</b>             | 5900   |
| <b>Second-year target/outcome measurement:</b>            | 6000   |
| <b>Data Source:</b>                                       | Provider Information Exchange (PIE) and FAVOR reports  |
| <b>Description of Data:</b>                               | Totals of participants at training, support groups and outreach activities. Total families served by FPSS's.   |
| <b>Data issues/caveats that affect outcome measures::</b> | Integrity of PIE data source and other data tracking methods   |

**Priority #:** 8  
**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.

**Objective:**

Increase the number of faculty and students trained in modules on EBP treatment at the graduate and undergraduate level to ensure students are exposed to best practices to make informed career an employment decisions

**Strategies to attain the objective:**

- 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**

|   |  |
|---|--|
| <b>Indicator #:</b>                           | 1  |
| <b>Indicator:</b>                             | Maintain the number of faculty trained in the curriculum |
| <b>Baseline Measurement:</b>                  | 32 faculty trained                                       |
| <b>First-year target/outcome measurement:</b> | 2 additional faculty trained due to attrition            |

**Second-year target/outcome measurement:** additional faculty trained due to attrition

**Data Source:**

Wheeler Clinic provider report

**Description of Data:**

Number of faculty trained and total number of faculty

**Data issues/caveats that affect outcome measures::**

none

**Indicator #:**

2

**Indicator:**

Maintain the number of students that receive certificates of completion

**Baseline Measurement:**

65 students to receive certificates

**First-year target/outcome measurement:**

65 students to receive certificates

**Second-year target/outcome measurement:**

65 students to receive certificates

**Data Source:**

Wheeler Clinic provider report

**Description of Data:**

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

**Data issues/caveats that affect outcome measures::**

None

**Priority #:**

9

**Priority Area:**

Prevention of Mental Illness

**Priority Type:**

MHS

**Population(s):**

SMI, SED

**Goal of the priority area:**

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

**Objective:**

To enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide

**Strategies to attain the objective:**

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

**Annual Performance Indicators to measure goal success**

**Indicator #:**

1

**Indicator:**

Distribution of social marketing materials throughout the state of Connecticut

**Baseline Measurement:**

115,000 items distributed

**First-year target/outcome measurement:** 1200,000 items distributed

**Second-year target/outcome measurement:** 125,000 items distributed

**Data Source:**

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

**Description of Data:**

Reports of actual numbers

**Data issues/caveats that affect outcome measures::**

None

**Indicator #:** 2

**Indicator:** Increase the number of individuals receiving suicide prevention/crisis response training

**Baseline Measurement:** 430 Individuals trained

**First-year target/outcome measurement:** 445 Individuals trained

**Second-year target/outcome measurement:** 460 Individuals trained

**Data Source:**

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

**Description of Data:**

Reports of actual numbers

**Data issues/caveats that affect outcome measures::**

None

**Priority #:** 10

**Priority Area:** Prevention

**Priority Type:** SAP

**Population(s):** PP

**Goal of the priority area:**

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

**Objective:**

Decrease access to ENDs among individuals under 21 years old

**Strategies to attain the objective:**

Conduct unannounced inspections of a random sample of ENDs vendors across the state, establish a failure rate and take enforcement action for vendors who are non-compliant with the laws.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

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

**Baseline Measurement:** 16%

**First-year target/outcome measurement:** 13%

**Second-year target/outcome measurement:** 10% or below

**Data Source:**

The Department of Mental Health and Addiction Services' Tobacco Prevention and Enforcement unit

**Description of Data:**

Annual analysis of the inspections of a random sample of ENDS vendors to assess the non-compliance rate

**Data issues/caveats that affect outcome measures::**

Availability of and gender and racial diversity for youth investigators

**Indicator #:**

2

**Indicator:**

Percentage of students who report ever using an electronic cigarette

**Baseline Measurement:**

14.7%

**First-year target/outcome measurement:**

less than 14%

**Second-year target/outcome measurement:**

less than 14%

**Data Source:**

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

**Description of Data:**

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

**Data issues/caveats that affect outcome measures::**

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

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**Footnotes:**

NOT FINAL

## Planning Tables

**Table 2 State Agency Planned Expenditures [SA]**

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

| Activity<br>(See instructions for using Row 1.)   | A.Substance Abuse Block Grant | B.Mental Health Block Grant | C.Medicaid (Federal, State, and Local) | D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.) | E.State Funds        | F.Local Funds (excluding local Medicaid) | G.Other             |
|---|-------------------------------|-----------------------------|--|--|----------------------|--|---------------------|
| 1. Substance Abuse Prevention* and Treatment  | \$27,433,624                  |                             | \$0                                    | \$24,879,538   | \$242,342,699        | \$0                                      | \$31,741,331        |
| a. Pregnant Women and Women with Dependent Children**   | \$6,437,834                   |                             | \$0                                    | \$110,686  | \$5,537,877          | \$0                                      | \$1,646,218         |
| b. All Other  | \$20,995,790                  |                             | \$0                                    | \$24,768,852   | \$236,804,822        | \$0                                      | \$30,095,113        |
| 2. Primary Prevention   | \$8,986,446                   |                             | \$0                                    | \$23,849,400   | \$9,718,542          | \$0                                      | \$2,769,628         |
| a. Substance Abuse Primary Prevention   | \$0                           |                             | \$0                                    | \$0  | \$0                  | \$0                                      | \$0                 |
| b. Mental Health Primary Prevention   |                               |                             |  |  |                      |  |                     |
| 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) |                               |                             |  |  |                      |  |                     |
| 4. Tuberculosis Services  | \$0                           |                             | \$0                                    | \$0  | \$0                  | \$0                                      | \$0                 |
| 5. Early Intervention Services for HIV  | \$0                           |                             | \$0                                    | \$0  | \$0                  | \$0                                      | \$0                 |
| 6. State Hospital   |                               |                             |  |  |                      |  |                     |
| 7. Other 24 Hour Care   |                               |                             |  |  |                      |  |                     |
| 8. Ambulatory/Community Non-24 Hour Care  |                               |                             |  |  |                      |  |                     |
| 9. Administration (Excluding Program and Provider Level)  | \$0                           |                             | \$0                                    | \$0  | \$26,753,297         | \$0                                      | \$0                 |
| <b>10. Total</b>  | <b>\$36,420,070</b>           | <b>\$0</b>                  | <b>\$0</b>                             | <b>\$48,728,938</b>  | <b>\$278,814,538</b> | <b>\$0</b>                               | <b>\$34,510,959</b> |

\* Prevention other than primary prevention

\*\* The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.



**Footnotes:**

NOT FINAL

## Planning Tables

**Table 2 State Agency Planned Expenditures [MH]**

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

| Activity<br>(See instructions for using Row 1.)   | A.Substance Abuse Block Grant | B.Mental Health Block Grant | C.Medicaid (Federal, State, and Local) | D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.) | E.State Funds          | F.Local Funds (excluding local Medicaid) | G.Other             |
|---|-------------------------------|-----------------------------|--|--|------------------------|--|---------------------|
| 1. Substance Abuse Prevention and Treatment   |                               |                             |  |  |                        |  |                     |
| a. Pregnant Women and Women with Dependent Children   |                               |                             |  |  |                        |  |                     |
| b. All Other  |                               |                             |  |  |                        |  |                     |
| 2. Primary Prevention   |                               |                             |  |  |                        |  |                     |
| a. Substance Abuse Primary Prevention   |                               |                             |  |  |                        |  |                     |
| b. Mental Health Primary Prevention <sup>†</sup>  |                               | \$0                         | \$0                                    | \$0  | \$0                    | \$0                                      | \$0                 |
| 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)** |                               | \$1,894,776                 | \$0                                    | \$0  | \$0                    | \$0                                      | \$0                 |
| 4. Tuberculosis Services  |                               |                             |  |  |                        |  |                     |
| 5. Early Intervention Services for HIV  |                               |                             |  |  |                        |  |                     |
| 6. State Hospital   |                               |                             | \$0                                    | \$0  | \$495,461,495          | \$0                                      | \$6,454,610         |
| 7. Other 24 Hour Care   |                               | \$2,275,434                 | \$0                                    | \$38,233,873   | \$368,052,844          | \$0                                      | \$1,308,628         |
| 8. Ambulatory/Community Non-24 Hour Care  |                               | \$9,319,930                 | \$0                                    | \$11,985,101   | \$681,006,605          | \$0                                      | \$7,277,626         |
| 9. Administration (Excluding Program and Provider Level)***   |                               | \$30,000                    | \$0                                    | \$0  | \$75,770,844           | \$0                                      | \$0                 |
| <b>10. Total</b>  | <b>\$0</b>                    | <b>\$13,520,140</b>         | <b>\$0</b>                             | <b>\$50,218,974</b>  | <b>\$1,620,291,788</b> | <b>\$0</b>                               | <b>\$15,040,864</b> |

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

\*\* Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

\*\*\* Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

**Footnotes:**

NOT FINAL

## Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

|  | Aggregate Number Estimated In Need | Aggregate Number In Treatment |
|--|------------------------------------|-------------------------------|
| 1. Pregnant Women                        | 2747                               | 271                           |
| 2. Women with Dependent Children         | 5059                               | 3289                          |
| 3. Individuals with a co-occurring M/SUD | 36845                              | 12362                         |
| 4. Persons who inject drugs              | 8503                               | 8417                          |
| 5. Persons experiencing homelessness     | 166                                | 4387                          |

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

NA

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### Footnotes:

Aggregate number estimated in need - For Pregnant women: National Vital Statistics Report, vol. 67, no. 8. Final Report for 2017, Nov. 7, 2018. There were 35,221 births in CT in 2017. Taking this amount and multiplying by the 7.8% from NSDUH State Reports based on 2016-2017 data from Table 26 - Needing but not receiving treatment at a specialty facility for SUD in the past year. For Women with Dependent Children: US Census Bureau data for CT for family households with co-resident children led by female with no husband present: 64,863 multiplied by 7.8% from NSDUH State Reports based on 2016-2017 data from Table 26: Needing but not receiving treatment at a specialty facility for SUD in past year. Co-occurring M/SUD: US Census Bureau number of CT adults (2,834,259) multiplied by 1.3% from NSDUH 2017 as percentage of adults with both an SMI and SUD diagnosis. People who inject drugs: US Census Bureau number of CT adults (2,834,259) multiplied by estimate of injection drug use based on 2014 study by Lansky et al. of 0.30% of the population. Homelessness: Based on CT Coalition to End Homelessness data from 2018 that 3,383 total homeless in CT, 166 were identified as having substance use issues.

Aggregate number in treatment - These data were compiled from assessments collected at admission to and discharge from substance use

treatment programs funded and operated by DMHAS. The following data were collected from required TEDS data fields: SuDS6, Pregnant at Admission; SuDS5, Co-occurring substance abuse and mental health problems; MDS15ABC, Route of Administration; SuDS8, Living Arrangements. "Women with dependent children" is not a TEDS or NOMS data element, but is part of DMHAS' periodic assessment data set.

NOT FINAL

# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

| Expenditure Category                           | FFY 2020 SA Block Grant Award |
|--|-------------------------------|
| 1 . Substance Abuse Prevention and Treatment * | \$13,716,812                  |
| 2 . Primary Substance Abuse Prevention         | \$4,493,223                   |
| 3 . Early Intervention Services for HIV**      | \$0                           |
| 4 . Tuberculosis Services                      | \$0                           |
| 5 . Administration (SSA Level Only)            | \$0                           |
| <b>6. Total</b>                                | <b>\$18,210,035</b>           |

\* Prevention other than Primary Prevention

\*\* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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**Footnotes:**

NOT FINAL

# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

| Strategy                               | A            | B                                |
|--|--------------|----------------------------------|
|  | IOM Target   | FFY 2020<br>SA Block Grant Award |
| 1. Information Dissemination           | Universal    | \$343,164                        |
|  | Selective    | \$13,163                         |
|  | Indicated    | \$14,461                         |
|  | Unspecified  | \$0                              |
|  | <b>Total</b> | <b>\$370,788</b>                 |
| 2. Education                           | Universal    | \$1,078,691                      |
|  | Selective    | \$41,376                         |
|  | Indicated    | \$45,455                         |
|  | Unspecified  | \$0                              |
|  | <b>Total</b> | <b>\$1,165,522</b>               |
| 3. Alternatives                        | Universal    | \$43,099                         |
|  | Selective    | \$1,653                          |
|  | Indicated    | \$1,816                          |
|  | Unspecified  | \$0                              |
|  | <b>Total</b> | <b>\$46,568</b>                  |
| 4. Problem Identification and Referral | Universal    | \$28,868                         |
|  | Selective    | \$1,108                          |
|  | Indicated    | \$1,216                          |
|  | Unspecified  | \$0                              |
|  | <b>Total</b> | <b>\$31,192</b>                  |
|  | Universal    | \$2,154,129                      |



|  |              |                     |
|--|--------------|---------------------|
| 5. Community-Based Process                   | Selective    | \$82,627            |
|  | Indicated    | \$90,774            |
|  | Unspecified  | \$0                 |
|  | <b>Total</b> | <b>\$2,327,530</b>  |
| 6. Environmental                             | Universal    | \$417,977           |
|  | Selective    | \$16,033            |
|  | Indicated    | \$17,613            |
|  | Unspecified  | \$0                 |
|  | <b>Total</b> | <b>\$451,623</b>    |
| 7. Section 1926 Tobacco                      | Universal    | \$100,000           |
|  | Selective    |                     |
|  | Indicated    |                     |
|  | Unspecified  |                     |
|  | <b>Total</b> | <b>\$100,000</b>    |
| 8. Other                                     | Universal    |                     |
|  | Selective    |                     |
|  | Indicated    |                     |
|  | Unspecified  |                     |
|  | <b>Total</b> | <b>\$0</b>          |
| <b>Total Prevention Expenditures</b>         |              | <b>\$4,493,223</b>  |
| <b>Total SABG Award*</b>                     |              | <b>\$18,210,035</b> |
| <b>Planned Primary Prevention Percentage</b> |              | <b>24.67 %</b>      |

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**

## Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

| Activity                                     | FFY 2020 SA Block Grant Award |
|--|-------------------------------|
| Universal Direct                             | \$3,154,692                   |
| Universal Indirect                           | \$1,003,786                   |
| Selective                                    | \$159,509                     |
| Indicated                                    | \$175,236                     |
| <b>Column Total</b>                          | <b>\$4,493,223</b>            |
| <b>Total SABG Award*</b>                     | <b>\$18,210,035</b>           |
| <b>Planned Primary Prevention Percentage</b> | <b>24.67 %</b>                |

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**

NOT FINAL

## Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

| Targeted Substances                          |                                     |
|--|-------------------------------------|
| Alcohol                                      | <input checked="" type="checkbox"/> |
| Tobacco                                      | <input checked="" type="checkbox"/> |
| Marijuana                                    | <input checked="" type="checkbox"/> |
| Prescription Drugs                           | <input checked="" type="checkbox"/> |
| Cocaine                                      | <input type="checkbox"/>            |
| Heroin                                       | <input checked="" type="checkbox"/> |
| Inhalants                                    | <input type="checkbox"/>            |
| Methamphetamine                              | <input type="checkbox"/>            |
| Synthetic Drugs (i.e. Bath salts, Spice, K2) | <input type="checkbox"/>            |
| Targeted Populations                         |                                     |
| Students in College                          | <input checked="" type="checkbox"/> |
| Military Families                            | <input checked="" type="checkbox"/> |
| LGBTQ  | <input checked="" type="checkbox"/> |
| American Indians/Alaska Natives              | <input checked="" type="checkbox"/> |
| African American                             | <input checked="" type="checkbox"/> |
| Hispanic                                     | <input checked="" type="checkbox"/> |
| Homeless                                     | <input checked="" type="checkbox"/> |
| Native Hawaiian/Other Pacific Islanders      | <input checked="" type="checkbox"/> |
| Asian  | <input checked="" type="checkbox"/> |
| Rural  | <input checked="" type="checkbox"/> |
| Underserved Racial and Ethnic Minorities     | <input checked="" type="checkbox"/> |

**Footnotes:**

NOT FINAL

# Planning Tables

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

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

| FY 2020   |                   |                    |                   |
|---|-------------------|--------------------|-------------------|
| Activity  | A. SABG Treatment | B. SABG Prevention | C. SABG Combined* |
| 1. Information Systems  | \$0               | \$0                | \$0               |
| 2. Infrastructure Support                                     | \$0               | \$0                | \$0               |
| 3. Partnerships, community outreach, and needs assessment     | \$0               | \$0                | \$0               |
| 4. Planning Council Activities (MHBG required, SABG optional) | \$0               | \$0                | \$0               |
| 5. Quality Assurance and Improvement                          | \$0               | \$0                | \$0               |
| 6. Research and Evaluation                                    | \$0               | \$0                | \$0               |
| 7. Training and Education                                     | \$0               | \$0                | \$0               |
| <b>8. Total</b>   | <b>\$0</b>        | <b>\$0</b>         | <b>\$0</b>        |

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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**Footnotes:**

NOT FINAL

## Planning Tables

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

MHBG Planning Period Start Date: 10/01/2019

MHBG Planning Period End Date: 09/30/2021

| Activity  | FFY 2020 Block Grant |
|---|----------------------|
| 1. Information Systems  | \$200,000            |
| 2. Infrastructure Support                                     | \$450,000            |
| 3. Partnerships, community outreach, and needs assessment     | \$100,000            |
| 4. Planning Council Activities (MHBG required, SABG optional) | \$15,000             |
| 5. Quality Assurance and Improvement                          | \$80,000             |
| 6. Research and Evaluation                                    | \$0                  |
| 7. Training and Education                                     | \$75,000             |
| <b>8. Total</b>   | <b>\$920,000</b>     |

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**Footnotes:**

NOT FINAL

# Environmental Factors and Plan

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

### Narrative Question

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

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>27</sup> Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>28</sup>

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

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>30</sup> Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>31</sup> and ACOs<sup>32</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

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



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

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>40</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>41</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>22</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>24</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

<sup>26</sup> <http://www.samhsa.gov/health-disparities/strategic-initiatives>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

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

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

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

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

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

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

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

<sup>37</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>38</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>39</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORX/PEP13-RTC-BHWORX.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

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

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

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

The state has been actively working to integrate mental health and primary health care. Several years ago, DMHAS initiated Behavioral Health Homes (BHHs) in 14 agencies across the state. This includes all the Local Mental Health Authorities (LMHAs) and one other private agency. The BHHs are an innovative, integrated healthcare service delivery model that is recovery-oriented, person and family-centered and promises better patient experiences and outcomes than those achieved in traditional services. 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. The services are designed to achieve the triple aim of improving individual experience of care, improve population health, and reduce per capita health care costs. These services are funded by DMHAS and Medicaid and include care management and coordination, health and wellness activities, and referral to community support services. DMHAS serves approximately 10,000 individuals through these services annually.

Integration also occurs outside of these BHHs. Various mental health providers across the state have developed relationships with local medical providers. In some instances the medical services are co-located at community mental health centers. This integration may also occur in other ways. One LMHA is a Federally Qualified Health Center (FQHC) Look Alike and delivers integrated services. In addition to these activities, DMHAS was awarded the Promoting Integration of Primary and Behavioral Health Care Integration Grant (PIPBHC) which is allowing Connecticut to further expand our integration efforts.

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

Connecticut has long recognized that mental health and substance use conditions often occur in the same individuals, consequently, DMHAS has been providing integrated services for co-occurring clients since the 1990s. Mental health and addiction treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders. Specialized staff training, consultation, and pilot treatment projects for persons with co-occurring disorders have been put in place over the last twenty years to address the treatment needs of individuals with co-occurring disorders. The thirteen 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 its 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. Since then, an additional residential treatment program has reached co-occurring enhanced status for a total of three programs in the PNP sector.

DMHAS contracted with an IDDT consultant from Dartmouth Medical School for 9 years (2002-2011) and with Dr. Mark McGovern (also from Dartmouth) for about 10 years to train and consult with DMHAS providers on the DDCAT. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and addiction treatment agencies on a combined Co-Occurring and Supervision model for a couple of year.

Additionally, as part of the system change to ensure that mental health and substance use treatment providers were considering all relevant conditions, DMHAS instituted a policy in 2009 that all providers had to conduct co-occurring screenings at the time of admission and this process continues. These client-level screening data are collected through DMHAS' statewide data collection system.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  Yes  No

b) and Medicaid?  Yes  No

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

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

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

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

a) Prevention and wellness education  Yes  No

b) Health risks such as

ii) heart disease  Yes  No

iii) hypertension  Yes  No

iv) high cholesterol  Yes  No

v) diabetes  Yes  No

c) Recovery supports  Yes  No

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

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

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

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

As for non-Medicaid covered services, DMHAS has representation on a workgroup chaired by the Commissioner of the Connecticut Insurance Department to review the practices of all payers in Connecticut.

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

No.

Please indicate areas of technical assistance needed related to this section

None.

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**Footnotes:**

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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

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

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

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

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

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

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<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**Please respond to the following items:**

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
- a) Race  Yes  No
  - b) Ethnicity  Yes  No
  - c) Gender  Yes  No
  - d) Sexual orientation  Yes  No
  - e) Gender identity  Yes  No
  - f) Age  Yes  No

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

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

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

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

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

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

Since 2003 there have been ongoing efforts to utilize the Office of Multicultural Healthcare Equality (OMHE) to identify and remediate disparities in behavioral health care. This process uses data from a variety of sources (DMHAS, Yale University and Beacon Health Options - DMHAS' ASO) and responds with targeted activities.

Multicultural Enhancement Plan (MEP) is an initiative in which facilities are evaluated every 2 years with respect to meeting CLAS standards. Results are analyzed and then reviewed with facilities which are then provided training and technical assistance to implement CLAS standards. The MEP initiative has focused on state-operated programs, but interested private nonprofits are welcome to participate.

Multicultural Advisory Committee (MCAC) brings together state-operated regional facilities' multicultural councils statewide to strategize ways to enhance implementation of CLAS standards. Some of the activities that have occurred are facility (Lunch and Learns), and community conversations, "Chicago Dinners" about health disparities held in each DMHAS region of the state. We have worked with faith based organizations on community building with cultural relevance, to transform and expand the Connecticut crisis response capacity to be a fully person and family-centered, trauma informed, and culturally responsive array of easy to access, readily available, continuous services and community supports that offer a range of pre-crisis, & post crisis options, from which persons may choose those most effective in meeting their needs wherever they may be in their recovery process.

We are providing training throughout the DMHAS system of care on Diversity, Equity & Inclusion to enhance understanding of difference and provide skill building opportunities to better engage with clients and staff.

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

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

Please indicate areas of technical assistance needed related to this section

None

**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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

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

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

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

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

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)<sup>54</sup> 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**)<sup>55</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

<sup>49</sup> 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

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

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

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

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

**Please respond to the following items:**

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
2. Which value based purchasing strategies do you use in your state (check all that apply):
  - a)  Leadership support, including investment of human and financial resources.
  - b)  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)  Use of financial and non-financial incentives for providers or consumers.
  - d)  Provider involvement in planning value-based purchasing.
  - e)  Use of accurate and reliable measures of quality in payment arrangements.
  - f)  Quality measures focus 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?

The child serving system has developed a robust Evidence Base Practice Service Array as highlighted in the overview of the DCF service system.

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

None

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**Footnotes:**



## Environmental Factors and Plan

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

#### Narrative Question

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

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

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

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

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

#### Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  Yes  No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?  Yes  No

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

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

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?  
- DMHAS has been supporting her operated and funded mental health and substance use treatment providers in use of the

following evidence-based and best practices, including: assertive community treatment (ACT), Integrated Treatment for Individuals with co-occurring disorders (IDDT), DDCAT, DBT, Supported Employment using Individualized Placement and Support (IPS), Supported Education, Supportive Housing, Housing First, Trauma-informed and Trauma-specific (and gender-responsive) services, MAT, MI, and CBT. Alternative Services Statewide Integrative Medicine Committee has been established and more information is available from the DMHAS website at <http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=580236>.

- DMHAS and DCF support 2 programs providing specialized FEP services (STEP and Potential)

- DMHAS provides young adult services (YAS) specially designed for young adults, most of whom are aging out of DCF and transitioning to the adult system

- Alternative treatments and initiatives targeting wellness have become more generally accepted and are providing opportunities for clients with behavioral health issues to empower themselves and take control of their own recovery. Healthy activities related to diet, exercise, meditation, etc. are offered in group settings that also provide an opportunity for positive social interactions and the forming of friendships with peers. TOIVO is one such entity in Hartford, where persons in recovery operate programs and engage others in yoga, mindfulness and other creative activities.

- Since 2011, DMHAS and its Evidence-based and Best Practices Governance Committee meets quarterly. DMHAS also has a Director of Evidence Based Practices (EBPs) which provides staff support to the Governance group as well as other functions that promote adoption of EBPs throughout the system of care. Four managers report to the Director of EBPs which further enhances the necessary infrastructure to complete the many and varied goals involving Evidence-based and Best practices in the DMHAS system. The EBP division created a series of webpages on the DMHAS website that describe different EBPs and various available publications to help implement the practices. This is a valuable resource for providers, consumers and families: <http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912>.

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

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

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

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

The Coordinated Specialty Care (CSC) model continues to be provided.

EBPs include: peer support, cognitive remediation (individual & group treatment), CBT for psychosis (individual & group treatment), outreach and engagement, expert diagnostic assessment, family education and support, medication management, social cognition intervention therapy (SCIT) based groups, case management, and supported education and employment. Additionally, the STEP program is providing:

- implementation of a performance improvement system to monitor and improve rates of engagement post-discharge

- beta testing of informatics platform to allow periodic dashboards of population outcomes

- training of CSC clinicians in personal therapy approach to supportive psychotherapy

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Potential: planning to add a multi-family therapy group to further expand the family support/education component of the program.

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

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

Both programs submit data on admissions, discharges, discharge status, service hours, NOMS - including social support, stable living situation and employment status.

Potential Program - also collects duration of untreated psychosis (DUP) and Brief Psychiatric Rating Scale (BPRS) data.

STEP: STEP completed the first US-based randomized controlled trial in 2013 with NIH-funding demonstrating the effectiveness of this approach. STEP has continued to collect comprehensive measures reported in that study (Srihari et. al., Psychiatric Services, 2015) including symptoms, functioning, quality of life, and healthcare utilization. Since 2014, STEP has added measures of Pathways to Care and Duration of Untreated Psychosis (DUP). In 2019, STEP will launch an online informatics platform that will enable dashboards of population outcomes to enable performance improvement. STEP has published on this approach (Srihari et. al., JAMA Psychiatry, 2016).

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

schizophrenia

schizophreniform

all primary psychotic illnesses in the schizophrenia spectrum

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

**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

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

#### Narrative Question

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

1. Does your state have policies related to person centered planning?  Yes  No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.  
NA
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.  
A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. Starting in 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) were participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons were trained in person-centered planning by Yale PRCH. More recent initiatives related to person-centered planning include a multi-state agency workgroup that DMHAS is participating in and a pilot project with PRCH across several CSP teams called Recovery Roadmap.
4. Describe the person-centered planning process in your state.  
A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. Starting in 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) were participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons were trained in person-centered planning by Yale PRCH. More recent initiatives related to person-centered planning include a multi-state agency workgroup that DMHAS is participating in and a pilot project with PRCH across several CSP teams called Recovery Roadmap.  
Please indicate areas of technical assistance needed related to this section.  
None.

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

#### Footnotes:

## Environmental Factors and Plan

### 6. Program Integrity - Required

#### Narrative Question

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

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

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

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

#### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight?  
No.  
Please indicate areas of technical assistance needed related to this section  
None

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#### 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](#)<sup>56</sup> 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.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?  
The DMHAS Local Mental Health Authority (LMHA) in the southeastern part of the state near the Mashantucket and Mohegan tribes continues to participate in regional coordinating/collaborative meetings with tribal leadership as part of the Regional Human Services Coordinating Council; the Southeastern Connecticut Health Improvement Collaborative; Eastern Connecticut Health Collaborative and Mashantucket Pequot Annual Children's Mental Health Awareness Day in May. There has not been formal "consultation" provided.
2. What specific concerns were raised during the consultation session(s) noted above?  
The Mashantucket and Mohegan tribes continue to provide behavioral health services to their members who typically do not seek DMHAS services. However, ongoing efforts to coordinate and collaborate continue.
3. Does the state have any activities related to this section that you would like to highlight?  
No.  
Please indicate areas of technical assistance needed related to this section.  
NA

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### Footnotes:

## Environmental Factors and Plan

### 8. Primary Prevention - Required SABG

#### Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

#### Please respond to the following items

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - a)  Data on consequences of substance-using behaviors
  - b)  Substance-using behaviors
  - c)  Intervening variables (including risk and protective factors)
  - d)  Other (please list)  
Demographic data, qualitative provider and stakeholder data
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - Children (under age 12)
  - Youth (ages 12-17)
  - Young adults/college age (ages 18-26)
  - Adults (ages 27-54)
  - Older adults (age 55 and above)
  - Cultural/ethnic minorities
  - Sexual/gender minorities
  - Rural communities
  - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

Archival indicators (Please list)

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

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

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

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?  Yes  No

If yes, (please explain)

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

If no, (please explain) how SABG funds are allocated:

NOT FINAL



SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  Yes  No  
If yes, please describe  
The Connecticut Certification Board manages the Certified Prevention Specialist (CPS) credentialing
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  Yes  No  
If yes, please describe mechanism used  
In July 2015, the CT Prevention Training & Technical Assistance Service Center (TTASC ) through Cross Sector Consulting to provide targeted training and technical assistance for substance abuse prevention efforts. Utilizing the SPF process, the TTASC conducted a workforce needs assessment, created a strategic plan and implements workforce development strategies that include the delivery of targeted technical assistance and training (in person, and web based).
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No  
If yes, please describe mechanism used  
The CT Center for Prevention Evaluation & Statistics (CPES) at the University of CT is funded to implement a biennial Community Readiness Survey (CRS) in CT that assesses community readiness to address substance abuse throughout the state. The next survey will be conducted in 2020.

## Narrative Question

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## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No  
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b)  Timelines
  - c)  Roles and responsibilities
  - d)  Process indicators
  - e)  Outcome indicators
  - f)  Cultural competence component
  - g)  Sustainability component
  - h)  Other (please list):
  - i)  Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No

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

The Evidence Based Workgroup meets bi-monthly and provides guidance for the selection of evidence based strategies based on a number of factors including SAMHSA guidance, and research conducted by evaluators. The Evidence Based Workgroup is developing 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.

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

## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)

Directly implements tobacco merchant inspections and education for the Synar requirement

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- a) Information Dissemination:
  - CT Clearinghouse Patron Services
  - Clearinghouse/Information Resource Center
  - Health Fairs
  - Health Promotions
  - A/V Material Disseminated
  - Printed Material Disseminated
  - Periodicals Disseminated
  - Public Service Announcements Disseminated
  - Media Campaigns Conducted
  - Speaking Engagements
  - Telephone/Email/Website Information Requests
- b) Education:
  - Educational Services for Youth Groups
  - Peer Leader/Helper Programs

Small Group Sessions

**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
- Community Team Service
- Training Services
- Technical Assistance
- Systematic Planning

**f)** Environmental:

- Enforcement of Alcoholic Beverage Laws or Policies
- Enforcement of Illicit Drug Laws or Policies
- Preventing Underage Sale of Tobacco--Synar Amendment
- Preventing Underage Alcoholic Beverage Sales
- Public Policy Efforts

**3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

Yes  No

If yes, please describe

NOT FINAL

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

## Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

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

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

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

- a)  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):

Services, strategies and activities implemented, substance(s) addressed

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

- a)  30-day use of alcohol, tobacco, prescription drugs, etc
- b)  Heavy use
- Binge use
- Perception of harm

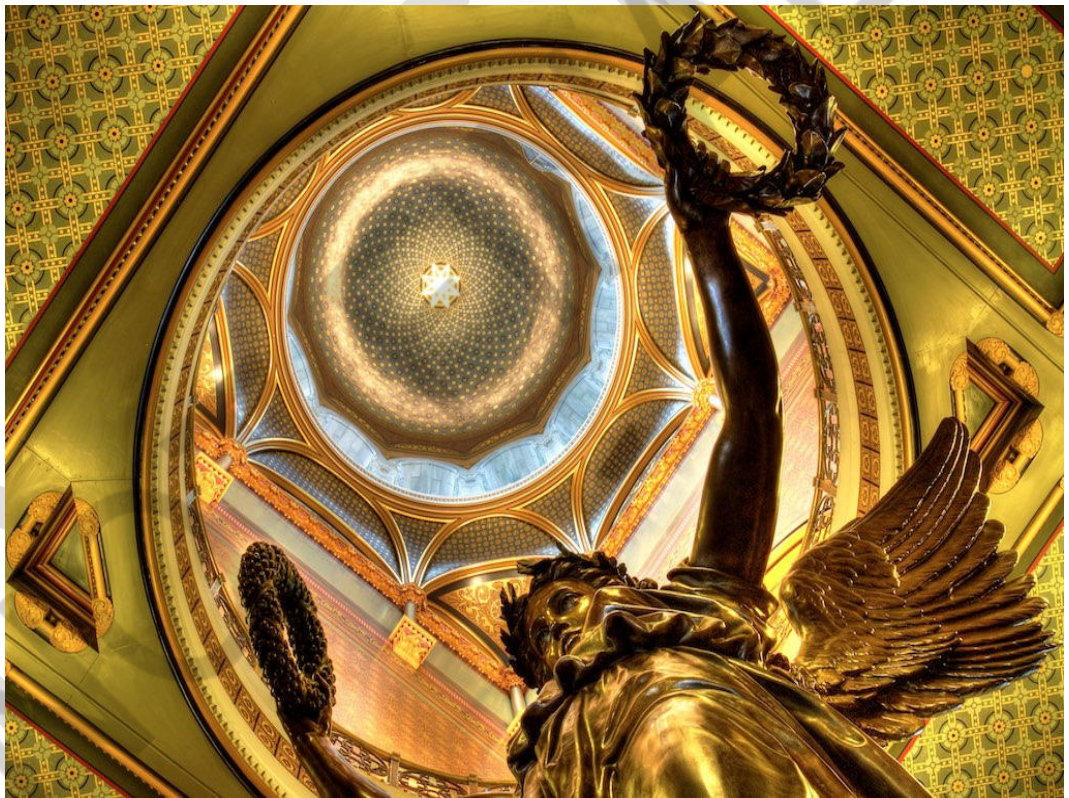
- c)  Disapproval of use
- d)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)  Other (please describe):

NOT FINAL

**Footnotes:**

NOT FINAL

# STRATEGIC DIRECTION AND PLAN FOR PREVENTION



Fiscal Year  
2017 – 2022

State of Connecticut Department of Mental  
Health and Addiction Services: Prevention and  
Health Promotion Division



# Strategic Direction and Plan for Prevention

## STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES: PREVENTION AND HEALTH PROMOTION DIVISION

### FOREWORD

The Department of Mental Health and Addiction Services, (DMHAS) is Connecticut's Single State Agency (SSA) for substance abuse prevention and mental health services. DMHAS is committed to improving the lives of people across the state by providing an integrated network of comprehensive, effective and efficient substance abuse prevention and mental health promotion services that fosters self-sufficiency, dignity and respect.

In realizing this vision, the DMHAS Prevention and Health Promotion Unit is committed to supporting an inclusive, comprehensive planning process at the local, regional and state level. This is accomplished using a diverse public health framework that is data driven, collaborative and community based. DMHAS capitalizes on the unique aspects of each community by incorporating capacity building, planning and implementation process.

DMHAS' strategic direction and plan for prevention and health promotion are grounded in Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) and its belief that "the success of state and community prevention efforts lies, in part, in the effective use of data to identify needs and to plan for and monitor the effectiveness of prevention strategies." The Strategic Prevention Framework changed Connecticut's approach to prevention, and has helped move the state toward a healthier population through data-driven, community-based programs and strategies.

The DMHAS Prevention and Health Promotion Unit has embedded SAMHSA's goals of accountability, capacity and effectiveness into its overall statewide approach to service delivery and program management. The following principles or core functional areas have guided our efforts:

- Using quality care management systems to achieve defined goals, service outcomes, and continuous improvement of prevention services.
- Maintaining a broad spectrum of programs and practices that are data informed and respond to changing needs as the prevention system grows.
- Enhancing workforce capacity to provide culturally competent and integrated services to persons whose needs are not well met.
- Leveraging funding to fill unmet needs, support prevention service and management goals and obtain technical assistance from state and national experts.

It is grounded in the SPF five steps of profiling needs and response capacity; mobilizing and building statewide infrastructure to respond to needs; developing regional and community level strategic prevention plans; implementing effective programs, policies and practices; and evaluating program efforts to sustain what works.

Using the SPF as our guide, DMHAS, in collaboration with its state partners and The State Epidemiological Outcomes Workgroup, examined a myriad substance use and consequence indicators to inform planning and resource allocation. SEOW data, input from state partners, advisory councils and community based organizations informed the prioritization of prevention initiatives at the state, regional and local levels. Connecticut priorities currently being addressed include: preventing and reducing underage alcohol use, reducing youth access to tobacco products, preventing prescription drug and opiate misuse, suicide

prevention, youth violence and addressing problems associated with marijuana, cocaine and heroin.

Connecticut has made tremendous progress in the last five years in the areas of underage smoking and drinking. Looking forward, Connecticut must continue to take additional steps to address challenges in prescription drug and opiate misuse, suicide and youth violence. By redirecting SAMHSA funds to these critically important issues, Connecticut has already started to realize substantial improvements in these areas.

Carol P. Meredith, MPA  
Director of Prevention and Health Promotion Division

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## SECTION 1 | INTRODUCTION

The Connecticut Department of Mental Health and Addiction Services (DMHAS), is the Single State Agency (SSA) for substance abuse and mental health services. These issues cut across all walks of life and impact most if not all, state agency resources in Connecticut. To ensure that the agency uses federal and state prevention resources as effectively as possible, the DMHAS Prevention and Health Promotion Unit has developed this strategic plan to guide our efforts. The plan serves as a framework for the work of the DMHAS Prevention and Health Promotion Unit and its infrastructure of programs and collaborators. The plan is updated as needed and sets direction based on new initiatives that are funded with state or federal resources including trends uncovered by the Connecticut State Epidemiological Outcomes Workgroup (SEOW). The plan compliments other state agency plans and initiatives which focus improving the health and wellbeing of Connecticut's citizens

## SECTION 2 | APPLYING THE SPF



The SPF process was applied to effectively address the goals and objectives of the plan. Culture has been considered throughout the SPF process to ensure that diverse population groups are contributors to and beneficiaries of prevention services. Each SPF step was applied in the following way:

**Assessment:** The 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.

**Capacity:** The DMHAS organizes its Prevention and Health Promotion Division to maintain a statewide Strategic Prevention Framework 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 13 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.

**Planning:** The DMHAS Prevention and Health Promotion Unit: 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 in as part of the development of this strategic plan.

**Implementation:** To address priorities, DMHAS has re-bid a portion of Block Grant funds competitively sought 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 identifying 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.

**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.

- 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.
- Maintain an annual DMHAS Prevention and Health Promotion Unit 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)

## SECTION 3 | CONNECTICUT DEMOGRAPHICS



CT's population is comprised of 3.59 million people (2014) and its racial makeup is becoming increasingly diverse. According to the U.S. Census Bureau, between 2010 and 2014 the percentage of the population that identified as Hispanic showed the steepest growth in population at 10.9%, followed by Asians at 9.8% Black/African American by 4.8%, and American Indian/Alaska Native by 3.9%. In the same time period the population of the White Non-Hispanic group had dropped by 2.9%. during this time period. Overall, according to the 2014 Census Bureau statistics, White Non-Hispanic comprise of 69.7% of Connecticut's population, followed by Hispanic 15%, Black Non-Hispanics by 10.4%, Asian 4.0%,

and others 0.9%. Approximately 3% of Connecticut residents self-identified as two or more races. CT has two federally recognized tribal nations, the Mashantucket Pequot Nation (pop. 785), and the Mohegan Tribe (pop. 1,700); three state recognized tribal nations, the Eastern Pequot Nation, the Golden Hill Paugusset Tribe (pop. 100), the Pawcatuck Eastern Pequot Tribe (pop. 920), and the Schaghticoke Indian Tribe (pop. 300).

According to the 2015 American Community Survey (U.S. Census, 2010), 13.7% of the people living in CT from 2010-2014 were foreign-born. Among people at least 5 years old living in CT from 2009-2013, 21.5% spoke a language other than English at home. From 2009-2013, 10.2% of CT's residents lived in poverty. In 2013, 13.5% of children under 18 were below the poverty level. CT's urban centers especially are stressed by significant social problems, having some of the highest national rates for crime, violence, school

dropout, teen pregnancy, drug arrest, and unemployment. Hartford and Bridgeport have been ranked among the ten poorest large cities in the U.S. In 2013, the state's largest cities had increasingly high child poverty rates: Waterbury

(36% vs. 31% in 2007), New Haven (33% vs. 29% in 2007) and Bridgeport (32% vs. 28% in 2007). Only Hartford, with the highest poverty rate in the state, went down from 47% in 2007 to 45% in 2013.

## SECTION 4 | EPIDEMIOLOGICAL PROFILE

In September 2004, the Connecticut State Epidemiological Outcomes Workgroup (SEOW) was convened to bring systematic analytical thinking to the prevalence and incidence of alcohol, tobacco and other drug use in Connecticut. The SEOW immediately identified the causes and consequences of substance use and abuse that drives effective and efficient allocation of prevention resources. Its initial role in was to select of a set of indicators to monitor over time; produce epidemiologic profiles of substance use; develop a methodology for prioritizing substance abuse related problems; and expand state agency collaboration to access, interpret and use data.

Today, the SEOW has been revitalized and expanded under the Center for Prevention Evaluation and Statistics (CPES). Operated by the UConn Department of Community Medicine, the CPES collects, manages, disseminates and utilizes epidemiological data for decision-making and provides technical assistance and training on evaluation-related tasks and topics. Under this new structure, the SEOW will continue to update state-level epidemiological profiles every two years and



make recommendations for state and community-level data collection.

The following pages outline and summarize data pertaining to prevalence, consequence and trends among population subgroups for six substances and two behaviors identified as priorities by the SEOW in 2016: alcohol, prescription drugs, heroin (opiates), tobacco, marijuana, cocaine, suicide and gambling. Gambling data has been omitted from this plan. Profiles are used to improve needs assessment and planning, inform policy development, target prevention resources, and monitor outcomes.

EPIDEMIOLOGICAL PROFILE | **ALCOHOL**

| CT Indicators                 | Timeframe       | Value | Trend                  |
|-------------------------------|-----------------|-------|------------------------|
| <b>Ever alcohol use</b>       |                 |       |                        |
| 12 and over                   | NSDUH 2014-2015 | 60.3% | Stable since 2008-9    |
| 12 – 17 years-old             | NSDUH 2014-2015 | 13.6% | Decrease since 2008-9  |
| <b>Past month alcohol use</b> |                 |       |                        |
| Grades 9-12                   | YRBSS 2015      | 30.2% | Decrease since 2008-9  |
| 18-25                         | NSDUH 2014-2015 | 67%   | Decrease since 2009-10 |
| 26 and older                  | NSDUH 2014-2015 | 64.8% | Increase since 2009-10 |
| <b>Prevalence of AUD</b>      |                 |       |                        |
| 18-25                         | NSDUH 2014-2015 | 13%   | Decrease since 2008-9  |

FINDINGS | **ALCOHOL**

- Alcohol is the most commonly used substance in Connecticut and is higher in the state compared to the national average.
- An estimated 30,000 Connecticut high school students (17.6%) had their first drink of alcohol before the age of 13 years.
- CT is ranked 6th among states in the prevalence of alcohol use.
- Boys are more likely to binge drink than girls.
- In 2014, alcohol-impaired driving fatalities accounted for 31% of total fatalities in the U.S. In Connecticut, 39% of total fatalities were the result of alcohol impaired driving.
- Of all treatment admissions in Connecticut in 2016, 18.9% were for alcohol as the primary substance (12,689 people), and 14% were for alcohol with a secondary drug.
- One in five Connecticut adults in 2015 had excessive alcohol consumption. Approximately one in six Connecticut adults engaged in binge drinking, while one in 16 engaged in heavy drinking (BRFSS 2015).
- 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 the multiple problems resulting from the use of alcohol by youth.

EPIDEMIOLOGICAL PROFILE | **PRESCRIPTION DRUG**

| Indicators  | Timeframe              | Value       | Trend                                     |
|---|------------------------|-------------|---|
| <b>Nonmedical use of prescription drugs (NMUPD)</b> |                        |             |   |
| Youths in Connecticut ages 12-17                    | <b>2013-2014 NSDUH</b> | <b>2.9%</b> | <b>Relatively unchanged since 2009/10</b> |
| Young adults ages 18-25                             | <b>2013-2014 NSDUH</b> | <b>8.6%</b> | <b>Decline since 2009/10</b>              |
| Adults ages 26 or older                             | <b>2013-2014 NSDUH</b> | <b>4.1%</b> | <b>Decline since 2009/10</b>              |

FINDINGS | **PRESCRIPTION DRUGS**

- The state’s 2015 YRBSS found that 6.3% of high school students reported having taken over-the-counter drugs to get high.
- In 2016, Connecticut saw 853 opioid-involved fatalities, including 111 that involved Oxycodone, 7 involving Oxymorphone, 20 with Hydrocodeine, 85 with Methadone, 17 with Tramadol, and 25 with Morphine.
- Between 2012-2015, the majority of opioid overdoses in Connecticut occurred among non-Hispanic white males.
- Analyses of the 2015 national NSDUH data show that the majority of persons misusing prescription drugs report obtaining those drugs from families and friends, or being prescribed them by medical providers.



EPIDEMIOLOGICAL PROFILE | HEROIN & OPIOIDS

| Indicators                                  | Timeframe      | Value | Trend               |
|---|----------------|-------|---------------------|
| Heroin involved overdose deaths             | 2016 TEDS data | 494   | Increase since 2012 |
| Lifetime heroin use of high school students | 2015 YRBSS     | 2.2%  | Down since 2009     |

FINDINGS | HEROIN & OPIOIDS

- Overall in Connecticut, the prevalence of ever heroin use is slightly higher among males and Hispanics.
- In Connecticut, 2.2% of high school students used heroin (also called smack, junk, or China White) one or more times during their life (i.e., ever heroin use).
- Over half of heroin treatment admissions in 2016 were between the ages of 21-35 years old.
- Of all Connecticut treatment admissions in 2016, 36.7% were for heroin as the primary substance.
- According to youth reports, males and Hispanics are at higher risk for using heroin at least once in their lifetime.
- Fentanyl, a synthetic opioid pain medication often mixed with heroin to increase its potency, is now a rapidly rising cause of overdose deaths in the state.

EPIDEMIOLOGICAL PROFILE | ALL FORMS OF TOBACCO & ELECTRONIC NICOTINE DELIVERY SYSTEMS

| Indicators  | Timeframe                    | Value | Trend                     |
|---|------------------------------|-------|---------------------------|
| <b>Current Tobacco Use</b>                                |                              |       |                           |
| Middle School Students                                    | 2015 CT Youth Tobacco Survey | 3.0%  | Decrease since 2011       |
| High School Students                                      | 2015 CT Youth Tobacco Survey | 14.3% | Decrease since 2011       |
| <b>Current Use of E-cigarettes</b>                        |                              |       |                           |
| Middle School Students                                    | 2015 CT Youth Tobacco Survey | 1.4%  | Increase since 2011, 2013 |
| High School Students                                      | 2015 CT Youth Tobacco Survey | 7.2%  | Increase since 2011, 2013 |
| Grade 12 students who report use of electronic cigarettes | 2015 CT Youth Tobacco Survey | 30%   | Increase since 2011, 2013 |

FINDINGS | ALL FORMS OF TOBACCO & ELECTRONIC NICOTINE DELIVERY SYSTEMS

- Connecticut Youth Tobacco Survey data indicate that use of electronic cigarettes and vape pens increases with grade.
- One in seven Connecticut adults in 2015 had tried using vapor, vape pen or e-cigarettes, one in eight had tried smoking hookah and one in three had tried smoking cigars, cigarillos, or flavored little cigars (BRFSS 2015)
- Data from the 2015 DataHaven Community Well-being Survey show that current cigarette smoking is lowest (9%) in the wealthy suburban communities and highest (34%) in the three urban core communities of Hartford, Bridgeport and New Haven.
- In Connecticut, 38.3% of high school students who currently smoke cigarettes want to quit smoking cigarettes for good.

EPIDEMIOLOGICAL PROFILE | CANNABIS

| Indicators   | Timeframe     | Value | Trend                  |
|--|---------------|-------|------------------------|
| <b>Marijuana use in CT</b>                             |               |       |                        |
| 12-17 years old  | 2014-15 NSDUH | 8.3%  | Stable since 2010-11   |
| 18-25 years old  | 2014-15 NSDUH | 25%   | Stable since 2010-11   |
| 26 and older   | 2014-15 NSDUH | 7.3%  | Increase since 2010-11 |
| <b>Perception of great risk from smoking marijuana</b> |               |       |                        |
| 12-17 years old  | 2014 MTF      | 22%   | Decrease since 2004    |
| 18-25 years old  | 2014 MTF      | 12%   | Decrease since 2004    |

FINDINGS | CANNABIS

- In Connecticut, 5.8% of high school students tried marijuana for the first time before age 13 year.
- In Connecticut, 35.4% of high school students used marijuana one or more times during their life (i.e., ever marijuana use).
- Marijuana use is widespread among youth adults and adolescents in Connecticut and above the national average for both age groups.
- Overall, 35.4% of students between 9th and 12th grade have used marijuana.
- On 2015, the YRBS showed that 21% of female and 19.7% of male Connecticut high school students currently used marijuana.

EPIDEMIOLOGICAL PROFILE | **COCAINE**

| Indicators                           | Timeframe            | Value        | Trend                         |
|--------------------------------------|----------------------|--------------|-------------------------------|
| Prevalence for residents 12 and over | <b>NSDUH 2014-15</b> | <b>2.43%</b> | <b>Increase since 2008-09</b> |
| Prevalence for 18-25                 | <b>NSDUH 2014-15</b> | <b>7.6%</b>  | <b>Increase since 2009-10</b> |
| Prevalence for 26 and older          | <b>NSDUH 2014-15</b> | <b>1.8%</b>  | <b>Increase since 2009-10</b> |

FINDINGS | **COCAINE**

- In Connecticut, 4.6% of high school students used any form of cocaine, such as powder, crack, or freebase one or more times during their lifetime (i.e., ever cocaine use).
- Use of cocaine has remained at consistently low levels among adolescents.
- Males reported significantly higher rates than females.
- According to treatment admissions data from 2016, Connecticut saw 4,221 admissions for cocaine as the primary substance, which made up 6.2% of all admissions. The majority of cocaine-related admissions (2,447) were for smoking the drug.

EPIDEMIOLOGICAL PROFILE | **SUICIDE**

| Indicators  | Timeframe  | Value | Trend                |
|---|------------|-------|----------------------|
| Adults diagnosed with depression  | BRFSS 2015 | 17.6% | Unchanged since 2012 |
| students felt so sad or hopeless almost every day during the past 12 months | YRBSS 2015 | 26.6% | Increase since 2009  |
| High school students inflicted self-injury                                  | YRBSS 2015 | 18.5% |                      |
| High school students Seriously Considered Attempting Suicide                | YRBSS 2015 | 13.4% | Decrease since 2009  |

FINDINGS | **SUICIDE**

- During the past 12-months, 26.6% of Connecticut students felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities.
- One in six Connecticut adults in 2015 had been diagnosed with depression (17.6%) (BRFSS 2015).
- Overall in CT, the prevalence of feeling sad or hopeless among females, Hispanics and in grade 11.
- In Connecticut, 25.4% of high school students most of the time or always get the kind of help they need when they feel sad, empty, hopeless, angry, or anxious.
- Overall in CT, the prevalence of seriously considering attempting suicide is significantly higher among females and Hispanics and does not vary significantly by grade.

## SECTION 5 | PREVENTION 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 Unit 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 the services to the needs of the individuals and 169 local communities. The DMHAS uses 13 subdivisions across Connecticut as the geographic basis for prevention services. The prevention infrastructure, in its present form, consists of the following components:

- Four Statewide Service Delivery Agents support prevention programs statewide:
  1. DMHAS Prevention Training and Technical Assistance Services Center's goal is to maintain a robust, well-informed and well educated prevention workforce throughout Connecticut by providing training/ TA across all domains of substance abuse prevention. Building on Connecticut's capacity to implement the strategic prevention framework (SPF) and evidence based practices (EBPs) at the state and community levels, the TTASC investigates and gathers current data and effective strategies for promoting culturally and linguistically proficient ATOD prevention services for African origin, Latino, and other disenfranchised groups, .and providing training / technical assistance on evidence-based strategies, practices, and programs to improve the quality of Connecticut's prevention workforce.
  2. The Connecticut Clearinghouse/ Connecticut Center for Prevention, Wellness and Recovery (CCPWR) is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues. The Clearinghouse provides staffing, logistical support, meeting space and coordination of activities related to the successful implementation of the Best Practices, Partnerships for Success, Tobacco Prevention and Enforcement and Healthy Campus initiative.
  3. The Governor's Prevention Partnership (GPP) is a statewide organization comprised of public/ private partnerships designed to change the attitudes and behaviors of youths and adults toward substance through its School, Campus, Workplace and Media Partnerships. GPP's involvement in the SPF and PFS initiatives has included providing ongoing technical assistance to community grantees on the 5 Step process and implementation of environmental strategies. Additionally, GPP has been instrumental in providing data and technical assistance on compliance checks that includes the recruitment, training and scheduling as well as supervising youth for compliance checks.
  4. The Center for Prevention Evaluation and Statistics (CPES) collects, manages, analyzes and disseminates epidemiological and evaluation data and provides TA and training on data and evaluation topics to prevention partners and providers. The CPES also convenes the Statewide Epidemiological Outcomes Work Group (SEOW) comprised of representatives from several state agencies and meets on a regular basis to discuss pertinent data related issues with an emphasis on ATOD prevention and use data.

- 13 Regional Action Councils (RACs) operate as subcontractors to DMHAS to carry out ATOD prevention initiatives, among their other mission driven objectives. These private non-profit organizations, comprised of a board of directors of community stakeholders build capacity of communities to conduct data driven decision making and effective substance abuse prevention. The RACs may conduct comprehensive analyses of community needs and response capacity data and produce Sub-Regional Profiles to establish local substance abuse prevention priorities.
- 150 Local Prevention Councils (LPCs) address primary prevention in the 169 communities throughout the state of Connecticut. The LPCs contain representatives who are elected officials, police officers, educators, faith / spiritual leaders, business leaders, social and human service providers, and parents, among others.
- Campus/Community-Based ATOD Prevention Initiatives including:
  1. CT SPF Coalitions (CSC). The 12 community-based programs/coalitions implement evidence based strategies to prevent underage drinking using the Strategic Prevention Framework (SPF) 5 Step process. The CSC programs use the SPF 5 Step process to address other priority substances such as marijuana and Prescription Drug abuse.
  2. CT SPF Coalitions (CSC). The 12 community-based programs/coalitions implement evidence based strategies to prevent underage drinking using the Strategic Prevention Framework (SPF) 5 Step process. The CSC programs use the SPF 5 Step process to address other priority substances such as marijuana and Prescription Drug abuse.
  3. A Statewide Healthy Campus Coalition is comprised of Connecticut colleges and universities who are participating in activities to address the reduction of ATOD use and abuse amongst their student populations.
- Healthy Transitions - CT STRONG (Seamless Transition and Recovery Opportunities through Network Growth) initiative which engages and connects transition age youth and young adults between ages 16-25 to high quality behavioral health care.
- 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 network in the town of Manchester which will be the focus of an intensive community-based effort that seeks 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.
- A Tobacco Prevention and Enforcement Program (TPEP) implemented by the DMHAS Prevention staff implements as part of the Synar Amendment requirements. Activities include un-announced inspections of retail outlets for compliance with age and photo identification and advertising and labeling restrictions. TPEP administers a Merchant Education and Awareness Campaign throughout the state as well as the federal FDA Tobacco Prevention and Enforcement program statewide.
- The MOSAIX Impact prevention data collection system that captures provider activities across the 5 SPF steps.

The Prevention Infrastructure links to other State Advisory Councils such as the Connecticut Alcohol and Drug Policy Council (ADPC). 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 serves as conduit for Connecticut's Strategic Prevention Enhancement Consortium to move forward recommendations.

Page 14 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 (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, loss of funding), the system remains stagnant and less likely to achieve measurable gains. The visual metaphor remains a work in process by the DMHAS and will undergo additional refinements during the five year implementation period of this plan.





## Section 6 | PREVENTION AND HEALTH PROMOTION VISION



Prevention is the first step in the substance abuse and mental health continuum of care. Interaction with the prevention system often serves as a catalyst for individuals to seek intervention and treatment services. Prevention means creating conditions that promote good health. Good health is achieved by reducing negative factors that are known to cause illness and problem behaviors and encouraging positive factors that buffer individuals and promote good health. Prevention promises a reduction in illness and problem behavior. When conducted with fidelity, an effective preventive intervention is long lasting, reduces vulnerability and enhances wellness.

To achieve this vision, the DMHAS Prevention and Health Promotion Unit constructs strategic action plans to structure its goals, objectives and service functions in an efficacious and deliberate manner. Using its comprehensive statewide infrastructure of services, DMHAS provides leadership and a broad array of programs promoting healthy communities while addressing gaps and high priority needs across the state.

FIGURE 3. | CONNECTICUT’S LOGIC MODEL TO GUIDE DEVELOPMENT OF THE FIVE YEAR PLAN

| Goal Provide quality programs that address prevention priorities and gaps, promote health and reduce the likelihood of substance abuse and related consequences.  |   |   |   |
|---|---|---|---|
| INPUTS  | ACTIVITIES  | OUTPUTS   | OUTCOMES and IMPACT   |
| <i>Human, financial, organizational, and community resources to reach our goal</i>  | <i>Activities to address our problems</i>   | <i>Products of our activities and service delivery</i>  | <i>The short- and long-term changes produced by our activities</i>  |
| <ul style="list-style-type: none"> <li>• Diverse stakeholder groups that include parents, behavioral health consumers and youth.</li> <li>• A Statewide Epidemiological Outcomes Workgroup.</li> <li>• Five resource link entities that provide training, consultation and technical assistance at the state and community levels.</li> <li>• A tobacco prevention and enforcement program.</li> <li>• 19 Partnership for Success and 12 CT SPF Coalitions addressing community-specific risk factors.</li> <li>• 150 Local Prevention Councils conducting primary prevention in 169 towns.</li> <li>• A statewide healthy campus coalition of colleges and universities.</li> <li>• Suicide prevention and mental health promotion initiatives.</li> </ul> | <ul style="list-style-type: none"> <li>• Assess needs on multiple levels (state, region, community, provider).</li> <li>• Convene advisory groups to inform and coordinate prevention programs, plans and direction.</li> <li>• Invest in activities that leverage and/or enhance the capacity of the prevention infrastructure and implement evidence-based, model and promising programs to address priorities.</li> <li>• Develop a multi-year strategic prevention plan.</li> <li>• Monitor, evaluate, and continuously improve.</li> </ul> | <ul style="list-style-type: none"> <li>• Implementation of culturally competent, evidence-based prevention services that address substance use and promote mental health.</li> <li>• Increase in the quality and number of the prevention workforce.</li> <li>• Increased awareness of prevention resources and the existing prevention infrastructure.</li> <li>• A multi-year strategic plan.</li> <li>• Data driven decision making.</li> <li>• More effective use of existing prevention infrastructure (e.g., coordination of training, data collection).</li> <li>• Increased partnerships and coordination between DMHAS-funded coalitions and other community prevention efforts.</li> <li>• Policy and legislative changes.</li> </ul> | <ul style="list-style-type: none"> <li>• Measureable reduction in current use of ATOD by youth.</li> <li>• Reduced deaths from ATOD including opioids.</li> <li>• Reduced numbers of CT residents seeking treatment for ATOD.</li> <li>• Reduced ATOD societal cost to the state related to medical care, criminal justice, property damage, work loss pain and suffering.</li> <li>• Increase age of first use for tobacco and alcohol.</li> <li>• Reduce binge use for alcohol.</li> <li>• Reduce ATOD-related school suspensions &amp; expulsions.</li> <li>• Reduce adult DUI arrests.</li> </ul> |

**SECTION 7 | PREVENTION AND HEALTH PROMOTION GOALS**

The Prevention and Health Promotion Unit has reviewed the SEOW data regarding state priorities and utilized the SPF process to develop capacity to address these priorities. The following table shows the intersection of the SEOW priorities and the DMHAS Prevention programs to be used to accomplish the following objectives:

| Prevention Programs Alignment with Priorities   | DMHAS PREVENTION PRIORITIES |                    |                |              |          |         |         |          |
|---|-----------------------------|--------------------|----------------|--------------|----------|---------|---------|----------|
|   | Alcohol                     | Prescription Drugs | Heroin/Opioids | Tobacco/ENDS | Cannabis | Cocaine | Suicide | Gambling |
| CT SPF Coalitions                               | ✓                           | ✓                  |                |              |          |         |         |          |
| Center for Prevention Evaluation & Statistics   | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       | ✓        |
| CT Healthy Campus Initiative                    | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       |          |
| CT Clearinghouse                                | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       | ✓        |
| The Governor’s Prevention Partnership           | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       |         |          |
| Healthy Transitions Grant                       | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       |         |          |
| Local Prevention Councils                       | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       |          |
| Partnership for Success 2015                    | ✓                           | ✓                  |                |              |          |         |         |          |
| Regional Behavioral Health Action Organizations | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       | ✓        |
| Statewide Networks of Care (GLS)                |                             |                    |                |              |          |         | ✓       |          |
| Tobacco Prevention & Enforcement Program        |                             |                    |                | ✓            |          |         |         |          |
| Training & Technical Services Center            | ✓                           | ✓                  | ✓              | ✓            | ✓        | ✓       | ✓       | ✓        |

**SECTION 8 | PREVENTION AND HEALTH PROMOTION IMPLEMENTATION PLAN LOGIC MODEL**

**LOGIC MODEL | CONNECTICUT STRATEGIC PREVENTION FRAMEWORK COALITIONS (CSC) INITIATIVE**

**Problem Statement: In 2017 30.4% of Connecticut high school students reported actively drinking alcohol in the past month; and 20.4% used marijuana one or more times during the past 30 days.**

| Goal   | Objectives  | Intervention/Inputs   | Outcomes  |
|--|---|---|---|
| <b>To prevent the start and reduce the progression of substance abuse and to promote positive mental health by implementing SAMHSA’s Strategic Prevention Framework public health model.</b> | Increase strong collaborations among communities and with State agencies  | DMHAS Block Grant Funding<br>DMHAS Administrator<br>CT Regional Resource Links  | 12 community coalitions funded<br>Guidance to resources accessing State, regional and local agencies<br>Guidance promoting partnerships with local, state and federally funded coalitions                                   |
|  | Achieve measurable long and short term outcomes in reducing substance use and abuse while also promoting mental health in the focused populations | DMHAS Block Grant Funding<br>Center for Prevention Evaluation and Statics (CPES)<br>Mosaix IMPACT Data Reporting System, DMHAS Administrator<br>Connecticut Clearinghouse | Grantees funding local evaluators<br>Evaluation TA with needs assessment reporting, accessing data, and evaluator meetings<br>Block Grant and State reporting<br>Mental Health First Aid trainings and supporting resources |
|  | Implement and sustain culturally competent, evidence-based prevention services that address substance abuse and promote mental health             | Prevention Training and Technical Assistance Service Center (TTASC)<br>DMHAS Administrator<br>CPES<br>Governor’s Prevention Partnership (GPP)                             | Coalition TA: strategic planning, capacity building, and strategy implementation<br>Annual Evaluation Reports<br>Youth Peer Advocate engage in coalition’s SPF process  |

GENERAL WORK PLAN | CONNECTICUT STRATEGIC PREVENTION FRAMEWORK COALITIONS (CSC)

| Activities to Be Completed   | Timeline  | Responsibility  | Milestone  |
|--|---|---|--|
| <b>Assessment</b> <ul style="list-style-type: none"> <li>Design needs assessment guidance and data resources</li> <li>Grantee TA</li> <li>Mosaix IMPACT reporting stars</li> </ul>   | July 2015<br>September 2015, January 2016<br>March 2016 – on going                    | Center for Prevention Evaluation and Statics (CPES) and DMHAS Administrator<br>CPES and DMHAS Administrator<br>Mosaix and DMHAS Administrator | Guidance presentation with data resources for grantees<br>Needs Assessment Reports reviewed and approved<br>IMPACT grantees training regular reporting of services         |
| <b>Capacity</b> <ul style="list-style-type: none"> <li>Identify gaps in community, resources and readiness</li> <li>Engage Youth Peer Advocates</li> </ul>   | September 2015 – on going<br>June 2016 – on going                                     | Prevention Training and Technical Assistance Service Center (TTASC)<br>Governor’s Prevention Partnership (GPP)                                | TA & capacity building trainings for grantees and coalition members<br>Quarterly Youth Advisory Board meetings facilitated by Youth Peer Advocates                         |
| <b>Planning</b> <ul style="list-style-type: none"> <li>Design strategic plan guidance</li> <li>Grantee and Evaluator TA</li> <li>Design sustainability plan guidance</li> </ul>  | February 2016 – June 2016<br>January 2016 – on going<br>September 2018 – January 2018 | TTASC and DMHAS Administrator<br>TTASC and CPES<br>TTASC and DMHAS Administrator  | Strategic Plans reviewed and approved<br>Ongoing workforce development<br>Sustainability Plans reviewed and approved   |
| <b>Implementation</b> <ul style="list-style-type: none"> <li>Design implementation plan</li> <li>Design IMPACT data entry guidance for implementation</li> </ul>   | June 2016 – October 2016<br>August 2016 – October 2016                                | TTASC and DMHAS Administrator<br>TTASC and DMHAS Administrator  | Execute the Work Plan<br>Grantee services reported in IMPACT   |
| <b>Evaluation</b> <ul style="list-style-type: none"> <li>Design evaluation and data collection plan guidance</li> <li>Design evaluation summary and info brief guidance</li> <li>Design end of program evaluation report guidance</li> </ul> | April 2016 – August 2016<br>September 2017 – January 2018<br>October 2019 – May 2020  | CPES<br>CPES and DMHAS Administrator<br>CPES, TTASC and DMHAS Admin.  | Evaluation and Data Collection Plans reviewed and approved<br>Evaluation summaries and Info Briefs reviewed and approved<br>Final Evaluation Reports reviewed and approved |

LOGIC MODEL | COURAGE TO SPEAK FOUNDATION, INC. (CTSF)

**Problem Statement: More than 20 million Americans 12 and older had a substance use disorder and more than 8 million Americans 18 and older had co-occurring mental health and substance use disorders.**

| Goal   | Objectives  | Intervention/Inputs   | Outcomes  |
|--|---|---|---|
| <p><b>To prevent the start and reduce the progression of substance abuse and to promote positive mental health</b></p> | <p>Increase strong collaborations among schools, youth, parents and guardians</p>   | <p>Positive Youth Development</p> <ul style="list-style-type: none"> <li>• Presentations</li> <li>• CTSF Website</li> </ul> | <p>Identify trusted adult(s) to talk about the problems, pain, stress, and secrets</p> <p>Understand the dangers of alcohol and drug use</p> <p>Web site content to find help and support</p> |
|  | <p>Educate parents on how to have open and meaningful conversations with youth about the dangers of alcohol and drug misuse and abuse</p> | <p>Helping Families Heal Support Groups</p>   | <p>Support for parents and families in developing safe and healthy relationships</p>  |

GENERAL WORK PLAN | COURAGE TO SPEAK FOUNDATION, INC. (CTSF)

| Activities to Be Completed   | Timeline                     | Responsibility                                    | Milestone   |
|--|------------------------------|---|---|
| <p>Youth Development Presentations</p> <p><b>Mailings to Connecticut School Principals &amp; School Counselors</b></p> <p><b>Presentation marketing via electronic newsletter, social media, CT 211,</b></p> <p><b>Booking presentations, research, prepare and deliver Presentation</b></p> <p><b>Information dissemination, audience evaluation and evaluations analysis</b></p> | <p>July 2017 – June 2018</p> | <p>Program Director</p> <p>CEO and Co-Founder</p> | <p>12 Youth Presentations conducted</p>                                     |
| <p>Helping Families Heal</p> <ul style="list-style-type: none"> <li>• <b>Support Groups 2-hour sessions</b></li> <li>• <b>Individual guidance, and services provided outside the support group sessions</b></li> </ul>   | <p>July 2017 – June 2018</p> | <p>CEO and Co-Founder</p>                         | <p>9 Support Groups sessions conducted</p>                                  |
| <p>CTSF Website</p> <p><b>Educational blogs; CTSF Programs and Services; events; news articles; media</b></p> <p><b>Video training for prevention professionals and links to resources and where to get help</b></p>   | <p>July 2017 – June 2018</p> | <p>Program Director</p>                           | <p>A comprehensive resource for parents, students, educators and others</p> |



LOGIC MODEL | THE GOVERNOR’S PREVENTION PARTNERSHIP

**a. Problem Statement: Information on substance abuse prevention in schools and the workplace in Connecticut is often fragmented and requires coordination of partnerships that focuses on schools, workplaces, the public and private sectors and the media to reduce alcohol, tobacco and other drug (ATOD) abuse and promote anti-bullying activities throughout the state.**

| Goal  | Objectives  | Intervention/Inputs  | Outcomes   |
|---|---|--|--|
| <ul style="list-style-type: none"> <li>• <b>Provide leadership in the areas of positive school climate, bullying prevention, mentoring, the prevention of underage drinking and drug abuse and positive youth development to promote healthy development of youth</b></li> <li>• <b>Respond to emerging threats facing youth and raise awareness through the media</b></li> </ul> | <ul style="list-style-type: none"> <li>• Build capacity of peer to peer groups to provide education on alcohol, marijuana and other substances by providing training</li> <li>• Provide quality mentoring programs to increase youth connection with caring adults</li> </ul> | <ul style="list-style-type: none"> <li>• E3 – Encourage, Empower, Engage program statewide</li> <li>• SADD chapters</li> <li>• Youth Involvement via Youth Advisory Board and Council</li> <li>• Peer to Peer and other web based resources</li> <li>• Lunch and Learn and Current Trends trainings</li> <li>• Distribution of resources from Partnership at Drug Free Kids, etc.</li> <li>• Participation in advisory groups and task forces</li> <li>• Coordination of mentoring services</li> <li>• Training and technical assistance in mentoring</li> <li>• National Mentoring Month activities</li> <li>• National Mentoring Fund</li> <li>• School Peer Mediation Teams &amp; School Climate</li> </ul> | <ul style="list-style-type: none"> <li>• Reduction in alcohol, tobacco and other drug (ATOD) abuse in CT</li> <li>• Reduction in bullying occurrences in CT</li> </ul> |

## GENERAL WORK PLAN | THE GOVERNOR'S PREVENTION PARTNERSHIP

| Activities to Be Completed   | Timeline                   | Responsibility | Milestone   |
|--|----------------------------|----------------|---|
| <b>Implement E3 Statewide</b>  | 2017 – Ongoing             | GPP            | E3 Groups implemented   |
| <b>Coordinate SADD Chapters</b>  | 2017 - Ongoing             | GPP            | 2 new SADD chapters and receive monthly contact   |
| <b>Recruit youth to participate in Youth Advisory Board and Council</b>              | 2017 – Quarterly meetings  | GPP            | Youth Advisory Board and Council meetings are held quarterly  |
| <b>Develop and disseminate web based resources on peer to peer best practice</b>     | Ongoing- Monthly           | GPP            | Materials have been developed and disseminate monthly   |
| <b>Provide lunch and learn trainings on alcohol, marijuana and other drug trends</b> | Ongoing – 3 times per year | GPP            | 3 trainings per year are held   |
| <b>Disseminate resources from Partnership for Drug Free Kids</b>                     | Ongoing – 1 per month      | GPP            | At least 1 resource per month is disseminated   |
| <b>Connect with media outlets to increase public awareness of substance abuse</b>    | 2017 - Monthly             | GPP            | Monthly press releases, blog posts and website updates are developed and disseminated                                   |
| <b>Coordinate mentoring services throughout CT</b>                                   | Ongoing                    | GPP            | Mentoring hubs are created in Bridgeport, New Haven, Stamford and Hartford  |
| <b>Raise awareness on the importance of mentoring</b>                                | 2017 - Monthly             | GPP            | Social media posts disseminated along with monthly Mentoring Partnership newsletter                                     |
| <b>Update and enhance resources for mentoring coordinators</b>                       | Ongoing - Quarterly        | GPP            | Materials updated regularly and are available in Spanish  |
| <b>Participate in and contribute to statewide mentoring taskforces and networks</b>  | 2017- Ongoing              | GPP            | Participation in CT Afterschool Network meetings, Bridgeport Prospers/STRIVE Initiative and Waterbury Bridge to Success |
| <b>Provide training to improve School Climate</b>                                    | Ongoing - Annually         | GPP            | Annual train-the-trainer series for school professionals  |

LOGIC MODEL | CENTER FOR PREVENTION EVALUATION & STATISTICS

**Problem Statement: There is limit knowledge regarding data collected and generated by agencies as well as a lack of willingness or mechanism to share data. Additionally there is a lack of staff to manage data collection, analysis and reporting.**

| Goal   | Objectives  | Intervention/Inputs   | Outcomes   |
|--|---|---|--|
| <ul style="list-style-type: none"> <li>• <b>Increase access to and use of data</b></li> <li>• <b>Increase capacity among state and local stakeholders to use data</b></li> <li>• <b>Provide technical expertise in data collection, analysis and interpretation of data</b></li> </ul> | <ul style="list-style-type: none"> <li>• Conduct data gathering, prioritization, interpretation and management</li> <li>• Develop user friendly data repository</li> <li>• Maintain the Statewide Epidemiological and Outcomes Workgroup (SEOW)</li> <li>• Provide training, technical assistance and consultation on evaluation related activities</li> <li>• Assist in the implementation of substance use related surveys</li> <li>• Deliver technical assistance in data collection and analysis</li> </ul> | <ul style="list-style-type: none"> <li>• Prevention data collection and management</li> <li>• Epidemiological data for decision making</li> <li>• Technical assistance and training</li> <li>• Functioning SEOW</li> <li>• Behavioral health profiles and products</li> <li>• Evaluation services</li> <li>• Logic Model template</li> <li>• Tracking of indicators and outcomes</li> <li>• Maintenance of surveys</li> </ul> | <ul style="list-style-type: none"> <li>• A highly functioning DMHAS Prevention data center responsible for the identification, collection, assessment, analysis, and dissemination of data that can be used to support substance abuse prevention and mental health promotion initiatives.</li> <li>• Increased capacity of staff to collect and report on behavioral health data</li> </ul> |

## GENERAL WORK PLAN | CENTER FOR PREVENTION EVALUATION &amp; STATISTICS

| Activities to Be Completed   | Timeline                     | Responsibility              | Milestone   |
|--|------------------------------|-----------------------------|---|
| <b>Convene the SEOW and conduct SEOW Priority Setting process</b>                            | Quarterly meetings - Ongoing | CPES                        | Quarterly SEOW  |
| <b>Develop State Epidemiologic Profiles</b>  | 2017 – Every 2 years         | CPES                        | EPI Profiles published  |
| <b>Develop Prevention Data Repository</b>  | 2017                         | CPES, CT Data Collaborative | Prevention Data Collaborative is maintaining data portal                |
| <b>Support Community Readiness Survey Implementation and Analysis and develop Info Brief</b> | 2016- every 2 years          | CPES                        | 2016 Readiness Survey conducted   |
| <b>Participate in PFS 2015 Implementation Team Meetings</b>                                  | 2015 – Monthly               | CPES                        | UCHC staff participate in PFS 2015 Implementation Team Meetings         |
| <b>Develop and maintain CPES Website and SEOW Page</b>                                       | 2017 – Ongoing               | CPES                        | CPES website is developed   |
| <b>Provide technical assistance on data/evaluation issues</b>                                | 2016 – as requested          | CPES                        | Technical assistance to DMHAS funded Prevention entities                |
| <b>Provide technical on Logic Model development and use</b>                                  | 2017 – Ongoing               | CPES                        | Technical Assistance to DMHAS funded Prevention entities on Logic Model |
| <b>Participate in TTASC offered Learning Communities</b>                                     | As scheduled                 | CPES                        | UCHC staff participate in relevant TTASC sponsored Learning Communities |
| <b>Convene Local Evaluator Workgroup</b>   | 2017 - bimonthly             | CPES                        | Quarterly meetings in 2017 and increasing to every other month in 2018  |
| <b>Conduct key informant survey</b>  | 2018 – every 2 years         | CPES                        | Key informant survey conducted in 2018                                  |
| <b>Monitor and analyze relevant Mosaix IMPACT data</b>                                       | Monthly                      | CPES                        | Mosaix IMPACT data and reports  |

LOGIC MODEL | WHEELER CLINIC/CONNECTICUT CLEARINGHOUSE

**Problem Statement: Information on substance abuse prevention and treatment, mental health promotion and other behavioral health topics is often found from multiple sources and is difficult to coordinate. The need for a central repository of behavioral health printed, web based, and electronic visual materials and resources is needed.**

| Goal   | Objectives  | Intervention/Inputs  | Outcomes  |
|--|---|--|---|
| <p><b>Strengthen individuals and communities capacity to address substance abuse prevention and mental health promotion by maintaining a statewide Prevention Clearinghouse for the collection, maintenance and dissemination of information and material.</b></p> | <ul style="list-style-type: none"> <li>• Develop and provide behavioral health web and printed materials</li> <li>• Support Prevention efforts by participating on advisory committees, disseminating state of the art information and collaborating with other DMHAS funded prevention programs</li> <li>• Provide leadership and coordination of Connecticut Healthy Campus Initiative</li> <li>• Provide leadership and coordination of Mental Health First Aid in CT</li> </ul> | <ul style="list-style-type: none"> <li>• State of the art materials related to ATOD use and abuse and its effects</li> <li>• Strategic Plan</li> <li>• Prevention list serve</li> <li>• CSC &amp; PFS list-serve</li> <li>• Website</li> <li>• Monthly Healthy Campus Initiative meetings</li> <li>• Mental Health First Aid trainers list</li> <li>• Quarterly meetings of Mental Health First Aid trainers</li> <li>• Trainings in Mental Health First Aid</li> <li>• Participation on advisory boards and committees</li> </ul> | <ul style="list-style-type: none"> <li>• Increase in the number of persons who received appropriate behavioral health information and referral</li> </ul> |

## GENERAL WORK PLAN | WHEELER CLINIC/CONNECTICUT CLEARINGHOUSE

| Activities to Be Completed  | Timeline            | Responsibility | Milestone  |
|---|---------------------|----------------|--|
| <b>Clearinghouse staff to receive ongoing training</b>  | Ongoing             | Clearinghouse  | Clearinghouse staff continue to receive ongoing professional development to enhance their skills   |
| <b>Research new information to add to Clearinghouse resource collection</b>   | Ongoing             | Clearinghouse  | Staff update in house and web based materials on an ongoing basis  |
| <b>Provide behavioral health information, as requested, to the general public</b>   | Ongoing             | Clearinghouse  | Requests for information are processed in a timely manner  |
| <b>Develop and Maintain list-serves</b>   | Ongoing             | Clearinghouse  | Staff maintain list serves and disseminate new materials and information   |
| <b>Create Strategic Plan</b>  | Completed – Ongoing | Clearinghouse  | Strategic Plan is developed and strategies are being implemented   |
| <b>Coordinate CT Healthy Campus Initiative by maintaining list serve, coordinating and facilitating meetings and managing mini grants to campuses</b> | Ongoing             | Clearinghouse  | CHCI meetings are facilitated by Clearinghouse staff 8 times per year. Mini grants are monitored and list serve is maintained and information is distributed                     |
| <b>Coordinate Mental Health First Aid in Connecticut</b>  | Ongoing             | Clearinghouse  | Clearinghouse staff access reports from the National Council on number of CT Trainings/persons trained. They also facilitate quarterly meetings among MHFA trained facilitators. |
| <b>Maintain and update website</b>  | Ongoing             | Clearinghouse  | Website is developed and updated as information is acquired  |
| <b>Support DMHAS Prevention &amp; Health Promotion by participating on advisory committees</b>  | Ongoing             | Clearinghouse  | Participation on advisory bodies including the CT ADPC   |
| <b>Enter data into Mosaix IMPACT system and provide ad hoc reports as needed</b>  | Ongoing             | Clearinghouse  | Mosaix IMPACT data entry and ad hoc reports as needed  |

LOGIC MODEL | TRAINING AND TECHNICAL ASSISTANCE SERVICE CENTER (TTASC)

**Problem Statement: Few career pathways exist for prevention professionals; there are recruitment and retention gaps; trainings do not always align with the functions or requirements of 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  | Objectives  | Intervention/Inputs   | Outcomes  |
|---|---|---|---|
| <p><b>Create a robust and well informed and educated Prevention Workforce in Connecticut.</b></p> | <ul style="list-style-type: none"> <li>• Increase accessibility to training and technical assistance</li> <li>• Improve the quality of training and technical assistance</li> <li>• Increase the reach of Prevention training through the application of technology</li> <li>• Increase Prevention competencies across critical segments of the Prevention workforce</li> </ul> | <ul style="list-style-type: none"> <li>• Prevention Workforce Development Needs Assessment</li> <li>• Workforce Development Strategic Plan</li> <li>• Competency based training/technical support to coalitions</li> <li>• Evidence Based Programs Workgroup</li> <li>• Workforce Development Advisory Committee</li> <li>• Learning Communities to share Best Practices lessons learned/emerging trends</li> <li>• Competency based soft skills, including communication, writing skills prevention skills training/credentialing</li> <li>• Recruitment and retention of Prevention Professionals</li> <li>• Conference/education scholarships</li> </ul> | <ul style="list-style-type: none"> <li>• Increase in the number of well-educated and informed persons in the Connecticut Prevention Workforce.</li> <li>• Increase in the number of Certified Prevention Specialists (CPS) in Connecticut.</li> </ul> |

## GENERAL WORK PLAN | TRAINING AND TECHNICAL ASSISTANCE SERVICE CENTER (TTASC)

| Activities to Be Completed  | Timeline       | Responsibility                           | Milestone  |
|---|----------------|--|--|
| Conduct a training and technical assistance Needs Assessment                        | 2016           | Cross Sector Consulting                  | Needs Assessment Conducted   |
| Recruit and hire Project Manager and staff  | 2015           | Cross Sector Consulting                  | Project Manager and staff are hired and implementing goals   |
| Convene a Workforce Training and Technical Assistance Advisory Group                | 2016 – Ongoing | Cross Sector Consulting - other partners | Workforce TTAG is developed and meets quarterly  |
| Develop a Workforce Development Strategic Plan                                      | 2016           | Cross Sector Consulting                  | Strategic Plan is completed and strategies are being implemented   |
| Develop and maintain a website containing workforce relevant information            | 2016 – Ongoing | Cross Sector Consulting                  | Website is developed and continues to be updated with relevant training information  |
| Provide a minimum of five training events per year                                  | 2016 – Ongoing | Cross Sector Consulting – other partners | Training calendar is developed and 8 trainings were conducted in 2017  |
| Provide technical assistance to DMHAS funded agencies implementing the SPF          | 2015 – Ongoing | Cross Sector Consulting                  | TTASC completed initial T/A to the PFS subrecipients and continues to provide ongoing T/A to Prevention funded agencies on the SPF |
| Convene an Evidence Based Workgroup   | 2017 – Ongoing | Cross Sector Consulting – other partners | Evidence based workgroup was formed in 2017 and continues to meet monthly  |
| Provide scholarships to support attendance at the National Prevention Network (NPN) | 2016 – Ongoing | Cross Sector Consulting                  | Process was developed for selecting scholarship recipients. NPN Scholarships offered in 2016 and 2017                              |
| Enter data into Mosaix and provide ad hoc reports                                   | 2015 – Ongoing | Cross Sector Consulting                  | TTASC continues to enter process data into Mosaix IMPACT   |



LOGIC MODEL | PARTNERSHIPS FOR SUCCESS 2015 (PFS-2015)

**Problem Statement: Alcohol is the number one substance youth and young adults ages 12-20 report using, and there are an increasing number of youth and young adults (ages 12 to 25) who use abuse and misuse prescription drugs.**

| Goal  | Objectives  | Intervention/Inputs  | Outcomes   |
|---|---|--|--|
| <p><b>Utilizing the SPF, implement strategies and policies to prevent underage drinking (among 12-20 year olds) and non-medical use of prescription drugs (among 12-25 year olds) in Connecticut.</b></p> | <ul style="list-style-type: none"> <li>• Fund high-need communities to work with a local coalition to implement the SPF.</li> <li>• Increase the number of evidence based programs implemented in selected communities.</li> <li>• Increase and strengthen the capacity and infrastructure of the state and local communities to address underage drinking and nonmedical use of prescription drugs.</li> </ul> | <ul style="list-style-type: none"> <li>• 3 college campuses to implement the College AIM</li> <li>• 8 sub-recipients (community coalitions) to implement the SPF</li> <li>• Maintain the CT State Epidemiological Outcomes Workgroup (SEOW) to collect and analyze epidemiological data for CT populations.</li> <li>• Meet quarterly with the ADPC (CT SPF Advisory Council) for advice &amp; direction.</li> <li>• Provide ongoing training and technical assistance to sub-recipients.</li> </ul> | <ul style="list-style-type: none"> <li>• Reduction in reported 30-day use of alcohol, prescription drugs, and other substances selected by sub-recipients as measured by local student surveys.</li> <li>• Sustainable prevention programs.</li> </ul> |

## GENERAL WORK PLAN | PARTNERSHIPS FOR SUCCESS 2015 (PFS-2015)

| Activities to Be Completed   | Timeline  | Responsibility  | Milestone   |
|--|---|---|---|
| Attend trainings and receive TA on the SPF steps, the development of a logic model and the IMPACT data platform.                     | December 2016                                       | Project Directors   | Ongoing trainings and TA meetings; community capacity created to implement the SPF.   |
| Submit Community Needs Assessments, Logic Models, Strategic Plans, Implementation Plans, Evaluation Plans, and Sustainability Plans. | February 2017, April 2017, August 2017, Spring 2018 | Project Directors   | Approved Community Needs Assessment, Logic Model, Strategic Plan, Implementation Plan, Evaluation Plan, and Sustainability Plan for each sub-recipient. |
| Implement approved Strategic Plans   | Fall 2017   | Project Directors   | Data entered into Mosaix Impact on completed activities.  |
| Attend sub-recipient coalition meetings.   | Ongoing, bi-annually                                | DMHAS Project Manager, TTASC, Evaluation Team                                 | Meeting attended with minutes/notes to document activity.   |
| Bi-Annual sub-recipient Learning Communities on SPF steps and other topics.  | Ongoing, bi-annually                                | DMHAS Project Management Team, Evaluation Team, TTASC                         | Completed Learning Community evaluations to guide future training and TA.   |
| Provide technical assistance to sub-recipients.  | Ongoing   | DMHAS Project Management Team, Evaluation Team, TTASC                         | Returned e-mails, phone calls, and attendance at scheduled trainings.   |
| Submit reports/progress reports to SAMHSA.   | Ongoing   | DMHAS Project Management Team, Evaluation Team                                | Continuation Applications and quarterly reporting in SPARS and PEP-C.   |
| Convene quarterly Advisory Council/SEOW meetings; EBPW meets as needed   | Ongoing   | DMHAS Project Management Team, Evaluation Team, TTASC, SEOW, Advisory Council | Meeting attended with minutes/notes to document activity.   |
| <b>GENERAL WORK PLAN</b>   |   |   |   |
| Participate in monthly calls with the SAMHSA Grant Project Officer and SAMHSA Grantee Meetings                                       | Ongoing   | DMHAS Project Management Team   | Participate in monthly calls with the GPO or meeting attended with notes to document activity.  |
| Develop/submit final Evaluation Report on overall system changes, outcomes, lessons learned.   | September 2020                                      | DMHAS Project Management Team, UConn Evaluation Team                          | Completed final Evaluation Report.  |

LOGIC MODEL | NOW IS THE TIME/HEALTHY TRANSITIONS – CT STRONG

**Problem Statement: Youth and Young Adults age 16 to 25 years who have, or at risk of developing, serious behavioral health disorders are very often difficult to engage and retain into services as a result of behaviors that have led to being disconnected from school, unemployed, and separated from family and friends.**

| Goal  | Objectives  | Intervention/Inputs  | Outcomes  |
|---|---|--|---|
| <p><b>Engage and connect to services and supports, 150 transition age youth per year who reside in the communities of New London, Middletown and Milford.</b></p> | <ul style="list-style-type: none"> <li>○ Utilize the wrap-around approach by developing a staffing team in each of the 3 communities consisting of a wraparound coordinator, family advocate and peer advocate</li> <li>○ Create a State Level Transition Team comprised of various state and community agencies that impact the lives of 16-25 year olds to address policy and system issues pertaining to youth and young adults</li> </ul> | <ul style="list-style-type: none"> <li>○ Develop MOU with DCF/DMHAS to improve coordination</li> <li>○ Strengths based approach to engage high risk youth</li> <li>○ Peer Support</li> <li>○ Mental Health First Aid trainings in designated communities</li> <li>○ Family and other natural supports</li> </ul> | <ul style="list-style-type: none"> <li>○ Increased recognition of problems</li> <li>○ Connection to treatment and supports</li> <li>○ Improved functioning</li> <li>○ Fewer family problems</li> <li>○ Reduced need for hospitalization</li> <li>○ Reduced homelessness</li> <li>○ Less disruption of school/work</li> <li>○ Strengthened system</li> <li>○ Increased cooperation between child and adult agencies</li> <li>○ Families feel supported</li> <li>○ Reduction of arrests/incarceration</li> <li>○ Increased interest in joining support groups</li> <li>○ Decreased stigma and discrimination</li> </ul> |

GENERAL WORK PLAN | **NOW IS THE TIME/HEALTHY TRANSITIONS – CT STRONG**

| Activities to Be Completed  | Timeline | Responsibility                                  | Milestone   |
|---|----------|---|---|
| <b>Develop State Level Transition Team and conduct bi annual meetings</b>   | Ongoing  | Project Director/PI                             | SLTT is developed and continues to meet twice yearly                                |
| <b>Develop local teams by recruiting and hiring Wrap Coordinator, Peer Advocate and Family Advocate in each community</b> | Ongoing  | Project Director/Local Teams                    | Teams are developed and continue to work with youth                                 |
| <b>Develop engagement and documentation procedures</b>  | Ongoing  | Project Director/PI/Local Teams/Evaluation Team | Procedures development and enhanced utilization of Columbia Suicide assessment tool |
| <b>Teams are trained in Mental Health First Aid and provide training in their communities</b>                             | Ongoing  | Local Teams                                     | Two trainings per year are provided in each community                               |
| <b>Ongoing evaluation of project including 4 tier Nat. Evaluation</b>   | Ongoing  | Project Director/Evaluation Team                | Evaluation is ongoing   |
| <b>Technical Assistance by federally designated entity</b>  | Ongoing  | Project Director/Evaluation Team                | T/A partners have a monthly call with CT STRONG staff                               |
| <b>Submit reports to SAMHSA</b>   | Ongoing  | Project Director/PI/Evaluation Team             | Continuation Applications and quarterly reporting in SPARS                          |
| <b>Attend required grantee meetings</b>   | Ongoing  | Project Director/PI/Evaluation Team/Local Teams | Attendance at TCBH Conference and other designated conferences/meetings             |

LOGIC MODEL | STATE TARGETED RESPONSE

| Overarching Goal  | Inputs  | Outputs   | Outcomes   |
|---|---|---|--|
| <p><b>Prevent non-prescription opioid use and the progression from use of prescription opioids to the use of readily accessible and inexpensive heroin through multi-faceted prevention strategies.</b></p> | <ul style="list-style-type: none"> <li>Statewide Epidemiological and Outcomes Workgroup (SEOW)</li> <li>CT Prescription Monitoring &amp; Reporting System (CPMRS)</li> <li>Alcohol &amp; Drug Policy Council</li> <li>Connecticut's Opioid Drug Laws</li> <li>CT National Violent Death Reporting System (NVDRS)</li> <li>Current CDC and SAMHSA resources in the state to address prescription drug misuse/opioid overdose prevention activities</li> <li>A comprehensive Prevention Program Infrastructure consisting of: community coalitions that implement EBPs; regional substance abuse planning and coordination entities (RACs); municipal prevention programs (LPCs); a statewide youth development agency (GPP); a substance abuse resource clearinghouse; a statewide substance abuse prevention training and TA entity; and a statewide evaluation services provider.</li> </ul> | <ul style="list-style-type: none"> <li>Multimedia strategy aimed at: <b>1) raising awareness</b> of the dangers of sharing medication, heroin addiction and overprescribing opioids, and; <b>2) reducing stigma and barriers to treatment.</b> Strategies include statewide website, billboards, banners, PSAs, fact sheets, conferences, speaking engagements, etc.</li> <li><b>Educational strategies</b> for community members, first responders, prescribers, patients, family members and individuals in recovery to reduce access and availability.</li> <li><b>Safe storage and proper medication disposal</b> including drop boxes and drug take back events.</li> <li><b>Tracking and monitoring</b> strategies to help regulatory agencies to detect and intervene in unusual prescriber practices. This includes the CPMRS and medical and PDMP database integration.</li> <li><b>Harm reduction</b> strategies including overdose education and naloxone distribution (OEND) programs.</li> </ul> | <ul style="list-style-type: none"> <li>Increased public awareness of dangers of prescription drug misuse and non-prescription opioid use</li> <li>Enhanced and expanded statewide program infrastructure to reduce prescription drug misuse and opioid overdoses</li> <li>Stronger partnerships among key stakeholders to increase collaboration and coordination of efforts and create successful, comprehensive solutions</li> <li>Increased trainings on opioid overdose deaths prevention strategies to schools, communities, parents, prescribers and their patients</li> <li>Increased number of individuals listed above being trained</li> <li>Increased number of prescribers accessing the CT Prescription Monitoring &amp; Reporting System (CPMRS)</li> <li>Reduced number of students who report prescription drug and opioid misuse</li> </ul> |

## GENERAL WORK PLAN | STATE TARGETED RESPONSE

| Activities to Be Completed  | Timeline                                 | Responsibility                              | Milestone   |
|---|--|---|---|
| Implement safe storage, education, tracking and monitoring and harm reduction strategies                    | May 1, 2017 to April 30, 2019<br>Month 4 | STR sub-recipient communities/<br>providers | Proposed STR strategies are implemented in regions across the state |
| Collect and report on the numbers reached by strategies and the number of products developed and delivered. | May 1, 2017 to April 30, 2019            | STR sub-recipient communities/<br>providers | Reports submitted   |
| Develop and submit progress reports on STR sub-recipients and their activities.                             | As requested                             | DMHAS Project Team                          | Completed and submitted Progress Reports                            |
| Develop/submit final report on overall system changes, outcomes, lessons learned                            | April 2019                               | DMHAS Project Management Team               | Completed and submitted final report                                |

LOGIC MODEL | STRATEGIC PREVENTION FRAMEWORK FOR PRESCRIPTION DRUGS (SPF-Rx)

**PROBLEM STATEMENT: Increase in heroin admissions to TX 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.**

| Goal  | Objectives   | Intervention/Inputs   | Outcomes  |
|---|--|---|---|
| <p><b>GOAL: Increase awareness of the dangers of sharing medication for individuals age 12 and older, and the risks of overprescribing for prescribers and others in the medical community.</b></p> | <ul style="list-style-type: none"> <li>• Raise public awareness of and provide education on the dangers of prescription drug misuse and non-prescription opioid use</li> <li>• enhance and expand the statewide prevention infrastructure to reduce prescription drug misuse and opioid overdoses</li> <li>• Build partnerships among key stakeholders to increase collaboration and coordination of efforts and create successful, comprehensive solutions</li> </ul> | <ul style="list-style-type: none"> <li>• Statewide Epidemiological and Outcomes Workgroup (SEOW)</li> <li>• CT Prescription Monitoring &amp; Reporting System (CPMRS)</li> <li>• Alcohol &amp; Drug Policy Council – Prevention, Screening &amp; Early Intervention Subcommittee (PDO Advisory)</li> <li>• Good Samaritan Legislation</li> <li>• CT National Violent Death Reporting System (NVDRS)</li> <li>• Current CDC and SAMHSA resources in the state to address prescription drug misuse/opioid overdose prevention activities</li> </ul> | <ul style="list-style-type: none"> <li>• Increased trainings on opioid overdose deaths prevention strategies to schools, communities, parents, prescribers and their patients</li> <li>• Increased number of individuals listed above being trained</li> <li>• Increased number of prescribers accessing the CT Prescription Monitoring &amp; Reporting System (CPMRS)</li> <li>• Reduced number of students who report prescription drug use</li> <li>• Reduced number of prescription drug and opioid related deaths</li> </ul> |

## GENERAL WORK PLAN | STRATEGIC PREVENTION FRAMEWORK FOR PRESCRIPTION DRUGS (SPF-Rx)

| Activities to Be Completed   | Timeline | Responsibility                                | Milestone  |
|--|----------|---|--|
| Deploy the opioid misuse public awareness campaign in local communities and to prescribers encouraging them to integrate the CPMRS into their electronic health record.              | Ongoing  | Local Health Districts                        | <i>Change the Script</i> campaign deployed in traditional and social media and to prescribers across funded communities. |
| Create community-specific drug disposal programs in collaboration with law enforcement, local builders, municipalities, grocery, and convenience stores.                             | Ongoing  | Local Health Districts                        | Expanded drug disposal programs in communities   |
| Participate on existing coalitions convened to address the opioid crisis in communities  | Ongoing  | Local Health Districts                        | Sharing community programs; leveraging additional resources for communities to address the crisis                        |
| Continue the implementation of strategic plans that includes a social marketing strategy, strategies for evaluating the initiative and a strategy for identifying target communities | Ongoing  | Local Health Districts                        | A strategic plan that identifies community needs and strategies for addressing and evaluating them                       |
| Design a project-specific data model for ongoing and ad hoc reporting that is tailored to the CT SPF-Rx  | Ongoing  | Core Implementation Team                      | Reports generated on the updated PDMP  |
| Conduct a web-based survey of licensed prescribers in Connecticut to help inform DCP's social marketing and education campaign with providers.                                       | Ongoing  | Project Evaluation Team                       | Survey conducted   |
| Comply with all evaluation and data collection requirements at the community, state and multi-state levels.  | Ongoing  | Local Health Districts,<br>DMHAS Project Team | Required reports and evaluation activities documented and submitted  |



LOGIC MODEL | SYNAR – TOBACCO PREVENTION AND ENFORCEMENT PROGRAM

**Problem Statement:**

**The large majority of adults who are addicted to nicotine started using tobacco products before the age of 18 years old. Nicotine is highly addictive. Tobacco use has many harmful side effects that cause disease and premature death.**

| Goals   | Objectives  | Intervention/Inputs   | Outcomes  |
|---|---|---|---|
| <b>Reduce smoking behavior in all population groups</b>   | Prevent access to tobacco and ENDS products by minors   | Conduct statewide retailer compliance inspections to enforce state and federal law  | Reduce easy access to tobacco and ENDS products by minors   |
| <b>Provide education and awareness concerning tobacco access laws to tobacco retailers and the community at large</b> | Inform all licensed tobacco retailers of access laws regulating the sale of tobacco and ENDS products to minors. Also inform communities about tobacco possession and access laws | Direct mail and email to tobacco retailers providing information about state and federal access laws                                | Improved compliance of state and federal tobacco access laws thereby preventing tobacco and ENDS access to minors |
| <b>Measure impact and behavior change</b>   | Determine retailer compliance by conducting an annual scientific sample   | Conduct a scientific sample of tobacco retailers and carefully measure inspection outcomes to determine compliance with access laws | Establish the Retailer Violation Rate (RVR) to determine compliance rate with tobacco access laws                 |

## GENERAL WORK PLAN | SYNAR – TOBACCO PREVENTION AND ENFORCEMENT PROGRAM

| Activities to Be Completed   | Timeline   | Responsibility   | Milestone  |
|--|--|--|--|
| <b>State tobacco and ENDS compliance inspections</b>   | All year   | To enforce state tobacco and ENDS access laws  | A consistent RVR under 10% non-compliance annually   |
| <b>Update the tobacco and ENDS retailer listserv</b>   | February and March of each year                  | Upload the Department of Revenue Services updated license list   | Ensure an accurate and up to date tobacco retailer listserv  |
| <b>Annual Synar Tobacco Compliance Inspection Sample</b>   | Sample inspections are conducted April to August | Conduct sample tobacco inspections determined by a scientific random sample  | To determine the RVR that will be reported in the Annual Synar Report                                  |
| <b>Annual Synar Report</b>   | September to November                            | Complete the Annual Synar Report   | Submit to the oversight agency SAMHSA for review/acceptance  |
| <b>Federal tobacco and ENDS compliance inspections</b>   | All year   | To enforce federal tobacco and ENDS access laws specific to the Family Smoking Prevention and Tobacco Control Act  | A consistent RVR under 10% annually  |
| <b>Provide education and awareness to tobacco retailers and communities about state efforts to prevent access to tobacco and ENDS products</b> | All year   | Communication with tobacco retailers with 2 annual state mailings. Notice letters to retailers after inspection. The community is made aware of tobacco inspections in the media coverage and online | Market saturation with information about tobacco and ENDS access laws and enforcement efforts          |
| <b>FDA provides education and awareness material to retailers</b>  | All year   | The FDA communicates with retailers after inspections online and by direct mail with education material and notice letters.  | Market saturation with information about federal tobacco and ENDS access laws and enforcement efforts. |

## LOGIC MODEL/GENERAL WORK PLAN | REGIONAL BEHAVIORAL HEALTH ACTION ORGANIZATIONS (RBHAO)

| Activities to Be Completed  | Timeline         | Responsibility | Milestone  |
|---|------------------|----------------|--|
| <b>Finalize new organization structure</b>  | By February 2019 | RBHAO Staff    | New integrated behavioral health action organization |
| <b>Conduct regional needs assessment and gap analysis for region</b>                      | June 2018        | RBHAO Staff    | Regional Needs Assessment Report                     |
| <b>Develop organization strategic plan</b>  | September 2018   | RBHAO Staff    | Agency strategic plan                                |
| <b>Serve on local regional and statewide planning bodies</b>                              | Ongoing          | RBHAO Staff    | Meeting Attendance                                   |
| <b>Administer the Local Prevention Council grants to municipalities</b>                   | Ongoing annually | RBHAO Staff    | Small grants allocated to municipalities             |
| <b>Build capacity for region to address problem gambling</b>                              | Ongoing          | RBHAO Staff    | Problem gambling activities funded in regions        |
| <b>Leverage funds to support prevention, treatment and recovery initiatives in region</b> | Ongoing          | RBHAO Staff    | Number of resources acquired for region by RBHAO     |
| <b>Provide substance abuse/mental health advocacy for region</b>                          | Ongoing          | RBHAO Staff    | Attendance at events                                 |

LOGIC MODEL | CONNECTICUT NETWORKS OF CARE FOR SUICIDE PREVENTION (NCSP)

Logic Model CT Garrett Lee Smith Suicide Prevention Initiative 2015-2020

□ **Problem Statement/Need:** In CT, suicide is the 2<sup>nd</sup> leading cause of death for 10-14 year-olds and 3<sup>rd</sup> for youth ages 15-24. High school youth reported the following: In past 12 months 26.6% symptoms of clinical depressed; 13.4% seriously consider suicide; 7.9% attempted suicide; and 18.5% intentionally self-injury without intent to die; and overall 25.4% can't get the help they need when needed, and 32.8% believe they don't have an adult to talk to at school (DPH, 2015).  
**Goal:** Strengthen CT capacity and infrastructure in support of mental health promotion, suicide prevention, intervention and response with the use of evidence-based practices to reduce non-fatal suicide attempts and suicide deaths among at risk youth and young adults age 10-24 in CT.

| Resources/Inputs   | EB Strategies & Activities Services   | Objectives/Outputs   | Short Term Outcomes  | Long Term Outcomes  |
|--|---|--|--|---|
| <p><b>1. Existing federal, state, regional, local, private and institutional resources available to address the behavioral health needs of youth and young adults 10-24 y.o.</b></p> <p><b>2. Existing community resources available to enhance suicide prevention and response, and mental health promotion.</b></p> <p><b>3. Existing national, state, county and community data available pertaining to youth and young adult suicidal behaviors and death.</b></p> | <p>1. Use of the SPF; policy development; leveraging and coordinating resources; formal agreements; data management system linkages; CTSAB support &amp; leadership; consumer and family involvement</p> <p>2. Jed Foundation/SPRC Comprehensive Suicide Prevention and Mental Health Promotion Model (Strategic Areas): 1) Statewide Training: Gatekeeper; 2) NSPL advertising via statewide suicide prevention and mental health promotion campaign; 3) Screening, access to treatment, referral, and follow-up; clinical Workforce Development Promotion of behavioral health treatment, case management resources; 4) State &amp; community-level policies and procedures that support behavioral health service and crisis response system improvements; 5) Lethal means restriction activities; 6) Life skills training; 7) Enhanced community youth networks</p> <p>3. Process and outcome data collection, management, and reporting.</p> | <p>1. Integrate and coordinate suicide prevention, intervention and response activities across multiple sectors and settings through the enhancement and formalization of a sustainable Statewide Network of Care (SNC) for Suicide Prevention consisting of the CTSAB and five Regional Networks of Care (RNCs), and one Community Network of Care (CNC) in the town with the intensive effort to support prevention, intervention and response.</p> <p>2. Integrate and coordinate suicide prevention, intervention and response activities across multiple sectors and settings through the development and formalization of a sustainable CNC for suicide prevention, intervention and response linked to the RNC and SNC.</p> | <p>Objective 1:</p> <ol style="list-style-type: none"> <li>1. Identify state, regional and community needs and priorities.</li> <li>2. Build capacity, readiness and support statewide for suicide prevention, intervention and response efforts.</li> <li>3. Develop, enhance, implement, and monitor effective EBPs and strategies based on identified needs and priorities that promote wellness and prevent suicide and related behaviors, and address the unique needs of the priority population and sub-populations.</li> <li>4. Promote suicide prevention as a core component of health care services, and engage at least one local behavioral health or healthcare provider per region to adopt the Zero Suicide approach.</li> <li>5. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement.</li> <li>6. Increase the acquisition, timeliness, and utility of data and surveillance systems statewide relevant to youth/young adult suicide prevention, and improve the capacity to collect, analyze, and use this information for action.</li> </ol> <p>Objective 2:</p> <ol style="list-style-type: none"> <li>1. Identify community needs and priorities.</li> <li>2. and 3. Same as 2. and 3. under Objective 1.</li> <li>4. Provide early identification/screening, assessment, referral and connection to treatment, recovery support services, and follow-up services for at risk youth and young adults.</li> <li>5. Promote suicide prevention as a core component of health care services, and engage two local behavioral health and healthcare providers to adopt the Zero Suicide approach.</li> <li>6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement with an emphasis on the local providers.</li> <li>7. Same as 6. under Objective 1.</li> </ol> | <ol style="list-style-type: none"> <li>1. Reduced number/rate of youth 10-24 y.o. treated in hospitals for suicidal behavior (HIDD measures, baseline and follow-up).</li> <li>2. Reduced number/rate of youth 10-24 y.o. who die by suicide (OCME measures, baseline and follow-up)</li> </ol> |

GENERAL WORK PLAN | CONNECTICUT NETWORKS OF CARE FOR SUICIDE PREVENTION (NCSP)

| Activities to Be Completed   | Timeline     | Responsibility   | Milestone  |
|--|--------------|--|--|
| <ul style="list-style-type: none"> <li>Identify needs, priorities, and EBP strategies and select approaches to address them within the TJF/SPRC model; Zero Suicide approach; develop implementation plans; and implement age/culturally appropriate services.</li> <li>SNC-RNCs meet with CTSAB to identify and implement statewide approach</li> </ul> | Ongoing      | <ul style="list-style-type: none"> <li>DMHAS PI</li> <li>Project Directors</li> <li>Program Managers</li> <li>Contractors</li> <li>SPRC</li> </ul>           | <ul style="list-style-type: none"> <li>Needs and priorities identified</li> <li>EBP Strategies selected Implementation plans developed and accepted</li> <li>EBP strategies implemented</li> <li>Correct use and timely submission of evaluation data</li> <li>Services to youth 10-24 provided</li> <li>CNC, SNC and RNC meet regularly to address needs and perform CQI</li> </ul> |
| <ul style="list-style-type: none"> <li>Training and education that focus on suicide prevention, response and behavioral health promotion</li> <li>Enhancements identified for state campaign</li> </ul>  | Ongoing      | <ul style="list-style-type: none"> <li>DMHAS PI</li> <li>Project Directors</li> <li>Program Managers</li> <li>Contractors</li> </ul>                         | <ul style="list-style-type: none"> <li>gatekeepers and professionals trained</li> <li>production of new materials to support campaign dissemination</li> </ul>   |
| <ul style="list-style-type: none"> <li>Contractor and community meetings</li> <li>Report to SAMHSA as required Ongoing meetings with the CTSAB Ongoing training and workforce development</li> <li>Information and awareness campaign enhancement and dissemination</li> </ul>   | Ongoing      | <ul style="list-style-type: none"> <li>DMHAS PI</li> <li>Project Directors</li> <li>Program Managers</li> <li>Contractors</li> <li>CTSAB Advisory</li> </ul> | <ul style="list-style-type: none"> <li>Meetings scheduled -minutes/notes to document activity; submission and approval of program &amp; budget reports from contractors and communities; statewide campaign promoted</li> </ul>  |
| <ul style="list-style-type: none"> <li>Training and education of providers to utilize evaluation tools</li> <li>Attend required grant meetings and systems</li> </ul>  | As scheduled | <ul style="list-style-type: none"> <li>DMHAS PI</li> <li>Project Directors</li> <li>Program Managers</li> <li>Contractors</li> </ul>                         | <ul style="list-style-type: none"> <li>Data is collected and entered in a timely manner</li> <li>Project staff participate</li> </ul>  |
| <ul style="list-style-type: none"> <li>Budget management, review and preparation</li> </ul>  | Ongoing      | <ul style="list-style-type: none"> <li>DMHAS PI/Consultant</li> </ul>  | <ul style="list-style-type: none"> <li>Preparation and submission of FSRs and required reports to CMHS</li> </ul>  |
| <ul style="list-style-type: none"> <li>Develop sustainability plan within the existing infrastructure and services system.</li> </ul>  | Ongoing      | <ul style="list-style-type: none"> <li>DMHAS PI/Consultant</li> <li>Project Directors</li> </ul>   | <ul style="list-style-type: none"> <li>Redirected and/or new resources to sustain the NCSP</li> <li>Completed report on overall evaluation</li> </ul>  |

|   |  |  |   |
|---|--|--|---|
| <ul style="list-style-type: none"> <li>• <b>Document design/ polices/ procedures/ activities/ results and initiate analyzing outcome &amp; process data.</b></li> <li>• <b>Compile and submit Program Reports as required using surveillance data on system changes, outcomes, lessons learned</b></li> </ul> |  | <ul style="list-style-type: none"> <li>• Program Managers</li> <li>• Contractors</li> <li>• Communities</li> <li>• CTSAB Advisory</li> </ul> | <ul style="list-style-type: none"> <li>• Submission of reports</li> </ul> |
|---|--|--|---|

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**SECTION 9 | PREVENTION AND HEALTH PROMOTION UNIT SCORECARD**

The scorecard below annually tracks the progress being made on each priority. Using a color code from red indicating no progress to green (outcome met), the scorecard will inform planning, policies, resource allocation and mid-course corrections for the DMHAS PHP.

| Color Rating Scale to Track Progress                        |  |   |
|---|--|---|
| <b>Low</b><br><i>(Little or no action towards outcomes)</i> | <b>Medium</b><br><i>(Some or steady progress towards outcomes)</i> | <b>High</b><br><i>(Met or exceeding outcomes)</i> |

PHP Plan Scorecard

| PROGRAM/INITIATIVE  | Alcohol                           | 2018 | 2019 | 2020 | 2021 |
|---------------------|-----------------------------------|------|------|------|------|
| PFS 2015            | Current use                       |      |      |      |      |
| CPES                | Past month use                    |      |      |      |      |
| CSC                 | Binge Drinking                    |      |      |      |      |
| CT Healthy Campus   | Age of first use                  |      |      |      |      |
| CT Clearinghouse    | DUI arrests                       |      |      |      |      |
| GPP                 | Liquor law violations             |      |      |      |      |
| Healthy Transitions | Alcohol server violations         |      |      |      |      |
| TTASC               |                                   |      |      |      |      |
| RBHAO/LPCs          |                                   |      |      |      |      |
| PROGRAM/INITIATIVE  | Prescription Drugs                | 2018 | 2019 | 2020 | 2021 |
| PFS 2015            | Past year use                     |      |      |      |      |
| CPES                | Lifetime use                      |      |      |      |      |
| CSC                 | School attendance                 |      |      |      |      |
| CT Healthy Campus   | School suspensions                |      |      |      |      |
| CT Clearinghouse    | Drug law violations               |      |      |      |      |
| GPP                 | Reduction in opioid prescriptions |      |      |      |      |
| Healthy Transitions |                                   |      |      |      |      |
| TTASC               | Treatment admissions              |      |      |      |      |
| RBHAO/LPCs          |                                   |      |      |      |      |
| PROGRAM/INITIATIVE  | Heroin & Opioids                  | 2018 | 2019 | 2020 | 2021 |

|                           |                               |                           |             |             |             |
|---------------------------|-------------------------------|---------------------------|-------------|-------------|-------------|
| CPES                      | Lifetime use                  |                           |             |             |             |
| CSC                       | Treatment admissions          |                           |             |             |             |
| CT Clearinghouse          | School Attendance             |                           |             |             |             |
| CT Healthy Campus         |                               |                           |             |             |             |
| GPP                       |                               |                           |             |             |             |
| Healthy Transitions       |                               |                           |             |             |             |
| TTASC                     |                               |                           |             |             |             |
| RBHAO/LPCs                |                               |                           |             |             |             |
| <b>PROGRAM/INITIATIVE</b> |                               | <b>Tobacco &amp; ENDS</b> | <b>2018</b> | <b>2019</b> | <b>2020</b> |
| TPEP                      | Current use                   |                           |             |             |             |
| CPES                      | Past month use                |                           |             |             |             |
| CSC                       | Perception of risk            |                           |             |             |             |
| CT Healthy Campus         | Age of first use              |                           |             |             |             |
| CT Clearinghouse          | School suspensions/expulsions |                           |             |             |             |
| GPP                       | Tobacco seller violations     |                           |             |             |             |
| Healthy Transitions       | Tobacco retailer violations   |                           |             |             |             |
| TTASC                     |                               |                           |             |             |             |
| RBHAO/LPCs                |                               |                           |             |             |             |
| <b>PROGRAM/INITIATIVE</b> | <b>Cannabis</b>               | <b>2018</b>               | <b>2019</b> | <b>2020</b> | <b>2021</b> |
| CPES                      | Current use                   |                           |             |             |             |
| CSC                       | Past month use                |                           |             |             |             |
| CT Healthy Campus         | Lifetime use                  |                           |             |             |             |
| CT Clearinghouse          | Perception of risk of harm    |                           |             |             |             |
| GPP                       | Early onset use               |                           |             |             |             |
| Healthy Transitions       | School suspensions/expulsions |                           |             |             |             |
| TTASC                     |                               |                           |             |             |             |
| RBHAO/LPCs                |                               |                           |             |             |             |
| <b>PROGRAM/INITIATIVE</b> | <b>Cocaine</b>                | <b>2018</b>               | <b>2019</b> | <b>2020</b> | <b>2021</b> |
| CPES                      | Current use                   |                           |             |             |             |
| CSC                       | Past year use                 |                           |             |             |             |



|                                  |  |             |             |             |             |
|----------------------------------|--|-------------|-------------|-------------|-------------|
| CT Healthy Campus                | Lifetime use   |             |             |             |             |
| CT Clearinghouse                 | School suspensions/expulsions  |             |             |             |             |
| GPP                              | Treatment admissions   |             |             |             |             |
| Healthy Transitions              |  |             |             |             |             |
| TTASC                            |  |             |             |             |             |
| RBHAO/LPCs                       |  |             |             |             |             |
| <b>PROGRAM/INITIATIVE</b>        | <b>Suicide</b>   | <b>2018</b> | <b>2019</b> | <b>2020</b> | <b>2021</b> |
| Statewide Networks of Care (GLS) | Sad or hopeless almost daily for two plus consecutive weeks, stopped usual activities (12 mos) |             |             |             |             |
| CPES                             |  |             |             |             |             |
| CT Healthy Campus                | Seriously considered suicide (12 mos)  |             |             |             |             |
| CT Clearinghouse                 |  |             |             |             |             |
| LPCs                             | Suicide attempts (12 mos)  |             |             |             |             |
| RBHAOs                           | Self-injury without wanting to die (12 mos)  |             |             |             |             |
| TTASC                            |  |             |             |             |             |
|                                  | Getting help when needed   |             |             |             |             |

## SECTION 10 | SUMMARY

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The promotion of health, whether it entails substance abuse or the prevention of mental health disorders can be a daunting task for states. In an effort to provide a comprehensive statewide system of evidenced based prevention services, the DMHAS Prevention and Health Promotion Unit has taken a major leadership role in guiding state and community level stakeholders. Our work has been guided by data, the mission of our department as well as our funders (SAMHSA), and with the goal of building healthy resilient communities.

The SPF has provided an opportunity for the State to explore substance use and abuse patterns unique to Connecticut's communities and use these data to paint a picture of the nature and burden of the problem throughout the State. The State epidemiological profile, which was further illuminated by community needs and response capacity assessments, is based on data from state and national surveys conducted over the past 10 years. These data indicate a number of substance abuse problems in Connecticut.

Hidden behind the data are individuals and families feeling stress and uncertainty as a result of substance abuse. Children exposed to severe stress may be more vulnerable to drug abuse, risk for depression, and substance abuse in adulthood.

The DMHAS Prevention and Health Promotion Unit promotes prevention and the role it will play in health care reform. Through our funding to community based agencies with dedicated, highly trained staff, we support an array of effective and efficient prevention services. These services are broad in scope and work to assist individuals and families facing difficult challenges, thus reducing risk for substance abuse and mental illness disorders.

The DMHAS prevention plan has a strategic direction that is ambitious. In addition to promoting the health of individuals and communities, it moves us toward the accomplishment of our vision and mission and supports SAMHSA's strategies of accountability, capacity and effectiveness. Goals and priority areas have been identified; key performance measures have been established; and resources have been allocated to programs and strategies. Annual progress, in the form of performance targets and accomplishments, will continue to be reported to CSAP. We will measure our success using program specific action plans, management matrix tools, and data infrastructure, to name a few.

# 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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.
  - Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings.
  - Mobile emergency crisis services intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert as appropriate from inpatient stays.
  - Crisis Intervention Team (CIT) training trains law enforcement officers in responding to mental health emergencies so as to deescalate situations and access appropriate services; in addition, mental health professionals may be asked to assist law enforcement in responding to behavioral health calls.
  - Many types of services are provided to persons living in the community with mental health conditions to support their ability to continue to reside in the community (e.g., ACT, CSP, Supported Employment, Supported Education, Clubhouses, Outpatient Treatment, Supportive Housing)
  - For children with SED, EMPS-Mobile Crisis Service is available 24 hours a day 365 days a year. Care Coordination and Intensive Care Coordination (over 85 FTEs) are available to all children in Connecticut to provide in-home, family driven services to prevent residential institutional care and hospitalization and/or reduce hospital and institutional care stays.
2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
  - a) Physical Health  Yes  No
  - b) Mental Health  Yes  No
  - c) Rehabilitation services  Yes  No
  - d) Employment services  Yes  No
  - e) Housing services  Yes  No
  - f) Educational Services  Yes  No
  - g) Substance misuse prevention and SUD treatment services  Yes  No
  - h) Medical and dental services  Yes  No
  - i) Support services  Yes  No
  - j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  Yes  No
  - k) Services for persons with co-occurring M/SUDs  Yes  No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)  
NA

3. Describe your state's case management services  
Case management services are provided across a variety of levels of care within the DMHAS system. Persons with mental health conditions living in the community that receive supportive housing services, include case management that assists them with training, guidance and support to meet their needs and allow them to continue to reside in the community. Services provided are "wrap around" as needed to support the client. Case management is provided to homeless individuals in an attempt to engage them and have them willing to be connected to services. LMHAs provide case management services and strive to match clients

optimally to the level of care needed. The LMHAs meet with key stakeholders weekly to optimize client placement within the DMHAS system. Case management services are also typically provided within residential levels of care. Medicaid funded Targeted Case Management (TCM) services are provided in several levels of care. In 2010, DMHAS converted most of its mental health case management services to Community Support Program (CSP) teams that include a combination of TCM, non-TCM case management, and an emphasis on skill-building interventions. The ACT teams include TCM and non-TCM case management services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

- Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings.
- Mobile emergency crisis services intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert as appropriate from inpatient stays.
- Crisis Intervention Team (CIT) training trains law enforcement officers in responding to mental health emergencies so as to deescalate situations and access appropriate services; in addition, mental health professionals may be asked to assist law enforcement in responding to behavioral health calls.
- Many types of services are provided to persons living in the community with mental health conditions to support their ability to continue to reside in the community (e.g., ACT, CSP, Supported Employment, Supported Education, Clubhouses, Outpatient treatment, Supportive Housing).
- For children with SED, EMPS-Mobile Crisis Services is available 24 hours a day 365 days a year. Care Coordination and Intensive Care Coordination (over 85 FTEs) are available to all children in Connecticut to provide in-home, family driven services to prevent residential institutional care and hospitalization and/or reduce hospital and institutional care stays.

NOT FINAL

## Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

## Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

| Target Population (A) | Statewide prevalence (B) | Statewide incidence (C) |
|-----------------------|--------------------------|-------------------------|
| 1. Adults with SMI    | 116,000                  | 45,534                  |
| 2. Children with SED  | 73,597                   | 49,981                  |

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.

Connecticut is the 29th most populated state with 3.6 million residents of whom 735,969 (or 20.6 are children and youth). Children with Serious Emotional and Disturbance are estimated at 10% or over 73,500 children. 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 49,981 youth were served. 14,585 of this number were recipients of crisis services. which were largely unduplicated. 35,396 unduplicated children and youth received other services in the array.

For statewide prevalence of adults with SMI, DMHAS used the NSDUH 2017 Table 27 figures for SMI past year in adults (18+) in Connecticut: 116,000. For statewide incidence of adults with SMI, DMHAS used its Annual Statistical Report from FY 18 which includes the number of adults diagnosed/treated with SMI (defined to include schizophrenia and related disorders, bipolar disorder, major depression, and PTSD) in the state: 45,534. The Annual Statistical Report FY18 is available at: <https://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreport2018.pdf>

NOT FINAL

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services  Yes  No
- b) Educational services, including services provided under IDE  Yes  No
- c) Juvenile justice services  Yes  No
- d) Substance misuse prevention and SUD treatment services  Yes  No
- e) Health and mental health services  Yes  No
- f) Establishes defined geographic area for the provision of services of such system  Yes  No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

**a.** Describe your state's targeted services to rural population.

DMHAS continues to examine the need, accessibility and availability of behavioral health services in rural areas. Past efforts to develop local systems of care has taken into account issues such as lack of transportation. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices. The federally funded State opioid Response (SOR) and State Targeted Response (STR) grants have increased capacity for MAT services and recovery supports provided by agencies serving rural communities across the state. Newly funded services include recovery coaches, located at 13 hospital EDs, many of which serve patients from nearby rural towns.

**b.** Describe your state's targeted services to the homeless population.

In an effort to decrease the number of homeless individuals with SMI or with co-occurring substance use disorders (SUDs), DMHAS established Homeless Outreach and Engagement Teams. These teams provide outreach, assessment, engagement, and case management services to homeless individuals. DMHAS is a recipient of federal formula funds for Projects for Assistance in Transition from Homelessness (PATH) that serves persons with SMI and co-occurring SUDs who are homeless or at risk of becoming homeless. The Homeless Outreach teams are scattered across the state in urban, suburban and rural settings.

**c.** Describe your state's targeted services to the older adult population.

DMHAS' Long Term Services and Supports (LTSS) unit continues to broaden its statewide partnerships with providers of services to older adults. The LTSS Clinical Director attends the Office of Policy and Managements' Long Term Care Planning Committee and co-chairs the Older Adult Behavioral Health Workgroup with staff from the State Unit on Aging. The Older Adult Workgroup is comprised of public and private providers of services for older adults. The workgroup created an online training for professional staff on older adults and mental health and received 1.5 CEUs for all staff that take the training. The workgroup also organized the first annual conference on older adults, held March 2019. The conference was titled: Successful Aging: The Intersection of Behavioral and Physical Health. Over 180 people attended and plans are already being made for next year's conference.

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.

Another program that assesses for appropriate level of care is the Nursing Home Diversion and Transition Program (NHDTP). 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 programs described above identify individuals who are institutionalized or at risk of being institutionalized and attempt to provide them with the least restrictive setting for long term care.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

**Criterion 5**

Describe your state's management systems.

Block grant funds are a relatively small part of DMHAS' budget for mental health and substance use prevention and treatment services. The entire continuum of care is supported by DMHAS whose target population are the medically indigent. Even with the ACA/Medicaid Expansion, there continue to be persons who are underinsured and, at least periodically, uninsured. The Behavioral Health Planning Council conducts a priority setting process and annually evaluates the DMHAS system for strengths, needs/gaps, and recommendations. The results are shared with DMHAS leadership for planning purposes and the State Planner organizes this regional information into a statewide report to inform the block grant application and priorities. The results are also part of the annual DMHAS MHBG and SABG Allocation Plans which describe how block grant funds will be spent. These plans require approval from the CT Office of Planning and Management (OPM) prior to presentation to committees of the State Legislature which votes to approve and may request modifications. Regular meetings occur between DMHAS and Department of Children and Families (DCF) as both agencies share MHBG funds.

NOT FINAL



**Footnotes:**

NOT FINAL

# Environmental Factors and Plan

## 10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/social)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Services for special populations:

- Targeted services for veterans?  Yes  No
- Adolescents?  Yes  No
- Other Adults?  Yes  No
- Medication-Assisted Treatment (MAT)?  Yes  No

NOT FINAL

**Criterion 2**

NOT FINAL

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Women's Services staff conducts an on-site annual contract monitoring site visit which includes the following elements:

Leadership interview

Client Focus group

Clinical Chart Review

Policy Review

Facility and Program Tour and Evaluation

All programs are evaluated on each component and a comprehensive report is submitted to agency and program leadership. Based on the findings, agencies are given recommendations to improve service delivery. In the event that significant concerns are identified, programs may be placed on a Corrective Action Plan (CAP.) If on a CAP, a follow up visit is scheduled and a detailed remediation report is requested from the provider and reviewed by the department.

In addition, all programs participate in a bi-monthly learning collaborative which provides them with best practices, ongoing opportunities for learning, and training around new department initiatives and best practices.

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
  - a) 90 percent capacity reporting requirement  Yes  No
  - b) 14-120 day performance requirement with provision of interim services  Yes  No
  - c) Outreach activities  Yes  No
  - d) Syringe services programs  Yes  No
  - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
  
2. Has your state identified a need for any of the following:
  - a) Electronic system with alert when 90 percent capacity is reached  Yes  No
  - b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
  - c) Use of peer recovery supports to maintain contact and support  Yes  No
  - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  Yes  No
  
3. States are required to monitor program compliance related to activities 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) is 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 contracts, and facilitate the development of a publicly managed, integrated, behavioral health system of care. CSD 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. They collaborate with the Statewide Services Division (SSD) when reviewing Women's Services, Senior Services, Housing, Problem Gambling, and Prevention Services. CSD staff also collaborate with the Office Of Multicultural Healthcare Equity (OMHE) to monitor and review the cultural competence of services and environments and to address behavioral healthcare disparities. Monitoring activities vary in intensity and impact on the agency. When a performance issue is identified, CSD 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 dependent upon provider compliance, including focused and comprehensive site visits. Both routine and non-routine monitoring occur. Routine monitoring visits are based on when a program was last reviewed, outcome 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. Specific performance outcomes are also identified. Routine monitoring includes: data analysis/provider quality report reviews, CEO/provider meetings, site visits, fidelity reviews for evidence-based practices, and corrective action plan compliance. An on-site monitoring visit may be triggered by: critical incident, complaint, DPH 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.

Programs are required to submit data quarterly related to TB, including: number of TB tests conducted, number of persons referred for confirmatory testing, number 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 the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Establishment of EIS-HIV service hubs in rural areas  Yes  No
  - b) Establishment or expansion of tele-health and social media support services  Yes  No
  - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  Yes  No

### Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)?  Yes  No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  Yes  No

If yes, please 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.

NOT FINAL

**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of services for:
    - i) MAT  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  Yes  No
2. Does your state provide any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) An organized referral system to identify alternative providers?  Yes  No
  - c) A system to maintain a list of referrals made by religious organizations?  Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No

- c) Identify workforce needs to expand service capabilities  Yes  No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

**Patient Records**

- 1. Does your state have an agreement to ensure the protection of client records?  Yes  No
- 2. Has your state identified a need for any of the following:
  - a) Training staff and community partners on confidentiality requirements  Yes  No
  - b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
  - c) Updating written procedures which regulate and control access to records  Yes  No
  - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  Yes  No

**Independent Peer Review**

- 1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
- 2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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- 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](https://www.cga.ct.gov/current/pub/chap_319i.htm#sec_17a-450).

Licensing of substance use disorder programs is covered under a different state agency: Department of Public Health.

NOT FINAL

**Footnotes:**

DMHAS EQMI is in the process of conducting a survey on accreditation status of programs receiving block grant funds.

DMHAS is represented on the advisory board of the Prevention TTC, but has not utilized PTTC services as of yet.

NOT FINAL

## 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 2018-FFY 2019?  Yes  No

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

None

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#### Footnotes:

For Mental Health Service Provision DCF uses a Result Based Accountability and contract management structure that includes "Active Contract Management" activities. Including holding monthly administrative meetings with all contracted services by service category to review relevant CQI data reports.

NOT FINAL

# State of Connecticut Department of Mental Health and Addiction Services Continuous Quality Improvement Plan: 2019

## Overview

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut. While the Department's prevention services serve all Connecticut citizens, its mandate is to serve adults (ages 18 and older) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. Annually the Department serves over 106,000 individuals through a comprehensive network of over 150 contracted or state-operated providers. The Department oversees a broad spectrum of services that includes a range of inpatient, residential, outpatient, and rehabilitative services focused on promoting recovery and independent functioning.

## Quality Improvement

DMHAS continuously works to improve the quality of our service system through a comprehensive system designed to: ensure data quality, identify emerging behavioral health trends, establish and modify contractual goals and benchmarks, measure provider and program performance, and set annual quality improvement activities. Many of these activities are coordinated through the Department's Evaluation, Quality Management, and Improvement (EQMI) Division.

Quality activities at DMHAS have been shaped by a number of influences. The Connecticut Legislature has been very interested in Results Based Accountability (RBA), a quality improvement model that focuses on an agency's mission and whether the mission is being accomplished. Several of the Institute of Medicine's (IOM) Quality domains, access and patient centered care have been incorporated into the reports. A final influence is the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS). The NOMS examine areas like employment, living situation, arrests, abstinence, treatment completions, readmission, and social supports.

## Annual Quality Plan

The Evaluation, Quality Management and Improvement (EQMI) Division of DMHAS shall be responsible for developing and updating an Annual Quality Improvement Plan. The Plan will include regular activities that occur as routine efforts to improve system quality and the plan will also include annual quality improvement activities that will be informed by ongoing data analysis and emerging trends.

## Quality Council

DMHAS has developed a Quality Council comprised of senior representatives of the Department's major Departments or Divisions. The Council members includes the following departments or divisions: Commissioner's Executive Group (CEG), EQMI, Community Services Division (CSD), Statewide Services, Multi-Cultural Affairs, Research, Information Technology, Prevention, Fiscal, and one representative from a state-operated facility, and one representative from a mental health and substance abuse contracted provider.

The Director of EQMI will chair quarterly meetings of the Council. The Council will be charged with reviewing data trends, reviewing and modifying routine quality improvement activities, establishing annual quality activities based on data analysis, and approving the Annual System Report Card.

## **Routine Quality Improvement Activities**

EQMI employs a number of routine quality improvement activities that are designed to positively impact system quality. Routine activities are those that occur on a consistent basis. Some of these activities may occur annually and others may occur with much greater frequency, often on a monthly or quarterly basis. These routine activities are core components of our quality improvement system and rarely change from year-to-year. The core components and corresponding activities are described in greater detail below.

### **Data Quality**

A key to any quality improvement program is to ensure that the system has quality data. Areas needing improvement and the processes necessary to measure improvement are not possible unless the system has reliable and consistent data. DMHAS receives client level data from each contracted or operated and non-funded substance abuse provider. The DMHAS Data Performance System DDaP was developed by DMHAS and collects information from contracted providers and includes functionality to capture admissions, discharges, services to all programs and any information necessary to meet federal reporting requirements like Treatment Episode Dataset (TEDS) and the National Outcomes Measures (NOMS). DDaP also includes functionality to report Critical Incidents and Consumer Satisfaction. WITS is a comprehensive commercial electronic medical record system that is used to capture data from state-operated services. The data is then combined and normalized in what is called the Enterprise Data Warehouse (EDW). EQMI utilizes a comprehensive system to ensure data quality. The system includes the following:

- Annual Data Quality Reviews – Annually EQMI staff conducts a formal data quality review of each provider funded or operated by DMHAS. The review examines data submissions and ensures that providers are reporting admissions, discharges and services each month. The Annual Review also evaluates compliance with other data reporting requirements such as the National Outcomes Measures, co-occurring screenings, and the use of valid data that can be used to evaluate program performance. Providers receive feedback and these reviews form the basis for any corrective actions. State-operated Local Mental Health Authorities conduct the same review for agencies that are under their purview.
- Monthly Data Quality reviews – EQMI staff conduct regular data quality reviews on a monthly basis. These reviews focus on discrete areas of data submissions and are used to quickly identify provider reporting issues. This might include no data submissions for admissions, discharges, or services or they may also be used to identify residential or inpatient “outliers”, programs and clients who are clearly showing a length of stay that far exceeds the norm for a level of care. These reviews also inform the timing of monthly alerts which are described below.
- Quality Director’s and Data Quality Meetings – EQMI hosts monthly and bi-monthly data quality conference calls with providers. These conference calls are focused on issues or concerns related to data quality. They are also used to clarify reporting requirements and to alert providers to changes in existing reporting requirements.

- Monthly provider alerts – EQMI develops an annual schedule of monthly provider alerts that focus on discrete data quality issues or concerns. Examples include things like clients with no services, length of stay outliers, missing NOMS data. Providers that are not meeting expectations typically receive encrypted data advising them of clients that require action. Each data quality issue is typically repeated several times a year in order to monitor compliance and improvements in data reporting.
- Corrective Action Plans – EQMI periodically requires providers to submit Corrective Action Plans when data quality falls significantly below expectations and prior attempts have not improved data quality.
- Annual Review of Performance Measures and Benchmarks – DMHAS EQMI and the Community Services Division (CSD) will review contractual performance measures and benchmarks on an annual basis. This review will occur after the full year Provider Quality Reports are issued in August of each year. This exercise will review the appropriateness of established performance measures, determine if benchmarks have been set appropriately and will modify them as needed.
- Ongoing data cleaning activities – EQMI conducts a range of activities throughout the year to improve the overall quality of data collected. Examples include clean-up related to residential outliers, clients without services, and errors in file submissions.

#### **Annual Data Analysis and Evaluation**

While data quality remains a constant focus, overall data quality within the system is good. This allows EQMI to conduct regular analysis and evaluation. These analyses are used in a range of “annual reports” focusing on different aspects of our services. The following are examples of evaluations conducted by EQMI.

- Consumer Satisfaction – each DMHAS funded or operated agency is required to administer a Consumer Satisfaction Survey to a specific number of clients within the agency. These results are then entered into DMHAS’ data system. EQMI staff annually analyze these results in our Consumer Satisfaction Report. The report compares results across a number of variables. Each provider receives their composite report and also receives information regarding each answer on the survey. The report is scheduled to be published in the late fall of each year.
- Annual Statistical Report – EQMI introduced an Annual Statistical Report in 2014. The report examines information about unduplicated clients served, demographics, levels of care in which they received services, inpatient and residential utilization, and substance use trends. The report is intended to provide a snapshot of the individuals we served in a given year. The report is scheduled to be published in the late fall of each year.
- Critical Incident Analysis – All funded and operated providers are required to submit Critical Incidents into DDaP. EQMI compiles Monthly Critical Incident reports that identify CI trends, agencies reporting, and compares the data to previous months. Annually, all CI’s are analyzed and Annual Critical Incident Report is prepared.
- Seclusion and Restraint – EQMI analyzes the use of Seclusion and Restraint in each of our state-operated inpatient facilities on a monthly basis. The use within these facilities is compared to national rates distributed by the National Research Institute. These reports are distributed to each facility and to key agency personnel. Annual results are incorporated into a full-year Seclusion and Restraint report.
- Triennial Substance abuse Report and Plan – Every 3 years DMHAS must submit the Triennial Report to the State Legislature. The report is due to be submitted July 2019.

The report includes data from all state agencies that provide substance abuse services. The 2019 report will include a separate Opioid Annex and a Women's Service Report. The Women's Service report which was previously required to be submitted annually is now integrated into the Triennial Report after legislation was passed last year changing the requirement.

### **Provider and Program Performance**

Provider and program performance is regularly measured within the DMHAS system. DMHAS contracts for specific service types or levels of care across our system (i.e., ACT, Detox, Residential). All providers contracted to provide a specific level of care share a common set of performance measures and benchmarks which allows us to compare performance in like services across the state. The measures are related to the program's mission (i.e., bed utilization, employment, housing, intensive case management, reduction in substance use, socialization). DMHAS monitors performance through a comprehensive performance evaluation system. Comparative data is compiled into agency/program report cards which are routinely shared with providers and DMHAS monitoring or fiscal staff before being posted to the DMHAS website. These reports are used to identify poorly performing providers and to identify monitoring targets. Components of the performance evaluation system are described in greater detail below.

- Provider Dashboard Quality Reports (report cards) - The Department of Mental Health and Addiction Services (DMHAS) introduced Provider Quality Reports as part of a comprehensive performance evaluation system in 2009. These Provider Quality Reports were designed to evaluate consumer outcomes and agency and program performance on a wide range of indicators. The reports evaluate agency and program performance in relation to DMHAS contract measures and benchmarks. One section of these reports evaluates data quality. These reports are distributed to providers on a quarterly basis and then posted on the DMHAS website. They also provide summary demographic and service utilization information regarding an agency's consumers and the services they receive.
- Outlier Database – DMHAS introduced the “Outlier database” in 2014 as a complementary tool for comparing provider performance on a year-to-year basis and to compare program performance to other similar service types. This database incorporates data contained in the dashboard report cards and is refreshed every quarter. The Outlier Database is made available to monitoring staff in order to evaluate performance improvements/deficits. The information contained in these reports is also used to benchmark improvements in data quality submissions, performance issues or concerns, utilization for residential and inpatient programs, and areas needing to be improved. The data is also helpful in evaluating how realistic benchmarks are that have been established for certain measures.
- Provider and program monitoring visits – the DMHAS Community Services Division (CSD) conducts monitoring visits for contracted providers that are not affiliated with a state-operated Local Mental Health Authority (LMHA). A certain number of monitoring visits each year are considered routine while other monitoring visits are “targeted” due to contract compliance issues or performance issues that have been identified through Dashboard Quality Reports. State-operated LMHA's are responsible for conducting similar visits for any provider that is affiliated with the LMHA network.



- Evidence-Based Practices Fidelity reviews - In addition, CSD is also responsible for conducting fidelity reviews for certain program types or levels of care that have fidelity standards. The frequency of these reviews is determined by CSD but typically occurs every two years. Levels of care for which fidelity monitoring is conducted include: supported employment and education, assertive community treatment, community support programs, and medication-assisted treatment.

## **Annual Quality Improvement Activities**

Annually, DMHAS establishes focused quality improvement activities that relate to new directions in behavioral health, emerging issues, or identified system gaps. Examples might include taking steps to increase behavioral health and physical health integration, decreasing opiate use and overdose deaths, or increasing the rates of follow-up care that patients receive after discharge from intensive and costly levels of care. Other examples might include increasing same day access for outpatient clients or decreasing readmission rates for individuals that have been discharged from inpatient or residential care. Often, these activities will be identified through the ongoing review and analysis of data.

The Quality Council will determine the annual quality improvement activity/activities by one month after the new fiscal year begins. The Council will approve and distribute a work plan that describes the “problem”, goals and objectives, tasks and responsibilities, training plan if appropriate, and the process for evaluating whether goals were met. The Annual QI activities will be reviewed on a quarterly basis in order to see if goals or tasks need to be modified based on the evaluation process. A sample plan is included in the Appendix.

## **Training**

DMHAS EQMI will provide training annually to DMHAS senior managers to acquaint them with the Quality Improvement principles and with the QI Plan. Similar trainings will be provided to contracted and state-operated providers in order to orient them to “quality” in the DMHAS system. EQMI will coordinate additional trainings to assist providers to use their own data for quality activities. This might include training on how to use data contained in Provider Report Cards, Consumer Satisfaction Surveys, or Critical Incidents. Additional trainings may be provided over the course of the year as part of that year’s annual quality improvement activities. For example, a quality activity might be to try to reduce the number of overdose deaths related to heroin. Training on the use of Naloxone (Narcan) may be offered to police and providers in order to acquaint them with how this may be incorporated into their work.

## Appendix A. Annual Quality Improvement Work Plan

| Activity  | Responsible Dept. | Completion Date                        |
|---|-------------------|--|
| <b>Plan</b>                                     |                   |  |
| Update and modify plan annually                 | EQMI              | September 1                            |
| <b>Quality Council</b>                          |                   |  |
| Identify Quality Council members                | EQMI              | October (1 <sup>st</sup> year of plan) |
| Develop Council Charter                         | EQMI              | October (1 <sup>st</sup> year of plan) |
| Begin monthly meetings                          | EQMI              | Ongoing                                |
| Identify annual QI activities                   | EQMI              | September 1                            |
| Approve QI Plan                                 | Council           | November 1                             |
| <b>Routine QI Activities</b>                    |                   |  |
| <b>Data Quality</b>                             |                   |  |
| Complete annual Data quality reviews            | EQMI              | April 1                                |
| Complete monthly DQ reviews                     | EQMI              | ongoing                                |
| Develop annual schedule for DQ Provider Alerts  | EQMI              | June 15                                |
| Distribute monthly DQ Alerts                    | EQMI              | ongoing                                |
| Distribute data clean-up files to providers     | EQMI              | ongoing                                |
| Review provider response to data issues         | EQMI              | ongoing                                |
| Require submission of Corrective Action Plan    | EQMI              | PRN                                    |
| Conduct monthly Quality Director's meetings     | EQMI              | ongoing                                |
| Conduct bi-monthly DQ Provider meetings         | EQMI              | ongoing                                |
| <b>Data Analysis and Evaluation</b>             |                   |  |
| Complete Consumer Satisfaction Report           | EQMI              | October 1                              |
| Distribute to providers and post to web         | EQMI              | October 7                              |
| Complete Annual Statistical Report              | EQMI              | October 15                             |
| Distribute to providers and post to web         | EQMI              | October 22                             |
| Complete Critical Incident Report               | EQMI              | December 1                             |
| Distribute to providers and post to web         | EQMI              | December 8                             |
| Complete monthly Seclusion and Restraint report | EQMI              | monthly                                |
| Distribute to providers                         | EQMI              | monthly                                |
| Complete annual Seclusion and Restraint report  | EQMI              | November 1                             |
| Distribute to providers and post to web         | EQMI              | monthly                                |
| Conduct mid-year Statistical Analysis           | EQMI              | February 15                            |
| <b>Provider and Program Performance</b>         |                   |  |
| Compile quarterly dashboard quality reports     | EQMI              | Aug., Nov., Feb., May                  |
| Distribute final and post to web                | EQMI              | Sep, Dec., March, Apr.                 |

|  |         |                        |
|--|---------|------------------------|
| Run data to outlier reports                    | EQMI    | Sep, Dec., March, Apr. |
| Distribute to providers and DMHAS staff        | EQMI    | Sep, Dec., March, Apr. |
| Compile Annual System Report Card              | EQMI    | September 15           |
| Distribute and post to web                     | EQMI    | October 1              |
| Identify agencies to be monitored              | CSD     | August 1               |
| Conduct monitoring visits                      | CSD     | Ongoing                |
| Complete reports                               | CSD     | 30 days post visit     |
| Request Corrective Action Plans                | CSD     | PRN                    |
| Monitor improvements                           | CSD     | PRN                    |
| <b>Targeted Annual QI Activities</b>           |         |                        |
| Identify options for annual quality activities | EQMI    | July 1                 |
| Approve annual QI activity "target"            | Council | August 15              |
| Develop work plan                              | EQMI    | September 15           |
| Approve work plan                              | Council | November 1             |
| Distribute to staff and providers              | EQMI    | November 15            |
| Monitor progress                               | Council | Ongoing                |
| Modify as needed                               | Council | Ongoing                |
| Complete annual QI report                      | EQMI    | Ongoing                |
| <b>Training</b>                                |         |                        |
| Conduct annual CQI Training                    | EQMI    | June, December         |
| Conduct annual Report Card training            | EQMI    | July, January          |
| Conduct annual Consumer Satisfaction training  | EQMI    | October, March         |
| Conduct annual CI training                     | EQMI    | November, May          |
| Identify topics for monthly "Quality Rounds"   | EQMI    | June 15                |
| Develop schedule for monthly "Quality Rounds"  | EQMI    | July 15                |
| Conduct monthly "Quality Rounds"               | EQMI    | Monthly                |

## Appendix B. Targeted Annual Quality Improvement Work Plan Opiate Use and Overdose Deaths

### Problem Overview

The State of Connecticut and DMHAS have seen a significant increase in overdose deaths related to opiate use in the past several years. The increase in overdose deaths began in FY 13 and increased each year until 2018, although the primary driver of these deaths has transitioned from prescription opioids to heroin to fentanyl/fentanyl analogues. Opioid – related admissions slowed in the past several years, followed by a more recent leveling off/decrease of overdose deaths. Fentanyl is now involved in two-thirds of all overdose deaths in Calendar year 2018. The Connecticut Legislature passed a law in 2012 that allowed doctors to prescribe Narcan to family members or significant others in an attempt to reduce overdoses. In each successive legislative cycle, the laws regarding Narcan distribution have been enhanced. DMHAS has also been fortunate to receive several grants related to the expansion of Medication Assisted Treatment, specifically buprenorphine and has also received funding to expand Narcan distribution. The CQI goal for this year is to continue to reduce opioid-related overdose deaths through multiple activities including harm reduction, increased public awareness, access to medication assisted treatment, etc. and to monitor the potential threat of increased stimulant use associated with the recent opioid epidemic.

| Activity  | Responsible Dept. | Completion Date |
|---|-------------------|-----------------|
| <b>Provider Education</b>                             |                   |                 |
| Analyze OCME data                                     | EQMI              | 8/1/2019        |
| Disseminate info re overdose deaths                   | CSD and EQMI      | 10/1/2019       |
| Compile info re opiate admissions                     | EQMI              | 9/1/2019        |
| Disseminate to providers                              | EQMI and CSD      | 11/1/2019       |
| <b>Narcan Training</b>                                |                   |                 |
| Conduct Narcan training for all state-ops             | EQMI              | ongoing         |
| Conduct Narcan training for meth maint./detox program | EQMI              | ongoing         |
| Maintain Narcan resource area on DMHAS website        | EQMI              | ongoing         |
| Provide training to first responders                  | EQMI              | ongoing         |
| Train others as requested                             | EQMI              | ongoing         |
| <b>Increase Access to TX</b>                          |                   |                 |
| Continue call line                                    | OG                | ongoing         |
| Provide transportation to detox                       | OG                | ongoing         |
| Maintain SA residential wait list                     | CSD               | ongoing         |
| <b>Linkage to Treatment</b>                           |                   |                 |
| Expand recovery coaches in ED's                       | OG                | ongoing         |
| Expand access to MAT                                  | OG                | ongoing         |
| <b>CB MAT</b>   |                   |                 |

|   |            |          |
|---|------------|----------|
| Increase CB MAT                               | OG         | ongoing  |
| Increase clients served in CB MAT             | OG         | ongoing  |
|   |            |          |
| <b>Expand Use of Narcan w/DMHAS Providers</b> |            |          |
| Purchase Narcan                               | Prevention | ongoing  |
| Distribute Narcan following training          | Prevention | ongoing  |
|   |            |          |
| <b>Monitor Stimulant Use</b>                  |            |          |
| Analyze OCME data                             | EQMI       | 8/1/2019 |
| Compile info re stimulant admissions          | EQMI       | 9/1/2019 |

NOT FINAL

## APPENDIX C: DATA FOR TARGETED CQI ACTIVITIES

### Opioid Trends FY 15 -18

|                     | Total SA Admissions | Opioid Admissions | Prescription Opioids | Opioids as % of all admissions | Alcohol as % of all admissions | % change from prior year |
|---------------------|---------------------|-------------------|----------------------|--------------------------------|--------------------------------|--------------------------|
| <b>FY 19 6 mos.</b> | 33,347              | 12,170            | 1,411                | 36.5%                          | 38%                            | +4%                      |
| <b>FY 2018</b>      | 72,483              | 29,079            | 3,117                | 40%                            | 34%                            | +1%                      |
| <b>FY 2017</b>      | 71,743              | 29,566            | 2,995                | 41%                            | 33%                            | +1%                      |
| <b>FY 2016</b>      | 70,425              | 29,182            | 2,925                | 41%                            | 35%                            |                          |
| <b>FY 2015</b>      | 70,163              | 27,667            | 3,304                | 39%                            | 36%                            | -                        |

#### Monitor the potential threat of increased stimulant use

With regard to the involvement of cocaine in drug-related deaths, the following table (a subset of the OCME data) reflects an increase in cocaine involvement over the reporting period with an apparent stabilization from 2017 to 2018, similar to what has been seen with opioids. This data will continue to be monitored.

| Accidental Drug Related Deaths | 2015 | 2016 | 2017 | 2018 |
|--------------------------------|------|------|------|------|
| <b>Cocaine involved</b>        | 24%  | 27%  | 32%  | 32%  |

**APPENDIX D: Accidental Drug-Related Deaths in Connecticut (Jan 2015 -Dec 2018)**  
(Data from the Office of the Chief Medical Examiner)

|                              | <b>2015</b> | <b>2016</b>   | <b>2017</b>          | <b>2018</b> |
|------------------------------|-------------|---------------|----------------------|-------------|
| <b>Total Fatal Overdoses</b> | 723         | 917           | 1036                 | 1018        |
| <b>Opioids involved</b>      | 91%         | 94%           | 90%                  | 93%         |
| <b>Heroin involved</b>       | 55%         | 56%           | 48%                  | 38%         |
| <b>Fentanyl involved</b>     | 25%         | 52%           | 60%                  | 74%         |
| <b>Methadone involved</b>    | 10%         | 10%           | 9%                   | 8%          |
| <b>BZDs involved</b>         | 27%         | 28%           | 25%                  | 27%         |
| <b>Cocaine involved</b>      | 24%         | 27%           | 32%                  | 32%         |
| <b>Alcohol Involved</b>      | 25%         | 26%           | 14%                  | 26%         |
| <b>Males/Females</b>         | 74%/26%     | 75%/25%       | 73%/27%              | 76%/23%     |
| <b>White/non-Hispanic</b>    | 72%         | 78%           | 79%                  | 74%         |
| <b>White/Hispanic</b>        | 10%         | 11%           | 12%                  | 13%         |
| <b>Black/non-Hispanic</b>    | 6%          | 9%            | 8%                   | 10%         |
| <b>&lt;20</b>                | 1%          | 1%            | <1%                  | 1%          |
| <b>20s</b>                   | 20%         | 18%           | 15%                  | 16%         |
| <b>30s</b>                   | 24%         | 24%           | 27%                  | 26%         |
| <b>40s</b>                   | 20%         | 25%           | 21%                  | 24%         |
| <b>50s</b>                   | 27%         | 25%           | 27%                  | 23%         |
| <b>60s</b>                   | 7%          | 7%            | 9%                   | 9%          |
| <b>70+</b>                   | 1%          | <1%           | 1%                   | <1%         |
| <b>Town of residence</b>     |             |               |                      |             |
| <b>#1</b>                    | Waterbury   | Hartford      | Hartford             | Hartford    |
| <b>#2</b>                    | Hartford    | Bridgeport    | New Britain          | Waterbury   |
| <b>#3</b>                    | New Britain | New Haven     | Waterbury            | New Haven   |
| <b>#4</b>                    | New Haven   | Bristol & New | Bridgeport           | Bridgeport  |
| <b>#5</b>                    | Bridgeport  | Britain       | Meriden &<br>Norwich | New Britain |

## Environmental Factors and Plan

### 12. Trauma - Requested

#### Narrative Question

**Trauma**<sup>57</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>58</sup> paper.

<sup>57</sup> 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.*

<sup>58</sup> *Ibid*

#### Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

DCF as a trauma informed agency funds annual training through the Child Health and Development Institute to train all providers on being a trauma informed service array. DCF has been addressing trauma informed practice through policies and practices for a number of years.

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



Footnotes:

NOT FINAL

## Environmental Factors and Plan

### 13. Criminal and Juvenile Justice - Requested

#### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>59</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>60</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>59</sup> Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <http://csgjusticecenter.org/mental-health/>

#### Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  Yes  No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  Yes  No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No

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

The 21st century CARES Act - Opioid State Targeted Response (STR) grant provided funds to DMHAS, some of which will be used to support the Department of Correction (DOC), Court Support Services Division (CSSD), State's Attorney, and local police efforts. DOC, DMHAS, DPH and community providers are working together to maintain incarcerated clients on methadone. Efforts are underway to expand this to more prisons. Efforts are also underway to educate DOC employees about naloxone use and inmates and parolees are now being released with narcan kits.

"Second chance" is a Governor-led and legislatively supported initiative which helps to reduce prison populations and ensure nonviolent offenders are successfully reintegrated into society and become productive workers in Connecticut's economy, by emphasizing treatment and rehabilitation over punishment for nonviolent drug crimes.

Legislation also funds additional program expansion of vocational and job-based adult education, employment training, and school-based diversion initiatives (SBDI) to reduce suspensions, expulsions and school-based arrests; and supportive housing services for pregnant users or substances and individuals with mental health issues that cycle in and out of the corrections system. Reintegration units have been established for women, youth, and veterans for a focus on rehabilitation.

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

**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### 14. Medication Assisted Treatment - Requested (SABG only)

#### Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?  Yes  No
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately\*?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?

DMHAS conducts on-site monitoring of all methadone clinics.

There is a learning collaborative conducted twice a year with all methadone clinics.

Federal discretionary grants awarded will direct some of the funds to increase access to buprenorphine, naloxone and naltrexone.

*\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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#### Footnotes:

# Environmental Factors and Plan

## 15. Crisis Services - Requested

### Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.<sup>61</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please check those that are used in your state:

#### 1. Crisis Prevention and Early Intervention

- a)  Wellness Recovery Action Plan (WRAP) Crisis Planning
- b)  Psychiatric Advance Directives
- c)  Family Engagement
- d)  Safety Planning
- e)  Peer-Operated Warm Lines
- f)  Peer-Run Crisis Respite Programs
- g)  Suicide Prevention

#### 2. Crisis Intervention/Stabilization

- a)  Assessment/Triage (Living Room Model)
- b)  Open Dialogue
- c)  Crisis Residential/Respite
- d)  Crisis Intervention Team/Law Enforcement
- e)  Mobile Crisis Outreach
- f)  Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### 3. Post Crisis Intervention/Support

- a)  Peer Support/Peer Bridgers
- b)  Follow-up Outreach and Support
- c)  Family-to-Family Engagement
- d)  Connection to care coordination and follow-up clinical care for individuals in crisis
- e)  Follow-up crisis engagement with families and involved community members

- f)  Recovery community coaches/peer recovery coaches
- g)  Recovery community organization

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

The community Wellness and Recovery Coalition (CWRC), developed after DMHAS received a SAMHSA BRSS TACS grant (bringing recovery supports up to scale), related to introducing more peers into the DMHAS crisis system. A group of key stakeholders formed the coalition and continues to meet monthly working together toward the goal of enhancing the community resources available to persons in distress, by promoting and developing strong relationships with peer-run organizations, faith-based communities, law enforcement, and the community at large.

A mobile crisis team (MCT) learning collaborative of all state-funded team leaders meets monthly to discuss current and innovative practices, share information, etc.

A Crisis Intervention Team (CIT) meets quarterly with CIT-trained police departments, MCT and CIT clinicians to strengthen partnerships, discuss current practices, provide education and support, etc.

A workgroup developed at DMHAS' Office of the Commissioner is conducting a systematic review of the mobile response system in the state (data review, site visits, stakeholders' survey, technical assistance from Rhode Island International on the Crisis Now Model, etc.) to make recommendations to enhance services.

DMHAS received funding from SAMHSA through the National Association of State Mental Health Program Directors (NASMHPD) to establish a comprehensive psychiatric crisis bed registry system.

For SED youth CT has a robust EMPS-Mobile Crisis response system that is available 24 hours a day, 365 days a year for all Connecticut youth in behavioral health crisis. Crisis clinicians are required to respond within 45 minutes of the call. Last year's statewide average was 30 minutes for a face to face crisis assessment.

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

NA

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**Footnotes:**

NOT FINAL

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

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#### Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
- b) Required peer accreditation or certification?  Yes  No
- c) Block grant funding of recovery support services.  Yes  No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.  
 Connecticut offers many components for peer support, coaching, education about alternative approaches to healing and recovery, as well as self-management for individuals served and family support, warm lines, supported employment, recovery centers, peers bridgers, Certified Recovery Support Specialists (mental health) and Certified Recovery Coaches (substance use).

In 2014, DMHAS implemented a Commissioner's Policy Statement on supporting the creation of Advance Directives. Since then, DMHAS has collaborated with the Connecticut Legal Rights Project (CLRP) to train staff at DMHAS programs across the state to assist individuals in completing the Advance Directives Workbook and follow the process to completion of an executed Advance Directive.

The DMHAS funded training academy for Recovery Support Specialists is managed by Advocacy Unlimited. Training is offered in specific ways to provide peer support services to military veterans, people with a history of trauma, members of racial/ethnic groups, LGBTQI populations, and families/significant others.

DMHAS launched the Hearing Voices Network in 2014. As part of this initiative, five international trainers in the Hearing Voices approach and the Maastricht Interview Technique were brought together with voice hearer, family members, professionals and the public. The centerpiece of the initiative has been the training of certified Hearing Voices Network support group facilitators and the creation of a network of peer-run community-based support groups for voice hearers.

Regional Behavioral Health Action Organizations (RBHAOs), which have strong representation of persons in recovery, provide evaluation and ongoing dialogue with DMHAS leadership through a variety of forums on service design and strategic planning. Satisfaction and other evaluative tools are used for ongoing quality improvement.

The manager at the Office of the Commissioner that is responsible for Recovery Community Affairs is a liaison to agency leadership providing ongoing input from grassroots advocacy organizations and programming.

DMHAS contracted with Pat Deegan Associates (PDAs) to conduct a year-long Decision Support Learning Collaborative with 8 agencies. The project included training, technical assistance and the use of PDA's web-based recovery library.

DMHAS requires all state-operated and funded Assertive Community Teams (ACT) and Community Support Program (CSP) teams to employ at least one certified Recovery Support Specialist.

Parent's of children with SED receive supportive services from Peer Support Specialist who have lived experience.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.  
 CCAR operates three recovery community centers (Bridgeport, Windham and Hartford) which offer a place to go and spend time with others in recovery from substance use, participate in 12-step meetings, and participate in other group activities. CCAR operates a Telephone Recovery Support program in which persons in recovery call others early in their recovery who are requesting the support. Assistance may also be provided in the form of transportation to self-help support meetings, information about available resources, etc. CCAR initiated a new program in March 2017 which involves hospital EDs contacting a CCAR-trained Recovery Coach when they have a patient present with a substance-related issue (such as an overdose). The Recovery Coach attempts to engage the patient and get them to take the next step toward recovery. This initiative now includes 13 hospital EDs and in the coming year will include 21 hospital EDs. Expansion of CCAR recovery centers into two additional areas in the state (New Haven and Manchester) are underway.

Another recovery activity related to the current opioid epidemic is the "Gone But Not forgotten Quilt Project" which celebrated its first event in January 2017. Family members and significant others of persons who have died as a result of substance use are offered the opportunity to make a quilt square in memory of the loved one they lost to substances. The events are being held around the state and they provide an opportunity to raise awareness and reduce stigma.

DCF services for substance use adults or children all include recovery support services as part of the model. This includes FBR, MST, ACRA-ACA, MDFT, and ASSERT. Social Clubs are also supported for teens and young adults.

5. Does the state have any activities that it would like to highlight?  
 No

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



None.

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**Footnotes:**

NOT FINAL

## 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:

#### Please respond to the following items

- 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
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

In 2011, the DMHAS Commissioner issued a departmental policy statement, Accessibility to Services, Programs, Facilities, and Activities, which outlines the requirements of facilities in regard to their responsibilities pursuant to Title II of the Americans with Disabilities Act and section 504 of the Rehabilitation Act. All state-operated and contracted agencies are required to meet these requirements. The policy can be found at: <http://www.ct.gov/dmhas/lib/dmhas/policies/chapter2.20.pdf>

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

NA

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#### Footnotes:

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>63</sup> 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.<sup>64</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.<sup>65</sup>

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.<sup>66</sup> 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.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> 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).

<sup>63</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>64</sup>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.

<sup>65</sup>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](http://www.cdc.gov/injury/wisqars/index.html).

<sup>66</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>67</sup>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>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- 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:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system?  Yes  No
  - for youth in foster care?  Yes  No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Currently, Connecticut is finishing a no cost extension year for a System of Care Grant. This is the third System of Care Grant DCF has received. Although we are working towards a fully intergraded approach CT has eleven different state departments which share part of the role for the Behavioral Health System. CT has partially implements a "Care Management Entity (CME)" approach to allow for full integration of the Behavioral Health System. CT has hopes of implementing a more completed CME approach for improved, intergraded behavioral health care. CT has also applied for a sustainability grant.

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

DCF is committed to integration in infrastructure and development of the behavioral health system. To this end, through the federal System of Care CONNECT grant, seven work groups have been formed to facilitate this process. They include Fiscal Analysis and Mapping, Network of Care Analysis, Data Integration, Workforce Development, Communication, Family and Youth Engagement, and Implementation of the National CLAS Standards (and racial justice activities). CT has a sustainability plan that will allow most of these grant funded activities to continue in the fall after the completion of the SOC grant.

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

None

Footnotes:

NOT FINAL

## Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

#### Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

The current suicide prevention plan is still in effect until fall 2020. It is being revised at present for a new plan release fall 2020. The CT Suicide Advisory Board (CTSAB) state coalition, co-chaired by the CT Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF) and the CT Chapter of the American Foundation for Suicide Prevention leads the implementation of the state plan, advises all suicide-related federally funded initiatives directed by state departments (e.g., Garrett Lee Smith Grant, CT Violent Death Reporting System). Many subcommittees lead efforts to reduce suicides and attempts. These efforts include: the CT Zero Suicide Learning Community and Committee on Clinical Workforce Development; Reducing Access to Lethal Means; Data and Surveillance; and Intervention and Postvention Planning and Response. The CTSAB and its committees are comprised of a diverse group of partners representing hundreds of sectors, settings and populations; there are more than 700 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 establishment of signage on bridges, and the plan to increase barriers on one in particular; release of a firearm safety and suicide prevention campaign and a poison prevention campaign; development of a children's book and accompanying elementary curriculum that is the only curriculum that teaches mental health planning and self care, along with connecting to trusted adults and making connections to care; gatekeeper training statewide to raise awareness and encourage connections to care; 43 health and behavioral health sites with membership on the CT Zero Suicide Learning Community that are engaged in evidence-based practices; the development of 5 regional suicide prevention coalitions linked to the CTSAB.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  Yes  No

If so, please describe the population targeted.

In Connecticut, DMHAS, DCF and DPH co-direct the Garrett Lee Smith grant (2015-2020) which focuses on youth 10-24 years of age. Since the last plan, some primary examples are: expansion of Zero Suicide efforts statewide; initiation of a 20 school system mini-grant to enhance suicide prevention and mental health promotion practices, policies, and faculty/staff training; establishment of 5 regional suicide prevention coalitions linked to the CTSAB; expansion of the postvention response system; and development of young adult peer support groups for survivors of suicide loss and survivors or attempts in collaboration with NAMI-CT, AFSP-CT and Advocacy Unlimited. In addition, suicide prevention and opioid prevention efforts have been integrated by adding QPR Gatekeeper Training to Naloxone training and distribution in statewide events; 2 local National Suicide Prevention Lifeline providers have been funded with opioid grants for substance using populations; MHBG funding for SED/SMI and GLS for youth.

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

We are in regular contact with the National Suicide Prevention Resource Center and the New England Mental Health Technology Transfer Center to plan strategies an activities so we are currently receiving the assistance we need.

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#### Footnotes:

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

NA

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.

DMHAS partners with a number of other state agencies in the process of fulfilling its mission. Many individuals, families and children receive services across state agencies or transition between departments as their needs dictate. Communication and coordination among these state agencies, therefore, is critical to providing efficient and effective care. The cross agency programming and prevention efforts on behalf of these shared individuals, families and children s not only provides better integrated care, but also helps to reduce the likelihood of such adverse outcomes as recidivism, institutionalization, and homelessness.

Close collaboration with the Department of Children and Families (DCF) must exist as DMHAS shares 30% of its CMHS block grant allocation with DCF to provide services to SED children and their families. Those children and adolescents under age 18 receiving behavioral health services from DCF may ultimately require transition to the adult system operated by DMHAS. DMHAS has services specifically for young adults (young adult services - YAS) ages 18-26. Both departments jointly plan all aspects of the transition, communicate regularly concerning the referral, identify and resolve any issues which arise, and provide ongoing operational support. DMHAS and DCF serve together on the Connecticut Behavioral Health Partnership (CT BHP) to further develop an integrated behavioral health system of care for Medicaid eligible children and adults. DMHAS' Adult Behavioral Health Planning Council and DCF's Children's Behavioral Health Advisory Council come together as the Joint Behavioral Health Planning Council

for the purpose of fulfilling block grant related responsibilities. The joint meeting of these two councils provides opportunities for sharing common concerns and collaborating on common efforts.

The Department of Social Services (DSS) likewise serves with DCF and DMHAS on the CT BHP. Further, DSS works with both departments on a number of other efforts. With DCF, DSS works collaboratively to identify strategies and resources to advance evidence-based treatments for children and families and to improve access, quality and outcomes of interventions. With DMHAS, DSS supports integration of primary and behavioral health care in outpatient clinics, Behavioral Health Homes, and works collaboratively through the Mental Health Home and Community Based Medicaid Waiver to return nursing home residents with psychiatric illnesses to their communities.

With a focus on the needs of older adults and the disabled, Connecticut's Department of Rehabilitation Services (DORS) collaborates with DMHAS to integrate and coordinate services and to provide leadership on aging and disability issues statewide, including on the Older Adult Behavioral Health Workgroup.

The Department of Public Health (DPH) partners with both DMHAS and DCF to work collaboratively to promote integration and coordination of behavioral health and primary care services among federally qualified health centers and community mental health providers; supports efforts to identify health disparities of both physical and behavioral health services and builds awareness and compels action to address such disparities; supports activities to strengthen school-based health clinics; supports implementation of a medical home model of care; and promotes quality behavioral health services through routine sharing of licensing and other quality review reports with DMHAS staff; and coordinates licensing rules and regulations for child-serving agencies.

Additionally DMHAS, DPH and DCF partner to oversee activities related to suicide prevention and the CT Suicide Prevention Plan which is under the auspices of the Connecticut Suicide Advisory Board (CT-SAB) and co-chaired by DMHAS and DCF.

The Department of Housing (DOH) and the Connecticut Housing Finance Authority (CHFA) collaborate with DMHAS in efforts to increase the availability of supportive housing for those who are homeless and have a mental illness or co-occurring mental illness and substance use disorder. DOH, CHFA and DMHAS join with other agency partners through the Interagency Council on Supportive Housing and Homelessness to expand access to permanent supportive housing.

The Court Support Services Division (CSSD) shares many of the same individuals and their concerns as DMHAS and DCF. Together, DCF and CSSD work to strengthen and better integrate the shared service network and initiatives for youth and to share blended funding for certain evidence-based treatment for young people and their families. DMHAS and CSSD collaborate on jail diversion for adults and continue to fund and manage two programs for criminal justice involved adults with mental illness and/or co-occurring disorders. The Department of Correction (DOC), in their work with adult criminal justice clients, collaborates with DMHAS by continuing to refer to DMHAS all discharging sentenced inmates with a serious mental illness, supporting Re-entry Counselors in their work with offenders discharged from DOC custody to connect them with behavioral health and related support services, participates in monthly interagency meetings to resolve system issues, and continues to support the Advanced Supervision Intervention and Support Team (ASIST) initiative designed to increase the number of persons with behavioral health issues who are diverted or released early from jail or prison by providing multiagency supports in the community.

The Alcohol and Drug Policy Council (ADPC) was directed by the Governor's Office to take on new membership (including people in recovery from substance use and their family members) and to focus on the Opioid Epidemic. The ADPC is co-chaired by the Commissioners of DMHAS and DCF and includes representation from state legislators as well as all the state agencies involved in responding to the opioid epidemic, including Consumer Protection, Aging, Education, Public Health, Emergency Services and Public Protection, Corrections, etc. There are four active subcommittees of the ADPC: Prevention, Treatment, Recovery, and Criminal Justice. Activities and recommendations originating in the subcommittees are brought forward to the ADPC and have resulted in successful passage of legislation targeting various aspects of addressing the opioid crisis, education for prescribers and consumers, public service announcements to raise public awareness, etc.

Legislation in late 2015 (PA15-27) on children's behavioral health added ten additional state agencies to share the responsibility of children's behavioral health in CT; they include the Department of Public health, Department of Social Services, Judicial Court Support Services Division, Department of Developmental Services, State Department of Education, Connecticut Insurance Department, Office of Early Childhood, Office of the Child Advocate, Office of the Healthcare Advocate and the Commission on Women, Children and seniors.

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

None

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

**Footnotes:**





**State of Connecticut**  
JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR  
COURT SUPPORT SERVICES DIVISION  
455 Winding Brook Drive, Glastonbury, CT 06033

Miriam Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> floor  
Hartford, CT 06134

Vannessa Dorantes,  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioner Delphin-Rittmon and Commissioner Dorantes:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Judicial Branch Court Support Services Division (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.

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,

A handwritten signature in blue ink that reads "Gary A. Roberge".

Gary A. Roberge  
Executive Director



**DEPARTMENT of CHILDREN and FAMILIES**  
*Making a Difference for Children, Families and Communities*



Vannessa L. Dorantes  
Commissioner

Ned Lamont  
Governor

August 6, 2019

The Honorable Miriam Delphin-Rittmon, PhD  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment 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 2020-2021 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 L. Dorantes, LMSW  
Commissioner

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**STATE OF CONNECTICUT**  
**DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**  
*A Healthcare Service Agency*

NED LAMONT  
GOVERNOR

MIRIAM E. DELPHIN-RITTMON, Ph.D.  
COMMISSIONER

June 26, 2019

The Honorable Vanessa Dorantes, MA  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106

Dear Commissioner Dorantes:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Connecticut Department of Mental Health and Addiction Services (DMHAS) will continue its strong partnership with 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 quality of behavioral health services for those with a serious emotional disturbance or a mental or substance use disorder.

The focus of our shared work is to facilitate the coordination of services between DCF and DMHAS 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 transition services for those DCF-involved youth aging into the adult behavioral health system; regular communication to monitor the referral process for this population, and identify and resolve issues as they arise; and lastly, to continue our ongoing alliance to assure a smooth transition for youth and young adults so that they receive the very best care. Additionally, DMHAS looks forward to continuing such collaborative efforts as the joint initiative on suicide prevention.

DMHAS looks forward to advancing the statewide agenda for comprehensive, effective community-based system of care.

Sincerely,

A handwritten signature in black ink that reads "Miriam Delphin-Rittmon".

Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner

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State of Connecticut  
Department of Developmental Services

DDS

Ned Lamont  
Governor

Jordan A. Scheff  
Commissioner

Peter Mason  
Deputy Commissioner

June 18, 2019

Vannessa L. Dorantes, Commissioner  
Connecticut Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106.

Dear Commissioner Dorantes:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 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.

Very truly yours,

  
Jordan A. Scheff  
Commissioner  
Department of Developmental Services

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# STATE OF CONNECTICUT DEPARTMENT OF CORRECTION



Ned Lamont  
Governor

Rollin Cook  
Commissioner

July 24, 2019

The Honorable Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> Floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment 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 all 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
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.

I and the DOC staff look forward to working in partnership with DMHAS to promote a comprehensive and effective community-based system of care for persons who are criminally-involved and in need of behavioral health and support services.

Sincerely,

Rollin Cook  
Commissioner

Phone: 860.692.7482 ♦ Fax: 860.692.7483  
24 Wolcott Hill Road ♦ Wethersfield, Connecticut 06109  
Website: [www.ct.gov/doc](http://www.ct.gov/doc)

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July 24, 2019

The Honorable Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> Floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

The Department of Rehabilitation Services (DORS) 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, DORS:

- 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.

DORS supports Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Rehabilitation Services 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.

With a focus on the needs of Connecticut's older adults and people with disabilities, DORS 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.

DORS looks forward to advancing the agenda for a comprehensive, effective, community-based system of care for those with behavioral health disorders.

Sincerely,



Amy Porter  
Commissioner

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Renée D. Coleman-Mitchell, MPH  
Commissioner

Ned Lamont  
Governor  
Susan Bysiewicz  
Lt. Governor

June 25, 2019

Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> Floor  
Hartford, CT 06134

Vannessa Dorantes, LMSW  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Dorantes:

I am pleased to provide a letter of support for Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Public Health (DPH) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to, and the quality of, behavioral health services, as well as the primary healthcare needs of those with a serious emotional disturbance or a mental or substance use disorder.

In partnership with DMHAS and DCF, DPH will:

1. Work collaboratively to promote integration and coordination of behavioral health and primary care services among federally qualified health centers and community mental health providers;
2. Support efforts to identify health disparities relating to both physical and behavioral health services and build awareness of and compel action to address such disparities;
3. Support activities to strengthen existing School Based Health Centers and Expanded School Health sites;
4. Support implementation of a medical home model of care; and
5. Promote quality behavioral health services through routine sharing of licensing and other quality review reports with DMHAS staff, and coordinate licensing rules and regulations for child-serving agencies.

DPH looks forward to advancing a statewide agenda for a comprehensive, effective, community-based system of behavioral and primary healthcare.

Sincerely,

A handwritten signature in black ink, appearing to read "Renée D. Coleman-Mitchell".

Renée D. Coleman-Mitchell, MPH  
Commissioner



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# STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES  
OFFICE OF THE COMMISSIONER

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DEIDRE S. GIFFORD, MD, MPH  
Commissioner

July 25, 2019

Miriam Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> floor  
Hartford, CT 06134

Vannessa Dorantes, Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioner Delphin-Rittmon and Commissioner Dorantes:

I am pleased to provide a letter of support for Connecticut's FY 2020-21 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 for a comprehensive, effective community-based system of care for those with a behavioral health disorder.

Sincerely,

Deidre S. Gifford, MD, MPH  
Commissioner





STATE OF CONNECTICUT  
*STATE BOARD OF EDUCATION*



June 12, 2019

The Honorable Vanessa Dorantes, Commissioner  
Connecticut Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106

Dear Commissioner Dorantes:

On behalf of the Connecticut State Department of Education (CSDE), I am pleased to provide a letter of support for Connecticut's FY 2020-2021 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 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.

We look forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Sincerely,

*Dianna R. Wentzell*

Dr. Dianna R. Wentzell  
Commissioner of Education

P.O. Box 2219 • Hartford, Connecticut 06145  
*An Equal Opportunity Employer*



Ned Lamont  
Governor

STATE OF CONNECTICUT  
DEPARTMENT OF HOUSING



Seila Mosquera-Bruno  
Commissioner

July 25, 2019

The Honorable Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> Floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

The Department of Housing (DOH) supports Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. DOH will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS), assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS, in collaboration with state and community partners, proposes to promote community integration and inclusion for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder through the provision of permanent housing.

DOH, as a collaborative partner, will assist DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the DMHAS population. DOH will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness to expand access to permanent supportive housing by assisting in the financing of supportive housing development projects.

DOH looks forward to working with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Seila Mosquera-Bruno  
Commissioner



**Diane L. Smith**  
Interim Executive Director

August 9, 2019

The Honorable Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> Floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

The Connecticut Housing Finance Authority (CHFA) is celebrating its 50<sup>th</sup> Anniversary (1969-2019) working on behalf of the citizens of Connecticut. Over this period, CHFA has partnered with and supported the State of Connecticut in achieving its policy goals. Importantly, CHFA has partnered with the Department of Mental Health and Addiction Services (DMHAS) in its work to end homelessness for over 25 years.

CHFA supports Connecticut's FY 2020-2021 combined Community Mental Health Services and Substance Abuse Prevention and Treatment block grant application. CHFA will continue its partnership with the DMHAS, assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS, in collaboration with state and community partners, proposes to promote community integration and inclusion through the provision of permanent housing for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder.

CHFA, as a collaborative partner, supports DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the DMHAS population. CHFA will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness. Our goal is to expand access to permanent supportive housing and increase the affordable housing stock by providing funding opportunities when available for supportive housing development projects.

CHFA looks forward to working with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Diane L. Smith  
Interim Executive Director

## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>69</sup>

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.

<sup>69</sup> <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

#### Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

DMHAS (Department of Mental Health and Addiction Services) has been a single integrated department since 1995, servicing all behavioral health needs of adults. In 2012, the Mental Health Planning Council expanded its purview and membership to include substance use concerns and became the Behavioral Health Planning Council. Connecticut has been submitting combined mental health/substance abuse block grant applications since 2014/15. In 2018, Connecticut restructured its advocacy/evaluation/planning entities from Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) into integrated Regional Behavioral Health Action Organizations (RBHAOs). The 5 RBHAOs cover the state via the 5 DMHAS regions for all behavioral health issues, including naloxone education and distribution. The RBHAOs are tasked with the annual review of the behavioral health service system and the priority setting process. Presentations for the Council are a mix of behavioral health concerns inclusive of substance use related topics.

The Children's Behavioral Health Advisory Council and the Adult Behavioral Health Planning Council were presented the 20/21 Block Grant Application at meetings in June and July and invited to comment and make recommendations. That information is included in the block grant application.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Joint Behavioral Health Planning Council in Connecticut is comprised of the Adult Behavioral Health Planning Council coordinated by DMHAS and the Children's Behavioral Health Advisory Council, coordinated by DCF. Meetings are held separately for the adult and children's council and also jointly.

Duties of the Behavioral Health Planning Council include:

- to review the combined SABG/MHBG application/plan provided by DMHAS and to submit any recommendations for modifications of those plans

- to serve as advocates for adults with DMI and children with SED and their families, as well as others with behavioral health problems

- to monitor, review, and evaluate, at least annually, the allocation and adequacy of behavioral health services in Connecticut  
Council membership includes representation from the RBHAOs, state agencies, other public and private entities concerned with

the need, planning, operation, funding, and use of behavioral health services; family members of adults with SMI and children with SED; persons in recovery from behavioral health conditions; representatives of organizations of individuals with mental health and/or substance use disorders and their families and community groups advocating on their behalf. Stakeholders from communities across Connecticut will find their interests represented by the RBHAO council members attending the meetings. Because the RBHAOs conduct an annual review of the service system in order to establish priorities to inform the block grant and other activities, they utilize community stakeholder connections to hold focus groups and community conversations with those regional stakeholders and other interested parties to collect information on the service system, including strengths, needs/gaps and barriers, and make recommendations. They construct regional reports based on their findings which are integrated into a statewide report.

Children's Behavioral Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) ) to "promote and enhance the provision of behavioral health services for all children" in Connecticut. The CBHAC serves as the state's Children's Mental Health Planning Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state's System of Care for children and families.

The 30 member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, five members appointed by the leadership of the General Assembly, as well as fifteen members appointed by the commissioner of DCF. The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. "At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." In addition, a parent is to serve as co-chair of the CBHAC/CMHPC.

CBHAC meetings held throughout the year include time for review of the MHBG. Meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan on January 4, 2019, March 1, 2019 and June 7, 2019.

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

None

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

NOT FINAL

## CBHAC 2018 Schedule

### 1<sup>st</sup> Fridays of most months

January 5, 2018 *subcommittees*

February 2, 2018

March 2, 2018 *subcommittees*

April 6, 2018

May 4, 2018—SCCC

June 1, 2018 *subcommittees*

July 13, 2018 **(One week later)**

No meeting in August

September 7, 2018

October 5, 2018 *subcommittees*

November 2, 2018—SCCC

December 7, 2018

Note: CBHAC meetings will be canceled if DCF Training Academy is closed due to inclement weather

Subcommittees: We will meet for an hour to cover the business portion then break out into subcommittees for 45 minutes. We will reconvene to the full group for a 15-minute report out to the full group.

SCCC – Statewide Council of Community Collaboratives

CBHAC members and guests, including both family members and providers, were asked for recommendations that would reflect CBHAC'S FY2018 areas of focus. The specific areas are **Family and Youth Engagement; Access to a Comprehensive Array of Services and Supports; and, Health Promotion, Prevention, and Early Identification**. These areas of focus recognize the disparities that exist throughout the system. The intent is to strengthen Networks of Care and continue the development of a plan for state laws and initiatives regarding children's mental health. The following are the recommendations that arose from that discussion.

1. Respectfully include the family and youth voice at all levels of decision-making; and continue to support community initiatives that expand family driven systems.
2. Address disproportionality in order to reduce racial, ethnic, and other identified group disparities by providing racially just, culturally and linguistically appropriate services to the community, with increased attention on accountability through tracking and data.
3. Continue to provide training (e.g., Network of Care-Agents of Transformation, Data 101, Wraparound Practice Model Trainings, etc.) and support for parents, caregivers, young people, other family members, community members, and providers so they can be fully prepared participants as equal partners in the ongoing development of Connecticut's statewide, regional, and local networks of care. (took out "behavioral health networks of care" at the end)
4. Develop and update practice standards for all state-funded behavioral health programs with providers, stakeholders and most importantly youth and families.
5. Support and promote the use of data in order to inform decision-making discussions and activities (i.e. Results Based Accountability (RBA) measures, outcome data, program data, etc.).
6. Advocate for state funding to families, providers, community initiatives, and DCF in order to support true family driven and youth guided collaboration and full participation among them at statewide, regional and local meetings.
7. Expand resources/funding opportunities for family partners in paid positions and for the development of a family peer specialist workforce.
8. Engage with the State Department of Education to increase focus on advocacy for children and youth with mental and behavioral health conditions or other special needs that impact their educational performance.

**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, September 7, 2018**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

**Mission:**

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

**AGENDA**

|  |             |
|--|-------------|
| <b>Welcome and Introductions</b>   | 10:00—10:10 |
| • Doriana Vicedomini and Janice Bendall, Co-chairs                                       |             |
| <b>Approval of Minutes</b>   | 10:10—10:15 |
| • Doriana Vicedomini and Janice Bendall, Co-chairs                                       |             |
| <b>CBHAC Orientation Presentation</b>  | 10:15—10:50 |
| • <b>Doriana Vicedomini, Janice Bendall</b>  |             |
| <b>Membership—Seeking nominations for Provider Co-chair</b>                              | 10:50—11:00 |
| • Dave Tompkins, Membership Chair  |             |
| <b>Community Collaborative Practice Standards</b>  | 11:00—11:15 |
| • <b>Drew Lavalle</b>  |             |
| <b>Statewide Council of Community Collaboratives</b>                                     | 11:15—11:35 |
| • <b>Gabrielle Hall</b>  |             |
| o <b>SCCC Survey</b>   |             |
| o <b>September 26 Collaboratives Co-chairs meeting</b>                                   |             |
|  | 9:30-12:00  |
| <b>State Agency Updates</b>  | 11:35—11:45 |
| <b>Planning for next meeting and General updates</b>                                     | 11:45—12:00 |
| • Next CBHAC meeting: October 5, 2018  |             |
| • Next <u>Joint Council</u> meeting: September 13, 2018; 2-4pm, CVH; Page Hall, Room 217 |             |

**Announcements**

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.

**CBHAC AREAS OF FOCUS FOR 2018:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3-Health Promotion, Prevention and Early Identification

*These Areas of Focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

**Meeting Rules and Housekeeping Items**

- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.
- Be respectful; use intelligence rather than emotions; ELMO -- Everyone Let's Move On; Ouch!
- Hold questions until after presentations are finished.

**Beacon Health Options Requests**

- Take conversations/phone calls out to the atrium area where the elevators and restrooms are located.
- Young children are not permitted to attend meetings.



**Statewide Council of Community Collaboratives**

**&**

**Children's Behavioral Health Advisory Committee**

**Joint Quarterly Meeting**

**Friday, November 2, 2018**

- |   |                   |
|---|-------------------|
| I. Introductions  | 10am – 10:10 am   |
| II. CBHAC Business  | 10:10 - 10:30 am  |
| a. Minutes  |                   |
| b. State Department Updates                               |                   |
| III. Children's Behavioral Health Plan<br>Progress Report | 10:30 – 11:00am   |
| IV. Community Conversations<br>Report Out                 | 11:00am – 11:30am |
| V. Websites   | 11:30am – 11:40am |
| a. HealthyLivesCT.org                                     |                   |
| b. Plan4Children.org                                      |                   |
| c. WrapCT.org   |                   |
| VI. Next Steps  | 11:50am - 12pm    |

# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, December 7, 2018

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## **CBHAC AREAS OF FOCUS FOR 2018:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3-Health Promotion, Prevention and Early Identification

*These Areas of Focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

## **AGENDA**

**Welcome, Introductions, Minutes Assignment** 10:00—10:10  
Doriana Vicedomini and Jo Hawke, Co-chairs

**Approval of Minutes**, Doriana and Jo 10:10—10:20  
October 5, 2018  
November 2, 2018

**State Agency Updates** 10:20—10:45

**Planning for Upcoming Meetings**  
Doriana and Jo

- **Discussion of Achievements and Objectives** 11:10—11:35
- **Priority Setting Activity** 11:35—11:40
- **Voting on Next Year's Priorities**
- **Volunteers for Taking Minutes** 11:40—11:45

**General updates** 11:45—12:00

- Next CBHAC meeting: January 4, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217

### **Announcements**

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
- **Meeting Cancellation Policy:** *If either the DCF Training Academy is cancelled or Rocky Hill Schools are closed, the meeting is cancelled. If either has a late start, the meeting will be held.*

### **Meeting Rules and Housekeeping Items**

- Hold questions until after presentations are finished.
- Be respectful; use intelligence rather than emotions; ELMO – Everyone Let's Move On; Ouch!
- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.

### **Beacon Health Options Requests**

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, January 4, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## CBHAC AREAS OF FOCUS FOR 2018:

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

## AGENDA

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana and Jo<br>December 7, 2018   | 10:05—10:15 |
| <b>State Agency Updates</b>   | 10:15—10:35 |
| <b>Overview of CSSD Service Outcomes</b> , Talia Nunez  | 10:35—10:50 |
| <b>Discussion of CBHAC Reporting Process</b> , Jo Hawke   | 10:50—11:00 |
| <b>Subcommittees</b>  | 10:40—11:45 |
| <b>General updates</b>  | 11:45—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: February 1, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

### Announcements

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
- **Meeting Cancellation Policy:** *If either the DCF Training Academy is cancelled or Rocky Hill Schools are closed, the meeting is cancelled. If either has a late start, the meeting will be held.*

### Meeting Rules and Housekeeping Items

- Hold questions until after presentations are finished.
- Be respectful; use intelligence rather than emotions; ELMO – Everyone Let's Move On; Ouch!
- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.

### Beacon Health Options Requests

- Take conversations/phone calls out to the atrium area where the elevators and restrooms are located.
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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, February 1, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## CBHAC AREAS OF FOCUS FOR 2019:

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

## AGENDA

|  |             |
|--|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs  | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>January 4, 2019  | 10:05—10:15 |
| <b>State Agency Updates</b>  | 10:15—10:35 |
| <b>CT Budget Overview and Children's Services</b><br>Jamie Mills, CT Voices for Children   | 10:35—11:00 |
| <b>First Episode Psychosis Services</b><br>Erika Sharillo, Beacon Health Options   | 11:00—11:25 |
| <b>2018 Annual Report on Status of Local Systems of Care</b><br>Drew Lavallee, Beacon Health Options   | 11:25—11:40 |
| <b>Findings from the 2018 Community Conversations</b><br>Maguena Adetona Deslandes, FAVOR Inc.   | 11:40—11:50 |
| <b>General updates</b>   | 11:50—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: March 1, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

### Announcements

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
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### Meeting Rules and Housekeeping Items

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- Be respectful; use intelligence rather than emotions; ELMO – Everyone Let's Move On; Ouch!
- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.

### Beacon Health Options Requests

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, March 1, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## **CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

## **AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>February 1, 2019  | 10:05—10:10 |
| <b>State Agency Updates</b>   | 10:10—10:30 |
| <b>The Opioid Crisis and Services for Children and Adolescents in C</b><br>Mary Painter, Department of Children and Families  | 10:30—10:55 |
| <b>General updates</b> <ul style="list-style-type: none"><li>• Next CBHAC meeting: April 5, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> | 10:55—11:00 |
| <b>Community Conversation</b> <ul style="list-style-type: none"><li>• FAVOR Staff</li></ul>   | 11:00—12:00 |

## **Announcements**

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## **Meeting Rules and Housekeeping Items**

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- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.

## **Beacon Health Options Requests**

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**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, April 5, 2019**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

**Mission:**

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**CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

**AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>March 1, 2019   | 10:06—10:10 |
| <b>State Agency Updates</b>   | 10:11—10:30 |
| <b>Services for Children on the Autism Spectrum</b><br>Jennifer Krom, LPC, Beacon Health Options  | 10:31—10:55 |
| <b>Integrated Care for Kids Grant Opportunity</b><br>Bill Halsey, Department of Social Services   | 10:56—11:25 |
| <b>Recommendations for Bi-Annual Report</b>   | 11:26—11:50 |
| <b>General updates</b>  | 11:51—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: May 3, 2019</li><li>• Next <u>Joint Council</u> meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

**Announcements**

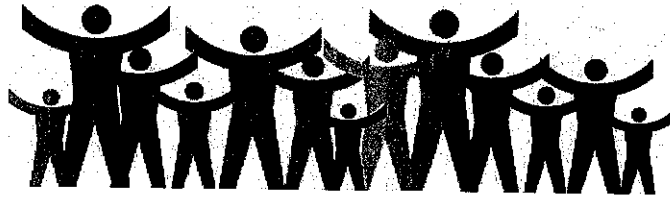
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**Beacon Health Options Requests**

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## Statewide Council of Community Collaboratives

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The Statewide Council of Community Collaboratives  
&  
The Children's Behavioral Health Advisory Council  
Bi- annual Joint Meeting

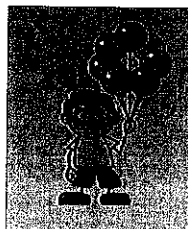
Friday, May 3, 2019

10:00a – 12:00p

### AGENDA

1. Welcome and Introductions
2. CBHAC minutes approval
3. State Department Updates
4. Suicide Prevention Presentation
5. Mental Health Awareness Month
6. SCCC and Community Collaborative Highlights
7. Community announcements
8. Kindness Rocks
9. Wrap-up/Networking

*Next SCCC/CBHAC meeting: November 1, 2019*



**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, June 7, 2019**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

**Mission:**

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

**CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

**AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini<br>May 5, 2019  | 10:06—10:10 |
| <b>Membership List and Survey</b>   | 10:11-10:20 |
| <b>State Agency Updates</b>   | 10:21—10:35 |
| <b>Special Education</b><br>Bryan Klimkiewicz, State Department of Education,<br>Chief for the Bureau of Special Education,   | 10:35—11:15 |
| <b>Subcommittee Breakouts</b>   | 11:15—11:50 |
| <b>General updates</b>  | 11:51—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: September 6, 2019</li><li>• Next <u>Joint Council</u> meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

**Announcements**

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**Beacon Health Options Requests**

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, September 7, 2018

## Minutes

(Revised October 2018 to reflect actual attendees)

**In Attendance:** Mary Cummins, Bill Halsey, Scott Newgass, Niki Richer, Dorian Vicedomini, Gabrielle Hall, Janice Bendall, Brenetta Henry, Evelyn Melendez, Crica Charles-Davy, Natine Feldman, Cindy Thomas, Debbie McCusker, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Sandra Rivera, Cassandra Vega, Luz Villatañe, Rosita I. Torres, Nydia Dominguez, Lorna Grivois, David Olivo, Carmen Puertas-Burgas, Dave Tompkins, Rosa Serrano, Maria Feliciano, April Mayo, Quiana Mayo, Andrew Lavallee, Wanda Roman, Ray Bieber, Denetra McBride, Ismirna Rosado, Elmer Garcia, Maguena Adifono Reslandos, Iris Ortiz Anedez, Pamela Roberts, Kathleen Birchard, Elsa N. Cordova, Michelle Rodriguez, Tyrone Calloway, Briannali Rivera, Katherine Downing Ahmed, Celeste Flores, Patricia Gaylord, Antonio Thomas, Marshall Demorest III, Javoni Ambrose, Nathen Zadora, Teresa Rosario, Felicita Cruz, Graciela Davila, Jules Calabro, Jeana Bracey, and Alice Farrell.

### Welcome and Introductions

#### Approval of Minutes

The Spanish version wasn't ready to distribute. Co-chairs decided to table this until next meeting when both the Spanish and English versions would be offered for approval together.

#### CBHAC Orientation Presentation

- Jan and Dorian
  - Clarified Purpose of CBHAC: to promote and enhance the provision of behavioral health services for all children in the State of CT.
  - Discussion around the makeup of CBHAC: 51% are families; "Members" always refer to voting members; guests may participate in discussions, but may not vote on CBHAC business.

#### Community Collaborative Practice Standards

- Drew Lavallee
  - Will ask for CBHAC vote on new Practice Standards at the October 5th meeting; Drew will email a draft before the meeting to *CBHAC members only* for review prior to the meeting
  - The goals of the revisions are to make the language more family friendly; to separate care coordination language into a different set of standards; and to reflect changes in the system since 2001.

#### Statewide Council of Community Collaboratives (SCCC)

- **Gabrielle Hall**
  - The SCCC Survey will be emailed to collaborative co-chairs soon. The 2018 survey is identical to the 2017 survey.
  - One goal is to develop more continuity between all collaboratives' structure and practice.
  - The September 26 Collaboratives Co-chairs meeting is in response to multiple requests from co-chairs to have meeting dedicated to collaboratives without other organizations in attendance in order to focus on collaborative issues.

#### **State Agency Updates**

- **DMHAS, Nikki Richer**
  - CT Strong received an additional \$25,000- a portion of which will be used to provide a summit for youth and possibly one for providers.
  - A brief overview of the CT Strong grant was provided.
- **DDS, Bill Halsey**
  - Waiting for news about whether DDS will win a grant for integrated services for kids, integrating medical and social services
  - DSS is awaiting the release of an opportunity for funding called Integrated Care for Kids (InCK), integrating medical and social services
- **SDE, Scott Newgass**
  - Five-year Federal grant for \$1,750,000 Project AWARE, integration of MH services and schools
- **DCF, Mary Cummins**
  - Reminders: Joint Council meeting 9/13/18; allocation hearing at LOB for MHBG In 9/26/18 at 12:30

#### **Planning for next meeting and General updates**

- Next CBHAC meeting: October 5, 2018

Next Joint Council meeting: September 13, 2018; 2-4pm, CVH, Page Hall, Room 217

**Comité Asesor de la Salud Conductual Infantil (CBHAC, por sus siglas en inglés)**  
**Viernes, 7 de septiembre, 2018**  
**Minutas**  
**(Revise Octubre 2018 a reflecté presente)**

***Presente:** Mary Cummins, Bill Halsey, Scott Newgass, Niki Richer, Doriana Vicedomini, Gabrielle Hall, Janice Bendall, Brenetta Henry, Evelyn Melendez, Crica Charles-Davy, Natine Feldman, Cindy Thomas, Debbie McCusker, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Sandra Rivera, Cassandra Vega, Luz Villatañe, Rosita I. Torres, Nydia Dominguez, Lorna Grivois, David Olivo, Carmen Puertas-Burgas, Dave Tompkins, Rosa Serrano, Maria Feliciano, April Mayo, Quiana Mayo, Andrew Lavallee, Wanda Roman, Ray Bieber, Denetra McBride, Ismirna Rosado, Elmer Garcia, Maguena Adifono Reslandos, Iris Ortiz Anedez, Pamela Roberts, Kathleen Birchard, Elsa N. Cordova, Michelle Rodriguez, Tyrone Calloway, Briannali Rivera, Katherine Downing Ahmed, Celeste Flores, Patricia Gaylord, Antonio Thomas, Marshall Demorest III, Javoni Ambrose, Nathen Zadora, Teresa Rosario, Felicita Cruz, Graciela Davila, Jules Calabro, Jeana Bracey, and Alice Farrell.*

### **Bienvenida y presentaciones**

#### **Aprobación de las minutas**

La versión en español no estaba lista para ser distribuida. Los vicepresidentes decidieron posponerlo para la próxima reunión en la que se ofrecerán ambas versiones, en español y en inglés, para su aprobación.

#### **Presentación de orientación del CBHAC**

- Jan y Doriana
  - Aclaratoria del objetivo del CBHAC de promover y fomentar la prestación de servicios de la salud conductual para todos los niños del estado de CT.
  - Discusión en referencia a la composición del CBHAC: 51 % son familias; «Integrantes» siempre se refiere a los integrantes que votan; los invitados pueden participar en las discusiones, pero no pueden votar en los asuntos del CBHAC.

#### **Estándares de prácticas de las comunidades cooperativas**

- Drew Lavallee
  - Pedirá al CBHAC que vote sobre los nuevos estándares de prácticas en la reunión del 5 de octubre; Drew enviará un borrador por correo electrónico, previo a la reunión, *solo a los integrantes del CBHAC*, para su revisión antes de la reunión.
  - Los objetivos de las revisiones es hacer el lenguaje más amigable para la familia; separar el lenguaje de la coordinación de atención en un conjunto distinto de estándares y reflejar los cambios en el sistema desde 2001.

## **Consejo Estatal de Comunidades Cooperativas (SCCC)**

- **Gabrielle Hall**
  - La encuesta del Consejo Estatal de Comunidades Cooperativas (SCCC, por sus siglas en inglés) se enviará por correo electrónico a las vicepresidencias cooperativas. La encuesta 2018 es idéntica a la encuesta 2017.
  - Un objetivo es desarrollar mayor continuidad entre la estructura y práctica de todos los colaboradores.
  - La reunión de las Vicepresidencias Cooperativas del 28 de septiembre es una respuesta a múltiples solicitudes de los vicepresidentes de tener reuniones dedicadas a los colaboradores sin la asistencia de otras organizaciones, para enfocarse en los problemas de los colaboradores.

## **Actualizaciones de la Agencia Estatal**

- **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS, por sus siglas en inglés), Nikki Richer**
  - CT Strong (CT fuerte) recibió \$ 25.000 adicionales, de los cuales una porción será utilizada para proporcionar un auge para los jóvenes y posiblemente uno para los proveedores.
  - Se proporcionó un breve resumen del subsidio CT Strong.
- **DDS, Bill Halsey**
  - Está en espera de noticias referentes a si el Departamento de Servicios del Desarrollo (DDS, por sus siglas en inglés) ganará un subsidio para servicios integrados para niños, que integre servicios médicos y sociales.
  - El DSS está en espera de la divulgación de una oportunidad de financiamiento llamada Atención Integrada para Niños (InCK, por sus siglas en inglés), que integra servicios médicos y sociales.
- **Departamento Estatal de Educación (SDE, por sus siglas en inglés), Scott Newgass**
  - Subsidio federal de cinco años por el Proyecto AWARE de \$ 1.750.000, integración de servicios de salud mental y escuelas
- **Departamento de Niños y Familias (DCF, por sus siglas en inglés), Mary Cummins**
  - Recordatorio: Reunión del Consejo Conjunto el 13/9/18; audiencia de adjudicación en el Edificio de Oficinas Legislativas (LOB, por sus siglas en inglés) para el Subsidio Global del Servicio de Salud Mental (MHBG, por sus siglas en inglés), el 26/9/18, a las 12:30.

## **Planificación para la próxima reunión y actualizaciones generales**

- Próxima reunión del CBHAC: 5 de octubre de 2018.

Próxima reunión del Consejo Conjunto: 13 de septiembre de 2018; 2-4 p. m., Hospital del Valle de Connecticut (CVH, por sus siglas en inglés), Page Hall, Sala 217.

NOT FINAL

**Children's Behavioral Health Advisory Committee (CBHAC)**  
**Friday, October 5, 2018**  
**Minutes**

(Approved 12-7-2018)

***In Attendance:*** Mary Cummins, Bill Halsey, Scott Newgass, Doriana Vicedomini, Gabrielle Hall, Janice Bendall, Debbie McCusker, Susan Graham, Josephine Hawke, Nan Arnstein, Evelyn Melendez, George McDonald, Maureen O'Neill-Davis, Benita Toussaint, Antonia Edwards, C. Teresa Rosario, Ana Jimenez, Kathy Huse, Lorna Girvois, Nydia Dominquez, Mary Held, Andrew Lavallee, Sandra Rivera, Ellen Mathis, Marie M. Spivey, Dona Ditrio, Wanda Roman, Renerba Galaraza, Dave Tompkins, Lyne Landry, Allyson Nadeau, Jeana Bracey, Iris Ortiz-Sanchez, Pamela Roberts, Jacquese Patterson, Graciela Davila, Felicita Cruz, Christola Calloway, Carmen Aldomer, Cindy Thomas, Marschall Demorest III, Jiovani Ambrose, Ginny Gerena, Katherine Downing Ahmed, Elsa N. Cordova, Michelle Rodriguez and Nadine Feldman.

**Welcome and Introductions** – Co-Chairs, Jan Bendall and Doriana Vicedomini

**Approval of Minutes**

Both June 2018 and September 2018 minutes were approved.

**Membership** — Dave Tompkins

- Heather Tartaglia was unanimously voted in as a new member.
- Jo Hawke was unanimously voted in as a co-chair to replace Janice Bendall who is resigning that position and her membership in CBHAC as of 12-31-18.

**Practice Standards for Community Collaboratives** – Gabrielle Hall

- Gabrielle Hall and Drew Lavallee presented the "Practice Standards for Community Collaboratives." Per CBHAC's bylaws, members are charged with "...drafting or reviewing and making recommendations regarding practice for all state- and federally-funded behavioral health programs, as per P.A. 00-188."
- The document had been distributed to CBHAC members prior to the meeting for review.
- A PowerPoint and tool kit are being developed in order to help Collaborative Chairs review the Practice Standards and to help develop their structure and membership.
- There was a discussion about the use of the terms and the need to use them consistently throughout the document, i.e., to be specific with respect to system of care vs systems of care. Gabrielle indicated that they would review the document for consistency.

- CBHAC members voted to approve the Practice Standards document. It will be prepared to be forwarded to the DCF Commissioner.

#### **Community Collaboratives – Gabrielle Hall**

- Collaborative Chairs requested a meeting in order to enable them to have more time to interact with other collaboratives chairs; the joint SCCC/CBHAC meetings do not provide enough time for networking
- In September, the Statewide Council of Community Collaboratives (SCCC) held a meeting at Beacon Health Options of all the chairs of the Community Collaboratives to get feedback on their needs. They said:
- Many Community Collaboratives do not have by-laws or mission statements. They want help building the structure of the Collaboratives.
- *Family* was the most often-mentioned primary stakeholder that Chairs say are not represented at their Collaborative meetings. Others were *schools, police and municipalities*. A discussion about challenges that Collaboratives have engaging families resulted in the following ideas/suggestions/thoughts:
  - Recruit from meetings that families already attend, e.g., PTAs and support groups.
  - Schedule meetings at times that families can attend.
  - Parents who work for providers should be considered parents.
  - Engagement is key; parents need to know what they will get out of attending Collaborative meetings. Susan suggested that families need a document that explains why they should be there. Gabrielle reported that they are drafting this document now.
  - Beresford pointed out that a benefit for families is how other parents interact with providers (modeling behavior) at Collaborative meetings.
- The November CBHAC meeting will be a joint SCCC/CBHAC.

#### **Culturally and Linguistically Appropriate Services (CLAS)**

- Gabrielle Hall proposed creating a CLAS subcommittee of CBHAC.
- Members voted to add CLAS Subcommittee to CBHAC.

#### **State Agency Updates**

##### **DSS-- Bill Halsey**

- DSS is anticipating a funding opportunity and will need some time in the November or December CBHAC meeting to get family input.
- Non-emergency Medical Transportation (NEMT) – There are still issues with Veyo. They are transporting thousands of people a day. As expected, there are some late pick-ups. However, there has been some improvement especially with wheelchair pick-ups from the hospitals.
- With regard to Autism Services, there are delays for kids under 21 years of age to receive services. There is state funding available and DSS is working on initiating five

new contracts to provide services that are not available through the Medicaid state plan services. The Autism Advisory Council has a retreat planned to review these issues.

- More information on Autism services can be found at [CTBHP.com](http://CTBHP.com) and [Plan4Children.org](http://Plan4Children.org).

#### DCF and SDE--Mary Cummins

- The AWARE grant has been awarded. It is a partnership between SDE, DCF, and CHDI and will support pilot projects in Naugatuck, Windham and Middletown School Districts. Funds will be used to address non-academic barriers to learning through integrated support systems; to build staff capacities and partnerships between families, schools, and communities; and to assess interventions that can develop emotional intelligence.
  - Jeana Bracey indicated that the project will use the SHAPE assessment.
  - Funding will go through the schools.
- The CONNECT grant extension was granted and will end on September 30, 2019.
- DCF and DMHAS received a grant called SERG to help families displaced by the hurricane in Puerto Rico. Funds will be used at child guidance clinics in Hartford, New Haven, Bridgeport, Waterbury, and New Britain for services such as outpatient counseling, care coordination, CBITS, and community outreach.

#### General Updates

- ICAN was held on September 22<sup>nd</sup>; it was a great success.

#### Planning for next meeting

- Next CBHAC meeting will be the Fall combined meeting with SCCC: November 2, 2018
- Next Joint Council meeting: November 8, 2018; 2-4pm, CVH, Page Hall, Room 217

NOT FINAL



**Statewide Council of Community Collaboratives and  
Children's Behavioral Health Advisory Committee (CBHAC)  
Friday, November 2, 2018**

**Minutes**

(Approved 12-7-2018)

***In Attendance:** Daisy Ortiz, Nikki Richer, Gabrielle Hall, Debbie McCusker, Susan Graham, Josephine Hawke, Nan Arnstein, Evelyn Melendez, Ofelia Velazquez, George McDonald, Maureen O'Neill-Davis, Kathleen Birchard, Javoni Ambrose, Celeste Flores, Kelly Waterhouse, Wanda Roman, Jeana Bracey, O. Davilia, Felicita Cruz, Alicia Reinn, Patricia Gaylord, Jill Coffin, Ismirna Rosado, Elmer Garcia, Elsa Cordova, Michelle Rodriguez, Ana Jimenez, Teresa Rosario, T. Chipman, Lisa Palazzo, Cindy Thomas, Antonio Thomas, Marshall Demorest III, Luz Villafane, Casandra Vega, Sandra Rivera, Michael Wynne, Lorna Girvois, Kym Batam, Christy Piepmier, Kathy Waters, Jules Calabro, April Mayo, Quiana Mayo, Givey Gerena, Laura Hadder, Ray Bieber, Ann Petitti, Taylor Ford, Maria Feliciano, Katherine Downing Ahmed, Reineta Galanza, Natine Feldman*

**Welcome and Introductions** – Co-Chair, Jo Hawke

**October Minutes**– Co-Chair, Jo Hawke

- There was not a quorum, so approval of minutes was postponed to December.

**State Agency Updates**

DCF –Tim Marshall

- Due to the upcoming November elections, there is uncertainty about the leadership of DCF. Tim explained that Commissioners are required to submit letters of resignation to the incoming Governor. The Governor can choose to either accept or decline the resignation. As a result, it is possible that the leadership of DCF will change.
- There are some Requests for Proposals that are being prepared for programs that address substance use.

CSSD – Daisy Ortiz

- As of July 1, the Judicial Branch became responsible for juvenile justice involved children.
- They have started congregate care centers for higher level juveniles which are slated to open in December.
- They are looking for hardware secure placement programming for adjudicated delinquents.

- There are several procurements in process for juveniles with special needs such as cognitive impairment.
- They are investing in new service models; MST-EA will continue to be funded.
- Center-based models are being revamped for re-entry youth. CSSD continues to want community feedback from CBHAC and parents regarding these models.

#### DMHAS—Nikki Richer

- DMHSA is pretty much in the same position as DCF since our Commissioner also must submit her resignation. We are hoping that she will continue in her current position. We have experienced an increase in referrals to young adult services this year.
- DMHAS YAS is looking for additional funding and may apply for a grant through the Healthy Transitions Project.

#### Children's Behavioral Health Plan –Tim Marshall

- The 2018 Progress Report was submitted on 10/1. It is available on line at [www.plan4children.org](http://www.plan4children.org) . It is 58 pages long, but the first 12 pages summarize the progress. The remainder is addendums which describe the activities of each state department and how they align. Tim summarized each of the 7 recommendations from the Connecticut Behavioral Health Advisory Board and the 4 recommendations from the Commissioner.
- A member asked when the material would be available so that parents can lobby for dollars in your community. Tim pointed out that all the report is currently online at [www.plan4children.org](http://www.plan4children.org) .
- Another expressed concern about the need to direct funds to services for 18-26 years. Tim responded that in the last 5-7 years there has been improved cross-state department collaboration especially around services for transition age youths.
- Tim pointed out that the recommendations were influenced by the family voice and parents/guardians can continue to strengthen family involvement. We are seeing more emerging adults and youth involved, but we still need to see more.
- It was suggested that each person can personally invite other families to attend community collaboratives and advisory board meetings.
- Support groups are important for mobilizing for families and that support groups could collaborate more together.
- FAVOR runs family champions leadership calls on Thursdays and Mondays weekly. There are copies of the flyers with more information, so that families could leave today's meeting which have the exact times for families to call in.

#### Community Conversations –Maria Feliciano and Taylor Ford

Presentation on findings from the 2017 Community Conversation reports and updates on the 2018 Community Conversations.

- In 2018, there were 33 community conversations conducted across the state. Of the 33 community conversations, 8 were for youth and 4 were for Spanish-speaking. In total, 298 family members participated. Of this number, 88 were youths.

- FAVOR is working on two reports: one is for all findings and one is for findings from the youth community conversations. They will take the reports to the community to share and get community feedback before finalizing the report.
- A member asked if the PowerPoint presentations will be shared with their communities. Community conversation presentations did go out for this round and will be going out for the next round. The full report is also online at [www.Plan4children.org](http://www.Plan4children.org).
- FAVOR can present the information at the community collaboratives.
- Additional member/guests comments included:
  - It was pointed out that parents need a clearinghouse that provides information specifically for parents.
  - The family champions leadership calls can be used to collect feedback from parents.
  - Parents are often frustrated because they participate in activities like community conversations and they cannot see any changes result from it.
  - It was shared that there has been a lot of changes for the better over the past 30 years ago.
  - A member pointed out that it is everyone's responsibility to share the information with their communities and choose how they will work locally to advocate for change.
  - Some parents do not have computers and would like to have paper copies available.
  - It is important to get this information to the schools.

#### **Websites – Drew Lavallee**

- [www.plan4children.org](http://www.plan4children.org) has all the information from 2014 and has recently been redone to make it more easy to navigate. It can be translated into different languages.
- The [www.healthylivesct.org](http://www.healthylivesct.org) website is good a resource for supports and screening assessments. It links directly to 211 for service provider information. It also can be translated into multiple languages and it is mobile friendly.
- There are plans to revamp the [www.wrapct.org](http://www.wrapct.org) website. It gives community collaborative information such as when and where meetings occur. It has a calendar of WrapCT trainings and collaborative news. The newsletter for CONNECTing Children and Families to Care can be found there.
- Additional member/guest comments
  - Concern around Emergency Mobile Psychiatric Services not being available after 10pm; response shared adult services are available until midnight, but research that the Department did on the frequency of calls indicated that Monday and Tuesday at 10am-12pm and 3pm-5pm were the highest frequency for children.

#### **Planning for next meeting**

- Next CBHAC meeting will be on December 7, 2018
- Hartford Public Library has resources on job training and bilingual services.

- FAVOR will have a “Celebrate Spanish Culture Day Potluck.” A flyer was available with details at the door. RSVP to Maria Feliciano.

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, December 7, 2018  
Minutes**

**Welcome, Introductions**

**Approval of Minutes**

- Minutes for October 5, 2018 were reviewed. There was a discussion of corrections to the attendance list which will be corrected. Nan motioned to approve, and Benita seconded, Brenetta abstained, and it passed unanimously.
- Minutes for November 2, 2018 were reviewed. There was a discussion of corrections to the attendance list which will be corrected. Natine motioned to approve and Maureen seconded, no one abstained, and it passed unanimously.

**State Agency Updates**

**DSS – Rod Winstead**

- He oversees non-emergency services. Call responses are improving. The Department continues to work on improving transportation. There is a new mandatory training for drivers that focuses on helping drivers understand the importance of their work for the people with disabilities that they serve and the need to be on time.

**DCF – Mary Cummins**

- The Department is waiting for the announcement regarding the new commissioner. They expect that the announcement will be coming soon.
- DCF and DMHSA will have a conference for providers to improve services for first time psychosis in underserved areas. Eligibility for these services has been for youths 16-26 years of age. DCF has found that there is a high number of 16-year-olds needed these services, so they will be expanding the focus to 14-26 years of age.
- A CBHAC member indicated that there is a need to better train first responders. Mary Cummins and Nikki Richer indicated that there are trainings being conducted by both DCF and DMHAS.

**SDE – Scott Newgass**

- SDE and DCF are continuing to collaborate on the Project Aware grant from SAMHSA. Project AWARE grants promote youth mental health awareness among schools and communities and improve connections to services for school-age youth. It is a five-year grant that will focus on the Windham, Naugatuck, and Middletown school districts.
- SDE and FAVOR are collaborating to disseminate lessons learned from the Safe Schools Health Students grant.
- There is a new webpage on school safety (see <https://portal.ct.gov/SDE/School-Safety-and-Security/School-Safety-and-Security>).
- SDE is working on a webpage to provide parents with information on substance abuse and related services.
- A CBHAC member asked about trauma-informed services in schools. It was pointed out that Stamford is a leader in trauma-informed training for staff. Each school district is managed locally and decides whether to use their funding for training and which trainings will be offered.
- A CBHAC member asked how parents can become involved in anti-bullying efforts in their schools. Parents are encouraged to become involved in school governance councils and their local youth services bureaus.
- More information about anti-bullying initiatives can be obtained from [judy.carson@Ct.gov](mailto:judy.carson@Ct.gov).
- A CBHAC member indicated concerns that FERPA and HIPAA concerns inhibit communications between school-based clinics and schools. There are plans to improve communication between school-based clinics and schools.
- There are also efforts to improve youth involvement
- SDE recognizes that evidence-based interventions need to be replicable to all populations and is promoting a health disparities/CLAS focus.

**DMHAS – Nikki Richer**

- The Department is waiting for the announcement regarding the Commissioner's position.

- DMHAS applied for a Healthy Transitions Grant which will, if funded, continue the work started with CT Strong with a focus on improving treatment services. The grant focuses on East Hartford and New Britain.

#### CSSD – Talia Nunez

- Talia Nunez will replace Daisy Ortiz as the CBHAC liaison.
- Since July 1, CSSD has continued to strengthen the continuum of services.
- Starting January 1, referrals to the LINK programs will be open and the SYFSCs will be closed. 12 beds in Bridgeport and 12 beds in Hartford.
- Currently, there are 2 staff secure programs; one in Milford (12 beds) and one in Waterbury (8 beds). Admissions started in November 2018.
- There are 12 beds at Journey House for girls.
- Community-based LINK programs will come on line soon in New Britain and New Haven.
- A CBHAC member requested a presentation on secure programs and more full description of the transition services.
- There will be a request for proposals for secure community-based program for boys in the Spring.

#### Planning for Upcoming Meetings

- There was a discussion about the process of determining priorities and making recommendations to the Commissioner. There was concern about the process of writing and submitting the report; members expressed the desire to have more time to discuss the progress in the priority areas chosen through the year. As a result, the CBHAC leaders agreed to include discussion time quarterly to review progress, request that state agencies present specifically on the improvements and needs in the identified priority areas quarterly and develop a process that encourages more membership involvement in the writing of the report.
- Jo motioned that CBHAC consider disparities in access to culturally appropriate care across the three priorities chosen rather than consider it as a separate priority. Maureen seconded, none abstained, and the motion passed unanimously.
- Members participated in an activity to determine this year's priorities. The results were that Youth and Family Engagement, Access to a Comprehensive Array of Services and Supports, and System Organizations and Accountability were voted as the 2018 priority areas.

#### Planning for the Next Meeting

- Next CBHAC meeting: January 4, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217

**Statewide Council of Community Collaboratives and  
Children's Behavioral Health Advisory Committee (CBHAC)  
Friday, January 4, 2019  
Minutes**

**Welcome, Introductions, Minutes Assignment**

1. There is no Spanish translation for the minutes from the 07.December.2018 meeting. This service will be available going forward.

**Approval of Minutes – 07.December.2018**

1. Changes to the minutes: correction of spelling of attendees; addition of people to the attendance list.
2. Natine: motion to accept minutes as amended.
3. Daisy: 2<sup>nd</sup> to the motion to accept minutes as amended.
4. Motion to accept the minutes as amended passed unanimously.

**State Agency Updates**

1. DSS – Ron Winstead
  - a. No announcement on leadership change as of yet.
  - b. Bill Halsey report:
    - i. Update on grant (Integrative Care for Kids): RFP to be release in Q1 of 2019; allows for expansion of program; age range to be: 0 – 21.
    - ii. TeleHealth / TeleMedicine: proposal written to include behavioral health flexibility and where services will be offered; expansion of the proposal to include home bound and other demographics.
2. DCF – Marry Cummins
  - a. No announcement on leadership change as of yet. Joette Katz, current commissioner, has announced her intention not to continue in her position.
3. DMHAS – Nikki Richer
  - a. No announcement on leadership change as of yet.
4. SDE – Scott Negress
  - a. No announcement of leadership change as of yet.
  - b. Grant applications discussed in December have been completed.

**Overview of CSSD Service Outcome – Talia Nunez**

1. Review of timeline and changes for the period of October 2017 – July 2018:
  - a. FREE and CYFSC (center-based programs) end 31.December.2018.
  - b. LYNC referrals begin statewide on 01.January.2019.
  - c. The department will reissue an RFP for Secure Community Based Programs.

- d. RFPs for the following programs will be forthcoming: FFT / MST-FIT / Vocational Skills.
2. Review of JJ Continuum:
    - a. PREDICT is the JJS assessment tool:
      - i. LOW: tiers 1 – 2
      - ii. MEDIUM: tiers 3 – 4
      - iii. HIGH: tier 5
    - b. Residential programs are for individuals assessed at tier 3 and above.
    - c. HAMILTON: 2 week stabilization program; extension up to 1 week.
    - d. TRAC: 30 – 45 days; extension up to 120 days.
    - e. IRP: 4 months; MDFT model based program.
    - f. REGIONS: 6 months; length is based on goal attainment; various treatment modalities and interventions are used.
  3. Enhancing Community Services:
  4. List of services:
    - a. Mentoring;
    - b. ESP (educational support services);
    - c. LYNC (linking youth to natural communities);
    - d. FFT (family functional therapy);
    - e. MST / MST-TAY (transitional age youth);
    - f. MST-FIT (MT family integrated transitions);
    - g. TFCO (Treatment Foster Care Oregon): in the Hartford and New Britain areas only at this point; geared for 12 – 17 year olds; 9 months training and coaching; goal of reinstatement;
    - h. Reintegration mentors: for individuals discharged from REGIONS program
    - i. Vocational services: soft skills and specific focus areas.
  5. Expanding Residential Programs:
    - a. HAMILTON: 6 beds; 2 week stay;
    - b. Per Diem beds: for individuals with specialized needs;
    - c. REGIONS:
      - i. Bridgeport: 12 beds, Hartford: 12 beds, Milford: 12 beds, Waterbury: 6 beds;
      - ii. Programs are secure and staff secure
  6. Questions:
    - a. A copy of the PowerPoint presentation will be forward to council members.
    - b. Heavy on beds for boys – what about beds for girls: per diem beds are used for girls as needed.
    - c. What are the restrictions for individuals wearing ankle bracelets: depends on the length and terms of probation.



- d. What is involved in the Intensive Mentoring process: 5 hours v 1 hour per week; targeted for high risk individuals (higher risk of recidivism for individuals assessed in tiers 4 and 5).
- e. Are there plans to have different treatment modalities based on race as black and brown individuals are treated differently on the front end – looking at outcomes on black and brown individuals but no data because the programs are new.
- f. There is a wait list for the REGIONS program in hardware secure programs; stepdown takes court action.
- g. How many individuals are in the program: no data because the programs are new.
- h. Who decides which children have behavioral issues: judicial branch comes in after the court disposition; school placement is based on policies; DCF provides an array of services within the community.

### **CBHAC Reporting Process – Jo Hawke**

- 1. Information in PowerPoint presentation is taken from the CBHAC orientation packet.
- 2. Gabrielle Hall is instrumental in getting things done.
- 3. Behavioral Services recommendations are reported during odd years (2019).  
Recommendation that more data on programs be made available.
- 4. Mental Health Block Grant review is part of CBHAC responsibility.
- 5. Goals for 2019 voted on in December 2018:
  - a. Family and Youth Engagement
  - b. Access to a Comprehensive Array of Services and Support
  - c. System Organization and Accountability
- 6. Identifying topics for presentations and data collection are continually being reviewed.
- 7. The suggestion was made to have the monthly agency updates be targeted to include the areas of focus.

### **Subcommittees**

- 1. Mental Health Block Grant / Education Subcommittee:
  - a. How is the money being spent – early onset psychosis (IOL and Yale) and the MATCH program?
- 2. Community Collaborative Subcommittee:
  - a. Review 2017 recommendations and match them to the current year areas of focus.
  - b. Full presentation to be made at the February CBHAC meeting.

### **General Updates**

- 1. Hartford Public Library offerings supported by the Hartford Foundation for Public Giving:
  - a. Cooking industry training

- b. Computer skills training
- c. Driver's education classes
- d. Citizenship program

Respectfully submitted by Nan Arnstein on 07.January.2019.

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, February 1, 2019  
Minutes**

*In Attendance:*

**Welcome and Introductions**

**Approval of Minutes**, Doriana Vicedomini and Jo Hawke

- Changes to the January 4, 2019 minutes: correction of spelling of attendees.
- Benita: motion to accept minutes as amended.
- Daisy: 2<sup>nd</sup> to the motion to accept minutes as amended.
- Motion to accept the minutes as amended passed unanimously. No abstentions.

**State Agency Updates**

DCF --Tim Marshall

- DCF has a new commissioner—Vanessa Durantes. Because she is not officially confirmed yet, she has not yet named her deputy commission and chief of staff. As a result, there is not new business.
- It is a new legislative session with many bills and budget discussions.

DMHAS -- Nikki Richer

- Miriam Delphin-Rittmon will remain as commission.
- DMHAS is partnering with UMASS on grant initiative called HYPE to help youth find employment. We anticipate hearing from the funder in February.

SDE – Scott Newgass

- There are no new updates.

**CT Budget Overview and Children's Services**

- Jamie Mills from CT Voices for Children presented a historical overview of the budget.
- Connecticut is not among the highest taxed states, despite our reputation. We are 7<sup>th</sup> from bottom in country. When we add in federal dollars, we are 2<sup>nd</sup> from the bottom.
- Our budget is tight. Medicaid budget has been reduced, funding for school-based health centers have been cut, and DMHAS funding for young adult services has been decreased.
- Expenditure growth has been only 1.7% since 2011. Low growth. Gov has been cutting spending to cover fixed costs e.g., retirement promises or infrastructure
- This year, the revenue decrease will be about 4% and the future does not look promising.
- The government must have a balanced budget; the revenue decrease for next year will be about \$9 million. Half of the state budget is fixed and cannot be reduced. Only non-fixed funding can be cut; this Includes things we care a lot about e.g., schools, health and human services, judicial branch—estimated 20% cut. Fixed costs are increasing also.
- There are caps that restrict how the budget can be spent:
  - Spending cap—state cannot spend more this year than last year plus small percent (about 1.5%). The problem is that during recession years spending decreases—last was 10%--

rachets down the states ability to spend money during recovery and booming economy phases.

- Volatility cap—requires that the state save over cap. This this takes away funds that could be spend on children and families. Savings due to the volatility cap transfers to rainy day fund even in deficit years
- Bond cap; capped at 1.9 bill—limits the amount of money the state can borrow; funds go to bond holders.

#### Questions

- There was a discussion among CBHAC members which clarified that surplus funds go to rainy day fund. When gov Malloy took over, the rainy day fund was empty. During his administration, we borrowed about 2 bill from federal government which was paid back during his administration.
- There was a discussion about what happens to taxes paid by out-of-state companies and employees who work in Connecticut.
- A CBHAC member stated concerns about school closings and the effect that they have on students when teachers are laid off. Response: In Connecticut, school districts are managed locally. When a district closes a school, it is because the student population is low. Sometimes they use consolidation to lay off essential staff. We continue to work with local school district to get them the services they need despite these changes.

#### First Episode Psychosis Services

- Erika Sharillo and the team from Beacon Health Options described the First Episode Psychosis (FEP) program.
- Data from emergency departments show increasing numbers of young persons in need and there are not enough beds available, especially for acute cases. This is a growing crisis.
- The FEP Criteria: 16-26 yrs, 1<sup>st</sup> diagnosis of psychosis is within 2 years; on Medicaid for 2 years; no dual coverage; still take if they lost Medicaid and no one will take
- If on autism spectrum, the youth is not eligible due to the complexity of treatment required which is beyond the scope of the FEP program.
- Referrals come from clinical care managers at hospitals and pharmacy claims and from parents or social workers on inpatient units or emergency departments.
- Get a lot of referrals from out of state who are Connecticut residents e.g., college students studying in other states.
- Families often have difficulty accepting diagnosis, but early identification is easier to treat and has better outcomes.
- This population, if untreated, is at higher risk of suicide, chronically unemployed and chronically disabled. Evidence shows that the shorter the time between identification and treatment, the better the outcomes.
- Funding of the program comes from the mental health block grant; the federal government requires that 10% of budget be set aside for FEP. DMHAS passes funds to DCF, which in turn funds Yale, Beacon, and IOL. The STEP program at Yale is evidence based and Young Adult Program (YAS) at IOL also is evidence based; Services are harder to get in regions that are not in these program catchment areas.
- Beacon has services that they would refer persons to if they don't meet the criteria for FEP. They also partner with other providers to find the most appropriate places to get treatment. A member was concerned about people coming out of incarceration getting services. They are working to improve outreach.
- DCF is working on trying to expand the program; but do not have funds yet.

- FPE is working very well. A member remarked that she has noticed a significant difference in the last 2 years; she works with families who go to the ER and have significant wait periods she noticed a change.

### **2018 Annual Report on Status of Local Systems of Care**

- Drew Lavalley from Beacon Health Options reviewed CBHAC's recommendations for the annual report.
- Members discussed the frustration that families and youth feel when they give feedback to state agencies on services and then they do not see changes.
- Others indicated, although at times it seems slow, there has been significant improvements in children's behavioral health services over the long-term.
- A family member indicated that parents and caregivers need to also be aware of any of their service needs and pay attention to selfcare.

### **Findings from the 2018 Community Conversations**

- Maguena Adetona Deslandes from FAVOR Inc. reviewed the findings from the 2018 community conversations as outlined in the summary that is available from [www.plan4children.org](http://www.plan4children.org).
- 33 conversations, including 8 youth and 4 Spanish-speaking conversations
- 298 adult and 88 adult participants

### **General updates**

- Next CBHAC meeting: April 5, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, March 1, 2019  
Minutes**

**Welcome and Introductions**

**Approval of Minutes**

- February Minutes approved.

**State Agency Updates**

**DCF --Tim Marshall**

- The DCF Commissioner is still working on restructuring the department.
- First round of governor's budget came out, but we are a long way from having a budget

**DMHAS -- Nikki Richer/Jennifer Abbatemarco**

- HYPE grant was not selected as part of the research initiative, but DMHAS is working to get the training for CT providers.

**SDE -- Scott Newgass**

- No new updates regarding who will replace the Commissioner. Probably the announcement will be made at the end of June.

**CSSD -- John Torello**

- There are a lot of changes at CSSD; John will be attending CBHAC from now on and he will assign someone to attend with him. Otherwise, there are no other updates.
- The RFP has gone out for hardware securement.

**DSS -- Bill Halsey**

- The DSS Commissioner will change, but a new one has not yet been appointed.
- The federal government issued the RFP which was sent out last night. The letter of intent is due. DSS will identify a HIPAA covered entity to work with the Medicaid agency (DSS). The grant application is due next June.
- The organization must be committed to community-based involvement and required to establish a partnership council that includes families. SDE would have chosen organization to initiate process of getting an advisory board together to participate in the grant writing process. They could use existing community collaboratives.
- The organization cannot be statewide because requires an in-state comparison cohort. DSS and SDE are targeting state education opportunity districts.
- There will be opportunities to budget funds for community-based involvement.
- There is a requirement of the Medicaid agency (DSS) to develop an alternative payment strategy that is based on paying based on outcomes.
- This grant opportunity is a very competitive process—only 8 will be funded nationwide.

**Youth and Substance Use -- Mary Painter**

- Connecticut has a lot of effective treatments that is available to families, but a lot of people don't know about the services.
- Last year's statistics show that about 25 people per day enter the ED for opioid overdose.

- Tier 3: Wrap Around Level of Support Needed
- Will include members with highest needs and complexities
- Access to services is by calling 1-877-552-8247 Fax: 1-855-901-24
- Questions clarified that this data is a cause for celebration given the increase in the numbers served and that Beacon is trying to resolve geographic gaps and language issues. Also those waiting are working with peer specialists and care coordination.

#### **DSS – Roderick Winstead**

- DSS updated on the pending Integrated Care for Kids Grant. They are developing a FAQ section on the website. Application is due 6-10-19 and will begin in early 2020. Will be 16 million over 7 years and only 8 states receiving the award so highly competitive. Grant is improve quality of care for those under 21 who have physical and behavioral health challenges by early identification, integrate care, coordinating care and utilizing state specific program models. DSS will submit grant with Clifford Beers.
- Questions included if diverse family voice would be brought into the application, if opioid addictions would be addressed, if schools would be part of the grant and recommendations to use nontraditional pro social activities for youth.

**Gabrielle Hall** presented on May being Mental Health Awareness Month with the May 6 kick off at Beacon. Topic is suicide prevention. 31 days of Wellness Calendar distributed.

#### **Recommendations for Biannual Report- Jo Hawke**

- Review of the PP which was a summary of the presentations this year.
- After reviewing the topics of CBHAC presentations this fiscal year, she asked whether there are recommendations for expanding or improving services in these areas and what services/topics would CBHAC members want to hear about during future CBHAC meetings.

##### **Recommendations:**

- A CBHAC member requested that agency updates speak directly to the CBHAC focus areas for 2019.
- Housing policies should support having services on-site for youth and families.
- There needs to be continued focus on cultural competency of staff in youth development programs that address a greater array of cultures.
- It was recommended by a CBHAC member that FEP programming be expanded and supported.
- CBHAC members would like presentations on suicide prevention, sex trafficking, immigration, DCF culturally sensitivity around sexuality, trauma data, trauma specific programming, ACES study, FEP, availability of mental health support in public housing, DCF culturally sensitivity in investigations, hospital networks and their expansions and how it impacts levels of care, access/accessibility to state legislatures, opioid addiction and state agencies reporting on CBHAC's area of focus.

#### **Other Business**

- Next CBHAC meeting: May 3, 2019
- Next Joint Council meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217

# Statewide Council of Community Collaboratives and Children's Behavioral Health Advisory Committee (CBHAC)

Friday, May 3, 2019

## Minutes

*In Attendance: Mary Cummins, Tim Marshall, Mary Painter, John Torello, Jennifer Abatemarco, Scott Newgass, Bill Halsey, Doriana Vicedomini, Gabrielle Hall, Natine Feldman, Erica Charles-Davy, Jo Hawke, Debbie McCusker, Jo Hawke, Nan Arnstein, Daisy Olivo, Evelyn Melendez, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Benita Toussaint, Antonia Edwards, Gardenia Warren-Bey, Jules Calabro, Ann Pettiti, Allyson Nadeau, Lisa Palazzo, Shereffia Francis, Evelyn Melendez, Brannes Rivera, Maria Ramos, Ana Jimenez, Patricia Gaylord, Sandra Rivera Teresa Rosario, Alicia Divion, Dona Ditrio, Celeste Flores, Elsa Cordova, Kathleen Birchard, Jeana Bracey, Allyson Nadeau, Iris Ortiz Sanchez, Pamela Robert, Christola Calloway, Tyrone Calloway, Cindy Thomas, Marshall Demorest, Antonio Thomas, Mary Held, H. Fair, Alexandro Rivera, Ginny Gerena*

### Welcome and Introductions

#### Approval of Minutes

- February Minutes approved.

#### State Agency Updates

##### DCF --Tim Marshall

- The DCF Commissioner is still working on restructuring the department. There will be three Assistant Chiefs of Child Welfare. Michael Williams will be returning as the Chief of Operations.
- An application has been submitted to sustain funding for system of care efforts.
- Current CONNECT is expected to end at the end of June.
- Although they are still waiting for the budget to be finalized, the news for DCF has been good so far.

##### DMHAS -- Nikki Richer/Jennifer Abbatemarco

- The Commission has be reappointed.
- DMHAS is still waiting to hear about a grant to support young adult services.

##### SDE -- Scott Newgass

- No new updates regarding who will replace the Commissioner. Probably the announcement will be made at the end of June.

##### DSS -- Bill Halsey

- The DSS Commissioner will change, but a new one has not yet been appointed.
- DSS is working with Clifford Beers to submit an application for the Integrated Care for Kids grant from federal government which is due in June. New Haven will be the site. This grant opportunity is a very competitive process—only 8 will be funded nationwide.
- They are working on expanding telehealth services under the Medicaid proposal and researching a substance abuse initiative to bring federal dollars into the state.
- The legislative budget so far appears favorable to Medicaid.

##### Connecticut Suicide Advisory Board – Andrea Iger Duarte, Heather Spada, and Faith Vos Winkel



- The Connecticut Suicide Advisory Board (CTSAB) is a network of over 500 educators, advocates, and leaders who work to eliminate suicide across the lifespan. Meeting are open to the public and the meeting schedule is online.
- Between 2011 and 2018, 78 youth died from suicide; boys are at greatest risk.
- The youth survey indicates that one out of seven have had serious thoughts of suicide. Youth at risk tend to feel more depressed than those not at risk. They report feeling that they lack adult support and only about ¼ know where to get support.
- There is an overlap between opioid abuse and suicidality.
- The period when youth are transition to adulthood is a critical period. Youth who have skills to self-regulate and seek support when needed, and who feel a sense of connectedness do better.
- It is important
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#### **Mental Health Awareness – Ann Pettiti**

- Beacon has a 30-days of Wellness Calendar for Mental Health Awareness Month.
- Events have been planned across the state.

#### **SCCC and Collaborative Chairs**

- April 26 was the last meeting.
- This year, they have updated the practice standards and reviewed the survey data.
- They are currently working on the new survey which includes new questions about the number of meetings, active support groups, and service gaps identified. Some examples of the work that community collaboratives have done/are doing include:
  - Communities Raising Children has been working with the LISTs. They will be showing a documentary on toxic stress for Mental Health Awareness Month.
  - The Shoreline Collaborative changed leadership. Besides working on the practice standards, they have been doing a variety of trainings (e.g. QPR) and community events.
  - The Southeastern CT System of Care has revised their by-laws and recently changed leadership. They are hosting the film “Resiliency” this month.

#### **Kindness Rock – Jules Calabro**

- Jules shared a video that described in inspiration for the Kindness Rocks project and then offered members the opportunity to make kindness rocks to share.

#### **General updates**

- Together We Shine is offering a vision board training in Naugatuck.
- Hartford Public Library has an ongoing training program Next CBHAC meeting: June 7, 2019
- Next Joint Council meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

|   |   |               |
|---|---|---------------|
| <b>Meeting Day/Date:</b>  | Wednesday, April 17, 2019 - 12:30 PM – 2:30 PM  |               |
| <b>Location:</b>  | CVH, Page Hall, Room 212  |               |
| <b>Attendance:</b>  | Susan McLaughlin and Fred Fetta   |               |
| <b>Members Present:</b>   | Marcia DuFore, Lisa Jameson, Carol Meredith, Michele Devine, MuiMui Hin-McCormick, Janice Andersen and Pam Mautte   |               |
| <b>Staff Present:</b>   | Chrishaun Jackson, and Jim Siemianowski   |               |
| <b>AGENDA ITEM</b>  | <b>DISCUSSION</b>   | <b>ACTION</b> |
| <b>Introductions</b>  |   |               |
| <b>Review of Minutes</b>  | Minutes from previous meeting were approved   |               |
| <b>Problem Gambling Presentation</b><br>Susan McLaughlin and Fred | <p>Problem Gambling is the oldest continually running state sponsored gambling treatment program in the country. It started in 1980 and is funded by legislative mandate. There has been a dramatic increase in problem gambling in the state of CT.</p> <ul style="list-style-type: none"> <li>• From 1980-1990 we routinely saw 50 gamblers per year; white/male/middle aged/sports gamblers.</li> <li>• From 1990-2000 the number went from 50 to 90 per year; one third were women. The “casino” has contributed to this increase.</li> </ul> <p>Problem Gambling Services are extended to family members because of the impact that this has on the family <u>at little to no cost</u>. One to three percent of the general population meets the criteria for gambling disorder.</p> <p><b>Gambling is now considered the only behavioral addiction is the DSM:</b> One addiction is just like another addiction as far as the brain and body goes. Trauma and abuse is believed to be connected to women with gambling addiction.</p> <p>We are currently working on a project looking at southeast Asian populations and the high rate of gambling in those populations; trauma is a significant part of Cambodian refugees who have come to this country, fleeing horror and violence; and they go to the <b>casino</b> where there are people who speak their language. There is a connection.</p> <p>The ergonomic design of the casino experience is to have you play to extinction.</p> |               |

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|   | <p>There are currently <u>six bills</u> working their way through legislation. One is the proposed casino in South Windsor which has the federal approval that they need, and one is the expansion of the lottery to online. Along with the 3000 lottery outlets, it will expand to 2 million.</p> <p style="text-align: center;"><b><u>Gaming/ Gambling</u></b></p> <p style="text-align: center;"><b><u>Power Point Presentation (PSA) shown by youth from each region (materials distributed)</u></b></p> <p>Gaming has become more gambling like. Games allow others to watch you play and while you are playing, they are betting. In video games today there are little “pop ups” that appear that ask you to <u>purchase</u> designs specific to the game that you are playing. They ask you to <u>purchase</u> upgrades to your weapons or to <u>purchase</u> virtual prizes.</p> <p>There is an on-going study at UCONN of children ages 11-24, who game too much.</p> <ul style="list-style-type: none"> <li>• Many kids are on the spectrum and this is how they cope</li> <li>• Parental inability to set limits</li> <li>• Awareness and knowledge are one of the number one protectors in gaming/gambling</li> </ul> <p>Problem gambling is the only unfunded disorder in the state and there is a great disparity in the resources that we can afford due to lack of funding. This continues to be an uphill battle.</p> |  |
| <p><b>RBHAOs</b><br/><b>Priority setting</b><br/><b>process update</b></p> <p>RBHAO Directors</p> | <p>The three RBHAO representatives that were present shared the following:</p> <p><u>Region 1</u>: in the process of finishing up profiles and are on track with completing them on time</p> <p><u>Region 2</u>: slow long process with not previously having connections</p> <p><u>Region 3</u>: epidemiologic profiles are up and have required extensive work. Next workgroup meeting is next week. Fitting all the information into the format and simplifying all the data is proving challenging.</p>   |  |
| <p><b>Block Grant Update</b></p> <p>Jim Siemianowski<br/>on behalf of Susan Bouffard</p>          | <ul style="list-style-type: none"> <li>• Substance Abuse MOE has not been met for the 4<sup>th</sup> year in a row. Over the past several years there have been small cuts to SA services. In the past, when employees received raises, it pushed up expectations. When SA MOE’s are submitted, employee salaries of those working in SA are included, but we’ve had a period with very few salary increases. Last Friday the letter</li> </ul>   |  |

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|  | <p>requesting material compliance was submitted which we believe demonstrated that the number of people served is increasing.</p> <ul style="list-style-type: none"> <li>• New this year we did not meet the Mental Health Block Grant MOE due to an error in data submission. A year ago when DCF gave us their MOE, a new employee included 30 million in SA services into MH. We didn't catch the error at the time, but have notified SAMHSA and are hoping to be able to simply revise the report with the corrected information.</li> <li>• Susan has begun work on allocation plans for OPM due in July.</li> <li>• We have not yet received the report form our site visit one year ago.</li> <li>• There is a meeting in Lee Auditorium on May 14<sup>th</sup> to familiarize people with Block Grant expectations. We plan to have this meeting annually.</li> <li>• Full Block Grant application is due in September</li> </ul> |  |
| <p><b>DMHAS Update</b></p> <p>Jim Siemianowski</p> | <ul style="list-style-type: none"> <li>• Applying for a SAMHSA grant that will train First Responders and community sectors on Narcan. This award is for 45 grants up to \$800,000 per year for 4 years. We are unclear if CT will qualify because we are ahead in terms of municipalities, and not clear if we will be able to demonstrate the need.</li> <li>• Jim Siemianowski is retiring on May 31, 2019 and this will be his last meeting.</li> </ul>  |  |
| <p><b>Other Business</b></p>                       | None   |  |
| <p><b>Submitted by:</b></p>                        | Chrishaun Jackson  |  |

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

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|--|--|---|
| <b>Meeting Day/Date:</b>   | Wednesday, January 16, 2019 - 12:30 PM – 2:30 PM   |   |
| <b>Location:</b>   | CVH, Page Hall, Room 212   |   |
| <b>Attendance:</b>   |  |   |
| <b>Members Present:</b>  | Marcia DuFore, Janine Sullivan-Wiley, Lisa Jameson, Pam Mautte, Carol Meredith, Nikki Richer, Ed Renaud, Allison Fulton, Michele Devine, Ingrid Gillespie, and Magda Lekarcyk  |   |
| <b>Staff Present:</b>  | Chrishaun Jackson, Susan Bouffard and Jim Siemianowski   |   |
| <b>AGENDA ITEM</b>   | <b>DISCUSSION</b>  | <b>ACTION</b>   |
| <b>Introductions</b>   | Minutes from October 17, 2018 were reviewed and accepted with one change; the addition of Annie Harper’s email. Annie Harper presented on <i>Financial Health and Mental Health</i> at the October 2018 Council meeting.   | Susan will revise and resend the minutes.   |
| <b>Review of Minutes</b>   |  |   |
| <b>RBHAOs Priority setting process update</b><br><br>RBHAO Directors | <p>Region 1: has already conducted some focus groups and will use their February LPC meeting to collect additional information.</p> <p>Region 2: has a prevention meeting scheduled for February at which they will collect additional information; they are gathering, reviewing, and beginning to pull information together.</p> <p>Region 3: requested assistance with accessing more current data than what they were able to find in the data portal from CPES which goes back to 2016. They do have DMHAS regional profile data from the most recent fiscal year. They have started working on some of the epidemiologic profiles.</p> <p>Region 4: has a prevention meeting scheduled for February at which they will collect additional information.</p> <p>Region 5: is collecting information at CAC meetings and at community wide focus groups. They are trying to create an inventory and have expanded data collection duties. They asked about the new focus group questions and were told that they were attached to the guidelines already distributed.</p> | Susan will contact Jane Ungamack and Jennifer Sussman to ask about more current CPES data for the regions.                |
| <b>Block Grant Update</b><br><br>Susan Bouffard                      | <ul style="list-style-type: none"> <li>• Mental health, substance use, and Synar reports due in December 2018 were all submitted on time</li> <li>• SAMHSA has begun sending revision requests to the state which we are responding to</li> <li>• Jessica Brunetti in DMHAS fiscal has replaced Chris Beauty who transferred to CMHC</li> <li>• Per the state project officer, the current government shut down should not interfere with block grant dollars as SAMHSA has already received its FY 2019 allocation</li> <li>• No written report has yet been received from the April 2018 compliance monitoring visit at</li> </ul>   | Carol will follow up with the SAMHSA prevention project officer to ask about changes to the primary prevention set-aside. |

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|  | <p>DMHAS</p> <ul style="list-style-type: none"> <li>• Next in the block grant schedule will be a request from OPM for allocation plans which is expected in June 2019, followed by the full block grant application and plan due in September 2019</li> </ul> <p>Michele Devine said she'd heard an announcement at a conference that the primary prevention set-aside of 20% was going to be discontinued for 2020. She clarified that the funds would still be provided to the state, but would not have to be designated for primary prevention. Carol Meredith, the DMHAS Director of Prevention, has a monthly call with the SAMHSA prevention project officer and will follow up on this information.</p>   |  |
| <p><b>DMHAS Update</b></p> <p>Jim Siemianowski</p>                       | <ul style="list-style-type: none"> <li>• Relating back to the earlier discussion about data for the regions to use as part of their needs assessment/priority setting process, the EQMI Annual Statistical Report for FY 18 has been posted on the DMHAS website. While it does not provide information on demand or need for services per se, it does provide information on bed utilization. Additionally, the appendices include information by region. There was a request for more trend data. Jim responded that previous years' Annual Statistical Reports are also posted on the DMHAS website under the EQMI office in the reports section, but it is a good suggestion to include more trend data. The only trend data in the current Annual Statistical Report focuses on opioid admissions from 2013 through 2017.</li> <li>• Commissioner Delphin-Rittmon has been nominated for re-appointment by the new administration. Additionally, Julienne Giard will become the new Community Services Division (CSD) Director, taking over from Lauren Siembab who will be managing the numerous opioid-related grants. Related to this, while there is no definitive word, there's talk that the state might be awarded an additional \$5.5 million in grant dollars for opioid services and clarification is expected in the next week. These new funds would be in addition to the SOR grant dollars.</li> </ul> |  |
| <p><b>Suggestions for Future Presentations</b></p> <p>Susan Bouffard</p> | <p>Susan reported that there is only one presentation scheduled so far for 2019 and that is Pam Mautte for the March Joint Council meeting on the topic of Human Trafficking. Other suggestions made were:</p> <ul style="list-style-type: none"> <li>• ACEs (Adverse Childhood Experiences) - for the Joint Council with Celeste Jorge of DPH as a contact</li> <li>• Peer Support – Susan had organized a presentation by the Recovery Coaches, who focus on substance use, in 2018, but the suggestion was to look at the range of peer support options and perhaps have a panel. Chyrell Bellamy was recommended as a contact for this topic</li> </ul>   | <p>Susan will attempt to contact and schedule presentations on these topics for future Council meetings.</p> |

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|  | <ul style="list-style-type: none"> <li>• Problem Gambling – there are many new options for people to be exposed to gambling and March is problem gambling awareness month. Jeremy Wampler was suggested as the contact.</li> <li>• Parent/Family support programs are being created at a number of sites, including ones involving grandparents. This topic should be a joint effort with DCF.</li> <li>• Older adults – the population is aging and more specialized services are becoming available at rehabs, nursing homes, AA meetings (<i>gray AA</i>). Erin Levitt-Smith is the contact for this topic.</li> </ul>   |  |
| <b>Other Business</b>                      | <p>Nikki Richer reported that YAS has applied for a grant for 18 – 25 year olds who need, but don't meet criteria to receive YAS services. If awarded, the funds would go to outreach, engagement, and treatment. Awards will be made in March 2019.</p> <p>Using the WebEx system to conduct meetings remotely wasn't entirely smooth this first attempt. Before the next remote meeting, more clear instructions will be sent about what information has to be entered on the screen once the link to the meeting has been clicked.</p> <p>Janine Sullivan-Wiley announced that after her many years of involvement in the Planning Council, she will be retiring once the merger to the new RBHAO is finalized in region 5 at the end of February-beginning of March 2019. She is also expecting a new grandchild any day. Our congratulations and thanks to Janine for her many years of service.</p> <p>The next Council meeting will be the Joint meeting in March 17, 2019 from 2 – 4 pm in Page Hall room 217 with the presentation on Human Trafficking by Pam Mautte.</p> |  |
| <b>Submitted by:</b><br><br>Susan Bouffard | January 17, 2019.   |  |

**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

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|--|--|---------------|
| <b>Meeting Day/Date:</b>               | Thursday, March 14, 2019, 2:00 – 4:00 PM   |               |
| <b>Location:</b>                       | Connecticut Valley Hospital, Page Hall – Room 217  |               |
| <b>Attendance:</b>                     |  |               |
| <b>Members Present:</b>                | Jo Hawke, Marcia DuFore, Pam Mautte, Nan Arnstein, Margaret Watt, Melanie Wallace, Lisa Jamison, Nikki Richer, Jennifer Abbatemarco, Michele Devine, Kathy Flaherty, Ellen Econs   |               |
| <b>Staff Present:</b>                  | Susan Bouffard, Jim Siemianowski, Mary Cummins, Michael Giralmo, Chrishaun Jackson, and Tim Marshall   |               |
| <b>AGENDA ITEM</b>                     |  | <b>ACTION</b> |
|  | The minutes of November 8, 2018 were accepted without correction.  |               |
| <b>Human Trafficking</b><br>Pam Mautte | <ul style="list-style-type: none"> <li>• Pam Mautte provided an overview of human trafficking. Both sex and labor trafficking involve force, fraud and/or coercion and are the exchange of sex or labor for anything of value, including basic needs. Legislation has been enacted to try and help victims of trafficking and ensure that they are provided support services and protection. Human trafficking is a global problem and can happen anywhere, especially where young people are found. It not only occurs on the street, but also in clubs, casinos, escort services, private parties, etc. Many websites and apps are used for sex trafficking and there are ongoing efforts to intervene and close these sites down.</li> <li>• Be mindful of using certain terms such as “prostitute”, “John” and “pimp”. Persons should not be referred to as “prostitutes” when they are victims. The words “John and Pimp” glorify or mask the actual behaviors: buyers or purveyors of sexual molestation. There is a particular language used by those that are part of trafficking as well.</li> <li>• In Connecticut, legislation protects persons under the age of 18 from being arrested for prostitution. Suspected cases of underage sex trafficking should be reported to DCF at 1-800-842-2288. From 2008 – 2017 in Connecticut, 846 children (ages 2 – 18) were involved in sex trafficking and the majority were runaway/AWOL. In 2017 in our state, there were 212 children of every race/ethnicity involved. Often the trafficking occurs along the truck routes in the state.</li> <li>• Vulnerable children are the ones most at risk to become involved in trafficking. Risk factors include: drug use, juvenile justice involvement, trauma, LGBT, child welfare involvement, foster care, and most significantly, children that are runaways and/or homeless. The risk of being lured into trafficking should be discussed with children. Many victims aren’t aware that what they are involved in is a crime.</li> <li>• Many resources are available in Connecticut, including: Youth Awareness, Not a Number, My Life My Choice, Love 146, Foster Care, Mentoring, etc. The National Human Trafficking Resource Center website is also a good resource.</li> </ul> |               |



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| <p><b>Agency Updates (DMHAS)</b><br/>Jim Siemianowski</p> | <ul style="list-style-type: none"> <li>Retirements were announced: Nikki Richer is retiring the end of March and Jennifer Abbatemarco will be assuming her position on the Planning Council. Jennifer has worked for both DCF and DMHAS; Janine Sullivan-Wiley's retirement is effective March 15 and Jim is working on a Governor's proclamation for her; Jim himself is retiring effective May 30<sup>th</sup>.</li> </ul>  |  |
|   | <ul style="list-style-type: none"> <li>The Governor's budget includes a reduction to DMHAS of 1.7 million and includes privatization of the Torrington and Danbury Western CT Mental Health Network sites, along with 4 Young Adult Services group homes, Capitol Region Mental Health ITU unit, research funds cut to Yale/CMHC; but no layoffs associated with those sites – just re-assignment of staff</li> <li>A grant in the amount of 2 million/year for 5 years was awarded to DMHAS to add/enhance the behavioral health component of providers integrating primary care with behavioral health care. The grant is focused on FQHCs in Waterbury, Hartford, and Bridgeport and plays off the 16 Behavioral Health Homes as a model.</li> <li>DMHAS has received notice of technical assistance block grant fund dollars and Jim and Susan advocated for the Planning Council to be able to determine how to spend some of these dollars. The Commissioner has agreed. Jim and Susan will work with Carol Meredith in DMHAS Prevention and DCF and will send out information detailing the process after those discussions. The funds must be directed toward substance use technical assistance/training and must be spent this federal fiscal year (ending September 30, 2019). Ideas had been floated in this Planning Council previously. It was suggested that Susan look at the previous minutes to see what was proposed.</li> </ul> | <p>Susan will review the minutes from the previous meeting when suggestions were made for SAPT TA funds.</p> |
| <p><b>Agency Updates (DCF)</b><br/>Tim Marshall</p>       | <ul style="list-style-type: none"> <li>The new Commissioner is still making leadership appointments and modifying the reporting structure within DCF. The previous Commissioner had converted several positions into political appointments and the new Governor has asked all such appointments to submit their resignations so much remains up in the air with the leadership and reporting mechanism within the department.</li> <li>The DCF budget has been released and there is much anxiety about it, but primarily it's the uncertainty about the leadership positions and the reporting structure that have staff concerned at present.</li> </ul>   |  |
| <p><b>Block Grant</b><br/>Susan Bouffard</p>              | <ul style="list-style-type: none"> <li>Connecticut has a new Substance Use project officer at SAMHSA named Spencer Clark whom Jim and Susan spoke to on the phone today.</li> <li>The next item in the block grant calendar will be the Allocation Plans. OPM typically asks for these the beginning of June and the public hearing typically occurs in August. DMHAS does not anticipate significant changes in the Allocation Plans this year.</li> <li>In September, the full combined Block Grant Application and Plan will be due, including the description of the service system, priorities for the next 2-year cycle, etc.</li> <li>The written report from the Compliance Monitoring visit conducted in April 2018 has not yet been received, but at DMHAS work is being done on drafting policies/procedures for block grant requirements and activities.</li> </ul>   |  |

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|  | <ul style="list-style-type: none"> <li>• Revision requests for the SAPT Annual Report submitted last December are being addressed.</li> <li>• DMHAS has not received any news regarding its requests for material compliance related to the SAPT MOE.</li> </ul>  |  |
| <b>Other Business – recommendations for training needs</b> | <ul style="list-style-type: none"> <li>• The next Adult Planning Council meeting is scheduled for April 17, 2019 and there will be a presentation on problem gambling by Jeremy Wampler.</li> <li>• There is a Sports Betting breakfast (<i>free</i>) on March 20<sup>th</sup>, 9:30-11am at the Greek Olive in New Haven. A panel from the CT Counsel on Problem Gambling, and Problem Gambling services will talk about if sports betting comes to CT.</li> </ul> |  |
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| <b>Next Joint Meeting:</b>                                 | June 13, 2019 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.   |  |
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**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

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| <b>Meeting Day/Date:</b> | Thursday, June 13, 2019, 2:00 – 4:00 PM  |               |
| <b>Location:</b>         | Connecticut Valley Hospital, Page Hall – Room 217  |               |
| <b>Attendance:</b>       |  |               |
| <b>Members Present:</b>  | Doriana Vicedomini, Jo Hawke, Mary Cummins, Marcia DuFore, Angela Duhaime, Janice Anderson, and Jennifer Abbatemarco,  |               |
| <b>Staff Present:</b>    | Celeste Jorge and Xi Zheng, Epidemiologists, DPH, Tim Marshall, Michael Giralmo, Mary Cummins, Susan Bouffard  |               |
| <b>AGENDA ITEM</b>       |  | <b>ACTION</b> |
|                          | The minutes of 11/8/18 were accepted without correction.   |               |
| Pain & Opioids           | <p>Celeste Jorge and Xi Zheng from DPH presented on Adverse Childhood Experiences in CT (ACES) Survey Findings. DPH prepared the fact sheet from the Behavioral Risk Factor Surveillance System (BRFSS) information, a results-based survey conducted in all 50 states and some U.S. territories. Random phone numbers were used for adults ages 18 and over. The survey has collected data in Connecticut for several decades. The CDC sponsors the survey and allows DPH a 17- minute core set of questions that all states are required to ask. States are allowed to add modules, designed and approved by CDC, and may add a panel of state-specific questions. In 2017, DSS asked DPH about adding an ACES module. Adults answer questions from a 3-minute module about childhood experiences. DSS had money from Medicare and Medicaid to look at adults who experienced ACES and are now in the Medicare/Medicaid system. Conducting these surveys is expensive. ACES received a lot of attention from other domains in the last five years with continued interest in the data.</p> <p>The Fact sheet focused on the long-lasting negative impacts into adulthood with ACES not being uncommon. Out of the nine types of ACES asked about in 2017 - that fell into the two categories of childhood abuse or family dysfunction - 60% of CT adults said they experienced at least one. One out of five had three or more ACES in their childhood. The most common in CT were emotional abuse and having separated or divorced parents.</p> <p><u>Social Characteristics:</u> Those who reported ACES in the past are adults today with less education, under employed/ not employed, renters rather than homeowners, and enrolled in Medicaid. Certain types of ACES are more common by race and sex. Females were similar to males in having three or more ACES. Persons in the LGBTQI community had disproportionately higher numbers of ACES.</p> <p><u>Health Outcomes:</u> Adults having three or more ACES are three times more likely to be at risk for depression, five times more likely to be a victim of sexual violence, three times more likely</p> |               |

to be a cigarette smoker or have food insecurities, and more than twice as likely to suffer from certain chronic conditions. Increasing numbers of ACES are associated with poorer health outcomes.

Origins and Documentary: Celeste recommended participants watch “Resilience,” a one-hour documentary highlighting studies done on the connection between childhood experiences and the impact in adulthood. Multiple efforts to study this issue came together with an ACES study conducted in the late 1990’s. The movie looks at children experiencing toxic stress. DPH screened the movie for school-based health center staff several months ago.

Treatment Interventions: Promising practices and effective trauma-focused treatment are available in CT, such as at the Child Health Development Institute (CHDI) which is working with children in prevention and treatment. Children can be exposed to and experiencing stress for reasons other than abuse, such as poverty, lack of education and income and other adverse circumstances.

Costs: There are no plans to add ACES back to the Connecticut survey due to cost limitations (12 months of surveying cost about \$112,000 to conduct). The full survey had over 10,000 respondents that year; 8,000 answered the paneled questions. In 2016-2018, Connecticut was fortunate to have a lot of financial support for the BRFSS, partly from the state innovations model for Medicaid and Medicare. DSS sponsored these survey results. The preventive health block grant does provide funding to increase sample size and provide estimates to local health departments, but not for this specific module.

A question was asked about an equivalent add-on for the youth survey. DPH would like to ask about different types of trauma in the Youth Risk Behavior Survey (YRBS) done every other year with high schools only. There are some items on teen dating, but not on household abuse, neglect or violence. The next survey will be in two years. The YRBS is sponsored by the CDC and requires asking certain core questions, but states can modify questions to be more specific to their issues (e.g., Connecticut’s high rate of asthma). Connecticut went to an electronic format for more flexibility to modify the survey; the paper/pencil method with the Scantron sheet took approximately 40 minutes to complete and online took 25 minutes or less.

DPH will not have YRBS data this year because many schools refused to participate. This is the first year DPH won’t have representative data since 2005. Schools don’t want to be involved in surveys, yet it involves only four classrooms – 1 freshman, 1 sophomore, 1 junior and 1 senior class, done during advisory period with parental consent forms drafted with the school including an opt-out. School principals and superintendents say it will be disruptive and interfere with instructional time, even though DPH provides a financial incentive of \$1000 to the school for participating and encourages the school to use the funds for health-related activities. The survey

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|                               | <p>was previously under the SDE which required DPH to obtain clearance from the superintendent and principal as part of their protocol.</p> <p>DPH has presented to the BOE when principals felt that parents might react. Some were brought to the BOE because of parental consent policy in school districts. All Connecticut districts now have passive consent for similar activities that don't involve identifiable information.</p> <p>There are nine types of ACES, with examples given for each type; it takes two minutes to complete all modules. A crisis protocol is provided at the end of the survey in the event that it triggers emotions. The more interviewer time is involved, the more costly the survey becomes because of the pricing at the call center which includes length of minutes and the number of people surveyed.</p> <p>The CDC has a webpage devoted to adverse childhood experiences and trauma. Connecticut data, including the survey and fact sheet, are posted on the DPH website. A report can be found by local health departments and districts at <a href="http://www.ct.gov/dph/brfss">www.ct.gov/dph/brfss</a></p> <p>It takes approximately 127 attempts in Connecticut to get a person to complete the survey on their cell phone vs. 50 attempts in other states. This month, methodology changes are coming with Connecticut attempting to collect data on the phone. Interviewers will try to keep a person on the phone longer if a person answers yes to asthma. There's an attempt to ask a certain panel of questions on the phone, then push people to a website to complete online. This is an attempt to get people to complete the state specific survey but also gives DPH a look at the willingness to respond via the website.</p> <p>One of the first questions asked in the survey is "Are you a resident of CT?" to ensure only Connecticut residents are contacted, since people move to other states and keep their cell phones with the "860" prefix. If they are from out of state, they are asked the core questions and sent a link via text or email to complete the survey online. DPH is pushing CDC to be more accepting of different methodologies. Landlines are increasingly associated with an older population. The technology now uses phone calls that originate as voice over internet call, but phone calls originate from Virginia, and show a Connecticut DPH number.</p> |  |
| <p>Agency Updates (DMHAS)</p> | <p>Michael Giralmo:<br/>The DMHAS Commissioner has asked the quality division to take a look at opioid overdoses and deaths by race and gender in the Hartford area and trends over last 3 years by gender, race and town in response to a spike from suburbs to city.</p>   |  |

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|                             | <p>Legislative session coming to an end and there are several updates:</p> <ul style="list-style-type: none"> <li>• DMHAS is developing a task force to look at mental health treatment and prevention in higher education.</li> <li>• Tobacco 21 has passed and raises the legal age to purchase cigarettes and e-cigarettes from 18 to 21.</li> <li>• There is a plan to study the involuntary transport of those who have overdosed to get a medical evaluation and possible treatment for opioid overdose</li> <li>• As a result of legislation, DMHAS will discuss the need for in-home Medication Assisted Treatment</li> <li>• MAT services in correctional facilities are another new initiative.</li> <li>• There was a bill to increase minimum reimbursement rate for providers administering methadone maintenance services (MAT across the board). The increase is from \$77 for one client per week to \$88.</li> </ul>   |  |
| <p>Agency Updates (DCF)</p> | <ul style="list-style-type: none"> <li>• Tim Marshall: DCF has no Legislative updates. The department continues to transition with a new administration and restructuring. DCF and DMHAS are updating the Block Grant application and Allocation plan.</li> </ul>   |  |
| <p>Block Grant</p>          | <ul style="list-style-type: none"> <li>• Mary Cummins: DCF and DMHAS are working on the allocation plans. At Children’s Behavioral Health Advisory Council (CBHAC) last week, the group considered and approved the priority areas for the next year. CBHAC has traditionally used the mental health block grant priorities as their own areas of focus. This year they supported and endorsed: 1) family youth engagement; 2) access to a comprehensive array of services and supports; 3) system organization and accountability. Priorities in 2017 and 2018 were childhood trauma, family engagement, workforce development, suicide prevention, and FEP intervention and identification through Beacon Health Options. FAVOR will be doing a presentation in November about family engagement. DCF will send the allocation plan to DMHAS by June 28<sup>th</sup>. They are attempting to complete their portion of the full new mental health block grant application in July.</li> </ul> <p>Susan Bouffard: DMHAS has not received a written report from the Compliance monitoring visit in April 2018. DMHAS is working on the allocation plans for OPM and Legislature due July 10<sup>th</sup>. They are also working on the Block Grant application and using information from the 2017 submission as a basis for some updating. There are required priority (objective) areas which must be included including pregnant women with dependent children, people injecting drugs, serious emotionally disturbed children, first episode psychosis, TB, and SMI. DMHAS is waiting on results of the priority setting process that RBHAO’s must submit by the end of June to inform the selected priorities. Susan will be doing a presentation to the Adult Council on the Block Grant at July meeting. Need to</p> |  |

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|                     | <p>submit council membership contact information and double check addresses, phone numbers. People will be categorized as either parent, family member, person in recovery, provider or State employee to break down council membership in different way to meet required ratios that SAMSHA set. Mary and Susan will compile survey results by categories set by SAMSHA. Mary and Susan discussed presentations for end of year. Mary has FAVOR scheduled in November. Susan had proposed a presentation by Dr. Craig Burns from DOC's department of psychiatry to talk about behavioral health services. There was a suggestion to purchase the Resilience documentary for \$95 for group to view. There are other organizations that already have purchased it and could show it under their license.</p> |  |
| Other Business      | <ul style="list-style-type: none"> <li>• None</li> </ul>   |  |
| Next Joint Meeting: | September 12, 2019 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.   |  |

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**Adult State Behavioral Health Planning Council  
Meeting Minutes**

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| <b>Meeting Day/Date:</b>  | Wednesday, July 17, 2019 - 12:30 PM – 2:30 PM  |   |
| <b>Location:</b>  | CVH, Page Hall, Room 212   |   |
| <b>Attendance:</b>  |  |   |
| <b>Members Present:</b>   | Marcia DuFore, Carol Meredith, MuiMui Hin-McCormick, Pam Mautte, Margaret Watt, Angela Duhaime, Ed Renaud and Allison Fulton   |   |
| <b>Staff Present:</b>   | Susan Bouffard, Michael Giralmo  |   |
| <b>AGENDA ITEM</b>  | <b>DISCUSSION</b>  | <b>ACTION</b>   |
| <b>Introductions</b>  |  | Minutes will be corrected by adding Janice Andersen as having attended.   |
| <b>Review of Minutes</b>  | Minutes from the April 17 <sup>th</sup> meeting were approved with one correction in attendance.   |   |
| <b>20/21 Block Grant Application Presentation</b><br>Susan Bouffard | <p>Given scheduling constraints this year it was not feasible to present the block grant application to the Joint Council, so DCF presented to the Children’s Behavioral Advisory Council and DMHAS is now presenting to the Adult Behavioral Health Planning Council separately.</p> <p>The presentation of the 20/21 Block Grant Application was accompanied by a handout and covered:</p> <ul style="list-style-type: none"> <li>• <u>Funding</u>: For Mental Health, \$6,760,070 is the amount proposed by the President’s budget which is \$70,000 more than last year’s actual award. For Substance Abuse, \$18,210,035 is the amount proposed by the President’s budget which is \$5,000 less than last year’s actual award. The funding is subject to change.</li> <li>• <u>Changes from last block grant application</u>: No significant changes are noted</li> <li>• <u>Council Membership</u>: The Children’s Behavioral Health Advisory Council has 27 members and 4 vacancies. The Adult Behavioral Health Planning Council has 23 members with 1 vacancy. The council is always interested in expanding diversity. To this end, as was done at the last few meetings, anonymous surveys were distributed to all members asking them to check off all the various possible categories that apply to them and place their responses in the envelope for aggregation. It was explained that this information is required by SAMHSA. Susan also said she needed to know whether contact information for any members has changed so she will email out the contact list so members can check for accuracy.</li> </ul> | <p>Susan will email current contact information to members to have them check for accuracy.</p> <p>Susan will email members to verify their contact</p> |



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|  | <ul style="list-style-type: none"> <li>• <u>Priorities</u>: DCF has created priorities for the First Episode Psychosis (FEP) and the Serious Emotional Disturbance (SED) required areas which continue priorities from the previous block grant application:</li> <li>• <u>FEP</u>: Earlier identification and intervention for those with FEP through Beacon Health Options and their FEP Intensive Case Manager. The Council hosted a presentation by Beacon Health Options on this topic.</li> <li>• <u>SED</u> – Childhood Trauma – Ensure that children/ youth and their caregivers who have experienced trauma receive effective treatment using MATCH (Modular Approach to Therapy for Children with anxiety, depression, trauma and/or conduct disorder). The goal is to increase the number of agencies and clinicians trained and providing MATCH.</li> <li>• <u>SED</u> – Family Engagement – To insure that the voices, perspectives and input of family members are included in the development, planning and overseeing of the children’s behavioral health system using Family Systems Managers at FAVOR who recruit, train, and support youth and families to increase their participation.</li> <li>• <u>SED</u> – Workforce Development – To promote the development of a more informed and skilled workforce prepared to enter DCF positions and deliver evidence-based treatments by offering <i>Current Trends in Family Intervention: Evidence-based and promising practice models of In-home treatment in CT</i> curricula. The goal is to maintain the number of faculty trained and increase the number of students trained.</li> <li>• <u>SED</u> – Prevention of mental illness – The goal is to prevent/reduce suicide attempts and completions by distributing training materials and increasing the number of persons trained in suicide prevention and crisis response.</li> <li>• <u>Pregnant Women/Women with Dependent Children (PW/WDC)</u>: To ensure that women with substance use disorders/co-occurring conditions are educated about and have access to contraception, medication assisted treatment and other resources addressing both their substance use and reproductive needs. The goal is to educate all 15 of the recovery navigators that are part of the new Women’s REACH (recovery, engagement, access, coaching and healing) program on One Key Question and how to connect clients to appropriate resources.</li> <li>• <u>Serious Mental Illness (SMI)</u>: To automate real time availability of mental health community-based services and make them available to providers and the public for the purpose of decreasing hospitalization and increasing utilization of community-based beds.</li> </ul> | <p>information.</p> |
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- People who Inject Drugs (PWID): To increase engagement of people in medication assisted treatment as evidenced by their remaining in treatment at least 30-days post induction. To accomplish this goal, recovery coaches will be added to some methadone clinics and designated DMHAS managers will hold regular meetings with MAT providers to share data and best practices for engaging clients.
- Tuberculosis (TB): All substance use treatment program infection control nurses will be provided the most current information on infectious diseases, including high risk populations and current trends, including TB. At least 2 separate training sessions will be conducted by content experts and while a broad audience will be invited, the goal is to ensure that 100% of the infection control nurses participate in the education.
- Primary Prevention (PP): Based on the regions having submitted their priority setting reports, Susan has begun compiling the data into a statewide report. From these reports, she sent the DMHAS Prevention Division Director, Carol Meredith, a short list of suggested topics to serve as the primary prevention priority. Carol had requested that the Council first discuss the options as the discussion may serve to inform her selection. The topic list:
  - Vaping of nicotine and marijuana; use rates and perceived risk
  - Increase parental perception of risk of alcohol and ENDS (electronic nicotine delivery systems) via education
  - Address pro-social community beliefs/behaviors about marijuana
  - Use of prescription drugs other than opioids, namely, benzodiazepines and stimulants (including cocaine)
  - Confusion over CBDs (currently heavily marketed) versus THC
  - Development of a plan to address potential legalization of marijuana
  - Inclusion of fentanyl into cocaine and other products than heroin
  - Youth compliance inspections for under 21 purchases of alcohol/tobacco
  - Education for ages 14-25, 65+, and LGBTQI on alcohol/heroin/prescription drugs

It was pointed out that the Primary Prevention priority is funded by the substance abuse block grant and should focus on substance use issues, however, it did not necessarily have to be associated with an outcome that involved numbers. In other words, the goal could be legislation, policy development, education, etc.

Discussion/questions on the Block Grant Application presentation:

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|  | <ul style="list-style-type: none"><li>• It seems that most of the mental health focused priorities were proposed by DCF. Will DMHAS join DCF on the FEP priority? Which required priority areas are mental health versus substance abuse for DMHAS? The FEP priority represents the DCF portion of funds designated for the 10% FEP set-aside. For DMHAS, given that DCF has provided priorities for FEP and SED, only the SMI priority remains as part of the mental health requirements. The remainder are all required by the substance abuse block grant.</li><li>• Is the data needed for DCF's priority concerning suicide prevention going to be requested from the RBHAOs which are also conducting QPR training? Probably not as this is a continuation of a priority that DCF had from the previous block grant and if DCF did not previously request it, they probably have their own data source, but Susan will follow up with DCF.</li><li>• Project SAFE was replaced by DMHAS with the Women's REACH program. Who are the recovery navigators involved so that the RBHAOs know who to contact? Marcia looked up the information on her phone during the meeting and the recovery navigators can be contacted through their host providers.</li><li>• Regarding the priority on real time bed availability for mental health community-based levels of care, if there is no capacity for respite beds now, how will the bed availability system help? It's possible that, as was discovered with the inpatient psychiatric bed study previously produced by Jim Siemianowski, that there is capacity in the system, but due to lack of communication and coordination as would be provided by this system, the open beds aren't known at the time. It is an important first step to actually ascertain what kind of capacity the system has before any further steps can be taken. There was acknowledgement that this is a great step forward and something badly needed in the system. The question was asked whether transportation would also be available as part of this system. The answer to the transportation question was unknown, but Susan will attempt to find an answer.</li><li>• Concerning the priority on engaging clients in MAT, it appears that some people enrolled in MAT don't want to have to participate in the counseling that should be provided as an adjunct service and that reluctance serves as a barrier. Other barriers are transportation and childcare issues. It was asked whether clinicians would be using Motivational Interviewing. It is not possible to answer that question given private practitioners who have obtained the DATA waiver are able to provide MAT out of their private offices. Certainly, DMHAS has offered MI training sessions in the past.</li></ul> |  |
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- Proposals for the PP priority generated much discussion. The question was asked whether selection of a particular PP priority could mean additional funding would be made available. Susan responded that PP must be allotted a minimum of 20% of the substance abuse block grant, but she did not anticipate that additional funding beyond this would be made available regardless of which priority was selected. It was suggested that some of the topics could be grouped together as they were natural fits with each other. It was also suggested that as much education as possible on the proposed prevention topics be provided. Another proposal was that high risk groups be targeted with the prevention priority. In other words, that the training be population focused such that there would be multiple trainings targeted for specific populations. It was also encouraged that both students and parents be part of that targeted training. Another proposal was to take advantage of technology to reach a broader audience, although it was pointed out that there are generational differences in terms of who is comfortable using technology. It also was suggested that a small set of questions could be added at the end of the training. There are special populations, like non-primary English speaking and deaf/hard of hearing who may find the technology even more of a barrier and might be better off being trained in smaller in-person groups. Language translation services are available, however, and should be taken advantage of.
- Access to the results of a survey being conducted by Nydia Rios-Benitez on mobile crisis was requested. Susan was not familiar with this survey. The regions are expecting to be provided the results. Susan shared that the allocation plan for mental health did include additional funding for mobile crisis to be able to re-design and enhance the system, along with discharge funding dollars.
- Susan shared some of her conclusions based on reading the regional priority setting reports as she said much of the discussion around priorities mirrored what she had found in those reports. Each region presented the priority ranking matrix information differently in their respective reports. Some regions combined tobacco use and ENDS and others did not. One region split out various mental health conditions instead of staying with a single mental health category as the other regions did. One region filled out the priority ranking matrix as is, but other regions presented just the mean scores, just a ranked list, etc. However, Susan concluded that based on what was presented, the top three priorities state wide were:
  1. Mental Health Issues – focused on anxiety and depression in young people

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|   | <ol style="list-style-type: none"> <li>2. Alcohol use</li> <li>3. Non-medical use of prescription drugs</li> </ol> <ul style="list-style-type: none"> <li>• Susan and Carol will meet after this meeting to discuss these PP proposals.</li> </ul>  |  |
| <p><b>Block Grant Update</b><br/>Susan Bouffard</p> | <p>The Block Grant Application and Plan is due to SAMHSA by September 3<sup>rd</sup> and Susan and Mary are working on completing all the various component sections. The Application/Plan will be posted on both the DMHAS and DCF websites and a link will be sent to the Council members.</p> <p>The Allocation Plans were sent to OPM last Friday. OPM, after reviewing the plans, suggesting edits and asking questions, will send the approved plans to committees of the state legislature. A public hearing will be scheduled probably in August. When that date is known, it will be emailed to Council members. There can be little notice in terms of when the public hearing is scheduled. The public hearing on the block grants is typically a one-day all-day event in which all state agencies responsible for the several block grants will be expected to testify. The order in which the block grants will be heard is unknown beforehand as is the length of questioning which can be 5 minutes or 3 hours.</p> |  |
| <p><b>DMHAS Update</b><br/>Michael Giralmo</p>      | <ul style="list-style-type: none"> <li>• Jim Siemianowski retired but is back working as a Temporary Worker Retiree part time. The position of EQMI Director is expected to be posted this month.</li> <li>• DMHAS is working with DPH and OCME examining overdoses by location for the purpose of targeting interventions</li> <li>• DMHAS is working with state partners to apply for a grant on the Support Act for substance abuse disorder prevention. DSS will be the lead agency. All state agencies have met to plan their strategy.</li> <li>• DMHAS has multiple learning collaboratives underway, including for ACT, CSP, Supported Employment, Supported education, trauma &amp; gender, mobile crisis, CIT, clubhouses, mental health/co-occurring disorders outpatient, citizenship, a methadone roundtable, substance abuse residential, infectious diseases, group homes and recovery houses.</li> </ul>  |  |
| <p><b>Other Business</b></p>                        | <ul style="list-style-type: none"> <li>• Marcia asked whether other RBHAOs have been approached by the Lions Club or the Rotary Club concerning efforts around opioid education and medication disposal. Apparently these organizations are fundraising to support pharmacies giving away pharmacy disposal bags and information. The RBHAOs are already working on similar efforts. Ed suggested that anyone interested in reading about the origins of the opioid epidemic should read Sam Quinones' book entitled <i>Dreamland</i>.</li> </ul>   |  |

|   |  |  |
|---|--|--|
| <b>Meeting Adjourned</b><br>Marcia DuFore |  |  |
| <b>Next Adult Council Meeting</b>         | October 16, 2019 from 12:30 – 2:30 at CVH Page Hall room 212 with a presentation on Older Adults and Behavioral Health by Erin Leavitt-Smith |  |
| <b>Respectfully Submitted by</b>          | Susan Bouffard, PhD  |  |

NOT FINAL

**Footnotes:**

NOT FINAL

## CBHAC 2018 Schedule

### 1<sup>st</sup> Fridays of most months

January 5, 2018 *subcommittees*

February 2, 2018

March 2, 2018 *subcommittees*

April 6, 2018

May 4, 2018—SCCC

June 1, 2018 *subcommittees*

July 13, 2018 **(One week later)**

No meeting in August

September 7, 2018

October 5, 2018 *subcommittees*

November 2, 2018—SCCC

December 7, 2018

Note: CBHAC meetings will be canceled if DCF Training Academy is closed due to inclement weather

Subcommittees: We will meet for an hour to cover the business portion then break out into subcommittees for 45 minutes. We will reconvene to the full group for a 15-minute report out to the full group.

SCCC – Statewide Council of Community Collaboratives



CBHAC members and guests, including both family members and providers, were asked for recommendations that would reflect CBHAC'S FY2018 areas of focus. The specific areas are **Family and Youth Engagement; Access to a Comprehensive Array of Services and Supports; and, Health Promotion, Prevention, and Early Identification**. These areas of focus recognize the disparities that exist throughout the system. The intent is to strengthen Networks of Care and continue the development of a plan for state laws and initiatives regarding children's mental health. The following are the recommendations that arose from that discussion.

1. Respectfully include the family and youth voice at all levels of decision-making; and continue to support community initiatives that expand family driven systems.
2. Address disproportionality in order to reduce racial, ethnic, and other identified group disparities by providing racially just, culturally and linguistically appropriate services to the community, with increased attention on accountability through tracking and data.
3. Continue to provide training (e.g., Network of Care-Agents of Transformation, Data 101, Wraparound Practice Model Trainings, etc.) and support for parents, caregivers, young people, other family members, community members, and providers so they can be fully prepared participants as equal partners in the ongoing development of Connecticut's statewide, regional, and local networks of care. (took out "behavioral health networks of care" at the end)
4. Develop and update practice standards for all state-funded behavioral health programs with providers, stakeholders and most importantly youth and families.
5. Support and promote the use of data in order to inform decision-making discussions and activities (i.e. Results Based Accountability (RBA) measures, outcome data, program data, etc.).
6. Advocate for state funding to families, providers, community initiatives, and DCF in order to support true family driven and youth guided collaboration and full participation among them at statewide, regional and local meetings.
7. Expand resources/funding opportunities for family partners in paid positions and for the development of a family peer specialist workforce.
8. Engage with the State Department of Education to increase focus on advocacy for children and youth with mental and behavioral health conditions or other special needs that impact their educational performance.

**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, September 7, 2018**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

**Mission:**

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

**AGENDA**

|  |             |
|--|-------------|
| <b>Welcome and Introductions</b>   | 10:00—10:10 |
| • Doriana Vicedomini and Janice Bendall, Co-chairs                                       |             |
| <b>Approval of Minutes</b>   | 10:10—10:15 |
| • Doriana Vicedomini and Janice Bendall, Co-chairs                                       |             |
| <b>CBHAC Orientation Presentation</b>  | 10:15—10:50 |
| • <b>Doriana Vicedomini, Janice Bendall</b>  |             |
| <b>Membership—Seeking nominations for Provider Co-chair</b>                              | 10:50—11:00 |
| • Dave Tompkins, Membership Chair  |             |
| <b>Community Collaborative Practice Standards</b>  | 11:00—11:15 |
| • <b>Drew Lavalle</b>  |             |
| <b>Statewide Council of Community Collaboratives</b>                                     | 11:15—11:35 |
| • <b>Gabrielle Hall</b>  |             |
| o <b>SCCC Survey</b>   |             |
| o <b>September 26 Collaboratives Co-chairs meeting</b>                                   |             |
|  | 9:30-12:00  |
| <b>State Agency Updates</b>  | 11:35—11:45 |
| <b>Planning for next meeting and General updates</b>                                     | 11:45—12:00 |
| • Next CBHAC meeting: October 5, 2018  |             |
| • Next <u>Joint Council</u> meeting: September 13, 2018; 2-4pm, CVH; Page Hall, Room 217 |             |

**Announcements**

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.

**CBHAC AREAS OF FOCUS FOR 2018:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3-Health Promotion, Prevention and Early Identification

*These Areas of Focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

**Meeting Rules and Housekeeping Items**

- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.
- Be respectful; use intelligence rather than emotions; ELMO -- Everyone Let's Move On; Ouch!
- Hold questions until after presentations are finished.

**Beacon Health Options Requests**

- Take conversations/phone calls out to the atrium area where the elevators and restrooms are located.
- Young children are not permitted to attend meetings.

**Statewide Council of Community Collaboratives**

**&**

**Children's Behavioral Health Advisory Committee**

**Joint Quarterly Meeting**

**Friday, November 2, 2018**

- |   |                   |
|---|-------------------|
| I. Introductions  | 10am – 10:10 am   |
| II. CBHAC Business  | 10:10 - 10:30 am  |
| a. Minutes  |                   |
| b. State Department Updates                               |                   |
| III. Children's Behavioral Health Plan<br>Progress Report | 10:30 – 11:00am   |
| IV. Community Conversations<br>Report Out                 | 11:00am – 11:30am |
| V. Websites   | 11:30am – 11:40am |
| a. HealthyLivesCT.org                                     |                   |
| b. Plan4Children.org                                      |                   |
| c. WrapCT.org   |                   |
| VI. Next Steps  | 11:50am - 12pm    |

# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, December 7, 2018

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## **CBHAC AREAS OF FOCUS FOR 2018:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3-Health Promotion, Prevention and Early Identification

*These Areas of Focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

## **AGENDA**

**Welcome, Introductions, Minutes Assignment** 10:00—10:10  
Doriana Vicedomini and Jo Hawke, Co-chairs

**Approval of Minutes**, Doriana and Jo 10:10—10:20  
October 5, 2018  
November 2, 2018

**State Agency Updates** 10:20—10:45

**Planning for Upcoming Meetings**  
Doriana and Jo

- **Discussion of Achievements and Objectives** 11:10—11:35
- **Priority Setting Activity** 11:35—11:40
- **Voting on Next Year's Priorities**
- **Volunteers for Taking Minutes** 11:40—11:45

**General updates** 11:45—12:00

- Next CBHAC meeting: January 4, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217

### **Announcements**

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
- **Meeting Cancellation Policy:** *If either the DCF Training Academy is cancelled or Rocky Hill Schools are closed, the meeting is cancelled. If either has a late start, the meeting will be held.*

### **Meeting Rules and Housekeeping Items**

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- Be respectful; use intelligence rather than emotions; ELMO – Everyone Let's Move On; Ouch!
- CBHAC is a state-mandated advisory meeting; personal matters should be brought up at local collaboratives.

### **Beacon Health Options Requests**

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, January 4, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

*The mission of CBHAC is to promote and enhance the provision of behavioral health services for all children in the State of Connecticut.*

## CBHAC AREAS OF FOCUS FOR 2018:

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, promotion, prevention, and early identification.*

## AGENDA

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana and Jo<br>December 7, 2018   | 10:05—10:15 |
| <b>State Agency Updates</b>   | 10:15—10:35 |
| <b>Overview of CSSD Service Outcomes</b> , Talia Nunez  | 10:35—10:50 |
| <b>Discussion of CBHAC Reporting Process</b> , Jo Hawke   | 10:50—11:00 |
| <b>Subcommittees</b>  | 10:40—11:45 |
| <b>General updates</b>  | 11:45—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: February 1, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

### Announcements

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
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### Meeting Rules and Housekeeping Items

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### Beacon Health Options Requests

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, February 1, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

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## CBHAC AREAS OF FOCUS FOR 2019:

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

## AGENDA

|  |             |
|--|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs  | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>January 4, 2019  | 10:05—10:15 |
| <b>State Agency Updates</b>  | 10:15—10:35 |
| <b>CT Budget Overview and Children's Services</b><br>Jamie Mills, CT Voices for Children   | 10:35—11:00 |
| <b>First Episode Psychosis Services</b><br>Erika Sharillo, Beacon Health Options   | 11:00—11:25 |
| <b>2018 Annual Report on Status of Local Systems of Care</b><br>Drew Lavallee, Beacon Health Options   | 11:25—11:40 |
| <b>Findings from the 2018 Community Conversations</b><br>Maguena Adetona Deslandes, FAVOR Inc.   | 11:40—11:50 |
| <b>General updates</b>   | 11:50—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: March 1, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

### Announcements

- Table set up at meetings with announcements of events, meetings, opportunities for parents
- An Overview of CBHAC will be made available at 9:30 before meetings with prior notice to co-chairs.
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### Beacon Health Options Requests

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, March 1, 2019

10:00 AM – 12:00 PM

Beacon Health Options, Hartford Room 3D

## Mission:

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## **CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

## **AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>February 1, 2019  | 10:05—10:10 |
| <b>State Agency Updates</b>   | 10:10—10:30 |
| <b>The Opioid Crisis and Services for Children and Adolescents in C</b><br>Mary Painter, Department of Children and Families  | 10:30—10:55 |
| <b>General updates</b> <ul style="list-style-type: none"><li>• Next CBHAC meeting: April 5, 2019</li><li>• Next <u>Joint Council</u> meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> | 10:55—11:00 |
| <b>Community Conversation</b> <ul style="list-style-type: none"><li>• FAVOR Staff</li></ul>   | 11:00—12:00 |

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## **Beacon Health Options Requests**

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**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, April 5, 2019**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

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**CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

**AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini and Jo Hawke<br>March 1, 2019   | 10:06—10:10 |
| <b>State Agency Updates</b>   | 10:11—10:30 |
| <b>Services for Children on the Autism Spectrum</b><br>Jennifer Krom, LPC, Beacon Health Options  | 10:31—10:55 |
| <b>Integrated Care for Kids Grant Opportunity</b><br>Bill Halsey, Department of Social Services   | 10:56—11:25 |
| <b>Recommendations for Bi-Annual Report</b>   | 11:26—11:50 |
| <b>General updates</b>  | 11:51—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: May 3, 2019</li><li>• Next <u>Joint Council</u> meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

**Announcements**

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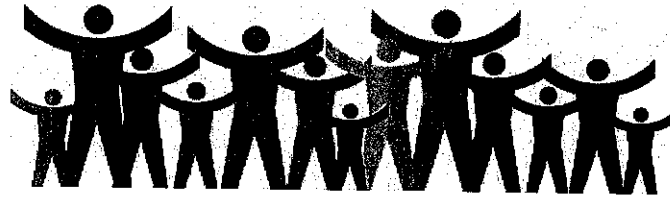
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## Statewide Council of Community Collaboratives

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The Statewide Council of Community Collaboratives  
&  
The Children's Behavioral Health Advisory Council  
Bi- annual Joint Meeting

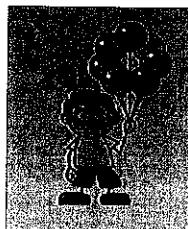
Friday, May 3, 2019

10:00a – 12:00p

### AGENDA

1. Welcome and Introductions
2. CBHAC minutes approval
3. State Department Updates
4. Suicide Prevention Presentation
5. Mental Health Awareness Month
6. SCCC and Community Collaborative Highlights
7. Community announcements
8. Kindness Rocks
9. Wrap-up/Networking

*Next SCCC/CBHAC meeting: November 1, 2019*



**Children's Behavioral Health Advisory Committee (CBHAC)**

**Friday, June 7, 2019**

**10:00 AM – 12:00 PM**

**Beacon Health Options, Hartford Room 3D**

**Mission:**

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**CBHAC AREAS OF FOCUS FOR 2019:**

- 1- Family and Youth Engagement
- 2- Access to a Comprehensive Array of Services and Supports
- 3- System Organization and Accountability

*These areas of focus recognize the disparities that exist in engagement, access, system organization.*

**AGENDA**

|   |             |
|---|-------------|
| <b>Welcome, Introductions, Minutes Assignment</b><br>Doriana Vicedomini and Jo Hawke, Co-chairs   | 10:00—10:05 |
| <b>Approval of Minutes</b> , Doriana Vicedomini<br>May 5, 2019  | 10:06—10:10 |
| <b>Membership List and Survey</b>   | 10:11-10:20 |
| <b>State Agency Updates</b>   | 10:21—10:35 |
| <b>Special Education</b><br>Bryan Klimkiewicz, State Department of Education,<br>Chief for the Bureau of Special Education,   | 10:35—11:15 |
| <b>Subcommittee Breakouts</b>   | 11:15—11:50 |
| <b>General updates</b>  | 11:51—12:00 |
| <ul style="list-style-type: none"><li>• Next CBHAC meeting: September 6, 2019</li><li>• Next <u>Joint Council</u> meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217</li></ul> |             |

**Announcements**

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**Beacon Health Options Requests**

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# Children's Behavioral Health Advisory Committee (CBHAC)

Friday, September 7, 2018

## Minutes

(Revised October 2018 to reflect actual attendees)

**In Attendance:** Mary Cummins, Bill Halsey, Scott Newgass, Niki Richer, Dorian Vicedomini, Gabrielle Hall, Janice Bendall, Brenetta Henry, Evelyn Melendez, Crica Charles-Davy, Natine Feldman, Cindy Thomas, Debbie McCusker, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Sandra Rivera, Cassandra Vega, Luz Villatañe, Rosita I. Torres, Nydia Dominguez, Lorna Grivois, David Olivo, Carmen Puertas-Burgas, Dave Tompkins, Rosa Serrano, Maria Feliciano, April Mayo, Quiana Mayo, Andrew Lavallee, Wanda Roman, Ray Bieber, Denetra McBride, Ismirna Rosado, Elmer Garcia, Maguena Adifono Reslandos, Iris Ortiz Anedez, Pamela Roberts, Kathleen Birchard, Elsa N. Cordova, Michelle Rodriguez, Tyrone Calloway, Briannali Rivera, Katherine Downing Ahmed, Celeste Flores, Patricia Gaylord, Antonio Thomas, Marshall Demorest III, Javoni Ambrose, Nathen Zadora, Teresa Rosario, Felicita Cruz, Graciela Davila, Jules Calabro, Jeana Bracey, and Alice Farrell.

### Welcome and Introductions

#### Approval of Minutes

The Spanish version wasn't ready to distribute. Co-chairs decided to table this until next meeting when both the Spanish and English versions would be offered for approval together.

#### CBHAC Orientation Presentation

- Jan and Dorian
  - Clarified Purpose of CBHAC: to promote and enhance the provision of behavioral health services for all children in the State of CT.
  - Discussion around the makeup of CBHAC: 51% are families; "Members" always refer to voting members; guests may participate in discussions, but may not vote on CBHAC business.

#### Community Collaborative Practice Standards

- Drew Lavallee
  - Will ask for CBHAC vote on new Practice Standards at the October 5th meeting; Drew will email a draft before the meeting to *CBHAC members only* for review prior to the meeting
  - The goals of the revisions are to make the language more family friendly; to separate care coordination language into a different set of standards; and to reflect changes in the system since 2001.

#### Statewide Council of Community Collaboratives (SCCC)

- **Gabrielle Hall**
  - The SCCC Survey will be emailed to collaborative co-chairs soon. The 2018 survey is identical to the 2017 survey.
  - One goal is to develop more continuity between all collaboratives' structure and practice.
  - The September 26 Collaboratives Co-chairs meeting is in response to multiple requests from co-chairs to have meeting dedicated to collaboratives without other organizations in attendance in order to focus on collaborative issues.

#### **State Agency Updates**

- **DMHAS, Nikki Richer**
  - CT Strong received an additional \$25,000- a portion of which will be used to provide a summit for youth and possibly one for providers.
  - A brief overview of the CT Strong grant was provided.
- **DDS, Bill Halsey**
  - Waiting for news about whether DDS will win a grant for integrated services for kids, integrating medical and social services
  - DSS is awaiting the release of an opportunity for funding called Integrated Care for Kids (InCK), integrating medical and social services
- **SDE, Scott Newgass**
  - Five-year Federal grant for \$1,750,000 Project AWARE, integration of MH services and schools
- **DCF, Mary Cummins**
  - Reminders: Joint Council meeting 9/13/18; allocation hearing at LOB for MHBG In 9/26/18 at 12:30

#### **Planning for next meeting and General updates**

- Next CBHAC meeting: October 5, 2018

Next Joint Council meeting: September 13, 2018; 2-4pm, CVH, Page Hall, Room 217

**Comité Asesor de la Salud Conductual Infantil (CBHAC, por sus siglas en inglés)**  
**Viernes, 7 de septiembre, 2018**  
**Minutas**  
**(Revise Octubre 2018 a reflecté presente)**

***Presente:** Mary Cummins, Bill Halsey, Scott Newgass, Niki Richer, Doriana Vicedomini, Gabrielle Hall, Janice Bendall, Brenetta Henry, Evelyn Melendez, Crica Charles-Davy, Natine Feldman, Cindy Thomas, Debbie McCusker, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Sandra Rivera, Cassandra Vega, Luz Villatañe, Rosita I. Torres, Nydia Dominguez, Lorna Grivois, David Olivo, Carmen Puertas-Burgas, Dave Tompkins, Rosa Serrano, Maria Feliciano, April Mayo, Quiana Mayo, Andrew Lavallee, Wanda Roman, Ray Bieber, Denetra McBride, Ismirna Rosado, Elmer Garcia, Maguena Adifono Reslandos, Iris Ortiz Anedez, Pamela Roberts, Kathleen Birchard, Elsa N. Cordova, Michelle Rodriguez, Tyrone Calloway, Briannali Rivera, Katherine Downing Ahmed, Celeste Flores, Patricia Gaylord, Antonio Thomas, Marshall Demorest III, Javoni Ambrose, Nathen Zadora, Teresa Rosario, Felicita Cruz, Graciela Davila, Jules Calabro, Jeana Bracey, and Alice Farrell.*

### **Bienvenida y presentaciones**

#### **Aprobación de las minutas**

La versión en español no estaba lista para ser distribuida. Los vicepresidentes decidieron posponerlo para la próxima reunión en la que se ofrecerán ambas versiones, en español y en inglés, para su aprobación.

#### **Presentación de orientación del CBHAC**

- Jan y Doriana
  - Aclaratoria del objetivo del CBHAC de promover y fomentar la prestación de servicios de la salud conductual para todos los niños del estado de CT.
  - Discusión en referencia a la composición del CBHAC: 51 % son familias; «Integrantes» siempre se refiere a los integrantes que votan; los invitados pueden participar en las discusiones, pero no pueden votar en los asuntos del CBHAC.

#### **Estándares de prácticas de las comunidades cooperativas**

- Drew Lavallee
  - Pedirá al CBHAC que vote sobre los nuevos estándares de prácticas en la reunión del 5 de octubre; Drew enviará un borrador por correo electrónico, previo a la reunión, *solo a los integrantes del CBHAC*, para su revisión antes de la reunión.
  - Los objetivos de las revisiones es hacer el lenguaje más amigable para la familia; separar el lenguaje de la coordinación de atención en un conjunto distinto de estándares y reflejar los cambios en el sistema desde 2001.

## **Consejo Estatal de Comunidades Cooperativas (SCCC)**

- **Gabrielle Hall**
  - La encuesta del Consejo Estatal de Comunidades Cooperativas (SCCC, por sus siglas en inglés) se enviará por correo electrónico a las vicepresidencias cooperativas. La encuesta 2018 es idéntica a la encuesta 2017.
  - Un objetivo es desarrollar mayor continuidad entre la estructura y práctica de todos los colaboradores.
  - La reunión de las Vicepresidencias Cooperativas del 28 de septiembre es una respuesta a múltiples solicitudes de los vicepresidentes de tener reuniones dedicadas a los colaboradores sin la asistencia de otras organizaciones, para enfocarse en los problemas de los colaboradores.

## **Actualizaciones de la Agencia Estatal**

- **Departamento de Servicios para la Salud Mental y la Adicción (DMHAS, por sus siglas en inglés), Nikki Richer**
  - CT Strong (CT fuerte) recibió \$ 25.000 adicionales, de los cuales una porción será utilizada para proporcionar un auge para los jóvenes y posiblemente uno para los proveedores.
  - Se proporcionó un breve resumen del subsidio CT Strong.
- **DDS, Bill Halsey**
  - Está en espera de noticias referentes a si el Departamento de Servicios del Desarrollo (DDS, por sus siglas en inglés) ganará un subsidio para servicios integrados para niños, que integre servicios médicos y sociales.
  - El DSS está en espera de la divulgación de una oportunidad de financiamiento llamada Atención Integrada para Niños (InCK, por sus siglas en inglés), que integra servicios médicos y sociales.
- **Departamento Estatal de Educación (SDE, por sus siglas en inglés), Scott Newgass**
  - Subsidio federal de cinco años por el Proyecto AWARE de \$ 1.750.000, integración de servicios de salud mental y escuelas
- **Departamento de Niños y Familias (DCF, por sus siglas en inglés), Mary Cummins**
  - Recordatorio: Reunión del Consejo Conjunto el 13/9/18; audiencia de adjudicación en el Edificio de Oficinas Legislativas (LOB, por sus siglas en inglés) para el Subsidio Global del Servicio de Salud Mental (MHBG, por sus siglas en inglés), el 26/9/18, a las 12:30.

## **Planificación para la próxima reunión y actualizaciones generales**

- Próxima reunión del CBHAC: 5 de octubre de 2018.

Próxima reunión del Consejo Conjunto: 13 de septiembre de 2018; 2-4 p. m., Hospital del Valle de Connecticut (CVH, por sus siglas en inglés), Page Hall, Sala 217.

NOT FINAL

**Children's Behavioral Health Advisory Committee (CBHAC)**  
**Friday, October 5, 2018**  
**Minutes**

(Approved 12-7-2018)

***In Attendance:*** Mary Cummins, Bill Halsey, Scott Newgass, Doriana Vicedomini, Gabrielle Hall, Janice Bendall, Debbie McCusker, Susan Graham, Josephine Hawke, Nan Arnstein, Evelyn Melendez, George McDonald, Maureen O'Neill-Davis, Benita Toussaint, Antonia Edwards, C. Teresa Rosario, Ana Jimenez, Kathy Huse, Lorna Girvois, Nydia Dominquez, Mary Held, Andrew Lavallee, Sandra Rivera, Ellen Mathis, Marie M. Spivey, Dona Ditrio, Wanda Roman, Renerba Galaraza, Dave Tompkins, Lyne Landry, Allyson Nadeau, Jeana Bracey, Iris Ortiz-Sanchez, Pamela Roberts, Jacquese Patterson, Graciela Davila, Felicita Cruz, Christola Calloway, Carmen Aldomer, Cindy Thomas, Marschall Demorest III, Jiovani Ambrose, Ginny Gerena, Katherine Downing Ahmed, Elsa N. Cordova, Michelle Rodriguez and Nadine Feldman.

**Welcome and Introductions** – Co-Chairs, Jan Bendall and Doriana Vicedomini

**Approval of Minutes**

Both June 2018 and September 2018 minutes were approved.

**Membership** — Dave Tompkins

- Heather Tartaglia was unanimously voted in as a new member.
- Jo Hawke was unanimously voted in as a co-chair to replace Janice Bendall who is resigning that position and her membership in CBHAC as of 12-31-18.

**Practice Standards for Community Collaboratives** – Gabrielle Hall

- Gabrielle Hall and Drew Lavallee presented the "Practice Standards for Community Collaboratives." Per CBHAC's bylaws, members are charged with "...drafting or reviewing and making recommendations regarding practice for all state- and federally-funded behavioral health programs, as per P.A. 00-188."
- The document had been distributed to CBHAC members prior to the meeting for review.
- A PowerPoint and tool kit are being developed in order to help Collaborative Chairs review the Practice Standards and to help develop their structure and membership.
- There was a discussion about the use of the terms and the need to use them consistently throughout the document, i.e., to be specific with respect to system of care vs systems of care. Gabrielle indicated that they would review the document for consistency.



- CBHAC members voted to approve the Practice Standards document. It will be prepared to be forwarded to the DCF Commissioner.

#### **Community Collaboratives – Gabrielle Hall**

- Collaborative Chairs requested a meeting in order to enable them to have more time to interact with other collaboratives chairs; the joint SCCC/CBHAC meetings do not provide enough time for networking
- In September, the Statewide Council of Community Collaboratives (SCCC) held a meeting at Beacon Health Options of all the chairs of the Community Collaboratives to get feedback on their needs. They said:
- Many Community Collaboratives do not have by-laws or mission statements. They want help building the structure of the Collaboratives.
- *Family* was the most often-mentioned primary stakeholder that Chairs say are not represented at their Collaborative meetings. Others were *schools, police and municipalities*. A discussion about challenges that Collaboratives have engaging families resulted in the following ideas/suggestions/thoughts:
  - Recruit from meetings that families already attend, e.g., PTAs and support groups.
  - Schedule meetings at times that families can attend.
  - Parents who work for providers should be considered parents.
  - Engagement is key; parents need to know what they will get out of attending Collaborative meetings. Susan suggested that families need a document that explains why they should be there. Gabrielle reported that they are drafting this document now.
  - Beresford pointed out that a benefit for families is how other parents interact with providers (modeling behavior) at Collaborative meetings.
- The November CBHAC meeting will be a joint SCCC/CBHAC.

#### **Culturally and Linguistically Appropriate Services (CLAS)**

- Gabrielle Hall proposed creating a CLAS subcommittee of CBHAC.
- Members voted to add CLAS Subcommittee to CBHAC.

#### **State Agency Updates**

##### **DSS-- Bill Halsey**

- DSS is anticipating a funding opportunity and will need some time in the November or December CBHAC meeting to get family input.
- Non-emergency Medical Transportation (NEMT) – There are still issues with Veyo. They are transporting thousands of people a day. As expected, there are some late pick-ups. However, there has been some improvement especially with wheelchair pick-ups from the hospitals.
- With regard to Autism Services, there are delays for kids under 21 years of age to receive services. There is state funding available and DSS is working on initiating five

new contracts to provide services that are not available through the Medicaid state plan services. The Autism Advisory Council has a retreat planned to review these issues.

- More information on Autism services can be found at [CTBHP.com](http://CTBHP.com) and [Plan4Children.org](http://Plan4Children.org).

#### DCF and SDE--Mary Cummins

- The AWARE grant has been awarded. It is a partnership between SDE, DCF, and CHDI and will support pilot projects in Naugatuck, Windham and Middletown School Districts. Funds will be used to address non-academic barriers to learning through integrated support systems; to build staff capacities and partnerships between families, schools, and communities; and to assess interventions that can develop emotional intelligence.
  - Jeana Bracey indicated that the project will use the SHAPE assessment.
  - Funding will go through the schools.
- The CONNECT grant extension was granted and will end on September 30, 2019.
- DCF and DMHAS received a grant called SERG to help families displaced by the hurricane in Puerto Rico. Funds will be used at child guidance clinics in Hartford, New Haven, Bridgeport, Waterbury, and New Britain for services such as outpatient counseling, care coordination, CBITS, and community outreach.

#### General Updates

- ICAN was held on September 22<sup>nd</sup>; it was a great success.

#### Planning for next meeting

- Next CBHAC meeting will be the Fall combined meeting with SCCC: November 2, 2018
- Next Joint Council meeting: November 8, 2018; 2-4pm, CVH, Page Hall, Room 217

NOT FINAL

**Statewide Council of Community Collaboratives and  
Children's Behavioral Health Advisory Committee (CBHAC)  
Friday, November 2, 2018**

**Minutes**

(Approved 12-7-2018)

***In Attendance:** Daisy Ortiz, Nikki Richer, Gabrielle Hall, Debbie McCusker, Susan Graham, Josephine Hawke, Nan Arnstein, Evelyn Melendez, Ofelia Velazquez, George McDonald, Maureen O'Neill-Davis, Kathleen Birchard, Javoni Ambrose, Celeste Flores, Kelly Waterhouse, Wanda Roman, Jeana Bracey, O. Davilia, Felicita Cruz, Alicia Reinn, Patricia Gaylord, Jill Coffin, Ismirna Rosado, Elmer Garcia, Elsa Cordova, Michelle Rodriguez, Ana Jimenez, Teresa Rosario, T. Chipman, Lisa Palazzo, Cindy Thomas, Antonio Thomas, Marshall Demorest III, Luz Villafane, Casandra Vega, Sandra Rivera, Michael Wynne, Lorna Girvois, Kym Batam, Christy Piepmier, Kathy Waters, Jules Calabro, April Mayo, Quiana Mayo, Givey Gerena, Laura Hadder, Ray Bieber, Ann Petitti, Taylor Ford, Maria Feliciano, Katherine Downing Ahmed, Reineta Galanza, Natine Feldman*

**Welcome and Introductions** – Co-Chair, Jo Hawke

**October Minutes**– Co-Chair, Jo Hawke

- There was not a quorum, so approval of minutes was postponed to December.

**State Agency Updates**

DCF –Tim Marshall

- Due to the upcoming November elections, there is uncertainty about the leadership of DCF. Tim explained that Commissioners are required to submit letters of resignation to the incoming Governor. The Governor can choose to either accept or decline the resignation. As a result, it is possible that the leadership of DCF will change.
- There are some Requests for Proposals that are being prepared for programs that address substance use.

CSSD – Daisy Ortiz

- As of July 1, the Judicial Branch became responsible for juvenile justice involved children.
- They have started congregate care centers for higher level juveniles which are slated to open in December.
- They are looking for hardware secure placement programming for adjudicated delinquents.

- There are several procurements in process for juveniles with special needs such as cognitive impairment.
- They are investing in new service models; MST-EA will continue to be funded.
- Center-based models are being revamped for re-entry youth. CSSD continues to want community feedback from CBHAC and parents regarding these models.

#### DMHAS—Nikki Richer

- DMHSA is pretty much in the same position as DCF since our Commissioner also must submit her resignation. We are hoping that she will continue in her current position. We have experienced an increase in referrals to young adult services this year.
- DMHAS YAS is looking for additional funding and may apply for a grant through the Healthy Transitions Project.

#### Children’s Behavioral Health Plan –Tim Marshall

- The 2018 Progress Report was submitted on 10/1. It is available on line at [www.plan4children.org](http://www.plan4children.org) . It is 58 pages long, but the first 12 pages summarize the progress. The remainder is addendums which describe the activities of each state department and how they align. Tim summarized each of the 7 recommendations from the Connecticut Behavioral Health Advisory Board and the 4 recommendations from the Commissioner.
- A member asked when the material would be available so that parents can lobby for dollars in your community. Tim pointed out that all the report is currently online at [www.plan4children.org](http://www.plan4children.org) .
- Another expressed concern about the need to direct funds to services for 18-26 years. Tim responded that in the last 5-7 years there has been improved cross-state department collaboration especially around services for transition age youths.
- Tim pointed out that the recommendations were influenced by the family voice and parents/guardians can continue to strengthen family involvement. We are seeing more emerging adults and youth involved, but we still need to see more.
- It was suggested that each person can personally invite other families to attend community collaboratives and advisory board meetings.
- Support groups are important for mobilizing for families and that support groups could collaborate more together.
- FAVOR runs family champions leadership calls on Thursdays and Mondays weekly. There are copies of the flyers with more information, so that families could leave today’s meeting which have the exact times for families to call in.

#### Community Conversations –Maria Feliciano and Taylor Ford

Presentation on findings from the 2017 Community Conversation reports and updates on the 2018 Community Conversations.

- In 2018, there were 33 community conversations conducted across the state. Of the 33 community conversations, 8 were for youth and 4 were for Spanish-speaking. In total, 298 family members participated. Of this number, 88 were youths.

- FAVOR is working on two reports: one is for all findings and one is for findings from the youth community conversations. They will take the reports to the community to share and get community feedback before finalizing the report.
- A member asked if the PowerPoint presentations will be shared with their communities. Community conversation presentations did go out for this round and will be going out for the next round. The full report is also online at [www.Plan4children.org](http://www.Plan4children.org).
- FAVOR can present the information at the community collaboratives.
- Additional member/guests comments included:
  - It was pointed out that parents need a clearinghouse that provides information specifically for parents.
  - The family champions leadership calls can be used to collect feedback from parents.
  - Parents are often frustrated because they participate in activities like community conversations and they cannot see any changes result from it.
  - It was shared that there has been a lot of changes for the better over the past 30 years ago.
  - A member pointed out that it is everyone's responsibility to share the information with their communities and choose how they will work locally to advocate for change.
  - Some parents do not have computers and would like to have paper copies available.
  - It is important to get this information to the schools.

#### **Websites – Drew Lavallee**

- [www.plan4children.org](http://www.plan4children.org) has all the information from 2014 and has recently been redone to make it more easy to navigate. It can be translated into different languages.
- The [www.healthylivesct.org](http://www.healthylivesct.org) website is good a resource for supports and screening assessments. It links directly to 211 for service provider information. It also can be translated into multiple languages and it is mobile friendly.
- There are plans to revamp the [www.wrapct.org](http://www.wrapct.org) website. It gives community collaborative information such as when and where meetings occur. It has a calendar of WrapCT trainings and collaborative news. The newsletter for CONNECTing Children and Families to Care can be found there.
- Additional member/guest comments
  - Concern around Emergency Mobile Psychiatric Services not being available after 10pm; response shared adult services are available until midnight, but research that the Department did on the frequency of calls indicated that Monday and Tuesday at 10am-12pm and 3pm-5pm were the highest frequency for children.

#### **Planning for next meeting**

- Next CBHAC meeting will be on December 7, 2018
- Hartford Public Library has resources on job training and bilingual services.

- FAVOR will have a “Celebrate Spanish Culture Day Potluck.” A flyer was available with details at the door. RSVP to Maria Feliciano.

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, December 7, 2018  
Minutes**

**Welcome, Introductions**

**Approval of Minutes**

- Minutes for October 5, 2018 were reviewed. There was a discussion of corrections to the attendance list which will be corrected. Nan motioned to approve, and Benita seconded, Brenetta abstained, and it passed unanimously.
- Minutes for November 2, 2018 were reviewed. There was a discussion of corrections to the attendance list which will be corrected. Natine motioned to approve and Maureen seconded, no one abstained, and it passed unanimously.

**State Agency Updates**

**DSS – Rod Winstead**

- He oversees non-emergency services. Call responses are improving. The Department continues to work on improving transportation. There is a new mandatory training for drivers that focuses on helping drivers understand the importance of their work for the people with disabilities that they serve and the need to be on time.

**DCF – Mary Cummins**

- The Department is waiting for the announcement regarding the new commissioner. They expect that the announcement will be coming soon.
- DCF and DMHSA will have a conference for providers to improve services for first time psychosis in underserved areas. Eligibility for these services has been for youths 16-26 years of age. DCF has found that there is a high number of 16-year-olds needed these services, so they will be expanding the focus to 14-26 years of age.
- A CBHAC member indicated that there is a need to better train first responders. Mary Cummins and Nikki Richer indicated that there are trainings being conducted by both DCF and DMHAS.

**SDE – Scott Newgass**

- SDE and DCF are continuing to collaborate on the Project Aware grant from SAMHSA. Project AWARE grants promote youth mental health awareness among schools and communities and improve connections to services for school-age youth. It is a five-year grant that will focus on the Windham, Naugatuck, and Middletown school districts.
- SDE and FAVOR are collaborating to disseminate lessons learned from the Safe Schools Health Students grant.
- There is a new webpage on school safety (see <https://portal.ct.gov/SDE/School-Safety-and-Security/School-Safety-and-Security>).
- SDE is working on a webpage to provide parents with information on substance abuse and related services.
- A CBHAC member asked about trauma-informed services in schools. It was pointed out that Stamford is a leader in trauma-informed training for staff. Each school district is managed locally and decides whether to use their funding for training and which trainings will be offered.
- A CBHAC member asked how parents can become involved in anti-bullying efforts in their schools. Parents are encouraged to become involved in school governance councils and their local youth services bureaus.
- More information about anti-bullying initiatives can be obtained from [judy.carson@Ct.gov](mailto:judy.carson@Ct.gov).
- A CBHAC member indicated concerns that FERPA and HIPAA concerns inhibit communications between school-based clinics and schools. There are plans to improve communication between school-based clinics and schools.
- There are also efforts to improve youth involvement
- SDE recognizes that evidence-based interventions need to be replicable to all populations and is promoting a health disparities/CLAS focus.

**DMHAS – Nikki Richer**

- The Department is waiting for the announcement regarding the Commissioner's position.

- DMHAS applied for a Healthy Transitions Grant which will, if funded, continue the work started with CT Strong with a focus on improving treatment services. The grant focuses on East Hartford and New Britain.

#### CSSD – Talia Nunez

- Talia Nunez will replace Daisy Ortiz as the CBHAC liaison.
- Since July 1, CSSD has continued to strengthen the continuum of services.
- Starting January 1, referrals to the LINK programs will be open and the SYFSCs will be closed. 12 beds in Bridgeport and 12 beds in Hartford.
- Currently, there are 2 staff secure programs; one in Milford (12 beds) and one in Waterbury (8 beds). Admissions started in November 2018.
- There are 12 beds at Journey House for girls.
- Community-based LINK programs will come on line soon in New Britain and New Haven.
- A CBHAC member requested a presentation on secure programs and more full description of the transition services.
- There will be a request for proposals for secure community-based program for boys in the Spring.

#### Planning for Upcoming Meetings

- There was a discussion about the process of determining priorities and making recommendations to the Commissioner. There was concern about the process of writing and submitting the report; members expressed the desire to have more time to discuss the progress in the priority areas chosen through the year. As a result, the CBHAC leaders agreed to include discussion time quarterly to review progress, request that state agencies present specifically on the improvements and needs in the identified priority areas quarterly and develop a process that encourages more membership involvement in the writing of the report.
- Jo motioned that CBHAC consider disparities in access to culturally appropriate care across the three priorities chosen rather than consider it as a separate priority. Maureen seconded, none abstained, and the motion passed unanimously.
- Members participated in an activity to determine this year's priorities. The results were that Youth and Family Engagement, Access to a Comprehensive Array of Services and Supports, and System Organizations and Accountability were voted as the 2018 priority areas.

#### Planning for the Next Meeting

- Next CBHAC meeting: January 4, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217



**Statewide Council of Community Collaboratives and  
Children's Behavioral Health Advisory Committee (CBHAC)  
Friday, January 4, 2019  
Minutes**

**Welcome, Introductions, Minutes Assignment**

1. There is no Spanish translation for the minutes from the 07.December.2018 meeting. This service will be available going forward.

**Approval of Minutes – 07.December.2018**

1. Changes to the minutes: correction of spelling of attendees; addition of people to the attendance list.
2. Natine: motion to accept minutes as amended.
3. Daisy: 2<sup>nd</sup> to the motion to accept minutes as amended.
4. Motion to accept the minutes as amended passed unanimously.

**State Agency Updates**

1. DSS – Ron Winstead
  - a. No announcement on leadership change as of yet.
  - b. Bill Halsey report:
    - i. Update on grant (Integrative Care for Kids): RFP to be release in Q1 of 2019; allows for expansion of program; age range to be: 0 – 21.
    - ii. TeleHealth / TeleMedicine: proposal written to include behavioral health flexibility and where services will be offered; expansion of the proposal to include home bound and other demographics.
2. DCF – Marry Cummins
  - a. No announcement on leadership change as of yet. Joette Katz, current commissioner, has announced her intention not to continue in her position.
3. DMHAS – Nikki Richer
  - a. No announcement on leadership change as of yet.
4. SDE – Scott Negress
  - a. No announcement of leadership change as of yet.
  - b. Grant applications discussed in December have been completed.

**Overview of CSSD Service Outcome – Talia Nunez**

1. Review of timeline and changes for the period of October 2017 – July 2018:
  - a. FREE and CYFSC (center-based programs) end 31.December.2018.
  - b. LYNC referrals begin statewide on 01.January.2019.
  - c. The department will reissue an RFP for Secure Community Based Programs.

- d. RFPs for the following programs will be forthcoming: FFT / MST-FIT / Vocational Skills.
2. Review of JJ Continuum:
    - a. PREDICT is the JJS assessment tool:
      - i. LOW: tiers 1 – 2
      - ii. MEDIUM: tiers 3 – 4
      - iii. HIGH: tier 5
    - b. Residential programs are for individuals assessed at tier 3 and above.
    - c. HAMILTON: 2 week stabilization program; extension up to 1 week.
    - d. TRAC: 30 – 45 days; extension up to 120 days.
    - e. IRP: 4 months; MDFT model based program.
    - f. REGIONS: 6 months; length is based on goal attainment; various treatment modalities and interventions are used.
  3. Enhancing Community Services:
  4. List of services:
    - a. Mentoring;
    - b. ESP (educational support services);
    - c. LYNC (linking youth to natural communities);
    - d. FFT (family functional therapy);
    - e. MST / MST-TAY (transitional age youth);
    - f. MST-FIT (MT family integrated transitions);
    - g. TFCO (Treatment Foster Care Oregon): in the Hartford and New Britain areas only at this point; geared for 12 – 17 year olds; 9 months training and coaching; goal of reinstatement;
    - h. Reintegration mentors: for individuals discharged from REGIONS program
    - i. Vocational services: soft skills and specific focus areas.
  5. Expanding Residential Programs:
    - a. HAMILTON: 6 beds; 2 week stay;
    - b. Per Diem beds: for individuals with specialized needs;
    - c. REGIONS:
      - i. Bridgeport: 12 beds, Hartford: 12 beds, Milford: 12 beds, Waterbury: 6 beds;
      - ii. Programs are secure and staff secure
  6. Questions:
    - a. A copy of the PowerPoint presentation will be forward to council members.
    - b. Heavy on beds for boys – what about beds for girls: per diem beds are used for girls as needed.
    - c. What are the restrictions for individuals wearing ankle bracelets: depends on the length and terms of probation.

- d. What is involved in the Intensive Mentoring process: 5 hours v 1 hour per week; targeted for high risk individuals (higher risk of recidivism for individuals assessed in tiers 4 and 5).
- e. Are there plans to have different treatment modalities based on race as black and brown individuals are treated differently on the front end – looking at outcomes on black and brown individuals but no data because the programs are new.
- f. There is a wait list for the REGIONS program in hardware secure programs; stepdown takes court action.
- g. How many individuals are in the program: no data because the programs are new.
- h. Who decides which children have behavioral issues: judicial branch comes in after the court disposition; school placement is based on policies; DCF provides an array of services within the community.

### **CBHAC Reporting Process – Jo Hawke**

- 1. Information in PowerPoint presentation is taken from the CBHAC orientation packet.
- 2. Gabrielle Hall is instrumental in getting things done.
- 3. Behavioral Services recommendations are reported during odd years (2019).  
Recommendation that more data on programs be made available.
- 4. Mental Health Block Grant review is part of CBHAC responsibility.
- 5. Goals for 2019 voted on in December 2018:
  - a. Family and Youth Engagement
  - b. Access to a Comprehensive Array of Services and Support
  - c. System Organization and Accountability
- 6. Identifying topics for presentations and data collection are continually being reviewed.
- 7. The suggestion was made to have the monthly agency updates be targeted to include the areas of focus.

### **Subcommittees**

- 1. Mental Health Block Grant / Education Subcommittee:
  - a. How is the money being spent – early onset psychosis (IOL and Yale) and the MATCH program?
- 2. Community Collaborative Subcommittee:
  - a. Review 2017 recommendations and match them to the current year areas of focus.
  - b. Full presentation to be made at the February CBHAC meeting.

### **General Updates**

- 1. Hartford Public Library offerings supported by the Hartford Foundation for Public Giving:
  - a. Cooking industry training

- b. Computer skills training
- c. Driver's education classes
- d. Citizenship program

Respectfully submitted by Nan Arnstein on 07.January.2019.

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, February 1, 2019  
Minutes**

*In Attendance:*

**Welcome and Introductions**

**Approval of Minutes**, Doriana Vicedomini and Jo Hawke

- Changes to the January 4, 2019 minutes: correction of spelling of attendees.
- Benita: motion to accept minutes as amended.
- Daisy: 2<sup>nd</sup> to the motion to accept minutes as amended.
- Motion to accept the minutes as amended passed unanimously. No abstentions.

**State Agency Updates**

DCF --Tim Marshall

- DCF has a new commissioner—Vanessa Durantes. Because she is not officially confirmed yet, she has not yet named her deputy commission and chief of staff. As a result, there is not new business.
- It is a new legislative session with many bills and budget discussions.

DMHAS -- Nikki Richer

- Miriam Delphin-Rittmon will remain as commission.
- DMHAS is partnering with UMASS on grant initiative called HYPE to help youth find employment. We anticipate hearing from the funder in February.

SDE – Scott Newgass

- There are no new updates.

**CT Budget Overview and Children's Services**

- Jamie Mills from CT Voices for Children presented a historical overview of the budget.
- Connecticut is not among the highest taxed states, despite our reputation. We are 7<sup>th</sup> from bottom in country. When we add in federal dollars, we are 2<sup>nd</sup> from the bottom.
- Our budget is tight. Medicaid budget has been reduced, funding for school-based health centers have been cut, and DMHAS funding for young adult services has been decreased.
- Expenditure growth has been only 1.7% since 2011. Low growth. Gov has been cutting spending to cover fixed costs e.g., retirement promises or infrastructure
- This year, the revenue decrease will be about 4% and the future does not look promising.
- The government must have a balanced budget; the revenue decrease for next year will be about \$9 million. Half of the state budget is fixed and cannot be reduced. Only non-fixed funding can be cut; this Includes things we care a lot about e.g., schools, health and human services, judicial branch—estimated 20% cut. Fixed costs are increasing also.
- There are caps that restrict how the budget can be spent:
  - Spending cap—state cannot spend more this year than last year plus small percent (about 1.5%). The problem is that during recession years spending decreases—last was 10%--

rachets down the states ability to spend money during recovery and booming economy phases.

- Volatility cap—requires that the state save over cap. This this takes away funds that could be spend on children and families. Savings due to the volatility cap transfers to rainy day fund even in deficit years
- Bond cap; capped at 1.9 bill—limits the amount of money the state can borrow; funds go to bond holders.

#### Questions

- There was a discussion among CBHAC members which clarified that surplus funds go to rainy day fund. When gov Malloy took over, the rainy day fund was empty. During his administration, we borrowed about 2 bill from federal government which was paid back during his administration.
- There was a discussion about what happens to taxes paid by out-of-state companies and employees who work in Connecticut.
- A CBHAC member stated concerns about school closings and the effect that they have on students when teachers are laid off. Response: In Connecticut, school districts are managed locally. When a district closes a school, it is because the student population is low. Sometimes they use consolidation to lay off essential staff. We continue to work with local school district to get them the services they need despite these changes.

#### First Episode Psychosis Services

- Erika Sharillo and the team from Beacon Health Options described the First Episode Psychosis (FEP) program.
- Data from emergency departments show increasing numbers of young persons in need and there are not enough beds available, especially for acute cases. This is a growing crisis.
- The FEP Criteria: 16-26 yrs, 1<sup>st</sup> diagnosis of psychosis is within 2 years; on Medicaid for 2 years; no dual coverage; still take if they lost Medicaid and no one will take
- If on autism spectrum, the youth is not eligible due to the complexity of treatment required which is beyond the scope of the FEP program.
- Referrals come from clinical care managers at hospitals and pharmacy claims and from parents or social workers on inpatient units or emergency departments.
- Get a lot of referrals from out of state who are Connecticut residents e.g., college students studying in other states.
- Families often have difficulty accepting diagnosis, but early identification is easier to treat and has better outcomes.
- This population, if untreated, is at higher risk of suicide, chronically unemployed and chronically disabled. Evidence shows that the shorter the time between identification and treatment, the better the outcomes.
- Funding of the program comes from the mental health block grant; the federal government requires that 10% of budget be set aside for FEP. DMHAS passes funds to DCF, which in turn funds Yale, Beacon, and IOL. The STEP program at Yale is evidence based and Young Adult Program (YAS) at IOL also is evidence based; Services are harder to get in regions that are not in these program catchment areas.
- Beacon has services that they would refer persons to if they don't meet the criteria for FEP. They also partner with other providers to find the most appropriate places to get treatment. A member was concerned about people coming out of incarceration getting services. They are working to improve outreach.
- DCF is working on trying to expand the program; but do not have funds yet.

- FPE is working very well. A member remarked that she has noticed a significant difference in the last 2 years; she works with families who go to the ER and have significant wait periods she noticed a change.

### **2018 Annual Report on Status of Local Systems of Care**

- Drew Lavallee from Beacon Health Options reviewed CBHAC's recommendations for the annual report.
- Members discussed the frustration that families and youth feel when they give feedback to state agencies on services and then they do not see changes.
- Others indicated, although at times it seems slow, there has been significant improvements in children's behavioral health services over the long-term.
- A family member indicated that parents and caregivers need to also be aware of any of their service needs and pay attention to selfcare.

### **Findings from the 2018 Community Conversations**

- Maguena Adetona Deslandes from FAVOR Inc. reviewed the findings from the 2018 community conversations as outlined in the summary that is available from [www.plan4children.org](http://www.plan4children.org).
- 33 conversations, including 8 youth and 4 Spanish-speaking conversations
- 298 adult and 88 adult participants

### **General updates**

- Next CBHAC meeting: April 5, 2019
- Next Joint Council meeting: March 14, 2019; 2-4pm, CVH, Page Hall, Room 217

NOT FINAL

**Statewide Council of Community Collaboratives and Children's  
Behavioral Health Advisory Committee (CBHAC)  
Friday, March 1, 2019  
Minutes**

**Welcome and Introductions**

**Approval of Minutes**

- February Minutes approved.

**State Agency Updates**

**DCF --Tim Marshall**

- The DCF Commissioner is still working on restructuring the department.
- First round of governor's budget came out, but we are a long way from having a budget

**DMHAS -- Nikki Richer/Jennifer Abbatemarco**

- HYPE grant was not selected as part of the research initiative, but DMHAS is working to get the training for CT providers.

**SDE -- Scott Newgass**

- No new updates regarding who will replace the Commissioner. Probably the announcement will be made at the end of June.

**CSSD -- John Torello**

- There are a lot of changes at CSSD; John will be attending CBHAC from now on and he will assign someone to attend with him. Otherwise, there are no other updates.
- The RFP has gone out for hardware securement.

**DSS -- Bill Halsey**

- The DSS Commissioner will change, but a new one has not yet been appointed.
- The federal government issued the RFP which was sent out last night. The letter of intent is due. DSS will identify a HIPAA covered entity wo work with the Medicaid agency (DSS). The grant application is due next June.
- The organization must be committed to community-based involvement and required to establish a partnership council that includes families. SDE would have chosen organization to initiate process of getting an advisory board together to participate in the grant writing process. They could use existing community collaboratives.
- The organization cannot be statewide because requires an in-state comparison cohort. DSS and SDE are targeting state education opportunity districts.
- There will be opportunities to budget funds for community-based involvement.
- There is a requirement of the Medicaid agency (DSS) to develop an alternative payment strategy that is based on paying based on outcomes.
- This grant opportunity is a very competitive process—only 8 will be funded nationwide.

**Youth and Substance Use -- Mary Painter**

- Connecticut has a lot of effective treatments that is available to families, but a lot of people don't know about the services.
- Last year's statistics show that about 25 people per day enter the ED for opioid overdose.



- Tier 3: Wrap Around Level of Support Needed
- Will include members with highest needs and complexities
- Access to services is by calling 1-877-552-8247 Fax: 1-855-901-24
- Questions clarified that this data is a cause for celebration given the increase in the numbers served and that Beacon is trying to resolve geographic gaps and language issues. Also those waiting are working with peer specialists and care coordination.

#### **DSS – Roderick Winstead**

- DSS updated on the pending Integrated Care for Kids Grant. They are developing a FAQ section on the website. Application is due 6-10-19 and will begin in early 2020. Will be 16 million over 7 years and only 8 states receiving the award so highly competitive. Grant is improve quality of care for those under 21 who have physical and behavioral health challenges by early identification, integrate care, coordinating care and utilizing state specific program models. DSS will submit grant with Clifford Beers.
- Questions included if diverse family voice would be brought into the application, if opioid addictions would be addressed, if schools would be part of the grant and recommendations to use nontraditional pro social activities for youth.

**Gabrielle Hall** presented on May being Mental Health Awareness Month with the May 6 kick off at Beacon. Topic is suicide prevention. 31 days of Wellness Calendar distributed.

#### **Recommendations for Biannual Report- Jo Hawke**

- Review of the PP which was a summary of the presentations this year.
- After reviewing the topics of CBHAC presentations this fiscal year, she asked whether there are recommendations for expanding or improving services in these areas and what services/topics would CBHAC members want to hear about during future CBHAC meetings.

##### **Recommendations:**

- A CBHAC member requested that agency updates speak directly to the CBHAC focus areas for 2019.
- Housing policies should support having services on-site for youth and families.
- There needs to be continued focus on cultural competency of staff in youth development programs that address a greater array of cultures.
- It was recommended by a CBHAC member that FEP programming be expanded and supported.
- CBHAC members would like presentations on suicide prevention, sex trafficking, immigration, DCF culturally sensitivity around sexuality, trauma data, trauma specific programming, ACES study, FEP, availability of mental health support in public housing, DCF culturally sensitivity in investigations, hospital networks and their expansions and how it impacts levels of care, access/accessibility to state legislatures, opioid addiction and state agencies reporting on CBHAC's area of focus.

#### **Other Business**

- Next CBHAC meeting: May 3, 2019
- Next Joint Council meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217

# Statewide Council of Community Collaboratives and Children's Behavioral Health Advisory Committee (CBHAC)

Friday, May 3, 2019

## Minutes

*In Attendance: Mary Cummins, Tim Marshall, Mary Painter, John Torello, Jennifer Abatemarco, Scott Newgass, Bill Halsey, Doriana Vicedomini, Gabrielle Hall, Natine Feldman, Erica Charles-Davy, Jo Hawke, Debbie McCusker, Jo Hawke, Nan Arnstein, Daisy Olivo, Evelyn Melendez, Ofelia Velazquez, Heather Tartaglia, George McDonald, Maureen O'Neill-Davis, Benita Toussaint, Antonia Edwards, Gardenia Warren-Bey, Jules Calabro, Ann Pettiti, Allyson Nadeau, Lisa Palazzo, Shereffia Francis, Evelyn Melendez, Brannes Rivera, Maria Ramos, Ana Jimenez, Patricia Gaylord, Sandra Rivera Teresa Rosario, Alicia Divion, Dona Ditrio, Celeste Flores, Elsa Cordova, Kathleen Birchard, Jeana Bracey, Allyson Nadeau, Iris Ortiz Sanchez, Pamela Robert, Christola Calloway, Tyrone Calloway, Cindy Thomas, Marshall Demorest, Antonio Thomas, Mary Held, H. Fair, Alexandro Rivera, Ginny Gerena*

### Welcome and Introductions

#### Approval of Minutes

- February Minutes approved.

#### State Agency Updates

##### DCF --Tim Marshall

- The DCF Commissioner is still working on restructuring the department. There will be three Assistant Chiefs of Child Welfare. Michael Williams will be returning as the Chief of Operations.
- An application has been submitted to sustain funding for system of care efforts.
- Current CONNECT is expected to end at the end of June.
- Although they are still waiting for the budget to be finalized, the news for DCF has been good so far.

##### DMHAS -- Nikki Richer/Jennifer Abbatemarco

- The Commission has be reappointed.
- DMHAS is still waiting to hear about a grant to support young adult services.

##### SDE -- Scott Newgass

- No new updates regarding who will replace the Commissioner. Probably the announcement will be made at the end of June.

##### DSS -- Bill Halsey

- The DSS Commissioner will change, but a new one has not yet been appointed.
- DSS is working with Clifford Beers to submit an application for the Integrated Care for Kids grant from federal government which is due in June. New Haven will be the site. This grant opportunity is a very competitive process—only 8 will be funded nationwide.
- They are working on expanding telehealth services under the Medicaid proposal and researching a substance abuse initiative to bring federal dollars into the state.
- The legislative budget so far appears favorable to Medicaid.

##### Connecticut Suicide Advisory Board – Andrea Iger Duarte, Heather Spada, and Faith Vos Winkel

- The Connecticut Suicide Advisory Board (CTSAB) is a network of over 500 educators, advocates, and leaders who work to eliminate suicide across the lifespan. Meeting are open to the public and the meeting schedule is online.
- Between 2011 and 2018, 78 youth died from suicide; boys are at greatest risk.
- The youth survey indicates that one out of seven have had serious thoughts of suicide. Youth at risk tend to feel more depressed than those not at risk. They report feeling that they lack adult support and only about ¼ know where to get support.
- There is an overlap between opioid abuse and suicidality.
- The period when youth are transition to adulthood is a critical period. Youth who have skills to self-regulate and seek support when needed, and who feel a sense of connectedness do better.
- It is important
- 

#### **Mental Health Awareness – Ann Pettiti**

- Beacon has a 30-days of Wellness Calendar for Mental Health Awareness Month.
- Events have been planned across the state.

#### **SCCC and Collaborative Chairs**

- April 26 was the last meeting.
- This year, they have updated the practice standards and reviewed the survey data.
- They are currently working on the new survey which includes new questions about the number of meetings, active support groups, and service gaps identified. Some examples of the work that community collaboratives have done/are doing include:
  - Communities Raising Children has been working with the LISTs. They will be showing a documentary on toxic stress for Mental Health Awareness Month.
  - The Shoreline Collaborative changed leadership. Besides working on the practice standards, they have been doing a variety of trainings (e.g. QPR) and community events.
  - The Southeastern CT System of Care has revised their by-laws and recently changed leadership. They are hosting the film “Resiliency” this month.

#### **Kindness Rock – Jules Calabro**

- Jules shared a video that described in inspiration for the Kindness Rocks project and then offered members the opportunity to make kindness rocks to share.

#### **General updates**

- Together We Shine is offering a vision board training in Naugatuck.
- Hartford Public Library has an ongoing training program Next CBHAC meeting: June 7, 2019
- Next Joint Council meeting: June 13, 2019; 2-4pm, CVH, Page Hall, Room 217

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

|   |   |               |
|---|---|---------------|
| <b>Meeting Day/Date:</b>  | Wednesday, April 17, 2019 - 12:30 PM – 2:30 PM  |               |
| <b>Location:</b>  | CVH, Page Hall, Room 212  |               |
| <b>Attendance:</b>  | Susan McLaughlin and Fred Fetta   |               |
| <b>Members Present:</b>   | Marcia DuFore, Lisa Jameson, Carol Meredith, Michele Devine, MuiMui Hin-McCormick, Janice Andersen and Pam Mautte   |               |
| <b>Staff Present:</b>   | Chrishaun Jackson, and Jim Siemianowski   |               |
| <b>AGENDA ITEM</b>  | <b>DISCUSSION</b>   | <b>ACTION</b> |
| <b>Introductions</b>  |   |               |
| <b>Review of Minutes</b>  | Minutes from previous meeting were approved   |               |
| <b>Problem Gambling Presentation</b><br>Susan McLaughlin and Fred | <p>Problem Gambling is the oldest continually running state sponsored gambling treatment program in the country. It started in 1980 and is funded by legislative mandate. There has been a dramatic increase in problem gambling in the state of CT.</p> <ul style="list-style-type: none"> <li>• From 1980-1990 we routinely saw 50 gamblers per year; white/male/middle aged/sports gamblers.</li> <li>• From 1990-2000 the number went from 50 to 90 per year; one third were women. The “casino” has contributed to this increase.</li> </ul> <p>Problem Gambling Services are extended to family members because of the impact that this has on the family <u>at little to no cost</u>. One to three percent of the general population meets the criteria for gambling disorder.</p> <p><b>Gambling is now considered the only behavioral addiction is the DSM:</b> One addiction is just like another addiction as far as the brain and body goes. Trauma and abuse is believed to be connected to women with gambling addiction.</p> <p>We are currently working on a project looking at southeast Asian populations and the high rate of gambling in those populations; trauma is a significant part of Cambodian refugees who have come to this country, fleeing horror and violence; and they go to the <b>casino</b> where there are people who speak their language. There is a connection.</p> <p>The ergonomic design of the casino experience is to have you play to extinction.</p> |               |

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|   | <p>There are currently <u>six bills</u> working their way through legislation. One is the proposed casino in South Windsor which has the federal approval that they need, and one is the expansion of the lottery to online. Along with the 3000 lottery outlets, it will expand to 2 million.</p> <p style="text-align: center;"><b><u>Gaming/ Gambling</u></b></p> <p style="text-align: center;"><b><u>Power Point Presentation (PSA) shown by youth from each region (materials distributed)</u></b></p> <p>Gaming has become more gambling like. Games allow others to watch you play and while you are playing, they are betting. In video games today there are little “pop ups” that appear that ask you to <u>purchase</u> designs specific to the game that you are playing. They ask you to <u>purchase</u> upgrades to your weapons or to <u>purchase</u> virtual prizes.</p> <p>There is an on-going study at UCONN of children ages 11-24, who game too much.</p> <ul style="list-style-type: none"> <li>• Many kids are on the spectrum and this is how they cope</li> <li>• Parental inability to set limits</li> <li>• Awareness and knowledge are one of the number one protectors in gaming/gambling</li> </ul> <p>Problem gambling is the only unfunded disorder in the state and there is a great disparity in the resources that we can afford due to lack of funding. This continues to be an uphill battle.</p> |  |
| <p><b>RBHAOs</b><br/><b>Priority setting</b><br/><b>process update</b></p> <p>RBHAO Directors</p> | <p>The three RBHAO representatives that were present shared the following:</p> <p><u>Region 1</u>: in the process of finishing up profiles and are on track with completing them on time</p> <p><u>Region 2</u>: slow long process with not previously having connections</p> <p><u>Region 3</u>: epidemiologic profiles are up and have required extensive work. Next workgroup meeting is next week. Fitting all the information into the format and simplifying all the data is proving challenging.</p>   |  |
| <p><b>Block Grant Update</b></p> <p>Jim Siemianowski<br/>on behalf of Susan Bouffard</p>          | <ul style="list-style-type: none"> <li>• Substance Abuse MOE has not been met for the 4<sup>th</sup> year in a row. Over the past several years there have been small cuts to SA services. In the past, when employees received raises, it pushed up expectations. When SA MOE’s are submitted, employee salaries of those working in SA are included, but we’ve had a period with very few salary increases. Last Friday the letter</li> </ul>   |  |

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|  | <p>requesting material compliance was submitted which we believe demonstrated that the number of people served is increasing.</p> <ul style="list-style-type: none"> <li>• New this year we did not meet the Mental Health Block Grant MOE due to an error in data submission. A year ago when DCF gave us their MOE, a new employee included 30 million in SA services into MH. We didn't catch the error at the time, but have notified SAMHSA and are hoping to be able to simply revise the report with the corrected information.</li> <li>• Susan has begun work on allocation plans for OPM due in July.</li> <li>• We have not yet received the report form our site visit one year ago.</li> <li>• There is a meeting in Lee Auditorium on May 14<sup>th</sup> to familiarize people with Block Grant expectations. We plan to have this meeting annually.</li> <li>• Full Block Grant application is due in September</li> </ul> |  |
| <p><b>DMHAS Update</b></p> <p>Jim Siemianowski</p> | <ul style="list-style-type: none"> <li>• Applying for a SAMHSA grant that will train First Responders and community sectors on Narcan. This award is for 45 grants up to \$800,000 per year for 4 years. We are unclear if CT will qualify because we are ahead in terms of municipalities, and not clear if we will be able to demonstrate the need.</li> <li>• Jim Siemianowski is retiring on May 31, 2019 and this will be his last meeting.</li> </ul>  |  |
| <p><b>Other Business</b></p>                       | None   |  |
| <p><b>Submitted by:</b></p>                        | Chrishaun Jackson  |  |

**Adult State Behavioral Health Planning Council  
Meeting Minutes**

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|--|--|---|
| <b>Meeting Day/Date:</b>   | Wednesday, January 16, 2019 - 12:30 PM – 2:30 PM   |   |
| <b>Location:</b>   | CVH, Page Hall, Room 212   |   |
| <b>Attendance:</b>   |  |   |
| <b>Members Present:</b>  | Marcia DuFore, Janine Sullivan-Wiley, Lisa Jameson, Pam Mautte, Carol Meredith, Nikki Richer, Ed Renaud, Allison Fulton, Michele Devine, Ingrid Gillespie, and Magda Lekarcyk  |   |
| <b>Staff Present:</b>  | Chrishaun Jackson, Susan Bouffard and Jim Siemianowski   |   |
| <b>AGENDA ITEM</b>   | <b>DISCUSSION</b>  | <b>ACTION</b>   |
| <b>Introductions</b>   | Minutes from October 17, 2018 were reviewed and accepted with one change; the addition of Annie Harper’s email. Annie Harper presented on <i>Financial Health and Mental Health</i> at the October 2018 Council meeting.   | Susan will revise and resend the minutes.   |
| <b>Review of Minutes</b>   |  |   |
| <b>RBHAOs Priority setting process update</b><br><br>RBHAO Directors | <p>Region 1: has already conducted some focus groups and will use their February LPC meeting to collect additional information.</p> <p>Region 2: has a prevention meeting scheduled for February at which they will collect additional information; they are gathering, reviewing, and beginning to pull information together.</p> <p>Region 3: requested assistance with accessing more current data than what they were able to find in the data portal from CPES which goes back to 2016. They do have DMHAS regional profile data from the most recent fiscal year. They have started working on some of the epidemiologic profiles.</p> <p>Region 4: has a prevention meeting scheduled for February at which they will collect additional information.</p> <p>Region 5: is collecting information at CAC meetings and at community wide focus groups. They are trying to create an inventory and have expanded data collection duties. They asked about the new focus group questions and were told that they were attached to the guidelines already distributed.</p> | Susan will contact Jane Ungamack and Jennifer Sussman to ask about more current CPES data for the regions.                |
| <b>Block Grant Update</b><br><br>Susan Bouffard                      | <ul style="list-style-type: none"> <li>• Mental health, substance use, and Synar reports due in December 2018 were all submitted on time</li> <li>• SAMHSA has begun sending revision requests to the state which we are responding to</li> <li>• Jessica Brunetti in DMHAS fiscal has replaced Chris Beauty who transferred to CMHC</li> <li>• Per the state project officer, the current government shut down should not interfere with block grant dollars as SAMHSA has already received its FY 2019 allocation</li> <li>• No written report has yet been received from the April 2018 compliance monitoring visit at</li> </ul>   | Carol will follow up with the SAMHSA prevention project officer to ask about changes to the primary prevention set-aside. |

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|  | <p>DMHAS</p> <ul style="list-style-type: none"> <li>• Next in the block grant schedule will be a request from OPM for allocation plans which is expected in June 2019, followed by the full block grant application and plan due in September 2019</li> </ul> <p>Michele Devine said she'd heard an announcement at a conference that the primary prevention set-aside of 20% was going to be discontinued for 2020. She clarified that the funds would still be provided to the state, but would not have to be designated for primary prevention. Carol Meredith, the DMHAS Director of Prevention, has a monthly call with the SAMHSA prevention project officer and will follow up on this information.</p>   |  |
| <p><b>DMHAS Update</b></p> <p>Jim Siemianowski</p>                       | <ul style="list-style-type: none"> <li>• Relating back to the earlier discussion about data for the regions to use as part of their needs assessment/priority setting process, the EQMI Annual Statistical Report for FY 18 has been posted on the DMHAS website. While it does not provide information on demand or need for services per se, it does provide information on bed utilization. Additionally, the appendices include information by region. There was a request for more trend data. Jim responded that previous years' Annual Statistical Reports are also posted on the DMHAS website under the EQMI office in the reports section, but it is a good suggestion to include more trend data. The only trend data in the current Annual Statistical Report focuses on opioid admissions from 2013 through 2017.</li> <li>• Commissioner Delphin-Rittmon has been nominated for re-appointment by the new administration. Additionally, Julienne Giard will become the new Community Services Division (CSD) Director, taking over from Lauren Siembab who will be managing the numerous opioid-related grants. Related to this, while there is no definitive word, there's talk that the state might be awarded an additional \$5.5 million in grant dollars for opioid services and clarification is expected in the next week. These new funds would be in addition to the SOR grant dollars.</li> </ul> |  |
| <p><b>Suggestions for Future Presentations</b></p> <p>Susan Bouffard</p> | <p>Susan reported that there is only one presentation scheduled so far for 2019 and that is Pam Mautte for the March Joint Council meeting on the topic of Human Trafficking. Other suggestions made were:</p> <ul style="list-style-type: none"> <li>• ACEs (Adverse Childhood Experiences) - for the Joint Council with Celeste Jorge of DPH as a contact</li> <li>• Peer Support – Susan had organized a presentation by the Recovery Coaches, who focus on substance use, in 2018, but the suggestion was to look at the range of peer support options and perhaps have a panel. Chyrell Bellamy was recommended as a contact for this topic</li> </ul>   | <p>Susan will attempt to contact and schedule presentations on these topics for future Council meetings.</p> |



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|  | <ul style="list-style-type: none"> <li>• Problem Gambling – there are many new options for people to be exposed to gambling and March is problem gambling awareness month. Jeremy Wampler was suggested as the contact.</li> <li>• Parent/Family support programs are being created at a number of sites, including ones involving grandparents. This topic should be a joint effort with DCF.</li> <li>• Older adults – the population is aging and more specialized services are becoming available at rehabs, nursing homes, AA meetings (<i>gray AA</i>). Erin Levitt-Smith is the contact for this topic.</li> </ul>   |  |
| <b>Other Business</b>                      | <p>Nikki Richer reported that YAS has applied for a grant for 18 – 25 year olds who need, but don't meet criteria to receive YAS services. If awarded, the funds would go to outreach, engagement, and treatment. Awards will be made in March 2019.</p> <p>Using the WebEx system to conduct meetings remotely wasn't entirely smooth this first attempt. Before the next remote meeting, more clear instructions will be sent about what information has to be entered on the screen once the link to the meeting has been clicked.</p> <p>Janine Sullivan-Wiley announced that after her many years of involvement in the Planning Council, she will be retiring once the merger to the new RBHAO is finalized in region 5 at the end of February-beginning of March 2019. She is also expecting a new grandchild any day. Our congratulations and thanks to Janine for her many years of service.</p> <p>The next Council meeting will be the Joint meeting in March 17, 2019 from 2 – 4 pm in Page Hall room 217 with the presentation on Human Trafficking by Pam Mautte.</p> |  |
| <b>Submitted by:</b><br><br>Susan Bouffard | January 17, 2019.   |  |

**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

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|--|--|---------------|
| <b>Meeting Day/Date:</b>               | Thursday, March 14, 2019, 2:00 – 4:00 PM   |               |
| <b>Location:</b>                       | Connecticut Valley Hospital, Page Hall – Room 217  |               |
| <b>Attendance:</b>                     |  |               |
| <b>Members Present:</b>                | Jo Hawke, Marcia DuFore, Pam Mautte, Nan Arnstein, Margaret Watt, Melanie Wallace, Lisa Jamison, Nikki Richer, Jennifer Abbatemarco, Michele Devine, Kathy Flaherty, Ellen Econs   |               |
| <b>Staff Present:</b>                  | Susan Bouffard, Jim Siemianowski, Mary Cummins, Michael Giralmo, Chrishaun Jackson, and Tim Marshall   |               |
| <b>AGENDA ITEM</b>                     |  | <b>ACTION</b> |
|  | The minutes of November 8, 2018 were accepted without correction.  |               |
| <b>Human Trafficking</b><br>Pam Mautte | <ul style="list-style-type: none"> <li>• Pam Mautte provided an overview of human trafficking. Both sex and labor trafficking involve force, fraud and/or coercion and are the exchange of sex or labor for anything of value, including basic needs. Legislation has been enacted to try and help victims of trafficking and ensure that they are provided support services and protection. Human trafficking is a global problem and can happen anywhere, especially where young people are found. It not only occurs on the street, but also in clubs, casinos, escort services, private parties, etc. Many websites and apps are used for sex trafficking and there are ongoing efforts to intervene and close these sites down.</li> <li>• Be mindful of using certain terms such as “prostitute”, “John” and “pimp”. Persons should not be referred to as “prostitutes” when they are victims. The words “John and Pimp” glorify or mask the actual behaviors: buyers or purveyors of sexual molestation. There is a particular language used by those that are part of trafficking as well.</li> <li>• In Connecticut, legislation protects persons under the age of 18 from being arrested for prostitution. Suspected cases of underage sex trafficking should be reported to DCF at 1-800-842-2288. From 2008 – 2017 in Connecticut, 846 children (ages 2 – 18) were involved in sex trafficking and the majority were runaway/AWOL. In 2017 in our state, there were 212 children of every race/ethnicity involved. Often the trafficking occurs along the truck routes in the state.</li> <li>• Vulnerable children are the ones most at risk to become involved in trafficking. Risk factors include: drug use, juvenile justice involvement, trauma, LGBT, child welfare involvement, foster care, and most significantly, children that are runaways and/or homeless. The risk of being lured into trafficking should be discussed with children. Many victims aren’t aware that what they are involved in is a crime.</li> <li>• Many resources are available in Connecticut, including: Youth Awareness, Not a Number, My Life My Choice, Love 146, Foster Care, Mentoring, etc. The National Human Trafficking Resource Center website is also a good resource.</li> </ul> |               |

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| <p><b>Agency Updates (DMHAS)</b><br/>Jim Siemianowski</p> | <ul style="list-style-type: none"> <li>Retirements were announced: Nikki Richer is retiring the end of March and Jennifer Abbatemarco will be assuming her position on the Planning Council. Jennifer has worked for both DCF and DMHAS; Janine Sullivan-Wiley's retirement is effective March 15 and Jim is working on a Governor's proclamation for her; Jim himself is retiring effective May 30<sup>th</sup>.</li> </ul>  |  |
|   | <ul style="list-style-type: none"> <li>The Governor's budget includes a reduction to DMHAS of 1.7 million and includes privatization of the Torrington and Danbury Western CT Mental Health Network sites, along with 4 Young Adult Services group homes, Capitol Region Mental Health ITU unit, research funds cut to Yale/CMHC; but no layoffs associated with those sites – just re-assignment of staff</li> <li>A grant in the amount of 2 million/year for 5 years was awarded to DMHAS to add/enhance the behavioral health component of providers integrating primary care with behavioral health care. The grant is focused on FQHCs in Waterbury, Hartford, and Bridgeport and plays off the 16 Behavioral Health Homes as a model.</li> <li>DMHAS has received notice of technical assistance block grant fund dollars and Jim and Susan advocated for the Planning Council to be able to determine how to spend some of these dollars. The Commissioner has agreed. Jim and Susan will work with Carol Meredith in DMHAS Prevention and DCF and will send out information detailing the process after those discussions. The funds must be directed toward substance use technical assistance/training and must be spent this federal fiscal year (ending September 30, 2019). Ideas had been floated in this Planning Council previously. It was suggested that Susan look at the previous minutes to see what was proposed.</li> </ul> | <p>Susan will review the minutes from the previous meeting when suggestions were made for SAPT TA funds.</p> |
| <p><b>Agency Updates (DCF)</b><br/>Tim Marshall</p>       | <ul style="list-style-type: none"> <li>The new Commissioner is still making leadership appointments and modifying the reporting structure within DCF. The previous Commissioner had converted several positions into political appointments and the new Governor has asked all such appointments to submit their resignations so much remains up in the air with the leadership and reporting mechanism within the department.</li> <li>The DCF budget has been released and there is much anxiety about it, but primarily it's the uncertainty about the leadership positions and the reporting structure that have staff concerned at present.</li> </ul>   |  |
| <p><b>Block Grant</b><br/>Susan Bouffard</p>              | <ul style="list-style-type: none"> <li>Connecticut has a new Substance Use project officer at SAMHSA named Spencer Clark whom Jim and Susan spoke to on the phone today.</li> <li>The next item in the block grant calendar will be the Allocation Plans. OPM typically asks for these the beginning of June and the public hearing typically occurs in August. DMHAS does not anticipate significant changes in the Allocation Plans this year.</li> <li>In September, the full combined Block Grant Application and Plan will be due, including the description of the service system, priorities for the next 2-year cycle, etc.</li> <li>The written report from the Compliance Monitoring visit conducted in April 2018 has not yet been received, but at DMHAS work is being done on drafting policies/procedures for block grant requirements and activities.</li> </ul>   |  |

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|  | <ul style="list-style-type: none"> <li>• Revision requests for the SAPT Annual Report submitted last December are being addressed.</li> <li>• DMHAS has not received any news regarding its requests for material compliance related to the SAPT MOE.</li> </ul>  |  |
| <b>Other Business – recommendations for training needs</b> | <ul style="list-style-type: none"> <li>• The next Adult Planning Council meeting is scheduled for April 17, 2019 and there will be a presentation on problem gambling by Jeremy Wampler.</li> <li>• There is a Sports Betting breakfast (<i>free</i>) on March 20<sup>th</sup>, 9:30-11am at the Greek Olive in New Haven. A panel from the CT Counsel on Problem Gambling, and Problem Gambling services will talk about if sports betting comes to CT.</li> </ul> |  |
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| <b>Next Joint Meeting:</b>                                 | June 13, 2019 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.   |  |
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**Joint DMHAS/DCF Council Meeting  
Meeting Minutes**

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| <b>Meeting Day/Date:</b> | Thursday, June 13, 2019, 2:00 – 4:00 PM  |               |
| <b>Location:</b>         | Connecticut Valley Hospital, Page Hall – Room 217  |               |
| <b>Attendance:</b>       |  |               |
| <b>Members Present:</b>  | Doriana Vicedomini, Jo Hawke, Mary Cummins, Marcia DuFore, Angela Duhaime, Janice Anderson, and Jennifer Abbatemarco,  |               |
| <b>Staff Present:</b>    | Celeste Jorge and Xi Zheng, Epidemiologists, DPH, Tim Marshall, Michael Giralmo, Mary Cummins, Susan Bouffard  |               |
| <b>AGENDA ITEM</b>       |  | <b>ACTION</b> |
|                          | The minutes of 11/8/18 were accepted without correction.   |               |
| Pain & Opioids           | <p>Celeste Jorge and Xi Zheng from DPH presented on Adverse Childhood Experiences in CT (ACES) Survey Findings. DPH prepared the fact sheet from the Behavioral Risk Factor Surveillance System (BRFSS) information, a results-based survey conducted in all 50 states and some U.S. territories. Random phone numbers were used for adults ages 18 and over. The survey has collected data in Connecticut for several decades. The CDC sponsors the survey and allows DPH a 17- minute core set of questions that all states are required to ask. States are allowed to add modules, designed and approved by CDC, and may add a panel of state-specific questions. In 2017, DSS asked DPH about adding an ACES module. Adults answer questions from a 3-minute module about childhood experiences. DSS had money from Medicare and Medicaid to look at adults who experienced ACES and are now in the Medicare/Medicaid system. Conducting these surveys is expensive. ACES received a lot of attention from other domains in the last five years with continued interest in the data.</p> <p>The Fact sheet focused on the long-lasting negative impacts into adulthood with ACES not being uncommon. Out of the nine types of ACES asked about in 2017 - that fell into the two categories of childhood abuse or family dysfunction - 60% of CT adults said they experienced at least one. One out of five had three or more ACES in their childhood. The most common in CT were emotional abuse and having separated or divorced parents.</p> <p><u>Social Characteristics:</u> Those who reported ACES in the past are adults today with less education, under employed/ not employed, renters rather than homeowners, and enrolled in Medicaid. Certain types of ACES are more common by race and sex. Females were similar to males in having three or more ACES. Persons in the LGBTQI community had disproportionately higher numbers of ACES.</p> <p><u>Health Outcomes:</u> Adults having three or more ACES are three times more likely to be at risk for depression, five times more likely to be a victim of sexual violence, three times more likely</p> |               |

to be a cigarette smoker or have food insecurities, and more than twice as likely to suffer from certain chronic conditions. Increasing numbers of ACES are associated with poorer health outcomes.

Origins and Documentary: Celeste recommended participants watch “Resilience,” a one-hour documentary highlighting studies done on the connection between childhood experiences and the impact in adulthood. Multiple efforts to study this issue came together with an ACES study conducted in the late 1990’s. The movie looks at children experiencing toxic stress. DPH screened the movie for school-based health center staff several months ago.

Treatment Interventions: Promising practices and effective trauma-focused treatment are available in CT, such as at the Child Health Development Institute (CHDI) which is working with children in prevention and treatment. Children can be exposed to and experiencing stress for reasons other than abuse, such as poverty, lack of education and income and other adverse circumstances.

Costs: There are no plans to add ACES back to the Connecticut survey due to cost limitations (12 months of surveying cost about \$112,000 to conduct). The full survey had over 10,000 respondents that year; 8,000 answered the paneled questions. In 2016-2018, Connecticut was fortunate to have a lot of financial support for the BRFSS, partly from the state innovations model for Medicaid and Medicare. DSS sponsored these survey results. The preventive health block grant does provide funding to increase sample size and provide estimates to local health departments, but not for this specific module.

A question was asked about an equivalent add-on for the youth survey. DPH would like to ask about different types of trauma in the Youth Risk Behavior Survey (YRBS) done every other year with high schools only. There are some items on teen dating, but not on household abuse, neglect or violence. The next survey will be in two years. The YRBS is sponsored by the CDC and requires asking certain core questions, but states can modify questions to be more specific to their issues (e.g., Connecticut’s high rate of asthma). Connecticut went to an electronic format for more flexibility to modify the survey; the paper/pencil method with the Scantron sheet took approximately 40 minutes to complete and online took 25 minutes or less.

DPH will not have YRBS data this year because many schools refused to participate. This is the first year DPH won’t have representative data since 2005. Schools don’t want to be involved in surveys, yet it involves only four classrooms – 1 freshman, 1 sophomore, 1 junior and 1 senior class, done during advisory period with parental consent forms drafted with the school including an opt-out. School principals and superintendents say it will be disruptive and interfere with instructional time, even though DPH provides a financial incentive of \$1000 to the school for participating and encourages the school to use the funds for health-related activities. The survey

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|                               | <p>was previously under the SDE which required DPH to obtain clearance from the superintendent and principal as part of their protocol.</p> <p>DPH has presented to the BOE when principals felt that parents might react. Some were brought to the BOE because of parental consent policy in school districts. All Connecticut districts now have passive consent for similar activities that don't involve identifiable information.</p> <p>There are nine types of ACES, with examples given for each type; it takes two minutes to complete all modules. A crisis protocol is provided at the end of the survey in the event that it triggers emotions. The more interviewer time is involved, the more costly the survey becomes because of the pricing at the call center which includes length of minutes and the number of people surveyed.</p> <p>The CDC has a webpage devoted to adverse childhood experiences and trauma. Connecticut data, including the survey and fact sheet, are posted on the DPH website. A report can be found by local health departments and districts at <a href="http://www.ct.gov/dph/brfss">www.ct.gov/dph/brfss</a></p> <p>It takes approximately 127 attempts in Connecticut to get a person to complete the survey on their cell phone vs. 50 attempts in other states. This month, methodology changes are coming with Connecticut attempting to collect data on the phone. Interviewers will try to keep a person on the phone longer if a person answers yes to asthma. There's an attempt to ask a certain panel of questions on the phone, then push people to a website to complete online. This is an attempt to get people to complete the state specific survey but also gives DPH a look at the willingness to respond via the website.</p> <p>One of the first questions asked in the survey is "Are you a resident of CT?" to ensure only Connecticut residents are contacted, since people move to other states and keep their cell phones with the "860" prefix. If they are from out of state, they are asked the core questions and sent a link via text or email to complete the survey online. DPH is pushing CDC to be more accepting of different methodologies. Landlines are increasingly associated with an older population. The technology now uses phone calls that originate as voice over internet call, but phone calls originate from Virginia, and show a Connecticut DPH number.</p> |  |
| <p>Agency Updates (DMHAS)</p> | <p>Michael Giralmo:<br/>The DMHAS Commissioner has asked the quality division to take a look at opioid overdoses and deaths by race and gender in the Hartford area and trends over last 3 years by gender, race and town in response to a spike from suburbs to city.</p>   |  |

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|                             | <p>Legislative session coming to an end and there are several updates:</p> <ul style="list-style-type: none"> <li>• DMHAS is developing a task force to look at mental health treatment and prevention in higher education.</li> <li>• Tobacco 21 has passed and raises the legal age to purchase cigarettes and e-cigarettes from 18 to 21.</li> <li>• There is a plan to study the involuntary transport of those who have overdosed to get a medical evaluation and possible treatment for opioid overdose</li> <li>• As a result of legislation, DMHAS will discuss the need for in-home Medication Assisted Treatment</li> <li>• MAT services in correctional facilities are another new initiative.</li> <li>• There was a bill to increase minimum reimbursement rate for providers administering methadone maintenance services (MAT across the board). The increase is from \$77 for one client per week to \$88.</li> </ul>   |  |
| <p>Agency Updates (DCF)</p> | <ul style="list-style-type: none"> <li>• Tim Marshall: DCF has no Legislative updates. The department continues to transition with a new administration and restructuring. DCF and DMHAS are updating the Block Grant application and Allocation plan.</li> </ul>   |  |
| <p>Block Grant</p>          | <ul style="list-style-type: none"> <li>• Mary Cummins: DCF and DMHAS are working on the allocation plans. At Children’s Behavioral Health Advisory Council (CBHAC) last week, the group considered and approved the priority areas for the next year. CBHAC has traditionally used the mental health block grant priorities as their own areas of focus. This year they supported and endorsed: 1) family youth engagement; 2) access to a comprehensive array of services and supports; 3) system organization and accountability. Priorities in 2017 and 2018 were childhood trauma, family engagement, workforce development, suicide prevention, and FEP intervention and identification through Beacon Health Options. FAVOR will be doing a presentation in November about family engagement. DCF will send the allocation plan to DMHAS by June 28<sup>th</sup>. They are attempting to complete their portion of the full new mental health block grant application in July.</li> </ul> <p>Susan Bouffard: DMHAS has not received a written report from the Compliance monitoring visit in April 2018. DMHAS is working on the allocation plans for OPM and Legislature due July 10<sup>th</sup>. They are also working on the Block Grant application and using information from the 2017 submission as a basis for some updating. There are required priority (objective) areas which must be included including pregnant women with dependent children, people injecting drugs, serious emotionally disturbed children, first episode psychosis, TB, and SMI. DMHAS is waiting on results of the priority setting process that RBHAO’s must submit by the end of June to inform the selected priorities. Susan will be doing a presentation to the Adult Council on the Block Grant at July meeting. Need to</p> |  |



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|                     | <p>submit council membership contact information and double check addresses, phone numbers. People will be categorized as either parent, family member, person in recovery, provider or State employee to break down council membership in different way to meet required ratios that SAMSHA set. Mary and Susan will compile survey results by categories set by SAMSHA. Mary and Susan discussed presentations for end of year. Mary has FAVOR scheduled in November. Susan had proposed a presentation by Dr. Craig Burns from DOC's department of psychiatry to talk about behavioral health services. There was a suggestion to purchase the Resilience documentary for \$95 for group to view. There are other organizations that already have purchased it and could show it under their license.</p> |  |
| Other Business      | <ul style="list-style-type: none"> <li>• None</li> </ul>   |  |
| Next Joint Meeting: | September 12, 2019 at CVH Page Hall, Room 217 from 2:00 – 4:00 pm.   |  |

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**Adult State Behavioral Health Planning Council  
Meeting Minutes**

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| <b>Meeting Day/Date:</b>  | Wednesday, July 17, 2019 - 12:30 PM – 2:30 PM  |   |
| <b>Location:</b>  | CVH, Page Hall, Room 212   |   |
| <b>Attendance:</b>  |  |   |
| <b>Members Present:</b>   | Marcia DuFore, Carol Meredith, MuiMui Hin-McCormick, Pam Mautte, Margaret Watt, Angela Duhaime, Ed Renaud and Allison Fulton   |   |
| <b>Staff Present:</b>   | Susan Bouffard, Michael Giralmo  |   |
| <b>AGENDA ITEM</b>  | <b>DISCUSSION</b>  | <b>ACTION</b>   |
| <b>Introductions</b>  |  | Minutes will be corrected by adding Janice Andersen as having attended.   |
| <b>Review of Minutes</b>  | Minutes from the April 17 <sup>th</sup> meeting were approved with one correction in attendance.   |   |
| <b>20/21 Block Grant Application Presentation</b><br>Susan Bouffard | <p>Given scheduling constraints this year it was not feasible to present the block grant application to the Joint Council, so DCF presented to the Children’s Behavioral Advisory Council and DMHAS is now presenting to the Adult Behavioral Health Planning Council separately.</p> <p>The presentation of the 20/21 Block Grant Application was accompanied by a handout and covered:</p> <ul style="list-style-type: none"> <li>• <u>Funding</u>: For Mental Health, \$6,760,070 is the amount proposed by the President’s budget which is \$70,000 more than last year’s actual award. For Substance Abuse, \$18,210,035 is the amount proposed by the President’s budget which is \$5,000 less than last year’s actual award. The funding is subject to change.</li> <li>• <u>Changes from last block grant application</u>: No significant changes are noted</li> <li>• <u>Council Membership</u>: The Children’s Behavioral Health Advisory Council has 27 members and 4 vacancies. The Adult Behavioral Health Planning Council has 23 members with 1 vacancy. The council is always interested in expanding diversity. To this end, as was done at the last few meetings, anonymous surveys were distributed to all members asking them to check off all the various possible categories that apply to them and place their responses in the envelope for aggregation. It was explained that this information is required by SAMHSA. Susan also said she needed to know whether contact information for any members has changed so she will email out the contact list so members can check for accuracy.</li> </ul> | <p>Susan will email current contact information to members to have them check for accuracy.</p> <p>Susan will email members to verify their contact</p> |

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|  | <ul style="list-style-type: none"> <li>• <u>Priorities</u>: DCF has created priorities for the First Episode Psychosis (FEP) and the Serious Emotional Disturbance (SED) required areas which continue priorities from the previous block grant application:</li> <li>• <u>FEP</u>: Earlier identification and intervention for those with FEP through Beacon Health Options and their FEP Intensive Case Manager. The Council hosted a presentation by Beacon Health Options on this topic.</li> <li>• <u>SED</u> – Childhood Trauma – Ensure that children/ youth and their caregivers who have experienced trauma receive effective treatment using MATCH (Modular Approach to Therapy for Children with anxiety, depression, trauma and/or conduct disorder). The goal is to increase the number of agencies and clinicians trained and providing MATCH.</li> <li>• <u>SED</u> – Family Engagement – To insure that the voices, perspectives and input of family members are included in the development, planning and overseeing of the children’s behavioral health system using Family Systems Managers at FAVOR who recruit, train, and support youth and families to increase their participation.</li> <li>• <u>SED</u> – Workforce Development – To promote the development of a more informed and skilled workforce prepared to enter DCF positions and deliver evidence-based treatments by offering <i>Current Trends in Family Intervention: Evidence-based and promising practice models of In-home treatment in CT</i> curricula. The goal is to maintain the number of faculty trained and increase the number of students trained.</li> <li>• <u>SED</u> – Prevention of mental illness – The goal is to prevent/reduce suicide attempts and completions by distributing training materials and increasing the number of persons trained in suicide prevention and crisis response.</li> <li>• <u>Pregnant Women/Women with Dependent Children (PW/WDC)</u>: To ensure that women with substance use disorders/co-occurring conditions are educated about and have access to contraception, medication assisted treatment and other resources addressing both their substance use and reproductive needs. The goal is to educate all 15 of the recovery navigators that are part of the new Women’s REACH (recovery, engagement, access, coaching and healing) program on One Key Question and how to connect clients to appropriate resources.</li> <li>• <u>Serious Mental Illness (SMI)</u>: To automate real time availability of mental health community-based services and make them available to providers and the public for the purpose of decreasing hospitalization and increasing utilization of community-based beds.</li> </ul> | <p>information.</p> |
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- People who Inject Drugs (PWID): To increase engagement of people in medication assisted treatment as evidenced by their remaining in treatment at least 30-days post induction. To accomplish this goal, recovery coaches will be added to some methadone clinics and designated DMHAS managers will hold regular meetings with MAT providers to share data and best practices for engaging clients.
- Tuberculosis (TB): All substance use treatment program infection control nurses will be provided the most current information on infectious diseases, including high risk populations and current trends, including TB. At least 2 separate training sessions will be conducted by content experts and while a broad audience will be invited, the goal is to ensure that 100% of the infection control nurses participate in the education.
- Primary Prevention (PP): Based on the regions having submitted their priority setting reports, Susan has begun compiling the data into a statewide report. From these reports, she sent the DMHAS Prevention Division Director, Carol Meredith, a short list of suggested topics to serve as the primary prevention priority. Carol had requested that the Council first discuss the options as the discussion may serve to inform her selection. The topic list:
  - Vaping of nicotine and marijuana; use rates and perceived risk
  - Increase parental perception of risk of alcohol and ENDS (electronic nicotine delivery systems) via education
  - Address pro-social community beliefs/behaviors about marijuana
  - Use of prescription drugs other than opioids, namely, benzodiazepines and stimulants (including cocaine)
  - Confusion over CBDs (currently heavily marketed) versus THC
  - Development of a plan to address potential legalization of marijuana
  - Inclusion of fentanyl into cocaine and other products than heroin
  - Youth compliance inspections for under 21 purchases of alcohol/tobacco
  - Education for ages 14-25, 65+, and LGBTQI on alcohol/heroin/prescription drugs

It was pointed out that the Primary Prevention priority is funded by the substance abuse block grant and should focus on substance use issues, however, it did not necessarily have to be associated with an outcome that involved numbers. In other words, the goal could be legislation, policy development, education, etc.

Discussion/questions on the Block Grant Application presentation:

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|  | <ul style="list-style-type: none"><li>• It seems that most of the mental health focused priorities were proposed by DCF. Will DMHAS join DCF on the FEP priority? Which required priority areas are mental health versus substance abuse for DMHAS? The FEP priority represents the DCF portion of funds designated for the 10% FEP set-aside. For DMHAS, given that DCF has provided priorities for FEP and SED, only the SMI priority remains as part of the mental health requirements. The remainder are all required by the substance abuse block grant.</li><li>• Is the data needed for DCF's priority concerning suicide prevention going to be requested from the RBHAOs which are also conducting QPR training? Probably not as this is a continuation of a priority that DCF had from the previous block grant and if DCF did not previously request it, they probably have their own data source, but Susan will follow up with DCF.</li><li>• Project SAFE was replaced by DMHAS with the Women's REACH program. Who are the recovery navigators involved so that the RBHAOs know who to contact? Marcia looked up the information on her phone during the meeting and the recovery navigators can be contacted through their host providers.</li><li>• Regarding the priority on real time bed availability for mental health community-based levels of care, if there is no capacity for respite beds now, how will the bed availability system help? It's possible that, as was discovered with the inpatient psychiatric bed study previously produced by Jim Siemianowski, that there is capacity in the system, but due to lack of communication and coordination as would be provided by this system, the open beds aren't known at the time. It is an important first step to actually ascertain what kind of capacity the system has before any further steps can be taken. There was acknowledgement that this is a great step forward and something badly needed in the system. The question was asked whether transportation would also be available as part of this system. The answer to the transportation question was unknown, but Susan will attempt to find an answer.</li><li>• Concerning the priority on engaging clients in MAT, it appears that some people enrolled in MAT don't want to have to participate in the counseling that should be provided as an adjunct service and that reluctance serves as a barrier. Other barriers are transportation and childcare issues. It was asked whether clinicians would be using Motivational Interviewing. It is not possible to answer that question given private practitioners who have obtained the DATA waiver are able to provide MAT out of their private offices. Certainly, DMHAS has offered MI training sessions in the past.</li></ul> |  |
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- Proposals for the PP priority generated much discussion. The question was asked whether selection of a particular PP priority could mean additional funding would be made available. Susan responded that PP must be allotted a minimum of 20% of the substance abuse block grant, but she did not anticipate that additional funding beyond this would be made available regardless of which priority was selected. It was suggested that some of the topics could be grouped together as they were natural fits with each other. It was also suggested that as much education as possible on the proposed prevention topics be provided. Another proposal was that high risk groups be targeted with the prevention priority. In other words, that the training be population focused such that there would be multiple trainings targeted for specific populations. It was also encouraged that both students and parents be part of that targeted training. Another proposal was to take advantage of technology to reach a broader audience, although it was pointed out that there are generational differences in terms of who is comfortable using technology. It also was suggested that a small set of questions could be added at the end of the training. There are special populations, like non-primary English speaking and deaf/hard of hearing who may find the technology even more of a barrier and might be better off being trained in smaller in-person groups. Language translation services are available, however, and should be taken advantage of.
- Access to the results of a survey being conducted by Nydia Rios-Benitez on mobile crisis was requested. Susan was not familiar with this survey. The regions are expecting to be provided the results. Susan shared that the allocation plan for mental health did include additional funding for mobile crisis to be able to re-design and enhance the system, along with discharge funding dollars.
- Susan shared some of her conclusions based on reading the regional priority setting reports as she said much of the discussion around priorities mirrored what she had found in those reports. Each region presented the priority ranking matrix information differently in their respective reports. Some regions combined tobacco use and ENDS and others did not. One region split out various mental health conditions instead of staying with a single mental health category as the other regions did. One region filled out the priority ranking matrix as is, but other regions presented just the mean scores, just a ranked list, etc. However, Susan concluded that based on what was presented, the top three priorities state wide were:
  1. Mental Health Issues – focused on anxiety and depression in young people

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|   | <ol style="list-style-type: none"> <li>2. Alcohol use</li> <li>3. Non-medical use of prescription drugs</li> </ol> <ul style="list-style-type: none"> <li>• Susan and Carol will meet after this meeting to discuss these PP proposals.</li> </ul>  |  |
| <p><b>Block Grant Update</b><br/>Susan Bouffard</p> | <p>The Block Grant Application and Plan is due to SAMHSA by September 3<sup>rd</sup> and Susan and Mary are working on completing all the various component sections. The Application/Plan will be posted on both the DMHAS and DCF websites and a link will be sent to the Council members.</p> <p>The Allocation Plans were sent to OPM last Friday. OPM, after reviewing the plans, suggesting edits and asking questions, will send the approved plans to committees of the state legislature. A public hearing will be scheduled probably in August. When that date is known, it will be emailed to Council members. There can be little notice in terms of when the public hearing is scheduled. The public hearing on the block grants is typically a one-day all-day event in which all state agencies responsible for the several block grants will be expected to testify. The order in which the block grants will be heard is unknown beforehand as is the length of questioning which can be 5 minutes or 3 hours.</p> |  |
| <p><b>DMHAS Update</b><br/>Michael Giralmo</p>      | <ul style="list-style-type: none"> <li>• Jim Siemianowski retired but is back working as a Temporary Worker Retiree part time. The position of EQMI Director is expected to be posted this month.</li> <li>• DMHAS is working with DPH and OCME examining overdoses by location for the purpose of targeting interventions</li> <li>• DMHAS is working with state partners to apply for a grant on the Support Act for substance abuse disorder prevention. DSS will be the lead agency. All state agencies have met to plan their strategy.</li> <li>• DMHAS has multiple learning collaboratives underway, including for ACT, CSP, Supported Employment, Supported education, trauma &amp; gender, mobile crisis, CIT, clubhouses, mental health/co-occurring disorders outpatient, citizenship, a methadone roundtable, substance abuse residential, infectious diseases, group homes and recovery houses.</li> </ul>  |  |
| <p><b>Other Business</b></p>                        | <ul style="list-style-type: none"> <li>• Marcia asked whether other RBHAOs have been approached by the Lions Club or the Rotary Club concerning efforts around opioid education and medication disposal. Apparently these organizations are fundraising to support pharmacies giving away pharmacy disposal bags and information. The RBHAOs are already working on similar efforts. Ed suggested that anyone interested in reading about the origins of the opioid epidemic should read Sam Quinones' book entitled <i>Dreamland</i>.</li> </ul>   |  |

|   |  |  |
|---|--|--|
| <b>Meeting Adjourned</b><br>Marcia DuFore |  |  |
| <b>Next Adult Council Meeting</b>         | October 16, 2019 from 12:30 – 2:30 at CVH Page Hall room 212 with a presentation on Older Adults and Behavioral Health by Erin Leavitt-Smith |  |
| <b>Respectfully Submitted by</b>          | Susan Bouffard, PhD  |  |

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## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
 State Vocational Rehabilitation Agency  
 State Criminal Justice Agency  
 State Housing Agency  
 State Social Services Agency  
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

| Name                  | Type of Membership*  | Agency or Organization Represented | Address, Phone, and Fax   | Email(if available)          |
|-----------------------|--|------------------------------------|---|------------------------------|
| Jennifer Abbatemarco  | Youth/adolescent representative (or member from an organization serving young people)    | DMHAS - YAS                        | 1800 Silver Ave<br>Middletown CT,<br>06457<br>PH: 860-262-6962<br>FX: 860-262-6962      | jennifer.abbatemarco@ct.gov  |
| Tiffanie Allain       | Providers  | PATH                               | 277 South St.<br>Brooklyn CT, 06234<br>PH: 860-412-0041                                 | tallain@pathct.org           |
| Nan Arnstein          | Providers  | Creative Arts for Developing Minds | 141 Weston St.<br>Hartford CT, 06142<br>PH: 860-834-3359                                | narnstein@creativeartsdm.org |
| Margaret (Peggy) Ayer | Parents of children with SED/SUD   |                                    | 151 Pond Rd. North<br>Franklin CT, 06254<br>PH: 860-642-4348                            | msayer7@comcast.net          |
| Craig Burns           | State Employees  | Dept of Correction (DOC)           | 24 Wolcott Hill Rd<br>Wethersfield CT,<br>06109<br>PH: 860-692-6262<br>FX: 860-730-8287 | craig.burns@ct.gov           |
| Erica Charles-Davey   | Parents of children with SED/SUD   |                                    | 247 Collins St.<br>Hartford CT, 06105<br>PH: 860-951-1830<br>FX: 860-310-2260           | ericadevy@gmail.com          |
| Joan Cretella         | Family Members of Individuals in Recovery (to include family members of adults with SMI) |                                    | 225 Beach St. West<br>Haven CT, 06516<br>PH: 203-933-4272                               |                              |
| Michele Devine        | Persons in recovery from or providing treatment for or advocating for SUD services       | SERAC                              | 228 West Town St.<br>Norwich CT, 06360<br>PH: 860-848-2800<br>FX: 860-848-2801          | serac.ed@sbcglobal.net       |
| Marcia DuFore         | Family Members of Individuals in Recovery (to include family members of adults with SMI) | Amplify                            | 151 New Park Ave.<br>Hartford CT, 06106<br>PH: 860-667-6388                             | mdufore@amplify.org          |
| Ellen Econs           | State Employees  | Bureau of Rehabilitation Services  | 410 Capitol Ave.<br>Hartford CT, 06134<br>PH: 860-308-4523<br>FX: 860-262-5852          | ellen.econs@ct.gov           |

|                       |  |                                     |   |  |
|-----------------------|--|-------------------------------------|---|--|
| Michaela Fissel       | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | Advocacy Unlimited                  | 300 Russell Rd.<br>Wethersfield CT,<br>06019<br>PH: 860-667-0460<br>FX: 860-666-2240  | mfissel@advocacyunlimited.org          |
| Kathy Flaherty        | Others (Advocates who are not State employees or providers)  | CT Legal Rights Project             | CLRP, PO Box 351<br>Middletown CT,<br>06457<br>PH: 860-262-5033<br>FX: 860-262-5035   | kflaherty@clrp.org                     |
| Allison Fulton        | Persons in recovery from or providing treatment for or advocating for SUD services                               | Western CT Coalition                | 7 Old Sherman<br>Turnpike<br>Danbury CT, 06810<br>PH: 203-743-7741                    | afulton@wctcoalition.org               |
| Ingrid Gillespie      | Persons in recovery from or providing treatment for or advocating for SUD services                               | CT Prevention Network               | c/o<br>Communities4Action<br>Stamford CT, 06902<br>PH: 203-588-0457                   | igillespie@communities4action.org      |
| Susan Graham          | Parents of children with SED/SUD   |                                     | 141 High St.<br>Thomaston CT, 06787<br>PH: 860-309-4322                               | sgraham141@yahoo.com                   |
| Natine Haley          | Parents of children with SED/SUD   |                                     | 101 Oak Aww 1st<br>floor Shelton CT,<br>06484<br>PH: 203-954-9025                     | msi32361@yahoo.com                     |
| Gabrielle Hall        | Providers  | Beacon Health Options               | 500 Enterprise Dr.<br>Rocky Hill CT, 06067<br>PH: 860-707-1016                        | gabrielle.hall@beaconhealthoptions.com |
| William (Bill) Halsey | State Employees  | Department of Social Services       | 25 Sigourney St.<br>Hartford CT, 06106<br>PH: 860-424-5077<br>FX: 860-424-4812        | william.halsey@ct.gov                  |
| Josephine Hawke       | Parents of children with SED/SUD   |                                     | 65 Woodmere Rd.<br>West Hartford CT,<br>06067<br>PH: 860-231-9856<br>FX: 860-563-3961 | johawke@sbcglobal.net                  |
| Brenetta Henry        | Parents of children with SED/SUD   |                                     | 73 Governor St. East<br>Hartford CT, 06108  | brenetta.henry@yahoo.com               |
| Irene Herden          | Others (Advocates who are not State employees or providers)  |                                     | 49 Bogue Ln East<br>Haddam CT, 06423<br>PH: 860-873-1999<br>FX: 860-873-1999          | evherd@comcast.net                     |
| MuiMui Hin-McCormick  | Persons in recovery from or providing treatment for or advocating for SUD services                               | Rushford                            | 1250 Silver St.<br>Middletown CT,<br>06457<br>PH: 860-852-1021<br>FX: 860-343-1732    | muihui.hin-mccormick@hhchealth.org     |
| Lisa Jameson          | Parents of children with SED/SUD   |                                     | 112 Bell-Aire Cir.<br>Windsor CT, 06096<br>PH: 860-623-5790                           | lisajameson22@gmail.com                |
| Tim Marshall          | State Employees  | Department of Children and Families | 505 Hudson St.<br>Hartford CT, 06105<br>PH: 860-550-6531<br>FX: 860-556-8022          | tim.marshall@ct.gov                    |

|                       |  |                                      |  |                             |
|-----------------------|--|--------------------------------------|--|-----------------------------|
| Mary Martinez         | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) |                                      | 7 Mary Shepherd Pl.<br>Hartford CT, 06120<br>PH: 860-719-5080                  | mryadvcomm35@gmail.com      |
| Donna Maselli         | State Employees  | Department of Public Health          | 410 Capitol Ave.<br>Hartford CT, 06134<br>PH: 860-509-7505                     | donna.maselli@ct.gov        |
| Pamela Mautte         | Others (Advocates who are not State employees or providers)  | Alliance for Prevention and Wellness | 127 Washington Ave.<br>North Haven CT,<br>06473<br>PH: 203-892-6418            | pmautte@bhcare.org          |
| Debbie McCusker       | Parents of children with SED/SUD   |                                      | 35 Maywood St.<br>Waterbury CT, 06704<br>PH: 203-757-7569                      | jamesmccusker@sbcglobal.net |
| George McDonald       | Parents of children with SED/SUD   |                                      | PO Box 2617 Hartford<br>CT, 06146<br>PH: 860-794-6283                          |                             |
| Evelyn Melendez       | Parents of children with SED/SUD   |                                      | 50 Larrabee St.<br>East Hartford CT,<br>06108<br>PH: 860-890-2469              |                             |
| Carol Meredith        | State Employees  | DMHAS - Prevention Division          | 410 Capitol Ave.<br>Hartford CT, 06134<br>PH: 860-418-6826<br>FX: 860-418-6792 | carol.meredith@ct.gov       |
| Bailey Mulqueen       | State Employees  | Office of Planning and Management    | 450 Capitol Ave.<br>Hartford CT, 06134<br>PH: 860-418-6257<br>FX: 860-418-6490 | bailey.mulqueen@ct.gov      |
| Scott Newgass         | State Employees  | CT State Department of Education     | 450 Columbus Ave<br>Hartford CT, 06106<br>PH: 860-807-2044<br>FX: 860-807-2127 | scott.newgass@ct.gov        |
| Daisy Olivo           | Providers  | FAVOR, Inc.                          | 185 Silas Dean Hwy.<br>Wethersfield CT,<br>06109<br>PH: 860-837-1436           | dolivo@favor-ct.org         |
| Maureen O'Neill-Davis | Parents of children with SED/SUD   |                                      | Torrington CT, 06790<br>PH: 561-762-4747                                       | maureenod65@gmail.com       |
| Edwin Renaud          | State Employees  | CVH                                  | PO Box 351<br>Middletown CT,<br>06457<br>PH: 860-262-5496<br>FX: 860-262-5895  | edwin.renaud@ct.gov         |
| Barbara Roberts       | Family Members of Individuals in Recovery (to include family members of adults with SMI)                         |                                      | 42 School St.<br>Woodbury CT, 06798<br>PH: 203-263-3250                        | barbararoberts882@gmail.com |
| Heather Tartaglia     | Providers  | CREC                                 | 111 Charter oak<br>Hartford CT, 06106<br>PH: 860-509-3732                      | heathertaglia@crec.org      |
| Peter Tolisano        | State Employees  | DDS                                  | 460 Capitol Ave.<br>Hartford CT, 06106<br>PH: 860-418-6086                     | peter.tolisano@ct.gov       |
|                       |  |                                      | 936 Silas Deane  |                             |

|                    |                                  |  |   |                           |
|--------------------|----------------------------------|--|---|---------------------------|
| John Torello       | State Employees                  | Court Support Services Division (CSSD) | Highway Wethersfield CT, 06109<br>PH: 860-721-2157                          | john.torello@jud.ct.gov   |
| Benita Toussaint   | Parents of children with SED/SUD |  | 45 Niles St. Hartford CT, 06105<br>PH: 860-249-4806                         | toussaintbenita@yahoo.com |
| Ofelia Velazquez   | Parents of children with SED/SUD |  | 55 Taylor Street Hartford CT, 06010<br>PH: 860-313-9130                     | ovy4252@yahoo.com         |
| Doriana Vicedomini | Parents of children with SED/SUD |  | 9 Kingfisher Ln. Suffield CT, 06078<br>PH: 504-259-4327                     | dmv35@aol.com             |
| Laura Watson       | State Employees                  | DOH                                    | 505 Hudson St. Hartford CT, 06106<br>PH: 860-270-8169<br>FX: 860-706-5741   | laura.watson@ct.gov       |
| Margaret Watt      | Parents of children with SED/SUD | The Hub                                | 1 Park St. Norwalk CT, 06851<br>PH: 203-840-1187                            | mwatt@thehubct.org        |
| Cara Westcott      | Providers                        | United Community and Family            | UCF Health Center Norwich CT, 06360<br>PH: 860-892-7042<br>FX: 860-886-6124 | cwestcott@ucfs.org        |

\*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

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## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

| Type of Membership  | Number    | Percentage of Total Membership |
|---|-----------|--------------------------------|
| <b>Total Membership</b>   | <b>49</b> |                                |
| Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services) | 2         |                                |
| Family Members of Individuals in Recovery* (to include family members of adults with SMI)                         | 3         |                                |
| Parents of children with SED/SUD*   | 15        |                                |
| Vacancies (Individuals and Family Members)  | 4         |                                |
| Others (Advocates who are not State employees or providers)   | 3         |                                |
| Persons in recovery from or providing treatment for or advocating for SUD services                                | 4         |                                |
| Representatives from Federally Recognized Tribes  | 0         |                                |
| <b>Total Individuals in Recovery, Family Members &amp; Others</b>   | <b>31</b> | <b>63.27%</b>                  |
| State Employees   | 12        |                                |
| Providers   | 6         |                                |
| Vacancies   | 0         |                                |
| <b>Total State Employees &amp; Providers</b>  | <b>18</b> | <b>36.73%</b>                  |
| Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations                                     | 11        |                                |
| Providers from Diverse Racial, Ethnic, and LGBTQ Populations  | 4         |                                |
| <b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>                         | <b>15</b> |                                |
| Youth/adolescent representative (or member from an organization serving young people)                             | 1         |                                |

\* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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#### 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:
  - c) Other (e.g. public service announcements, print media)  Yes  No

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**Footnotes:**

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