

# State Information

## State Information

### Plan Year

Start Year 2016

End Year 2017

### 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 860-418-8650

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

Mailing Address 410 Capitol Ave

City Hartford

Zip Code 06134

Telephone (860) 418-8650

Fax

Email Address Miriam.Delphin-Rittmon@ct.gov

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

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Susan

Last Name Wolfe

Telephone 860-418-6993

Fax 860-418-6896

Email Address susan.wolfe@ct.gov

Footnotes:

# State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 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 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
Section 1922	Certain Allocations	<a href="#">42 USC § 300x-22</a>
Section 1923	Intravenous Substance Abuse	<a href="#">42 USC § 300x-23</a>
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	<a href="#">42 USC § 300x-24</a>
Section 1925	Group Homes for Recovering Substance Abusers	<a href="#">42 USC § 300x-25</a>
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	<a href="#">42 USC § 300x-26</a>
Section 1927	Treatment Services for Pregnant Women	<a href="#">42 USC § 300x-27</a>
Section 1928	Additional Agreements	<a href="#">42 USC § 300x-28</a>
Section 1929	Submission to Secretary of Statewide Assessment of Needs	<a href="#">42 USC § 300x-29</a>
Section 1930	Maintenance of Effort Regarding State Expenditures	<a href="#">42 USC § 300x-30</a>
Section 1931	Restrictions on Expenditure of Grant	<a href="#">42 USC § 300x-31</a>
Section 1932	Application for Grant; Approval of State Plan	<a href="#">42 USC § 300x-32</a>
Section 1935	Core Data Set	<a href="#">42 USC § 300x-35</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
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	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

Note: 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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## LIST of CERTIFICATIONS

### 1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

### 3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

Footnotes:

# State Information

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Fiscal Year 2016

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  
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 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	<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>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
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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.
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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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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

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

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

NA

## Planning Steps

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

Narrative Question:

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Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

**State of Connecticut  
Combined SAPT/CMHS Block Grant Application  
Federal Fiscal Year (FFY) 2016-2017**

**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 2016-2017 combined Block Grant application. DCF contributed only to the development of the Community Mental Health Services (CMHS) Block Grant, as Connecticut has a consolidated child welfare agency. Both the Substance Abuse Prevention and Treatment (SAPT) and CMHS Block Grant components were developed in close collaboration with Connecticut's State Behavioral Health Planning Council (SBHPC), having transitioned the State Mental Health Planning Council to encompass substance use services as of October 2012.

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 service agencies in July 1995, DMHAS has expanded its vision to incorporate the growing body of promising behavioral health service 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 Action Councils (RACs) and Regional Mental Health Boards (RMHBs), 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) 2014, DMHAS provided and/or funded behavioral health services to over 107,000 individuals, through its inpatient, outpatient, and recovery support programs. Over 99,000 persons were recipients of prevention and health promotion activities in the Institute of Medicine (IOM) categories of selected and indicated, while over 18 million persons were potential target recipients of some form of universal prevention effort conducted within the state.

## **Behavioral Health Assessment and Plan**

### **A. Overview**

#### **Connecticut Demographic Data**

Connecticut is a small state with a net land area of 4,842 square miles and an average of 743 people per square mile. It has a total population of 3,596,677 according to the U.S. Census Bureau Quick Facts – as of July 1, 2013, which represents a slight increase of 0.6% from the 2010 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 (ORH) definition (census less than 10,000 **and** population density of 500 or less people per square mile). The total rural population of Connecticut is 334,275. 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 2013 U.S. Census Bureau estimates, Connecticut's racial composition is as follows:

- 81.6% White/Caucasian
- 11.3% Black/African American
- 4.3% Asian
- 0.5% American Indian/Alaska Native
- 0.1% Native Hawaiian/Other Pacific Islander
- 2.1% Two or more races

Hispanic/Latinos comprise 14.7% of the total population of Connecticut.

Based on estimated changes in the census data from 2010 to 2013, Connecticut has an increasing percentage of older people (15.2% are age 65 or older), as well as more Hispanic/Latino (up 2%) and white residents (up 4%). Eighty-nine percent of residents graduate high school and more than a third (36.5%) have a Bachelor's degree or higher education. Six percent of the state's population are veterans. Notably, 21.5% of Connecticut citizen's speak a language other than English at home (for persons age 5+).

## DMHAS Organizational Structure

### Overview

DMHAS' **mission** is "to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect." DMHAS' mission statement sets forth the department's vision and philosophy, providing the guiding principles upon which services are delivered. The values that define DMHAS' guiding principles, and to which DMHAS is strongly committed, are Quality, Responsibility, Diversity, Integrity, Respect, Empowerment, Collaboration, Hope, Trust, Communication and Recovery.

DMHAS is Connecticut's State 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, CMHS and SAPT block grant 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 abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the Department of Children and Families (DCF)'s 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 three inpatient hospitals and contracts with a number of community general hospitals and one private psychiatric hospital for inpatient and ambulatory care. Department-operated inpatient hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services for those with substance use disorders (SUD). In addition, one DMHAS hospital has a 20-bed co-occurring inpatient unit for those with SMI and a SUD. Substance use outpatient treatment services are also provided at one of the DMHAS hospitals. Community addiction treatment services are delivered by a vast network of private nonprofit providers and programs across all levels of care. These providers receive funding directly, as for the most part there are no intermediaries, except in a few instances such as Project SAFE and certain Medicaid services.

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 Regional Action Councils (RACs) and Local Prevention Councils (LPCs) across 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 (Criteria 1)**

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 sub-acute beds, including Southeastern Connecticut Mental Health System (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 Division, located on the campus of CVH, operates 232 beds. Services are provided to individuals who are admitted under the following categories:

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

In 2010, DMHAS consolidated inpatient psychiatric beds by relocating the former Cedar Ridge Hospital to its CVH hospital campus. The department restructured its existing inpatient facilities to maximize resources, pool staff and clinical expertise, and provide for the efficient delivery of quality services. The Young Adult Services Program increased capacity with the move to the CVH campus and a co-occurring inpatient unit was established at the GBMHC facility. Lastly, the department, in collaboration with the states' Medicaid Authority (Department of Social Services – DSS), procured intermediate duration acute care beds in the community to meet the needs of those individuals appropriate for this level of care.

### **Contracted Inpatient Services (Criteria 1)**

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 has contracts with twelve general hospitals and one private psychiatric hospital to provide acute inpatient services on a fee-for-service basis. DMHAS 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 specially skilled evaluation and treatment services for individuals with serious mental illness and/or substance use disorders who become involved in the criminal justice system, and to serve the courts and other components of the criminal justice system. 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-booking to end of sentence after incarceration and return to the community.

#### **I. Pre-Booking Diversion**

##### **DMHAS Crisis Intervention Team (CIT)**

CIT is a pre-booking 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.

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.

## **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 mental 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, Danielson, 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 is expanding to provide statewide consultation to JD staff.

### **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 pretrial defendants with substance dependence in New Haven court (mostly men; 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.

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

DFS funds CCAR activities targeting persons with criminal justice involvement. CCAR staff provides outreach to probation and parole offices and to jails and prisons as well as CJ-specific programming at their centers.

### **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 (Criteria 1)**

The department's **Community Services Division (CSD)** has direct responsibility for overseeing all DMHAS contracted services, which includes funded LMHAs (and their affiliates) 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 Local Mental Health Authorities, to ensure contract compliance;
- 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;
- Establishing best practices within the service system through fidelity reviews and other on-site and data monitoring;

- 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
- 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 Commissioner. CSD Regional Staff coordinates with the state-operated LMHAs regarding the nonprofit affiliate agencies in order to assure access and coverage to mental health services.

LMHA functions usually 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
- 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 Crisis and Respite Care (Criteria 1)**

**Mobile Emergency Crisis** services are delivered in safe community settings such as at the LMHA, at any provider with a contract with the department, at walk-in clinics or in other community settings, including collaborating with the police through the use of mobile emergency crisis teams. Such services provide concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, stabilize psychiatric symptoms, behaviors, and situational problems, and whenever possible, avert the need for hospitalization. Mobile emergency crisis services focus on evaluation and stabilization activities, which may include assessment and evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions, and arrangements for further care and assistance as required.

**Crisis Respite Services** are provided in a structured, appropriate community setting that is staffed 24/7 by professional and paraprofessional staff, including a licensed prescriber, to individuals in response to psychiatric distress or conflict in a current living situation of such intensity or duration to require such services in order to avoid hospitalization. Crisis Respite Services provide monitoring and stabilization activities, including medication monitoring; targeted clinical interventions; and an array of outpatient interventions that include, at a minimum, long-term and short-term individual and group therapy, medication prescribing, and medication management as needed. Services provided are based on a treatment plan developed with the individual to facilitate development of self-management skills, improved functioning, client choice, and help to avoid decompensation and hospitalization.

**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.

**Residential Services** provide engagement interventions, an array of skill building activities, and numerous opportunities to participate in integrated community organizations and activities to facilitate recovery and develop a personal recovery support system. Residential services include group homes and supervised apartments.

**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** 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** 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.

**Residential Support** is a set of recovery-oriented services provided for the purpose of assisting individuals to live independently in a community residence, fulfill tenant responsibilities, and access and use community resources and supports.

**Supported Housing** (called "Supportive Housing" by DMHAS) fosters the development of long-term solutions to the housing and service needs of families and individuals coping with psychiatric disabilities and consists of transitional and/or permanent housing subsidies with funding for supportive services (see **Evidence-Based Practices**).

### **Mental Health Case Management (Criteria 1)**

Case Management services remain an important element in the DMHAS community service system and are available at several levels of intensity from agencies funded or operated by DMHAS.

In SFY 2009, DMHAS began to re-align its Mental Health Case Management services and implemented an initiative to establish Assertive Community Treatment (ACT) services that meet the federal fidelity requirements (see

**Evidence-Based Services).** Four ACT teams existed up until 2014 when six additional ACT teams were implemented with new state mental health grant dollars allocated by the CT Legislature for this purpose. Currently, DMHAS has a total of 10 ACT teams, five are in the PNP system and five are in the state operated LMHA system.

In 2010, DMHAS implemented an initiative to enhance skill building and recovery supports through the conversion of much of its mental health case management services to Community Support Programs (CSP) and Recovery Pathways (RP) services. There are 21 agencies (and 29 teams) providing CSP/RP across the state. The CSP portion of this level of care is a higher intensity service intended for individuals who are interested in doing more skill building and/or need more TCM services (i.e., at least three hours face to face service/month). The RP portion of this level of care is intended for individuals who are not yet engaged in services and need outreach, or individuals who are doing very well in their recovery and need a lower intensity of skill building and/or TCM (i.e., at least one hour of face to face service/month).

Both CSP and RP services are designed to assist adults with severe and persistent psychiatric disorders (including those with co-occurring substance use disorders). CSP/RP 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](#)

In addition, ACT and CSP/RP include the use of peer staff to draw on their experiences with SMI and co-occurring disorders, and to further facilitate recovery and community participation of the individuals served. Each of these 39 ACT and CSP/RP teams is required to hire at least one full time certified recovery support specialist. Implementation of these models will more effectively and efficiently meet the identified needs of participants; increase staff productivity thus increasing the case management capacity within the DMHAS system, and facilitate and support use of peers as staff to further the recovery-orientation of services and the DMHAS system.

### **Mental Health Recovery Support Services (Criteria 1)**

**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 include access to peer groups and relationships.

**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, and sustain recovery through individualized, home-based services and supports that may be helpful, and to promote the utilization of temporary guardianships.

**Peer Engagement Specialists** work with a multi-disciplinary community-based treatment team comprised of psychiatrists, social workers, and case managers to assist individuals with mental illness who have not been responsive to traditional forms of treatment. Peer Engagement 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.

**Peer Support Training Program** provides three consumer-operated recovery/advocacy training academies that train persons with lived experience in the following technologies: General System & Legislative Advocacy (in English and Spanish); General System & Legislative Advocacy for Young Adults; Certified Hearing Voices Support Group Facilitation; Certified Alternatives to Suicide Support Group Facilitation; Peer Bridging; Peer Support in Forensic Facilities; Certified Recovery Specialist Training; Addiction Recovery Coaching; Wellness Recovery Action Planning (WRAP); Intentional Peer Support (IPS); Pathways to Recovery; and, conduct classes in self-esteem and in developing networks of support. 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.

**Consumer Peer Support – Vocational Services** provide peer-based vocational supports to individuals with psychiatric disabilities. Through the use of trained mentors, mental health consumers are provided opportunities that aid in the development and pursuit of vocational goals consistent with the individual's recovery; assist with finding, obtaining, and maintaining stable employment; and promote an environment of understanding and respect in which the individual is supported in their recovery. These supports foster peer-to-peer assistance to transition individuals with psychiatric disabilities toward stable employment and economic self-sufficiency.

**Consumer Peer Support in General Hospital Outpatient Department** 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** is a recently developed peer bridging service designed for individuals who have had heavy involvement with probate courts and involuntary hospitalization.

### **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 DMHSA Young Adult Services as 18 – 21 year old clients are discharged to supportive community settings.

### **Supported Housing (DMHAS Supportive Housing)**

Supportive/Supported Housing services reach out to individuals and families with children who are homeless and have a mental health or substance abuse disability. Supportive housing services assist these individuals in securing permanent housing. Services include education about successful tenancy skills including, knowledge of tenant's rights and responsibilities and managing payments for housing expenses, including a monthly budget. These services also facilitate access to clinical, medical, social, educational, rehabilitative, employment and other services essential to achieving optimal quality of life and community living, based on an individual needs assessment. Services and supports are available to individuals at the level of intensity needed and for as long as required. In addition, DMHAS follows a "housing first" policy as it relates to supportive housing, meaning that there are no conditions placed on an individual or family before entering the program or while in the program. A person is able to maintain housing as long as the individual complies 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. 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. The DMHAS employment manager conducts fidelity reviews every two years at each site to insure on-going 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 to assist employment service providers to become Ticket to Work Employment Networks and promotes comprehensive collaboration with the Bureau of Rehabilitation Services (BRS), Connecticut's Vocational Rehabilitation Agency. Additionally, DMHAS staff continues to encourage and monitor strategies to increase family and peer supports for employment and education in collaboration with Dartmouth College. It should be noted that DMHAS Employment and Education services are scheduled for a rebid during the second quarter of 2015-16.

With the award of a new 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 Individual Placement and Support (IPS) supported employment services at the Hispanic Health Council, serving the Hispanic population in the greater Hartford area and persons with criminal justice involvement at Career Resources, Inc. in the greater New Haven area.

## **1617 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, counseling and management of withdrawal for heroin and other opioids in a non-residential setting
- **Residential Detoxification:** medical management of the withdrawal from alcohol and drugs along with 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
- **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

## **Detoxification Services**

### **Medically Managed Detoxification**

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.

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

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.

## **Residential Rehabilitation Services**

### **Intensive Residential Rehabilitation – Co-Occurring**

Intensive Residential Rehabilitation – Co-Occurring 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.

### **Intensive Residential Rehabilitation**

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**

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**

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 to 9 months.

### **Transitional/Halfway House**

Transitional Living and Halfway Houses are licensed by DPH to offer intermediate, long-term treatment, care and rehabilitation. 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.

### **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 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 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.

#### *Ambulatory Detoxification*

Ambulatory detoxification is a non-residential service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer ambulatory chemical detoxification, or a state-operated facility. 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.

#### **Recovery Housing**

Support Recovery Houses (SRH) are 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. SRH 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. Case management services include assessment, recovery planning, and discharge planning with the goal of linking residents to substance abuse 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 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.

The **forensic ICM** program provides intensive wrap around community services including group modalities and coordination with the criminal justice system to assist with compliance of court-stipulated treatment focused on establishing lives in recovery and reduced involvement with the criminal justice system.

### **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, including consumer-operated transportation programs, are provided to individuals receiving services from a department-operated or funded service provider. Transportation services can include transporting individuals to various appointment, school programs, shopping centers, and family events. Transportation services may also be provided to individuals at an emergency room or department-funded provider agency to another treatment location and any individual who may require transportation from one level of care to another.

In FY 2011, DMHAS created an Evidence-Based (EB) and Best Practices Governance Committee chaired by the DMHAS Commissioner. This committee met for the first time in January 2011 and continues to meet on a quarterly basis. The Governance Group consists of 17 members in addition to the Commissioner and includes other executive staff and Office of the Commissioner Division Directors. In 2010, DMHAS had designated a new position in the Office of the Commissioner: Director of Evidence-Based Practices. 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. Three 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.

The first product from this Governance Committee was the *DMHAS Catalog of Evidence-Based and Best Practices*. This catalog includes several practices that are currently being implemented in various ways through the DMHAS system of care, across multiple divisions. The catalog describes each practice, the number of programs involved, the implementation process being used, training and technical assistance currently available, a summary of fidelity measurements being used, and a summary of how client outcomes are being measured. The second product is a series of webpages on the DMHAS website that describe different evidence-based practices 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>.

DMHAS has been supporting the DMHAS-operated and funded mental health and addiction treatment providers in the use of the following evidence-based and best practices, including:

**Assertive Community Treatment (ACT)** 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 crisis services are recovery-oriented, and include intensive engagement, skill building, community support, crisis services, and treatment interventions. Services are provided to individuals who are determined by a department-approved assessment tool to be clinically appropriate to receive such services;

and who have been unsuccessful in completing treatment or participating in lower levels of care, or who have been discharged from multiple or extended stays in hospitals; and who are medically indigent. There are 10 ACT teams.

**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 fifteen 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.

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. Over the past two years, DMHAS has 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. This work continues to use the IDDT and DDCAT models with an added emphasis on supervision infrastructure and best practices. DMHAS' Co-Occurring Practice Improvement Collaborative meetings continue and provide an opportunity for programs to hear from each other. Fidelity reviews continue to be done. In addition, two co-occurring enhanced residential treatment programs that were procured in 2009 continue (primarily for quadrant III individuals) and a co-occurring enhanced inpatient unit that started in 2010 continues as well (primarily for quadrant IV individuals).

**Dialectical Behavior Therapy (DBT)** continues to be implemented in the state-operated LMHAs (6) and inpatient settings. The CT Women's Consortium, as part of its contract with DMHAS, is planning several DBT trainings in the coming year.

**Supported Employment (SE)**, using Individual Placement and Support (IPS), is implemented in thirty programs. This evidence-based model is described in their contract language as the scope of work. Fidelity reviews continue to support high fidelity implementation. DMHAS continues to participate in the national supported employment collaborative convened by Dartmouth. In fall 2014, DMHAS was awarded a SAMHSA Supported Employment grant to strengthen and expand SE services across the state.

**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** 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, through a network of contracted national experts. The Consortium trains over 2,000 professionals annually on trauma-informed care and trauma-specific services, such as Seeking Safety, TREM, M-TREM, Beyond Trauma, and Helping Men Recover. Gender-responsive services are also part of these offerings, including training/technical assistance from Stephanie Covington.

**Medication Assisted Treatment (MAT)** is provided through a strong network of methadone providers statewide. The availability of Suboxone 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 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).

### **Targeted Services and Populations**

DMHAS provides a number of specific targeted services to various adult populations in need of mental health treatment and recovery services. A brief description of those services and the targeted populations served follows:

#### **Trauma Services**

Assisting in recovery from the effects of abuse and other forms of trauma is essential to the well-being of survivors. Because recovery is integral to the DMHAS mission, the department is committed to the provision of services that are responsive to clients who are trauma survivors. DMHAS supports trauma-informed and trauma-specific services through:

- Seeking to reduce and eliminate those practices identified as having a negative or re-traumatizing effect on trauma survivors;
- Ensuring that service providers are aware and respectful of the importance of the values, traditions, and customs of the clients they serve; and
- Combating barriers to the development and provision of trauma-sensitive services for all persons engaged in DMHAS or DMHAS-funded services.

Connecticut adopted a Trauma Services Policy in April 2010, which DMHAS believes to be one of very few in the country. The purpose of this policy is to foster a behavioral health system that employs and practices principles that are trauma-sensitive and trauma-informed to individuals served by DMHAS and funded agencies. Services within this system must meet the needs of individuals and their families who have experienced trauma by establishing an environment that is safe, protects privacy and confidentiality, and eliminates the potential for re-victimization. Standardized screening tools for trauma are used and staff training is available.

DMHAS contracts annually with the Connecticut Women's Consortium 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: <http://www.womensconsortium.org/online-course-catalogue.cfm>. Models trained on include Seeking Safety, TREM, M-TREM, Helping Women Recover, Helping Men Recover, and Beyond Trauma. Certain trauma-specific training provides a copy of the manual for each participant. The Seeking Safety training includes ongoing follow-up phone consultation with the trainer. 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 Consortium also collaborates with Trauma Recovery to provide EMDR training events.
- The Trauma and Gender (TAG) Agencies Project: On an annual basis, DMHAS releases a Request for Qualifications (RFQ) to recruit four DMHAS-operated or -funded agencies to guide through a two-year change process to become more trauma-informed and gender-responsive. This training and technical assistance (TA) is more focused on trauma-informed care, as opposed to trauma-specific, services. A Trauma and Gender Fidelity Scale is used to assess baseline and follow-up intervals. The Consortium contracts with expert trainers and consultants to staff this project. A comprehensive written toolkit is provided to the agencies as a resource.
- The Consortium publishes a *Trauma Matters* newsletter quarterly which is widely distributed.
- The Consortium maintains a Trauma Directory of trauma services statewide. It is currently being updated based on the first recent statewide trauma survey of DMHAS programs.
- A quarterly Trauma Providers Meeting is hosted by the Consortium for networking, presentations, and sharing lessons learned in providing trauma services.
- A statewide Trauma and Gender Guide Team meets monthly which includes representation from DMHAS, the Consortium, TAG Agency

Providers Project, persons in recovery, and consultants to share information, progress, and new directions.

- The DMHAS Trauma webpage:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335292>.
- DMHAS recently created a 30-minute video on Men and Trauma, which will be formally released in May 2015.

## **Women's Services**

In an effort to meet the many needs of addicted pregnant women and women with dependent children, DMHAS funds a number of programs established to provide comprehensive addiction services to substance abusing women, their infants and children.

Treatment services provided by these programs include individual, group, and family therapy, and where appropriate, family members are encouraged to participate in treatment sessions and self-help groups. The programs emphasize proper pre/post natal care in cooperation with local medical facilities. Educational and counseling groups concentrate on nutrition, hygiene, child development, substance abuse prevention, coping skills, and women's issues. These programs also allow participants to improve their education through GED classes or participation in courses at the local community college.

**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;
- Identify and provide 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, 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.

### **Women's Funded Services under the Block Grant**

**LMG – Families in Recovery**, a residential program for pregnant and parenting women and their children, offers services that assist women to develop and maintain a substance-free lifestyle, such as relapse prevention, access to primary health care, prenatal, delivery, and post-partum care. Other services offered include life skills development, anger and stress management, parenting skills, and self-esteem building. The capacity for this residential program is seven women and ten children.

**Family and Children's Agency – Project REWARD** provides a flexible program for outpatient substance use and child development services. Treatment topics include, but are not limited to the following: chemical dependence, relapse prevention, HIV/AIDS prevention and management, family planning, reproductive health, nutrition, parenting skills, self-esteem, stress management and life management skills.

**CASA – Project Courage** - outpatient treatment program is available to women sixteen years of age and older who have a history of chemical dependence and are pregnant or have delivered a baby within the last year. The program is divided into three treatment phases: Induction, Intensive Treatment, and Intermediate Treatment. Treatment topics include: chemical dependence, relapse prevention, HIV/AIDS prevention and management, family planning, reproductive health, nutrition, interpersonal communication, parenting skills, self-esteem, stress management and life management skills.

**Crossroads – Amethyst House** is a state-of-the-art residential care program for chemically dependent pregnant women and their infants with a full range of comprehensive treatment services. In addition to primary health care, prenatal, and pregnancy-related medical care, Crossroads provides for confidential HIV testing and transportation to medical appointments. Amethyst House has a capacity of fifteen beds.

**Crossroads -The Women's Program addresses** the specific needs of women, implementing evidence-based curriculum that is gender-responsive, including trauma informed and family centered services. The Women's Program at Crossroads is a 44-bed residential unit, located at the Juan B. Rosa House. Services include individual and group counseling, family therapy, domestic violence classes, and life re-orientation seminars designed specifically for women.

**The Connection – Hallie House** is a newly updated residential treatment center for substance abusing pregnant women. This program provides the opportunity

for mothers to bring their children and continue to stay in treatment if their child is born while they are in treatment. Women are admitted early in their pregnancy to minimize the impact of alcohol and other drugs on both the mother and the newborn. However, pregnant women are admitted at any stage of their pregnancy. Hallie House accommodates eight women and seven children.

**The Connection – Mothers’ Retreat** a residential program with state-of-the-art facility design offers the same set of services as its sister program, The Women and Children’s Center. Mothers’ Retreat accommodates eight women and seven children.

**Community Health Resources – New Life Center** is a residential treatment program designed to provide treatment services to pregnant and parenting women with accommodations for their children. Services are coordinated with the local hospital and community services within the area such as the Birth-to-Three program. The New Life Center has the capacity to serve six women and eight children.

**Inter-Community Resource Center (ICRC) – Coventry House** provides a secure, caring residential environment designed to build self-esteem and increase a woman’s ability to adopt a substance-free lifestyle and a new role as a parent. To ensure the health of the mother and her children, ADRC provides access to primary health care, prenatal, delivery, postpartum, and emergency care. This program accommodates ten women and twelve children.

**Wheeler Clinic Lifeline – Women’s Services of New Britain** provides a flexible program of intensive outpatient substance use treatment and child development services. The program has a capacity to serve sixteen women. The program offers transportation, meals, and assistance in helping women move into housing.

**Midwestern CT Council on Alcoholism** – This agency operates an outpatient program for pregnant and parenting women and their children. Treatment services include chemical dependence, relapse prevention, HIV/AIDS prevention and management, and family health and life skills development. The program capacity is twenty women.

**Wellmore – Women & Children’s Program** - is a long-term residential program for pregnant and parenting women and their children. Similar to the other residential programs for women and children, this program offers services in a gender-specific setting that fosters substance-free lifestyles, relapse prevention, and access to primary health care for both mother and child. This program has a strong family support component and is linked to the local therapeutic shelter allowing appropriate “women’s” treatment services to be provided to a larger population. The program capacity is eight women and eight children

**The Connection - Elm City Women and Children's Center** - is a licensed, fifteen-bed, criminal justice, residential treatment program for substance abusing women and their children. Services include: Drug education to prevent relapse, assistance in identifying and procuring housing, family reunification assistance, vocational skills, educational opportunities, parenting skills, and assistance in handling their legal issues. Clients enter the program for one of the following reasons:

- Pre -Trial – These clients have been charged with a crime but their case has not been resolved in court
- Condition of Probation – These clients have been placed at the program as a condition of their probation
- Direct Sentence – These clients are sentenced directly by the judge to the Elm City Program instead of incarceration
- Alternative to Probation Revocation – Clients are referred to the Elm City Program as an alternative to having their probation revoked

**Community Renewal Team - Fresh Start** is a six to twelve month, twenty-one-bed residential treatment program for female offenders in recovery and their children. The family is provided a safe, nurturing and healthful environment while the mothers are learning to live a drug free life. Only referrals from Bail and Probation (CSSD) are considered Residents are supported through recovery while mastering new life skills and learning how to be good mothers. Gender specific female-centered coping skills and trauma recovery are addressed in group sessions and workshops. Residents work towards continued self-reliance, sober living and integrating into the community. English and Spanish are spoken on site.

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 now 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 could not obtain timely treatment placement for the women, the DMHAS Women's Administrator and/or her designee were contacted to ensure timely access to care or interim services arranged. ABH produced quarterly reports that included 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.

In recent years, several DMHAS initiatives designed to enhance women's services statewide have been undertaken. Through collaboration with providers, DMHAS envisions that services for women will not only be accessible and effective, but will be trauma-informed and gender-responsive. Strategies were developed with key stakeholders to improve the quality of services for women and to measure the efficacy of these changes. Retreats involving national experts were held with several women's specialty program providers which resulted in the development of *Gender-Responsive Treatment Guidelines*; *Gender-Responsive Guidelines Self-Assessment Tool*; and *Outcomes Tool and Research Methodology*.

The **Trauma and Gender Practice Improvement Collaborative** merges the former Trauma Collaborative with the Women's Specialty Programs Improvement Collaborative to include 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 quarterly 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, two new programs that are co-occurring enhanced have been created not only for women, but for men as well.

Each year, DMHAS agencies have an opportunity to apply to participate in a practice improvement collaborative, including free training and consultation from nationally-recognized experts in the field of trauma and gender-responsive services. This initiative, which initially focused only on trauma-informed care, has expanded to focus on gender-responsive care as well. Currently, there are monthly and quarterly meetings to assist participant programs to explore and utilize evidence-based best practices. In 2015, two specialized Women and Children's programs will have completed the goal of measuring the extent to which they have developed a trauma-informed, gender-responsive care environment. This is accomplished by visiting the program and completing the Trauma Fidelity Tool, authored by Stephanie Covington, Maxine Harris and Roger Fallot, which assesses the implementation of the five trauma-informed values (i.e. safety, choice, empowerment, collaboration and trustworthiness) for clients and staff in the program. Gender-responsiveness is gauged in terms of site selection, staff selection, program development, and program content and materials that reflect an understanding of gender-specific concerns and encourage responses that respect strengths and challenges.

### **Project Substance Abuse Family Evaluation (SAFE)**

DCF initiated Project SAFE (Substance Abuse Family Evaluation) in 1995 as a way to connect its child protection system with the adult substance use treatment

system. DMHAS joined the initiative in 1999. The initial purpose of Project SAFE was to coordinate (via an ASO - Advanced Behavioral Health (ABH)) intake and priority access to drug screening, evaluation, and ambulatory treatment for substance using primary caregivers of children receiving protective services. With the addition of DMHAS, the goal expanded to effectively identify and address substance use issues and to coordinate and blend state, federal, and private resources to meet the needs of this vulnerable population. The project has been enhanced by the development and implementation of clinical models that have attempted to achieve improved show rates for substance use evaluations and treatment; improved client engagement, retention and completion of treatment; increased child safety; and improved family functioning. The services delivered under the Project SAFE contract include:

- Statewide priority access to drug screening, substance use evaluations, and outpatient treatment services;
- Statewide toll free line to process referrals for services to participatory providers available 24 hours per day, 365 days per year;
- Coordinated service delivery, on a regional basis, in collaboration with the ABH Program Manager, DCF, DMHAS, and the Provider Network;
- Centralized administrative services at ABH including: intake and referral, data collection, utilization and financial reporting, and electronic claims processing, and
- Quality management activities including: utilization analysis, chart reviews, provider and client surveys, and education and training.
- The Recovery Specialist Voluntary Program (RSVP) is a service available to parents/caregivers who have a substance abuse problem and have had a child removed by an Order of Temporary Custody (OTC). Recovery Specialists help create solutions with clients through case management services and recovery coaching.
- Recovery Case Management (RCM) services are available for parents/caregivers with substance use problems who are active Project SAFE referrals. This voluntary program for parents/caregivers who have open cases with the Department of Children and Families in Bridgeport, Hartford, Manchester, Middletown, New Britain, Norwalk, Norwich, and Willimantic provides recovery coaching and assistance with basic needs.

Persons are eligible for Project SAFE services if they meet the following criteria:

- Parent or primary caregiver (can be an individual under 18 years old)
- DCF has completed a Substance Abuse Screen, and suspects that a substance use problem may be affecting the ability to parent effectively; and
- Referral made by DCF Social Worker (i.e., involved in child protective services) for Project SAFE services.

### **Young Adult Services (Criteria 1A)**

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.

### **Military Personnel and their Families (Criteria 1A)**

Since 2007, the Military Support Program (MSP) has provided an array of behavioral health services to Connecticut's Citizen Soldiers and their family members. In 2012, eligibility for MSP services was extended to include veterans of active duty service and their families. The central feature of the MSP program is a statewide panel of licensed clinicians who provide free, confidential, outpatient counseling services to reserve component service members, veterans, and their family members (spouse, children, parents, grandparents, siblings and significant others). The clinical panel is managed through a contract with Advanced Behavioral Health. MSP services are accessed through a 24/7 toll-free call center.

The MSP panel provides counseling in matters relating to depression, anxiety, marriage and relationship issues, the special needs of children and adolescents, stress related to deployment, trauma-related problems and homecoming. In addition to outpatient counseling, MSP provides outreach; intensive case management; information, referral and advocacy; and transportation services (livery services and gas cards). In 2014, 425 licensed clinicians participated in MSP's statewide clinical panel. More than 4,800 individuals have accessed services through MSP's 24/7 call center.

In March 2009, the *MSP Embedded Clinician Program* was established in partnership with Connecticut's Adjutant General. MSP clinicians serve as Behavioral Health Advocates within Guard Units affected by deployment(s) in Operations Enduring Freedom, Iraqi Freedom, and New Dawn. MSP continues to provide a range of behavioral health services to reserve component military personnel and their family members. Thirty-one MSP clinicians currently serve as Embedded Clinicians within National Guard Units that have been affected by deployment(s). On drill weekends, they provide education on deployment health issues, serve as the key point of contact for behavioral health matters, and are now a well-known familiar presence among National Guard members.

MSP also participates in the National Guard and Reserves' Yellow Ribbon Reintegration Program, a thoughtful initiative that supports service members and their families during the pre-deployment, deployment, and post-deployment phases. MSP clinicians routinely facilitate workshops, particularly during 30-day and 60-day post-deployment events. MSP's transportation assistance initiative continues to be one of the most popular aspects of the program. Over 1,900 requests for transportation assistance have been received on behalf of veterans with transportation needs from DMHAS' partners in VA, the Vet Center System, and from MSP clinicians.

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

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

### 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 and dually diagnosed individuals who 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 over 2500 units of permanent supportive housing. These units of housing with case management services are dedicated to individuals that are homeless and have a mental health or co-occurring substance use disorder with the goal of stabilizing the individual with housing 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. The Bail Commission and 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 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 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 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 (Criteria 4)**

Based on the Connecticut Office of Rural Health (ORH) definition of “rural” (census less than 10,000 **and** population density of 500 people or less per

square mile) adopted by the CT- ORH Advisory Board November 2014 and using the 2010 U.S. Census Data, the total rural population in Connecticut is 334,275, which represents 11% of the state's population. Each county has some towns 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 for behavioral health services in those areas considered rural, and the accessibility and availability of such services. DMHAS' past efforts in developing local systems of care has taken into consideration geographic differences and the impact of these differences, such as lack of public transportation on service delivery. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices.

DMHAS continues to participate in Connecticut's ORH meetings as it provides a forum for information exchange, including a webpage.

### **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 (Criteria 4)**

As one in four older adults has a significant mental 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 disorders in older persons are associated with significant disability and impairment, including compromised quality of life, cognitive impairment, increased caregiver stress, disability, increased mortality and poor health outcomes. Older adults with mental health problems also have higher 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%. Future growth of the population of older adults with mental illness is predicted to overwhelm the available mental health service system. Proportionately, Connecticut has one of the largest older populations in the nation.

DMHAS' Older Adult Services (OAS) unit continues to broaden its statewide partnerships with providers of services to older adults by increasing collaboration with the Department of Social Services' (DSS) Unit on Aging. DMHAS is an active member of the Connecticut Association of Area Agencies on Aging Planning Committee for its Annual Conference. OAS offers training on a regular basis to DMHAS staff and grantee-agency providers on caring for older adults with co-occurring mental illnesses and substance use disorders. Additionally, OAS continues to collaborate with the CT Long-Term Care Ombudsman Program on major workgroups that address key issues that impact nursing home residents and staff. Examples of workgroups include managing challenging behaviors and fear of retaliation.

DMHAS OAS currently manages two statewide programs that serve older adults. One is the Senior Outreach Program that serves older adults who abuse substances, primarily alcohol, or are at risk for abusing substances. Eight agencies in Connecticut that focus on addiction services provide substance abuse outreach and treatment programs to older adults, including a weekly age-specific support group. The other program is the Gatekeeper Program, an evidence-based practice for identifying older adults in the community in need of some level of service. The Gatekeeper Program trains people in the community to recognize changes in the behaviors or condition of older adults and refers them to appropriate services. One of the goals is to avoid long-term institutional care. In May 2015, OAS is collaborating with one of the program agencies to present the first National Gatekeeper Conference, highlighting nationally-known speakers on topics such as suicide, hoarding behaviors, and Screening, Brief Intervention, Referral and Treatment (SBIRT) as they relate to older adults.

Through collaboration with DMHAS-funded agencies, the Nursing Home Diversion and Transition Program (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. Staff includes Nurse Clinicians and Case Managers, two of whom are bilingual to assist clients who are primarily Spanish-speaking. The NHDTP works in conjunction with the state's Money Follows the Person Demonstration Project, and also operates parallel to the Medicaid Home and Community-Based Services (HCBS) Waiver for Persons with Mental Illness. Persons who may not meet criteria for the waiver, or may not want wrap-around waiver services, may be served by the DMHAS NHDTP.

The four programs described above: The Medicaid HCBS Mental Health Waiver, The Nursing Home Diversion and Transition Program, The Gatekeeper Program, and The Senior Substance Abuse Outreach and Treatment Program, identify individuals who are needlessly institutionalized or at risk of being institutionalized and attempt to provide them with a least restrictive setting for long-term care.

Additionally, in collaboration with staff at the CT State Department of Aging, DMHAS chairs the Older Adult Behavioral Health Workgroup whose mission is to work towards an accessible, integrated, multi-disciplinary system of behavioral health services that promote improved health, wellness, and recovery for older adults in Connecticut. The workgroup is comprised of public and private providers of services to older adults. In the past year, the workgroup has joined efforts with the University of Connecticut Center on Aging to conduct a statewide assets mapping project to identify system strengths, needs, and service gaps. In the past year, 10 focus groups have been conducted, as well as 10 key informant interviews, 5 community forums, and an electronic survey widely distributed. The project is expected to be completed by June 30, 2015.

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

A recent 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. DMHAS receives comprehensive admission data from ASCEND that enable staff to track, treat, and discharge individuals who improve and do not continue to meet Nursing Home Level of Care.

### **Medicaid Home and Community-Based Waiver for Persons with SMI**

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 520 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. During the same time period, under the NHDTP, approximately 1,000 clients have been transitioned from Nursing Homes into the community.

## **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 then referred to the appropriate community provider for services. Through the Mental Health Waiver and the Nursing Home Diversion and Transition Program, DMHAS staff works with the DSS MFP Demonstration Grant to effectively discharge clients back into the community in a clinically safe manner. DMHAS meets with DSS (the MFP awardee) on a regular basis to identify individuals, specifically those in nursing homes, who may be eligible for MFP and then move onto the Home and Community-Based Waiver. DMHAS staff is an active member of the MFP Steering Committee, the 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 is working with both University of Connecticut and DSS to define a continuum of care strategy for aging clients with chronic conditions.

## **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 as well as the implementation of the Synar amendment. 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 abuse 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 prevention programs are organized into four major categories: (1) The prevention infrastructure resources that undergird and support prevention programs statewide; (2) evidence-based substance abuse projects aimed at preventing alcohol and other drug abuse; (3) suicide prevention and mental health promotion efforts funded through the Center for Mental Health Services

(CMHS); and (4) programs aimed at reducing access to tobacco products by underage youth. Other non-categorical prevention programs are funded as part of the infrastructure. These programs are smaller in nature and funded to address local needs.

### Prevention Infrastructure

Statewide Service Delivery Agencies (SSDA): DMHAS funds agencies that work at the state level to build the capacity of individuals and communities to deliver prevention services. The SSDAs maximize local, regional, and statewide prevention resources; disseminate state of the art information on the latest trends in the field, and provide consultation services, training and technical assistance.

Regional Action Councils (RACs): DMHAS funds thirteen sub-regional planning and action councils to conduct comprehensive needs assessments, planning and coordination of behavioral health services in the five service regions across the state. Additionally, the RACs provide funding to Local Prevention Councils (LPCs) established in each municipality throughout the region to support community mobilization, program development, media advocacy, and other activities to raise substance abuse awareness, provide education and sustain prevention efforts.

DMHAS Prevention Training Collaborative: is a collection of nonprofit providers contracted to provide training workshops that focus on prevention skills development, application of these skills, mental health promotion, violence and substance abuse prevention.

State Epidemiological Outcomes Workgroup (SEOW): The SEOW is charged with compiling indicators of substance abuse and related consequences, tracking data trends over time, and promoting the use of data to continually focus and strengthen ATOD prevention efforts statewide.

### Alcohol and Other Drug Programs (AOD)

Partnerships for Success (PFS) and Best Practices (BP): Through the PFS and BP initiatives, local coalitions are trained to implement the five steps of the Strategic Prevention Framework (SPF).

Connecticut Healthy Campus Initiative (CHCI): represents 62 associations (38 institutions of higher education and 24 community organizations and state agencies) whose mission is to create and sustain healthy college campuses and community environments. Institutions of higher education are supported by DMHAS to implement evidence-based programs that reduce underage drinking on campuses.

Mental Health Promotion Programs: CT Safe Schools Healthy Students Diffusion Project: is an \$8.6 million dollar, four-year grant intended to expand and enhance

improvements in school climate, access to behavioral health and other supports, and reduce substance use and exposure to violence in students Pre-K through 12th grade. This grant was awarded through a competitive application process to seven states including Connecticut by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS).

Tobacco Prevention and Enforcement Program: Tobacco Prevention and Enforcement Program (TPEP): TPEP monitors retailer vending of tobacco products through the municipal Police Partnerships Program, State Synar Program, and Federal Food and Drug Administration's enforcement contract. This includes conducting unannounced inspections of retail outlets for compliance with age, photo identification, and advertising and labeling restrictions of tobacco products. TPEP also administers the Tobacco Merchant and Community Education Initiative, which provides education materials, training, and technical assistance to tobacco merchants and communities statewide.

### Strengths/Challenges

#### State Prevention System Strengths

- Strong leadership and highly skilled team
- Strategic planning, systems alignment, and evidence-based practices
- Interagency collaboration and resource sharing
- Success in leveraging discretionary grants and building coalition capacity to contribute to the prevention portfolio
- Comprehensive system with unique infrastructure
- Infusion of SPF in SAPT BG and other department activities
- Unified prevention approach among partners
- Data system that facilitates the collection and reporting of SPF steps

#### Challenges

- Keeping pace with shifting and duplicative paradigms at the federal level, including health care reform, SAMHSA's Strategic Initiatives, FDA Tobacco Control Act and CDC grants
- Need for increased expertise in data collection and analysis
- Maintaining a reasonable balance of populations and individually-based programs

## **Other DMHAS Programs**

### **HIV Early Intervention Services**

Connecticut's status as an AIDS designated state has fluctuated over and under the threshold for the past several years. The most recent data available from the Centers for Disease Control and Prevention locate Connecticut's AIDS rate at 7.8

cases per 100,000 people for 2013, below the threshold. As previously when the state fell below the threshold, DMHAS will continue its HIV Early Intervention services, recognizing the importance of this service in a state with a high rate of IDUs. In addition, SAMHSA's ruling that a state may use SAPT Block Grant funds for the first year of being de-designated allows DMHAS to continue to support the full array of HIV Early Intervention Services through the SAPT Block Grant.

Since July 1, 2011, DMHAS directed those substance abuse treatment providers previously designated as "set aside" providers to implement "opt-out testing". This was based upon the Centers for Disease Control and Prevention 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. DMHAS has heard from providers that opt-out testing has increased the numbers of people being tested. 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.

## **TB Services**

During FFY 1995 and 1996, efforts were focused on developing procedures for Tuberculosis (TB) infection control. Protocols were developed in conjunction with the State Infection Control Officer and DPH and approved by the State Medical Director for Substance Abuse. The department implemented the infection control protocol by: 1) working with individual treatment programs to design implementation plans that met all mandated requirements; 2) developing and implementing protocols for the case management of individuals identified as TB infected; 3) developing effective monitoring strategies to ensure that infected individuals received TB services; and 4) establishing linkages with other state agencies and health care providers to ensure that required services were made available.

In FFY 1998, due to the appearance of new drug-resistant strains of TB, the Infectious Disease Control procedures needed to be strengthened. DMHAS, in partnership with the DPH, committed to reviewing and revising the protocol during the next federal year.

In FFY 2000, DMHAS' Medical Director reissued department guidelines for state TB control policies that incorporated more effective procedures and techniques for dealing with, among other things, new drug-resistant strains of tuberculosis. These protocols included medically approved procedures for: 1) proper screening of patients; 2) identifying individuals found to be at risk of becoming infected; 3) appropriate testing of those found to be at risk; and 4) meeting all state reporting requirements while adhering to federal and state confidentiality requirements.

These new guidelines were disseminated to all treatment programs throughout the state for inclusion in their infectious disease protocol.

DMHAS continues to assist treatment programs, as needed, in implementing and maintaining infectious disease procedures. The DMHAS Recovery Institute continues to deliver educational workshops which offer valuable resources targeting prevention of various infectious disease conditions. The collaboration between DMHAS and DPH continues to be an invaluable resource for questions or issues that arise within DMHAS supported substance use treatment programs.

DMHAS set-aside providers ensure that all persons admitted are informed of and offered infectious disease services, including TB testing, 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.

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.

In FY 2014 and 2015, DMHAS experienced issues around TB testing due to the shortage of testing supplies that was felt nationwide. DMHAS set-aside providers maintained efforts geared toward assessing at-risk individuals so that testing could be provided to those identified.

In FY 2016 and 2017, DMHAS will continue to encourage and provide relevant training/educational opportunities related to TB and other infectious diseases. DMHAS will maintain a collaborative relationship with the DPH TB Unit and participate in any training offered. Relevant topics for education and training [continue to](#) be further explored with treatment providers and qualified entities for providing such training.

### **Charitable Choice**

DMHAS continues to monitor programs affected by the SAPT block grant regulation of Charitable Choice, assuring compliance through routine monitoring by CSD Regional Teams across the DMHAS service system. Monitoring of the charitable choice requirement is by exception, i.e., the CSD Regional Teams follow up on any complaints received. Beginning in State Fiscal Year (SFY) 2012, DMHAS added contract language specifying the requirements of 42 CFR Part 54 and 54a prohibiting the use of SAPT block grant funds to support inherently religious activities in treatment services. 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 the Deaf and Hard of Hearing (DHOH)**

The Office of Multicultural Healthcare Equality (OMHE) coordinates behavioral health services for the deaf and hard of hearing. As part of this work, OMHE collaborates with local agencies to provide interpreter services for individuals and family members who are hearing impaired within the DMHAS system of care. Video phones are installed in each of the state operated facilities that serve the DHOH population. Interpreter services are available at DMHAS providers for all types of services, including evaluations; education/training; clinical activities; AA and NA meetings; and LGBT, peer and other social groups. Specialized services are also provided through an interpreter, including forensic evaluations, life skills training, job coaching, parenting education, and tutoring in American Sign Language (ASL) as well as other topics. Additional services and supports coordinated by DMHAS to address the needs of DHOH clients and their families include sign language classes with deaf culture orientation, shared personnel among programs and regions, and enhanced availability of interpreter services for staff and clients.

### **Office of Multicultural Healthcare Equality (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.

To reinforce the continued commitment of the department to culturally competent services and the elimination of healthcare disparities, OMA became the Office of Multicultural Healthcare Equality (OMHE) in 2013. OMHE, in collaboration with the Multicultural Advisory Council and DMHAS leadership, developed a new Multicultural Strategic Plan that seeks to further embed cultural competency within the DMHAS infrastructure and enhance in-depth understanding of cultural factors and forces.

The plan addresses identification and elimination of disparities through multicultural training and system development, program data review and analysis, and reinvigoration of the Regional Multicultural Action Councils. The Plan continues to emphasize cultural competence within the DMHAS funded service network. 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.

DMHAS introduced a Connecticut Health Foundation funded initiative, in collaboration with the Yale Program for Recovery and Community Health (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 the delivery of services. This ongoing effort, now called "Recovery Speaks", involves persons in recovery from substance use and mental health conditions sharing their success stories at different DMHAS 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, are 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 (Criteria 5)**

The DMHAS Human Resource Division (HRD) is responsible for providing a full range of human resource services to approximately 4,000 bargaining unit, confidential, and managerial employees at all locations throughout the state. HRD consists of six Divisions that include: Employment Services, Facility Operations; Labor Relations; Loss Prevention; Payroll and Benefits; Information Systems (CORE Unit), and Workforce Development. 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 an experienced medical recruiter with a track record of hiring psychiatrists, physicians and executive level mental health professionals. In addition, other Recruitment activities include hire day job fairs, career fairs, 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.

### **Staff Education and Training (Criteria 5)**

Through the DMHAS Education and Training Division, the department provides training to approximately 6,000 participants annually in a variety of topic areas including training in Recovery-oriented services and co-occurring disorders. Self-directed, web-based training offers courses on a variety of behavioral health care topics. The division assures the highest standards of recovery-oriented care by supporting and promoting the development of linkages with academia and providing professional development training to direct care, administrative, and managerial staff. The division provides training to support new initiatives as they emerge, along with courses aimed at ongoing staff competencies in DMHAS' recovery-supported and person-centered system of care. The division offers multiple courses related to evidence-based practices, including Cognitive Behavioral Therapy, Motivational Interviewing, Supportive Employment and working with people with co-occurring disorders. Courses related to cultural competence are offered regularly, including training on LGBT issues, working with the aging population, and working with a variety of diverse populations. The division offers three course catalogs a year and trainings are offered for free to staff at both DMHAS state-operated and DMHAS-funded agencies. The division also offers a separate course catalog to support the training needs of staff working in supportive housing programs.

In regard to patient confidentiality, DMHAS Compliance and Information Technology (IT) Security staff review, update, and develop self-directed web-based training, apprising employees of new laws and regulations affecting the DMHAS service system. In addition, the DMHAS Education and Training Division offers courses that integrate information on patient confidentiality and ethics into the standard curriculum.

### **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 Compliance Steering Committee, which is comprised of the Commissioner's Executive Group and other key department staff. Each DMHAS facility has a designated 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' 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.

### **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 Department of Children and Families, 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 substance abuse, 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 families, 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 CT Hearing Voices Network. This role is also responsible for the management Connecticut's peer workforce, including policy development and the training process for certified recovery support specialists.

Other administrative units include Statewide Services Division (including Older Adult Services, Women's Services, Infectious Diseases, Housing and Homeless Services, Acquired Brain Injury/Traumatic Brain Injury Program, and Problem Gambling Services) as well as Information Systems Division (ISD).

## **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 State Board of Mental Health and Addiction Services (SBMHAS), a 40-member advisory group consisting of gubernatorial appointees, Regional Mental Health Boards (RMHBs), and substance abuse Regional Action Councils (RACs), consumers/individuals in recovery, family members, providers and advocates. Concerning matters of importance regarding the CMHS block grant, the state's Adult Behavioral Health Planning Council plays a critical role, reporting its recommendations to the SBMHAS and the Commissioner.

The five RMHBs and thirteen RACs were created by Connecticut General Statute and play a fundamental role in planning, prevention and advocacy efforts. RMHBs work with local Catchment Area Councils (CACs) to ensure grassroots

involvement while RACs work in their local communities and are organized into the Connecticut Prevention Network. Through regular contact with persons in recovery, evaluations, and special studies, RMHB and RAC members monitor ongoing services and assess the need for services. Through these efforts, they identify service gaps and deficiencies. Their evaluations have resulted in 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 RACs and RMHBs are selected to represent all constituent groups – consumers of services, family members of consumers, municipalities, private and public providers of services, including community services. RACs and RMHBs examine issues from the varied perspectives of these constituent groups. In that role, RMHBs and RACs 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, e.g., 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. However, Connecticut is the 29th most populated state with a total population of just over 3.5 million residents, and just over 800,000 or 23% are children and youth under the age of eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, 7.1% or over 56,000 is the estimate of children in need of Mental Health Services in Connecticut. (CPES estimates).

Finally, 84% of residents are white, 10.4% are black, .4% are American Indian or Native Alaskan, 3.6% Asian, .1% Native Hawaiian and other Pacific Islander, and 1.5% of residents report 2 or more races and 8% of the general population is Hispanic (144,500). As of the 2010 census Connecticut has the highest personal per capita income level at \$56,001 and historically has had some of the largest gaps between the richest and poorest residents.

#### **The Department of Children and Families**

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 is the central focus of the Department of Children and Families (DCF). 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, including those committed to the Department by the juvenile justice system.

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, juvenile justice 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, are involved in the juvenile justice system, 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 in a

DCF facility, 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 four facilities:

***The Connecticut Juvenile Training School***, a secure facility for boys who are committed to the Department as delinquents by the juvenile courts;

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 five mandated areas which include child welfare, children's behavioral health, education, juvenile services 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 16,000 families across its programs and mandate areas each year. The average number of full-time employees is 3247. DCF’s recurring operational expenses total around \$807,655,195.

DCF's mission statement: ***“Working together with families and communities for children who are healthy, safe, smart and strong.”***

SEVEN CROSS-CUTTING THEMES: The following seven cross-cutting themes shall guide all DCF operational units in advancing the mission and strategies of the agency:

- implementing strength-based family policy, practice and programs;

- applying the neuroscience of early childhood and adolescent development;
- expanding trauma-informed practice and culture;
- addressing racial inequities in all areas of our practice;
- building new community and agency partnerships;
- improving leadership, management, supervision and accountability; and
- becoming a learning organization.

DCF STRATEGIES: Informed by the cross-cutting themes, DCF shall implement the following strategies to advance the well-being of children and their families in accordance with the DCF mission:

- increase investment in prevention, health promotion, early intervention and educational success;
- strengthen family-centered practice;
- expand regional networks of in-home and community services;
- continue to reduce congregate care by rightsizing and redesign;
- address the needs of identified populations of children and families;
- increase DCF and community partnerships;
- support the public and private sector workforce;
- manage ongoing DCF operations and change initiatives; and
- improve revenue maximization and develop new investment resources.

The DCF mission 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.

The structure of DCF consists of the Commissioner who has a Deputy Commissioner of Operations, a Chief of Quality and Planning, a Deputy Commissioner of Administration, six Regional Administrators, a Chief of Staff and the Facility Superintendents who all have direct report to the Commissioner.

### **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:

Following the tragic events that occurred in Newtown Connecticut in December 14, 2012, the Connecticut General Assembly passed Public Act 13-178 which specifically directed DCF to produce a children's behavioral health/mental health plan for the state of Connecticut. The public act pushed Connecticut to focus fully on child and family mental health and well-being. As of late 2014 there were approximately 783,000 children under age 18 in Connecticut, constituting 23% of the state's population. Epidemiological studies suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. However, many of these children are not able to access services. Public Act 13-178 is intended to address this and related children's mental health issues.

The public act required the behavioral health/mental health plan to be comprehensive and integrated and meet the behavioral and mental health needs of all children in the state, and to prevent or reduce the long-term negative impact for children of mental, emotional, and behavioral health issues. The public act 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

DCF contracted with the Connecticut Child Health and Development Institute (CHDI) and other stakeholder partners, to help develop the children's behavioral health/mental health plan by:

- Obtaining input from consumers, families, content experts, and other state and local stakeholders through family focus groups, facilitated discussions on specific topics and public forums
- Collecting, analyzing, and synthesizing data and information about the strengths and weaknesses of the current system and current services

- Developing a written plan for the State that will guide the ongoing development of a comprehensive and effective children’s mental health system

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 proposed timeline for implementation that focuses on the development of the infrastructure and the planning of the array of services that will comprise the 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

DCF is currently in the process of implementing the behavioral health/mental health plan, in partnership with other state agencies, private agencies and children and families. A number of steps remain to be taken in achieving the goals of the plan, ensuring that Connecticut’s children and families have full access to quality mental health care in support of achieving social, emotional, and behavioral well-being.

**Children’s Mental Health Oversight:**

The Commissioner of DCF, Joette Katz, 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):*** Mandated by Connecticut statute the State Advisory Council (SAC) is a fifteen-member committee appointed by the Governor to assist DCF by providing input into each of the Department's mandated areas of responsibility, including children's mental health. 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 of DCF 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 at least monthly and evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the Commissioner of DCF on children and families; and 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 actively participate in the CT Joint Behavioral Health Block Grant Planning Council.

The committee has three (3) ad hoc sub-committees to address three 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; and (3) 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. The boards empower children and youth to directly participate in and advocate for mental health and related system changes and development. Approximately 50 children and youth in "out-of-home care” participate on the boards. DCF Commissioner Joette Katz has dinner with the state wide Youth Advisory Board on a quarterly basis.

**Connecticut Community Providers Association (CCPA):** 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. CCPA collaborates with DCF in addressing the mental health needs of Connecticut’s children, youth and families.

**Connecticut Association of Non-Profits (CAN):** This member based association is a collaborative of over 500 non-profit organizations dedicated to building and sustaining healthy communities in Connecticut. This group also focuses on identifying needs, service priorities, coordination of service systems, and advocacy for effective mental health services. The Connecticut Association of Non-Profits 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:

- Alcohol and Drug Policy Council (DMHAS)
- Interagency Council on Supportive Housing and Homelessness (DOH)
- Transitioning Young Adults (DMHAS)

- Project Safe (DMHAS)
- Project Safe RSVP, (DMHAS) - a family court diversion program.
- 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
- timely identification of youth with serious emotional disturbance (DDS)
- shared dissemination of evidence-based practices such as Multi-Systemic Therapy, Multi-Dimensional Family Therapy, and Intensive In-Home Child and Adolescent Psychiatric Services (CSSD)
- Joint Justice Strategic Plan (CSSD)
- the Child and Adolescent Rapid Emergency Service (DSS)
- identifying and resolving disposition issues that interfere with timely discharge from the emergency department; (DSS)
- facilitate rapid transition back to the community from hospital care (DSS)
- to coordinate licensing regulations and policies (DPH)
- EMPS Emergency Mobile Crisis Services in schools (SDE)
- policy improvements, and, and transportation issues related to foster children (SDE)
- youth suicide prevention activities (DMHAS, SDE, CSSD, DPH, DSS)

### **Administrative Service Organization Partnership**

In its mental health oversight role DCF is in partnership with the Connecticut Behavioral Health Partnership (CT-BHP), the state's administrative service organization (ASO) in a number of initiatives and activities addressing the mental health needs of children, youth and families. This includes a joint requirement for Enhanced Care Clinics (ECC) to develop and implement MOUs with pediatric primary care providers such as pediatricians. 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 special services for CT-BHP members.

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 all 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 effectiveness 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

DCF staff are guided by the ***"Strengthening Families Practice Model"*** and the seven ***"Cross Cutting Themes."*** These themes also apply to the mental health service system implemented and overseen by the department. The seven cross cutting themes are:

- Implementing strength-based family policy, practice and programs
- Applying the neuroscience of early childhood and adolescent development
- Expanding trauma-informed practice and culture
- Addressing racial inequities in all areas of our practice
- Building new community and agency partnerships
- Improving leadership, management, supervision and accountability
- Becoming a learning organization

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. All DCF policies, practices, initiatives and services are aligned with this principle. 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.

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.”***

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-four 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 14-31 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.

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**
- 2. Care Coordination**
- 3. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**
- 4. Early Childhood Services - Child FIRST**
- 5. Functional Family Therapy (FFT)**
- 6. HOMEBUILDERS**
- 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. Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
- 16. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

**17. Triple P**

**18. Wrap Around New Haven**

**19. Child and Family Traumatic Stress Intervention (CFTSI)**

(For a full description of the Evidence Based Practices (EBPs) see pages 25-28)  
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.

Human Anti-Trafficking Response Team (HART): The State of Connecticut has taken a number of steps to identify and respond to victims of human trafficking, and DCF has taken a lead role in addressing the human trafficking of children and youth. The Human Anti-trafficking Response Team (HART) was created in order to focus on and reduce the commercial sexual exploitation of children (CSEC) and Domestic Minor Sex Trafficking (DMST).

The Connecticut State Legislature has created several pieces of legislation between 2010 and 2014 to promote public awareness and prevention of child sex trafficking, to provide for ongoing monitoring of efforts to combat trafficking, to clarify mandatory reporting, and to provide a statewide oversight and monitoring body. Consistent with legislative mandates DCF has increasingly sharpened its focus on the growing issue of DMST and CSEC afflicting children across the State. Since 2008, over 300 children have been referred to DCF as possible victims of DMST/CSEC. 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 federal System of Care grant and recent 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.

As a result of these collective efforts DCF has been able to achieve the following results between January 2013 and December 2014:

- 17.1% reduction in number of children in placement
- 82.7% reduction in number of children in out-of-state residential placement
- 29.9% reduction in number of children ages 12 and younger in congregate care
- 33.3% reduction in number of children ages 6 and younger in congregate care
- 38.2% increase in number of placements with relative foster families

With regards to the number of children and youth placed outside of Connecticut in congregate care programs, as of June 1st 2015 DCF had 11 youth placed outside the state, compared to the 367 children and youth placed outside the state in December 2010.

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

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

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

**Care Management Entity (CME)** - CME 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 Abuse Pediatricians (CAP)** – This service provides support and consultation regarding child safety, child abuse and neglect identification/confirmation, and safety planning and decision making. The CAP contractor also reviews a subset of non-accepted DCF reports for infants under 12 months of age who are the highest risk group. Additionally, the CAP contractor delivers education to Area Office and Careline staff regarding abuse and neglect prevention, early identification, recognition, and intervention.

**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.

**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.

**Positive Youth Development** - This service provides psycho-educational programming, opportunities for experiential learning and life skill building for youth. Among the topics are addressed are: peer support, conflict resolution, employment skills, anger management, leadership and the encouragement of empathy. The topics are discussed

and taught in a variety of venues from group discussions to team supports and other supervised play activities.

**Therapeutic Child Care** - This service offers a range of support services for children in a child care facility, including parent-child programs and an after school program. The target population is children ages 0-8. The primary focus is teaching parenting skills to parents as their child is actively involved in a child care setting. By developing a better understanding of child development and skills by the parents, DCF is less likely to become involved and children are less likely to be removed from their family.

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

**Physical and Sexual Abuse Evaluation** - This service provides sexual and physical abuse evaluations including a comprehensive and specialized medical examination, psychosocial assessment and a forensic interview of the child in order to determine if abuse has occurred. The evaluation process includes: an initial psychosocial assessment of the family; a physical exam; laboratory work; and a forensic interview of the child, when indicated.

### **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.

**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. Life skills assessment services are followed by 80 hours of classroom educational service to the clients and an additional 30 hours of one-to-one educational services.

**Community Targeted Re-Entry Pilot Program (CTRPP)** - This service provides pre-release and post-release support and training for male youth at the Connecticut Juvenile Training School (CJTS), the DCF operated facility for adjudicated youth, including social and life skill building, vocational and career development, psycho-educational programming including character development and leadership interwoven with recreational opportunities provided by the Boys & Girls Club on the campus of CJTS.

**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.

**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. One component of their work is the delivery of advocacy services to selected families. The primary goal is to empower these families to advocate for their own needs and services.

**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.

**Fostering Responsibility, Education and Employment (F.R.E.E.)** – F.R.E.E. provides reentry support to adolescents and young adults who have been committed to DCF as delinquent and are returning to their community from out-of-home care placement, including public and private congregate care treatment settings, Connecticut Juvenile Training School (CJTS), and youth correctional settings (e.g. York, Manson state correctional facilities). Service provision begins in advance of the child’s/youth’s return to the community while in congregate care and continues for a period of time after their return to the community. The service provides an array of services to support the adolescent's growth in all areas of functioning as well as family-focused interventions that build on natural supports, and accessing services and opportunities available in their local service continuum.

**Intimate Partner Violence (IPV-FAIR)** – This program provides 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. IPV-FAIR provides a supportive service array of assessments, safety planning, interventions and linkages to services to address the needs of families impacted by intimate partner violence and is responsive to both the caregivers and the children.

**Intermediate Evaluation for Juvenile Justice Involved Youth** - This service provides a comprehensive and multidisciplinary outpatient assessment and treatment plan development for children and youth involved in the Juvenile Justice System. 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. During breaks in the daily evaluation process, there are recreational and group activities for the children/youth.

**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 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.

**Multidisciplinary Team** – This service promotes the coordination of investigations of and interventions for cases of child abuse/neglect among agencies, including DCF, law enforcement, medical, mental health and community providers, victim advocates and prosecutors. Cases are referred to regularly scheduled team meetings by members of the team including DCF. 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. Forensic interviews are scheduled on an as-needed basis as determined by the team and permit the taping and live viewing of the interview process by members of the team to decrease the need and trauma related to multiple interviews by competing agencies.

**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 Project** - This service is a highly structured, 10-16 week parent training program under the nationally recognized trade mark *Parent Project*<sup>®</sup> and is designed specifically for parents/caregivers of youth/adolescents who engage in risky behaviors such as running away from home, truancy or "pre-delinquent behaviors".

**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 care for children and youth, at least 70% of whom are connected to DCF, 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. When respite is provided in a group setting, there is at least one (1) respite worker for every three children.

**Reunification and Therapeutic Family Time** - Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for families with children ages 0-17 removed from their home due to protective service concerns. This recently implemented model offers comprehensive support to the reunification process.

**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** - 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.

**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.

**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.

**Multi-systemic Therapy for Transition-Aged Youth** - This service provides intensive individual and community-based treatment to transition-aged youth with both antisocial behaviors and serious mental health conditions. The primary goals of the intervention are to reduce antisocial behaviors and recidivism, treat the mental health condition, and treat existing substance use disorders. Secondary goals are to encourage vocational engagement (schooling, training or working); improve social relationships; support community-based housing; and improve client parenting skills as indicated.

**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 program provides a range of outpatient mental health services for children, youth and their families, primarily individual, family and group treatment. Services promote mental health and improved functioning in children, youth and families and decreased the prevalence of mental illness, emotional disturbance and social dysfunction. DCF referrals receive priority consideration. The severity of each referral determines whether an appointment be given that same day, within 3 business days, within 14 calendar days or within 30 calendar days.

**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**

**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** - 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.

**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.

**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.

**HOMEBUILDERS** - This service is an evidence-based model designed to strengthen families, keep children safe while preventing unnecessary out-of-home placement or

safely reunify children with their family following a removal from their home. This is an intensive service providing in-home crisis intervention, counseling and life-skills education for families who have children at imminent risk for out-of-home placement or have children in placement that cannot be reunified without intensive services.

**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.

**Multidimensional Treatment Foster Care (MDFC)** - This service is an evidence-based treatment program that increases developmentally appropriate normative and pro-social behaviors in children and youth who are in out-of-home foster treatment and care. All children and youth in the program receive an all-inclusive array of services including a range of interpersonal skill training, supportive therapy, school-based behavioral interventions and academic supports, psychiatric consultation and medication management. Foster parents receive behavioral parent training and support while birth parents and/or caretakers receive family therapy and aftercare supports.

**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.

**Multi-systemic Therapy - Family Integrated Transitions (MST-FIT)** – MST-FIT uses the evidence-based Intensive Home Based (IHB) treatment model to provide integrated individual and family services to children/adolescents with co-occurring mental health and chemical dependency disorders upon their re-entry back into their communities from a residential or juvenile justice facility back into their communities. MST-FIT promotes behavioral change in the natural environment including helping parents learn to monitor and to intervene positively with their children/adolescents.

**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.

**Multisystemic Therapy – Transitional Age Youth (MST-TAY)** – This is a promising evidenced based model that provides intensive individual treatment for transitional age youth (ages 17-20) with both a recent history of criminal involvement and mental health challenges. The goal of MST-TAY treatment is to stabilize youth with significant mental health impairments and other high risk behaviors within the community through intensive multi-weekly treatment sessions for up to six months. The clinical focus is on safety preservation, crisis management, establishing natural supports and increasing life skills to support the youth’s transition into adulthood. Immediate social and family resources are also integrated into treatment to promote a healthy natural social support network for the client and to sustain treatment advances. Youth are treated as part of an interdisciplinary team and are assigned a life coach to work with the identified client on supplemental life skills, vocational, educational, and social reinforcement needs throughout treatment and for an additional 6 months of aftercare.

**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.

**Triple P** - This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-home parent education curriculum supporting and guiding parents to become resourceful problem solvers and create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition the program will provide short term case management supports to help parents fully utilize the parenting services.

**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.

#### **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.

#### **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**

**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**

**High Risk Infant Program** - This service is a long-term residential substance abuse treatment program for pregnant and/or parenting women and their children. Licensed by the Connecticut State Department of Public Health this program accommodates eight women and seven children in residence. The model is a structured, drug-free residential environment composed of various components to meet each resident's individual, medical, emotional and specific treatment needs. The parents receive educational and skills training in order to develop skills and implement positive interactions with their children.

**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 and health and wellness promotion. Sixth Connecticut has a strong family-centered child welfare practice model. (See Quality Improvement Plan referenced below.) Seventh, Connecticut has a number of infant and early childhood mental health initiatives. (See above description) Finally, Connecticut has engaged and developed strong partnerships with all the stakeholders including the behavioral health community providers, families, 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 22 clinics in Connecticut with more than 250 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.

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.

### **Infant Mental Health**

In 2011, The CT Department of Children and Families (DCF) received the Early Childhood, Child Welfare federal grant, "Strengthening Families, Infant Mental Health" and provided to 40 DCF and Early Head Start staff, through a partnership with the CT Head Start State Collaboration Office, Head Start/Early Head Start and the Connecticut Association for Infant Mental Health, an intensive series of 8 trainings on infant mental health in the Hartford/Manchester DCF Region. These sessions for state social workers, supervisors, managers, and their affiliated agencies were based on the Competencies in Culturally Sensitive, Relationship Focused Practice Promoting Infant Mental Health®.

The trainings were designed to enhance and support professionals' work with infants, toddlers and their families with a focus on relationships of non-verbal children and what impacts healthy relationship formation and emotional regulation. In addition, an opportunity to participate in reflective consultation groups where they learned about reflective practice, how to promote reflection in others and practice reflection through a series of activities was offered. Reflective Consultation/Supervision is one of the infant mental health competencies and is recommended for all persons working with infants/toddlers and their families. This opportunity to meet regularly in a cooperative setting to explore feelings and emotions that impact one's work is critical to the success of work that is difficult and relationship focused. The outcome is what is termed, the "parallel" process, that is, the way the supervisor/consultant interacts with the provider is how the provider will be with the caregiver, and thus, how the caregiver will treat their infant or toddler.

In 2015 through funding from the Department and Casey Family Services, the training was expanded to all regions of the state with providers and DCF staff attending

### **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. Please refer to Section 1, pages 5-7 for examples.

### **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. The combined programs provide low-cost or free health care coverage for 10% of Connecticut's children ( $\pm$ 315,000 children) as well as 80,000 parents and pregnant women.

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, (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.

## Planning Steps

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

Narrative Question:

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This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health 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 these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. 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 set 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](#), the annual [State and National Behavioral Health Barometers](#), 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 abuse prevention, and substance abuse 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 behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. 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>18</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.

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<sup>18</sup> <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

## **Behavioral Health Needs Assessment**

The behavioral health needs of the state of Connecticut can be ascertained from a variety of quantitative and qualitative sources, including national data from which state estimates are derived, state statistics based on surveys and state agency data collection (including DMHAS), provider and consumer surveys, and stakeholder focus groups and feedback. From this data array, we are able to construct a rich descriptive summary identifying what is working well within our state, and areas in need of improvement. Recommendations from all data sources are summarized at the end of this section.

### **Prevalence and Treated Prevalence (Criterion 2)**

#### **Any Mental Illness (AMI)**

According to the NSDUH 2012-13, estimated figures for having any mental illness in the past year found Connecticut with lower number across all age groups than national figures. Specifically, 17.26% of adolescents, 18.30% of young adults, and 17.10% of adults reported some type of mental illness, all at least one percent less than the national numbers. Per the Behavioral Health Barometer for CT 2014, Connecticut's percentage of mental health treatment among adults with any mental illness was similar to the US percentage (2009 – 2013). An average of 200,000 adults (45%) received counseling/treatment. In 2013, those being treated in the public system reported higher rates of improved functioning from treatment (84.3% of adults and 76.2% of children) than rates reported nationally by a substantial margin.

In FY 2014, DMHAS EDW reported that more than 58,000 persons were served in mental health programs. Sixty-six 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 (64%) followed by Black/African American (17%) and "Other" (14%) at nearly equivalent levels. Nineteen percent of clients served in DMHAS mental health programs were of Hispanic/Latino origins. With an eye to potential health care disparities, Connecticut is under serving white/Caucasian persons and serving more of the Black/African American and Hispanic/Latino populations than would be expected based on the 2013 Census Bureau projections.

#### **Serious Mental Illness (SMI)**

As with data on any mental illness, figures for serious mental illness (SMI) were below national figures for all groups, with Connecticut finding 3.38% of adolescents, 4.03% of young adults, and 3.28% of adults in the SMI category. The Behavioral Health Barometer (2014) figures indicate that about 82,000 adults had SMI in the past year in our state. Interestingly, this same data set from 2009 – 2013 showed that while Connecticut had experienced a small decrease over that period, the rest of the nation experienced the opposite trend.

In reviewing primary and non-primary diagnoses from Connecticut’s own DMHAS data, half of the clients served qualified for an SMI diagnosis, which involved having any (or multiple) of the following: schizophrenia (including related disorders), bipolar, or major depression. Almost one quarter (24%) of clients qualified for a dual diagnosis of both an SMI diagnosis and a substance use diagnosis.

**Depression**

Connecticut residents with at least one major depressive episode (MDE) in the prior year exhibited numbers lower than those found nationally. Specifically, 9.40% of adolescents, 8.37% of young adults, and 6.28% of adults had at least one MDE. Over time, based on the 2014 Behavioral Health Barometer, the figures have been slowly rising from 2009 and 2013. For adolescents with MDE, more than half (52.3%) received treatment over the period from 2006-2013.

DMHAS EDW data reflects that more than one-fourth (27%) of clients in Connecticut have a diagnosis of major mood disorder and another 18% have a diagnosis of major depression. Together, these diagnoses represent the largest mental health diagnoses in the system.

**Suicide/Suicidal thoughts**

A frequent component of depression is suicidal thought/attempts. Data from NSDUH 2012-13 reveal that 3.72% of adolescents, 6.78% of young adults, and 3.23% of adults had serious suicidal thoughts in the past year. All of these values are lower than national values. These numbers have been very stable from 2009 - 2013 and indicate that about 93,000 Connecticut adults had serious suicidal thoughts in the past year. Data from Connecticut’s Department of Public Health show 2010 rate data (per 100,000 persons) as

<b>Age group</b>	<b>Suicide Rate</b>
15 - 19	4.4
20 - 34	10.9
35 - 44	13.1
45 - 54	15.1
55 - 64	15.0

In Connecticut, the suicide rate is highest for those 45 – 54 years of age with males 1.6 times more likely than females to die from suicide and about one-third of suicides involving firearms.

**Alcohol**

Data from DMHAS’ Enterprise Data Warehouse (EDW) for FY 2014 indicates that across all substance use and mental health admissions to DMHAS programs, alcohol was the most frequently reported drug of abuse (37% or 19,152 admissions). Within substance use admissions, however, alcohol is at a virtual tie with heroin/opioids as reason for admission.

Most Connecticut data related to alcohol is similar to what is found nationally. For example, Behavioral Health Barometer data (2009-2013) revealed 243,000 persons per year of those 12 and older (8.1%) had alcohol dependence/abuse - similar to the national average. Likewise, the percentage of those 12 and older with alcohol dependence/abuse receiving treatment in the past year, 6% or 15,000 CT residents was similar to the US average. In reviewing the NSDUH 2012-13 data on those needing but not receiving treatment for alcohol use in the past year, it was revealed that 2.85% of adolescents (12 – 17), 14.34% of young adults (18 – 25), and 7.20% of those 18 and older found themselves in this situation. All of the state's values are within one percentage point of the national values.

No difference was found between our state and US estimates for heavy drinking in the past month of those 21 and older for 2009-2013 (about 167,000 residents or 6.5%), however, it is clear that binge drinking in Connecticut is a problem. Connecticut's percentage of underage (12 – 20) binge alcohol use from 2009 - 2013 was higher than the US average every year with about 88,000 (20.3%) reporting binge alcohol use in the previous month. Over this same time period, 61% of state adolescents (12 – 17) perceived no great risk associated with binge drinking – similar to the US average.

The trend for underage binge drinking, both in Connecticut and the nation, has been to decrease each year since 2009. A review of Connecticut DUI outcomes for 2013-14 found 10,308 total, the smallest amount in 15 years of data collection and nearly 700 less than the prior year. A review of Uniform Crime Reporting data from 2010 – 2013 revealed a similar trend toward decreasing numbers of liquor-related arrests over that period from a total of 1144 in 2010 to 412 in 2013. This decrease was found in all age groups, including less than 18 years old, 18 – 20 years of age, and 21 and older.

### **Tobacco**

Smoking is a major risk factor for cancer, as well as lung, cardiovascular and kidney diseases. Exceptionally high rates of nicotine dependence are found in behavioral health populations. Adult cigarette smoking rates declined over the past decade. Data from the Connecticut Behavioral Risk Factor Surveillance System (BRFSS) revealed that 16% of Connecticut adults were current smokers.

From 2009-2013, both Connecticut and the nation witnessed a dramatic decrease in adolescent (12-17) cigarette use with Connecticut experiencing a nearly 4% decrease. Connecticut's percentage per year of adolescent cigarette use was 6.8% (19,000). At the same time, 32% of adolescents in Connecticut in 2012-13 perceived no great risk associated with daily cigarette use, less than the national perceived risk.

## **Illicit Substances**

Illicit substances include marijuana, heroin, cocaine, and misuse of prescription medications. While persons in all age groups 12 and older in Connecticut used illicit substances at rates that exceeded the US average, illicit drug use other than marijuana was slightly *below* the US average, suggesting that the majority of the illicit substance use in our state was marijuana. Since 2009, estimated use of illicit substances has decreased slightly both nationally and in Connecticut.

Per the NSDUH 2012-13, past month illicit drug use was 9.95% for adolescents, 25.39% for young adults, and 9.93% for adults. Examining data on Illicit Drug Dependence or Dependence/Abuse indicates that rates in Connecticut are comparable or slightly below national figures, with the exception of the young adults (18 – 25) which are up to one percentage point higher.

Data from DMHAS' EDW for FY 2014 shows that for admissions to substance use programs, most admissions are for illicit substances, with heroin/opioids being the most frequent. Persons receiving treatment for illicit substance use in the past year 12 and older averaged 20.5% per year (2005 – 2013) or about 18,000 persons per year which was similar to the US average (Behavioral Health Barometer 2014). Estimates from the NSDUH 2012-13 reflect that 3.32% of adolescents, 7.33% of young adults, and 2.12% of adults needed treatment for illicit drug use in the past year, but did not receive it.

## **Marijuana**

Marijuana is the most abused illicit substance and, in Connecticut, both past month and past year estimates exceeded the national average for all age groups per the NSDUH 2012-13. Nine percent of adolescents and adults smoked marijuana in the past month while 24% of 18 – 25 year old young adults smoked marijuana in the past month. This is associated with an average of 77% of CT adolescents perceiving no great risk in smoking marijuana on a monthly basis, similar to the US average.

Ten percent (4,176) of admissions to substance use programs in Connecticut for adults are for a primary dependence on marijuana/hashish/THC compared to 21% (1,733) of admissions to mental health programs.

## **Heroin/Opioids**

Heroin and other Opioids have received much attention recently because of the rising numbers of persons misusing prescription painkillers. Associated with this increase has been a transition by former prescription painkiller misusers to heroin as it is cheaper and readily available. Additionally, there has been a significant rise in the number of overdoses and deaths due to licit and illicit opioids. DMHAS EDW data from FY 2014 finds a 3% increase in admissions for opioids from FY 2013 numbers. The most frequently cited substance category of abuse for those being admitted to DMHAS substance use programs is heroin/opioids. It's the

third most frequently identified substance category for these being admitted for a mental health concern.

NSDUH data for the past several years indicates that after marijuana, prescription medications are the most abused illicit substances. In Connecticut, the percentages for all age groups are actually less than the national averages. In our state, misuse of prescription painkillers was at 3.86% for adolescents, 8.52% of young adults, and 3.52% of those 18 and older.

Based on Behavioral Health Barometer data for Connecticut 2014, the number of persons enrolled in Medication Assisted Treatment (MAT) is an indirect indication of the number of persons dependent on opioids. This data indicates that Connecticut had an increase in the number of persons receiving both methadone (from 11,126 in 2009 to 15,509 in 2013) and buprenorphine (from 683 in 2009 to 980 in 2013).

Significant efforts have been underway in Connecticut over the past few years to address the increased use of prescription opioids and heroin, including legislation, public forums and summits to raise awareness, training on risks associated with heroin and misuse of prescription opioids as well as use of naloxone (narcan) to reverse opioid overdose, narcan education and dispensing as part of syringe exchange, and other cross agency collaborations.

### **Cocaine/Crack**

Figures for cocaine use in the past year from the NSDUH 2012-13 are almost identical for adolescents comparing Connecticut (0.60%) and the US (0.63%) and are only slightly higher for Connecticut use by young adults (6.33%) than nationally (4.53%) and those 18 and older (2.13% compared to 1.81%).

In FY 2014, DMHAS EDW admission data found that more than 7% of those entering substance use treatment programs in Connecticut had named cocaine/crack as their primary drug of choice while nearly 10% of those entering mental health treatment programs reported the same. Cocaine/crack remains an important substance of concern.

### **Co-Occurring Conditions**

Data from DMHAS' Enterprise Data Warehouse (EDW), which reflects services provided by all DMHAS funded or operated agencies, reveals that in State Fiscal Year (SFY) 2014, nearly one-quarter (22,939 or 22%) of all clients were "co-occurring" or had both a mental health and a substance use diagnosis. More than half of these co-occurring clients (54%) received mental health services only during the fiscal year. About half that many (26%) received substance use treatment services only for the same period. Twenty-one percent received both mental health and substance use treatment services for SFY 2014. This total may somewhat underestimate the number of people served in both settings, as the data for services was restricted to one fiscal year. It may also reflect the

differences in people's willingness to acknowledge certain types of conditions and be willing to seek treatment for them. Programs may also be labeled as either mental health or substance use treatment, when in reality they may be providing cross-spectrum services. Persons with co-occurring issues are receiving ever greater attention in light of the implementation of ACA and the need for ongoing integration of mental health, physical health and substance use concerns.

### **Persons Served in DMHAS Programs**

The following data is for SFY 2014 from DMHAS' EDW. The full Annual Statistical Report is available at:

[http://www.ct.gov/dmhas/lib/dmhas/publications/dmhas\\_annual\\_report\\_sfy2013-14.pdf](http://www.ct.gov/dmhas/lib/dmhas/publications/dmhas_annual_report_sfy2013-14.pdf).

During SFY 14 (July 1, 2013 – June 30, 2014), DMHAS served a total of 107,963 people; 56,782 were treated in substance abuse programs and 58,384 were served in mental health program. A smaller group of 7,230 received both mental health and substance abuse treatment services. An almost equal number of males and females received mental health services, while more males than females participated in substance abuse services at a ratio of 2.5 to 1. Most clients were White/Caucasian (64%), followed by Black/African American and "Other" at nearly equal levels, 16% and 15%, respectively. Twenty percent of DMHAS clients were of Hispanic/Latino ethnicity, with most of this twenty percent being of Puerto Rican origin (12%). Younger clients ( $\leq$  age 44) were more likely to receive substance abuse services while older clients ( $\geq$  age 45) were more likely to receive mental health services. The majority of substance abuse clients were in the 26 – 34 year old age group, while the majority of mental health clients were between 45 – 54 years of age. For mental health services, most clients were receiving outpatient services. For substance abuse services, most clients were receiving pre-trial intervention, followed by either residential care, outpatient services or medication assisted treatment. Clients receiving young adult (18-25) services during SFY 14 numbered 1,117.

Drug disorders (35%) were the most frequently diagnosed conditions among those receiving services from DMHAS. Over one-fourth (27%) of the clients had a diagnosis of major mood disorder; while close to 20% had a diagnosis of major depression. When looking at primary and non-primary diagnoses, half of the clients qualified for a Serious Mental Illness (SMI) diagnosis, which involves having any (or multiple) of the following diagnoses: Schizophrenia (including related disorders), Bipolar Disorder, or Major Depression. About 64% of clients had a substance use disorders. Almost one-quarter (24%) of clients qualified for a dual disorder, with both an SMI diagnosis and a substance use diagnosis.

Among admissions to substance abuse programs, heroin was the most frequently reported primary drug (42%), and when combined with other opioid drugs, reached 50%. Alcohol was the primary drug for 31% of substance abuse

admissions. Among admissions to mental health programs, alcohol was reported as the primary drug for more than half of the admissions (55%), followed by marijuana/hashish/THC at 18%.

**Persons receiving DMHAS Mental Health Services SFY 2014**

<b>Gender</b>	<b>Persons Served</b>	<b>Percent</b>
Female	29,743	50.94%
Male	28,609	49.00%
Unknown	32	0.05%
<b>Total</b>	<b>58,384</b>	
<b>Age</b>		
18-25	7,926	13.58%
26-34	10,190	17.45%
35-44	10,516	18.01%
45-54	14,903	25.53%
55-64	10,141	17.37%
65+	3,766	6.45%
Unknown	942	1.61%
<b>Race</b>		
American Indian/Native Alaskan	312	0.53%
Asian	467	0.80%
Black/African American	9,895	16.95%
Native Hawaiian/Other Pacific Islander	122	0.21%
Multi-race	193	0.33%
Missing/unknown	1,712	2.93%
Other	8,448	14.47%
White/Caucasian	37,235	63.78%
<b>Ethnicity</b>		
Hispanic-Cuban	123	0.21%
Hispanic-Mexican	231	0.40%
Hispanic-Other	4,132	7.08%
Hispanic-Puerto Rican	6,619	11.34%
<b>All Hispanics</b>	<b>11,105</b>	<b>19.02%</b>
Non-Hispanic	43,790	75.00%
Unknown	3,489	5.98%

**Persons receiving DMHAS Substance Use Services SFY 2014**

<b>Gender</b>	<b>Persons served</b>	<b>Percent</b>
Female	17,343	30.54%
Male	39,059	68.79%
Unknown	380	0.67%
<b>Total</b>	<b>56,782</b>	<b>100.00%</b>
<b>Age</b>		
18-25	12,054	21.23%
26-34	15,046	26.50%
35-44	11,386	20.05%
45-54	11,486	20.23%
55-64	4,859	8.56%
65+	811	1.43%
Unknown	1,140	2.01%
<b>Race</b>		
American Indian/Native Alaskan	261	0.46%
Asian	322	0.57%
Black/African American	8,517	15.00%
Native Hawaiian/Other Pacific Islander	80	0.14%
Multi-race	377	0.66%
Missing/unknown	2,157	3.80%
Other	8,491	14.95%
White/Caucasian	36,577	64.42%
<b>Ethnicity</b>		
Hispanic-Cuban	166	0.29%
Hispanic-Mexican	363	0.64%
Hispanic-Other	4,194	7.39%
Hispanic-Puerto Rican	6,892	12.14%
<b>All Hispanics</b>	<b>11,615</b>	<b>20.46%</b>
Non-Hispanic	41,025	72.25%
Unknown	4,142	7.29%

**Workforce Development & Shortages**

Connecticut, like the rest of the country, is facing shortages of behavioral health professionals, particularly nurses and psychiatrists. The most recently available

data from the Health Resources and Services Administration (HRSA) indicates that as of 4.17.12, Connecticut has a professional shortage of 38 mental health practitioners statewide. While this may not appear to be a significant shortage, according to the *Statewide Health Care Facilities and Services Plan* prepared in October 2012 by Connecticut's Department of Public Health (DPH), even when it appears that Connecticut has an adequate number of healthcare providers statewide, due to the geographic distribution of providers and refusals to accept insurance or Medicaid, not everyone who wants treatment can access it. The situation is further compromised by fewer medical students choosing to specialize in psychiatry and an aging workforce.

Through the Health Professional Shortage Area (HPSA)/Medically Underserved Area (MUA) designation program, the DPH Primary Care Office identified areas, populations and health care facilities in all eight Connecticut counties experiencing shortages of mental health professionals. As of April 2012, there were 106 HPSA designations in all or part of 99 mostly poorer communities, with a majority located in the three most populous counties (Fairfield, Hartford, and New Haven).

The shortage of psychiatrists has been particularly noted for children and for older adults. One-third of Connecticut's population is comprised of "baby boomers" and based on median age of its citizens; Connecticut is the seventh "oldest" state.

*The United States Department of Health and Human Services (US DHHS) Projected Supply, Demand and Shortages of RNs 2000 – 2020* report estimates by 2020, there will be a national shortage of over 800,000 nurses. Connecticut is projected to face a similar shortage of 21,791 nurses.

### **DMHAS Priority Setting Process**

While the Department of Mental Health and Addiction Services (DMHAS) is responsible for ensuring that the priority setting process occurs every two years, it depends upon the efforts and statewide planning, advisory and advocacy structures of the RMHBs and RACs to be realized. DMHAS wishes to thank the Regional Mental Health Board (RMHB) and Regional Action Council (RAC) members who participated in the 2014 priority setting process for their ongoing commitment and tireless efforts on behalf of those with behavioral health issues. Since the RMHBs and RACs form the basis of the regional priority setting process by facilitating grassroots input and independent viewpoints, the perceptions and views expressed and subsequently found in this report, are not always shared by DMHAS itself. However, it is through the process of navigating this array of potentially conflicting viewpoints that consensus themes and priorities inevitably emerge and are used to inform planning, budgeting, and development of Connecticut's Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Application.

As part of the priority setting process, the RMHBs and RACs promote interaction across a broad range of stakeholders to:

- Determine unmet behavioral health needs and identify emerging issues
- Gain broad stakeholder input on service priorities, needs and solutions
- Foster ongoing dialogue regarding identified unmet needs in the regions

The 2014 Priority Setting Process is the seventh since the initiation of this coordinated planning process in 2002. In the intervening years (odd numbered years), RMHBs and RACs provide “updates” informing DMHAS of progress made in addressing the identified unmet needs in their regions and alerting the department to any emerging issues. In conducting these regional assessments, the RMHBs and RACs utilize DMHAS service data, local needs assessments, and other planning documents to reach the conclusions found in their regional priority reports. Through various assessment methods, RMHBs and RACs collect information on: 1) root causes of identified problems and unmet needs; 2) solutions and resources that may be required, including those which may be low or no cost; 3) gaps and barriers to implementing proposed solutions; and 4) needed cross-system collaborations.

Each region developed a Regional Priority Setting Report which it presented to the DMHAS Commissioner and executive staff. Individual Regional Priority Setting Reports can be found on the DMHAS website at: <http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=451050>. The 2014 Statewide Priority Setting Report captures findings from each regional report based on qualitative efforts (Community Conversations, focus groups, ongoing meetings of the RMHBs and RACs), statistical data on clients served during state fiscal year 2014, and a summary of findings based on a Treatment Provider Survey. The Statewide Priority Setting Report is shared and discussed with the Adult Behavioral Health Planning Council and is posted to the DMHAS website: <http://www.ct.gov/dmhas/lib/dmhas/eqmi/priorityservices.pdf>. A summary of the different sections of the Statewide Priority Setting Report follows.

### **Treatment Provider Survey Overview**

A list of treatment providers in each region was reviewed and approved by members of the Adult Behavioral Health Planning Council. Additionally, survey questions were shared with the Council which provided feedback resulting in the final product of 4 open-ended questions:

- 1. How could the Regional Action Councils (RACs) and/or the Regional Mental Health Boards (RMHBs) collaborate with your agency to improve the services system?*
- 2. What do you identify as the greatest strengths of the mental health and/or substance abuse service system?*

3. *Where does the system have insufficient services or barriers to meeting service system demands?*
4. *If you were in charge of the DMHAS service system, what would you change to improve it?*

A list of DMHAS providers was reviewed and approved by the Adult Behavioral Health Planning Council for each of the five state regions. Surveys were sent electronically in April 2014 via survey monkey. In an effort to maximize responses, the survey was simplified to four questions and recipients were sent bi-weekly reminders and positive reinforcement for having responded. The 126 providers were given six weeks to respond and by the end of the survey period, 68 of them had, for a response rate of 54%. The report which follows organizes responses by themes to create a coherent integrated view of the perceptions and recommendations of providers.

## **2014 Treatment Provider Survey Results**

### **1. How could the Regional Action Councils (RACs) and/or the Regional Mental Health Boards (RMHBs) collaborate with your agency to improve the service system?**

- *Reach out to us more and help us coordinate with each other*
- *Support us, share with us, advocate on our behalf*
- *Provide/Coordinate Training for us and for the Community*
- *Provide assistance to clients*
- *Help us to coordinate Behavioral Health with Primary Health Care*
- *Re-Examine the Provider Evaluation Process*

### **2. What do you identify as the greatest strengths of the mental health (and/or substance abuse) service system?**

- *Responsiveness/Leadership of DMHAS and its Agents*
- *Approach toward Clients*
- *A Comprehensive Service System*
- *Collaborative Committed Staff*
- *Training Opportunities*

### **3. Where does the system have insufficient services or barriers to meeting service system demands?**

- *Lack of safe, quality, affordable, supportive Housing*
- *Lack of psychiatric services and outpatient mental health care*
- *Lack of Long-term inpatient/residential beds*
- *Lack of Transitional Services*
- *Lack of Substance Abuse Specific Services*

- *Lack of Transportation*
- *Lack of Young Adult Specific Services*
- *Lack of Mobile Crisis Specific Services*
- *Continuing Stigma of Persons in the service system*
- *Lack of services for primary Spanish speaking clients*

**4. If you were in charge of the DMHAS service system, what would you change to improve it?**

- *Make Housing Options more Available*
- *Provide Intermediate/Step Down Care for those Transitioning Clients*
- *Expand Psychiatric and Outpatient Mental Health Service Availability*
- *Expand Outreach Services*
- *Modify Funding*
- *Enhance Integration and Consistency*

**2014 Priority Setting Report Qualitative Overview**

The RMHBs and RACs in each region held focus groups and/or Community Conversations with key informants including consumers, family members, providers, referral organizations (such as town social workers, police, etc.) and concerned/interested citizens. Pre-established questions had been discussed and agreed upon by the Adult Behavioral Health Planning Council:

- What are the biggest challenges facing those in your community with substance abuse and/or mental health problems?
- Are people willing to talk about their substance use and/or mental health problems? Why or why not?
- How can the community best support its members with mental health and substance abuse problems, especially those at risk of winding up in the prison system?
- What are the strengths and weaknesses of your community with respect to caring for people with mental health and/or substance abuse problems?
- If you, or someone you know, had a substance use and/or mental health problem, would you know what resources were available and how to access them?
- Has the Sandy Hook school shooting and the resulting media coverage changed how you feel, think, or act with respect to mental health issues in your community?
- What kind of impact have you seen in your community as a result of healthcare reform (otherwise known as the Affordable Care Act or Obama care)
- If you were responsible for mental health and substance abuse services in your community, what kind of changes would you make?

- How are mental health, substance abuse, and medical problems intertwined in your community?

Details of data gathering by each region can be found in their individual reports: <http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=451050>.

In general, in addition to the focus groups and Community Conversations described above, data was also collected from the following:

- Local, state, and federal data
- Critical incident reports from DMHAS providers
- School/student surveys
- Reviews/fidelity reviews of DMHAS programs
- Individual key informant interviews and surveys
- Meetings of community organizations, committees, workgroups, councils and collaboratives
- Site reviews of DMHAS providers
- Community training events/forums

### **2014 Priority Setting Report Results**

The strengths of the service system, based on provider surveys, statistical reports, and the qualitative focus groups/interviews are described below.

In State Fiscal Year (SFY) 2014, DMHAS served 107,963 persons, an increase from the number served in SFY 2013. There has been a steady increase in the number of clients served by DMHAS each year and implementation of the Affordable Care Act (ACA) does not appear to have significantly affected this trend. Why a dramatic increase has not been seen is thought to be the result of efforts years ago by DMHAS through programs such as State Administered General Assistance (SAGA), followed by Medicaid for Low Income Adults (MLIA), to provide behavioral health services to the medically indigent. As a result, persons who would've otherwise enrolled when the ACA was implemented were already part of the system and receiving services.

Connecticut's block grant represents only a small proportion of spending on behavioral health within the state. In other words, Connecticut has made a financial commitment for the medically indigent. Even challenging budgetary times such as have been experienced since 2008; have not resulted in fewer clients receiving services. On the contrary, as was mentioned above, the number of clients served has continued to increase over time.

Data quality is a DMHAS priority and the unit responsible (Evaluation, Quality Management and Improvement – EQMI) has made great strides in aggregating the data submitted by providers into simple-to-understand “report cards” on various aspects of performance related to contract expectations. This allows programs to review their own performance and compare it to the performance of other comparable programs. Making these “report cards” available on the

DMHAS website also improves the transparency of the service system by providing an opportunity for review by the public. Standard reporting on the number and demographics of clients served, services received, and the most common diagnoses of those treated is made available in a new Annual Statistical Report, also posted to the DMHAS website. Consumer Satisfaction data from thousands of service recipients are summarized in a report posted to the website annually. At present, a variety of reports are in development to further inform DMHAS, service providers, and the public on the quantity and quality of services provided with an emphasis on examining disparities between groups and making data more routinely accessible.

Based on a survey of DMHAS providers across the state in 2014 in which 68 of 126 providers responded (54% return rate), the following strengths were identified:

- Responsiveness/leadership of DMHAS and its agents
- Recovery-oriented approach toward clients
- Comprehensiveness of the service system
- Collaborative, committed staff
- Opportunity for training

In addition to the provider survey, focus groups, interviews, and Community Conversations with a range of stakeholders from consumers/persons in recovery to family members, police, referral agencies, school and hospital personnel, and interested citizens conducted by the RMHBs and RACs resulted in the following description of strengths. Generally speaking, the array of DMHAS services across levels of care is comprehensive, high quality, and innovative, and was identified as one of the strengths of the service system. Another prime asset of the system are the compassionate, organized, recovery-oriented, flexible, highly skilled and experienced clinicians/staff that are willing to collaborate and partner with others on behalf of their clients. Other strengths of the system identified by the five regional reports: use of evidence based practices, programmatic flexibility, advocates working on behalf of clients, town substance use prevention coalitions, church and community centers, the grassroots style of the RMHB, the support provided by the Catchment Area Councils, the PUSH program, Young Adult Services, supervision, clubhouses (including Bridge House); SMHA's network of providers, the community college model, training courses, and visiting nurses/home health aids. The following services were singled out as helpful: occupational therapy to assist with skill building, dieticians to assess nutritional needs, outpatient services, social clubs, sober clubs, sober houses, residential treatment, strengths-based treatment, and 12-step programs. Hospitals were valued for their multiple behavioral health services; YAS; CIT services; programs which emphasize family support; accessibility of most agencies by bus; Mental Health Association of Connecticut training events; community resources like soup kitchens and food pantries; certain town and state officials; and the network of providers which, as quoted in one report "by and large understand all the

internal and external challenges the clients face on a daily basis and work tirelessly to deconstruct barriers in order to facilitate insight, growth and health”.

A review of all the data above has also provided a list of needs/gaps which follows.

- **Awareness – Stigma - Public Education:** Stigma/discrimination against those with behavioral health issues continues to function as a barrier impeding the decision to self-disclose, seek help, and obtain acceptance, exacerbated by the Sandy Hook School shootings. While more people overall reported that they would be willing to disclose their behavioral health issues, there was general recognition that most of the public is uninformed or misinformed on the topic of behavioral health. It was recommended to reduce stigma, raise awareness, and educate the public using all forms of social media so that behavioral health issues can be recognized, normalized, and responded to appropriately, including connection/referral to the appropriate care.
- **211 info line:** Connecticut’s free and confidential 24/7 info-line (211) which can link callers to Mobile Crisis services, on-site assistance, and transportation to the ED should be better known by the public and enhanced.
- **Prevention:** There have been many successful prevention campaigns including “One Word, One Voice, One Life” suicide prevention, Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Smoking Cessation efforts. These prevention efforts should be expanded, including agency collaboratives for high risk clients to more effectively (clinical and cost) manage their cases. The 132 clients that have been on the Middlesex CCT caseload for 6 months or more have had a 63% reduction in combined ED and inpatient visits. This model is being replicated in other areas of the state.
- **Early and Sustained Interventions for Mental Health:** In addition to the 5% set-aside work being done, earlier involvement of those with behavioral health concerns (including family involvement), as well as outreach to pediatricians, academic settings and the general public in an effort to reach those parties most likely to be the initial contact when behavioral health issues emerge.
- **Opioid Abuse:** The rise in prescription painkiller misuse in addition to heroin and subsequent overdoses have resulted in DMHAS and the RACs have been active in advocating for more medication drop boxes, community forums on opioids, educating providers on narcan (the antidote for an opioid overdose), and advocating for legislation. Coordinate state efforts on opioid abuse issues, increase public awareness of the dangers, address barriers to prescriber engagement in prevention of opioid abuse and overdose, and require use of the prescription drug monitoring program.
- **Insurance Issues/Affordable Care Act (ACA):** Despite more people now being eligible for and having access to affordable health care coverage,

there are a number of issues. Some people still can't afford premiums, refuse to enroll, or are impeded by not having internet access; some failed to check the behavioral health benefits before enrolling and only discovered later that their co-pays and deductibles were unaffordable or that their behavioral health provider of choice was out of network. A substantial amount of confusion remains, especially among those with behavioral health conditions. Further efforts to reach out to and educate the community about the ACA were recommended.

- **Peer Services:** Hundreds of persons in recovery have been trained through Advocacy Unlimited (AU) and many have been hired as Recovery Specialists. Several DMHAS funded providers are using persons in recovery (in paid or volunteer roles) as ambassadors for people using their services and standards for the provision of Community Support Services and ACT teams require that persons in recovery are hired to work on them. It is not just mental health programs that are involved in this effort. Connecticut Community for Addiction Recovery (CCAR) provides training for persons in recovery from substance use disorders as Recovery Coaches and uses volunteers to operate their Telephone Recovery Support Program. Recommendations for peer services included having them share their success stories with the media to reduce stigma, increase awareness among providers so they are integrated across the continuum, and arrange for peer support at critical junctures for clients, such as those new to treatment, recently released from incarceration, in shelters, with isolated seniors, and with teens and students.
- **Empowering Clients:** Clients may feel disrespected and intimidated by the provider and fail to speak up on their own behalf. People in recovery reported that their providers sometimes ignore their physical complaints, don't always tell them about all options, including non-pharmaceutical supports, nor are they informed about all possible side effects of medications. DMHAS has an initiative underway designed to empower clients to advocate for themselves to their providers. This initiative is the Decision Support Learning Collaborative (DSLCL). The DSLCL, working with persons in recovery at Pat Deegan Associates, consists of an 8 agency collaborative in which empowering clients to make decisions about their own treatment and recovery is moving forward. It was recommended that providers receive education on informed consent requirements and treating the person holistically, including their lifestyle, when discussing medication side effects.
- **Outpatient services:** Consequences of insufficient capacity of outpatient services are clients in crisis and clients seeking services at the ED. The lack of outpatient capacity is attributed to providers not accepting insurance and/or inadequate reimbursement rates which put a strain on providers and have forced some to close, in turn burdening those left behind. Recommendations include allowing walk-ins without appointments, providing evening and weekend hours, modifying funding or

reimbursement rates, making more services available on line, and hiring more providers.

- **Psychiatrists/Prescribers:** A shortage of psychiatrists, especially those accepting insurance/Medicaid. Lack of evening and weekend hours was cited as a barrier for clients who are employed. Wait times can be extended because of the shortage which can result in lapses of prescriptions with no means of refilling them. This can result in a client ending up in the ED or otherwise in a crisis situation. It was recommended that more psychiatrists be available, or that available psychiatrists be shared and that more after hours and weekend appointments be available.
- **Transitions/Discharge/Follow Up:** Concern was expressed for those clients transitioning from one level of care to another, including to the community, in terms of service availability, medication access, housing and making a successful connection. For some, the concern is a lack of satisfactory discharge planning, for others, it is a lack of follow through to make sure planned arrangements happen. The delay in accessing an outpatient or psychiatric appointment mentioned above can also contribute to an unsuccessful transition. It was recommended that there be more follow up to ensure clients make successful transitions.
- **Drop In/Respite/Support:** “Supports are critical in community settings because social skill development and fitting in are keys to healthy integration” was a quote from one respondent. Likewise, such supports are cost-effective prevention options. Creating more drop in centers, perhaps by partnering with community centers or schools, was recommended, along with more support groups, sober clubs, NAMI support groups and 12-step programs.
- **Social and Recreational Programs:** As an aid to strengthening recovery, more opportunities for social and recreational programs were identified as needed for all ages and in diverse locations. Increasing opportunities for social and recreational program, including at shelters, waiting rooms, libraries, YMCAs, schools, and park and rec departments was recommended.
- **Intermediate Level of Care:** For those who don’t need hospitalization, but need clinical care and support, a level of care is needed that would also serve as a transition between hospital discharge and community care. Without such support, the intended recipient could de-stabilize and fail to successfully transition, resulting in such unfortunate consequences as homelessness. An expansion of options at this level of care was recommended.
- **Long-term therapeutic Residential Programs:** Long-term therapeutic residential programs, like Medicaid Rehab Option (MRO) homes, but not time limited, are needed for clients that either require this level of care for many years or those who will always require a congregate living situation with supervision, but don’t meet the medical necessity of a nursing home. Creating permanent group homes that aren’t time limited was recommended.

- **Coordinated/Integrated Care:** A number of DMHAS efforts are in process to address what is perceived as a continued lack of integration for those with cross-spectrum issues. A new DMHAS initiative is the Behavioral Health Home model, designed as a cost-effective approach to facilitate access to an interdisciplinary array of behavioral health and medical care, along with community-based social services and supports. To address these concerns, it was recommended that collaboratives be created and training of providers be accomplished.
- **Housing/Homelessness:** Those with behavioral health issues are overrepresented among the homeless and, at present, there aren't enough shelter beds to accommodate them. This is despite the fact that Connecticut has continued to invest in supported housing, Community Care Teams are operating, Homeless coalitions are merging, and new initiatives, such as VI-SPDAT (Vulnerability Index – Service Prioritization and Decision Assistance Tool) is assisting providers in allocating resources in a logical and targeted way by prioritizing those most at risk among the homeless. In addition to creating more housing options, it was recommended that community-based options be expanded, a housing workgroup be created within the State Board, and education on the value and role of such housing options occur. Related to this topic, there were specific recommendations for shelters, including providing social, recreational and support groups, providing case management services, evaluating clients for behavioral health conditions which would help them get signed up for benefits, obtaining releases of information, and training shelter staff on how to support clients, understanding recovery, and Wellness Recovery Action Planning (WRAP).
- **Employment:** Meaningful employment builds self esteem and empowers individuals toward self-management and independence. Supported Employment services are a strength, but only 8% of DMHAS clients receive them. A lack of employment options for those with behavioral health needs continues, exacerbated by the economic downturn in 2008. Recommendations include explore models other than IPS which may not work for everyone, arrange for small grants to support consumer run businesses, expand job training and skills, educate potential employers to dispel misconceptions about those with behavioral health issues, support transitional and self-employment, focus on job maintenance and not just attainment, address client fears about losing entitlements if employed, offer services at hours that accommodate those that are employed, and educate community groups.
- **Transportation:** In the more rural parts of the state, transportation is a challenge. Those without private transportation find public transportation has limited routes and takes a long time. Those on Medicaid have access to med cab for medically necessary services, but there is an array of problems with contracted providers, including unreliable and sometimes rude drivers. Sharing transportation resources was recommended along with supporting client-owned and operated transportation services.

- **Young Adults:** DMHAS young adult services (YAS) are a “gem which incorporates an effective recovery model allowing young people to thrive and flourish at their own pace” was a quote from a respondent. YAS services are tailored to young adults to provide an essential transition between youth services provided by the Department of Children and Families (DCF) and DMHAS. Concern was expressed that young adults graduate from DCF without life skills. Schools were perceived as lacking training and resources to address behavioral health issues. There are students enrolling in college who fail to adjust and end up dropping out, without a sense of direction. Recommendations related to young adults included: enhancing provision of skills and training within YAS program, sharing what works in YAS programs with other providers to expand the reach of these services, expanding school-based health centers, reaching out to colleges/universities so they make accommodations to students with behavioral health issues, support depression screening efforts and ongoing efforts, train faculty and staff on MHFA and emerging drug trends, and provide social support.
- **Older Adults/Seniors:** One-third of Connecticut’s population is comprised of “baby boomers”. Seniors are often overlooked when it comes to behavioral health issues. This is despite the fact that seniors are more likely than any other age cohort to have a presentation complicated by medical issues and medication. DMHAS is collaborating with the University of Connecticut on projects to identify seniors with substance use issues and to integrate SBIRT into assessments in non-behavioral health settings are in process. Isolation, lack of engagement of seniors in social and recreational activities, and loss of family support are concerns. More seniors need nursing home care than capacity exists. Seniors may be living on fixed incomes and not have the resources to afford medications or transportation. Medical issues make them too much for a residential program, but not enough to qualify for a nursing home. Often seniors can’t remain in their homes because of physical limitations, but facilities won’t accept them because of their behavioral health issues. Training family members and caregivers of seniors to identify behavioral health issues and understand resources was recommended. Screening using SBIRT, especially for depression and substance use was another recommendation. More outreach to seniors is needed to increase social engagement and decrease isolation. Programming for seniors should be age-specific and creating a “warm line” by and for seniors was recommended. There is a need for more professionals with expertise in working with a geriatric population. It was also recommended that more assisted living arrangements be made available. Expanding the current “Gatekeeper” program (a referral program that maintains daily contact with seniors and refers professionals to the senior in the community as needed) was suggested.
- **Criminal Justice-involved:** Statewide concern was expressed for the incarceration of persons with behavioral health issues. While jail diversion

programs, especially a Veterans' jail diversion program were commended, a number of issues remain. When police are called to intervene on what should be a behavioral health call to 211, instead of 911, they don't necessarily want to take the person into custody, but want to resolve the situation. Crisis Intervention Team (CIT) training of police departments has proven to be a valuable resource. Once incarcerated, clients may not be willing to disclose behavioral health problems and problematic behavior by the client may not be tolerated. At discharge, clients may be given a two-week supply of medication and a follow up appointment, which does not ensure a successful transition to the next level of care. Such individuals need treatment, not incarceration and more diversion strategies are recommended. Educating judges about the benefits of jail diversion and placing persons with mental health expertise in police departments were recommended. Developing collaboration between the LMHA and police departments was suggested. The community needs to be educated about calling 211 instead of 911 for behavioral health concerns so the right kind of help responds. Specifically regarding the CIT, it was suggested that not just police, but clergy and community leaders could benefit from the training. Perhaps condensing the training to make it more manageable for persons to attend was recommended along with training all new police cadets at the academy. Specific to discharge planning, providing more training of inmates on computer skills may assist them in finding employment after release. Working with potential community employers to create jobs for those exiting jail. Through skill building and family reunification, it may be possible to reduce recidivism. More training, along with legal and community supports to help them successfully re-enter society. Having more thorough discharge planning (issuing ID card, reinstating benefits, housing, employment options, etc.) will result in more successful and cost-effective transitioning to the community.

- **Latino Clients:** The Hispanic population is challenged by discrimination, lack of health insurance and unemployment. Latino youth are reported to have higher rates of substance use, suicide and eating disorders. The lack of Spanish-speaking providers was noted to impede service delivery. Hiring more translators/bilingual providers or providing incentives for current providers to learn Spanish was suggested. Ensuring cultural competency for outreach and treatment were recommended.
- **LGBTQ:** Gay-affirming providers are not visible in the community. The Triangle Community Center is developing a registry of gay-affirming providers. But even those who consider themselves gay-affirming, may not have the training or cultural competency required. Strengthening gay-straight alliances and events was recommended.
- **Co-Occurring Clients:** There continues to be the impression that those with co-occurring conditions are not receiving appropriate treatment. Anecdotal reports of those with addiction histories being refused treatment for chronic pain and others with mental health diagnoses being refused detoxification for substance use exemplified the kinds of challenges faced

by this complex population. The need for integrated care for the co-occurring population was highlighted. Guidelines for provision of co-occurring services was recommended to ensure staff are cross-trained. It was further suggested that mentoring and peer training by those with expertise in co-occurring treatment should occur. A “no wrong door” approach was advocated accompanied by better cross-agency collaboration to manage these complex clients. Greater capacity to treat those with multiple diagnoses was recommended.

- **Caregivers:** Caregivers were noted to need care. It was postulated that staff burnout could be contributing toward insensitivity toward clients. Greater awareness of signs of burnout among staff was recommended along with re-assigning or re-training as indicated. Providing ongoing education and support for staff, especially training on relationship-based care, trauma-informed care, motivational interviewing, and other models that increase understanding and sensitivity. Supporting staff by monitoring workloads, training and capacity building, financial support, good communication and supervision, employee recognition and good benefits for part time employees were recommended.
- **Alternatives to Traditional Models/Wellness:** Beyond the usual conception of integrated treatment, a more comprehensive movement is operating with the goal of holistic health. This wellness initiative embraces non-traditional (including other than pharmaceutical) strategies. Part of this initiative is considering mental health to be part of overall health which should have regular checkups. The Advocacy Unlimited TOIVO initiative, offering classes/workshops and mind-body focused wellness support groups in clubhouses, was an exemplar of this approach. It was recommended that DMHAS invest in holistic efforts focusing on total wellness, including yoga, meditation, music/art therapy, diet and exercise. Training the community on this approach was recommended. Promoting recovery-oriented treatment and less reliance on medications were suggested. Creating a collaborative which is person-centered and covers all of health was also recommended. Ensuring that providers have the resources and training needed to support these holistic approaches was suggested.

### **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*.

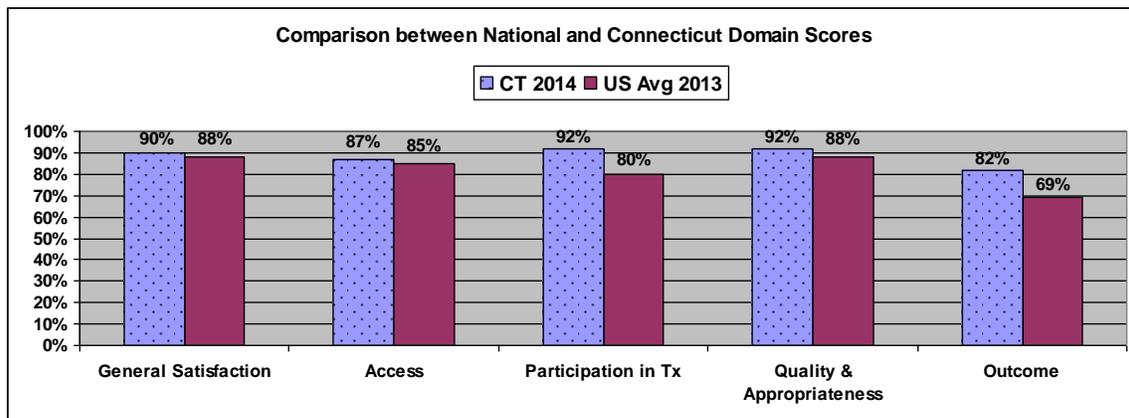
The survey is offered to consumers/individuals in recovery within the context of their treatment for behavioral health issues. Most levels of care are required to

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. The most recent version of this full report for FY 2014 is available at:

<http://www.ct.gov/dmhas/lib/dmhas/consumersurvey/cs2014final.pdf>

In 2005, DMHAS added the Recovery domain to the MHSIP survey. The Recovery domain is comprised of five questions which assess perception of “recovery oriented services”; these 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. Additionally, DMHAS uses an additional Respect domain to collect information about perceived respect towards people in recovery.

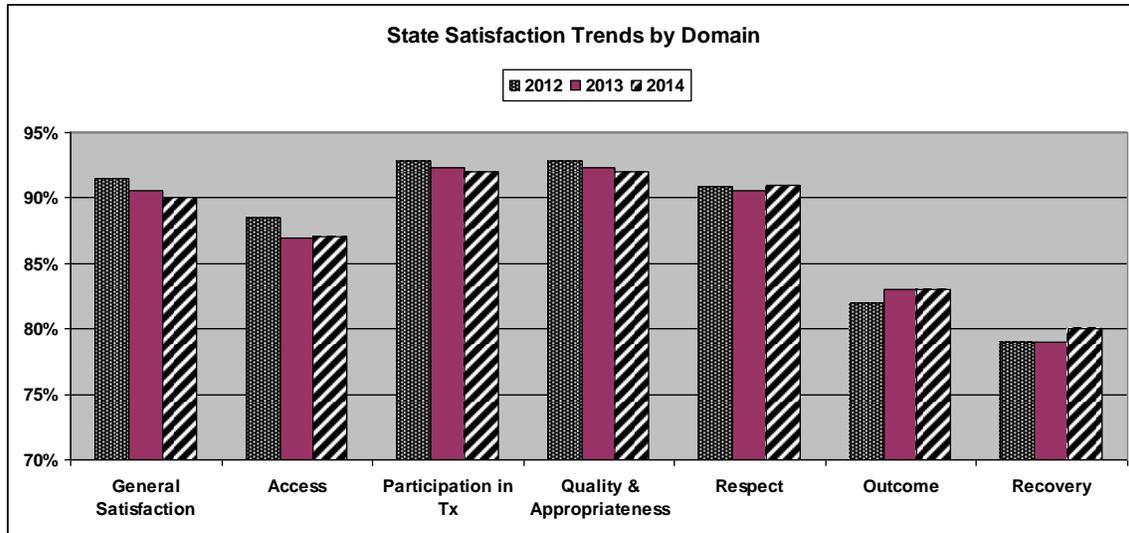
A comparison of consumer survey finds between Connecticut and national results follows



When compared to the latest MHSIP national survey results available (2013 CMHS Uniform Reporting System Output Tables), Connecticut consumers report higher levels of satisfaction in all domains: General Satisfaction, Access, Participation in Treatment, Quality and Appropriateness, and Outcome. Connecticut scores were 2% - 13% higher than the national average in each domain.

The following table shows satisfaction rates over the last three years for which Connecticut has reportable data:

	General Satisfaction	Access	Participation in Treatment	Quality & Appropriateness	Respect	Outcome	Recovery
2012	91.5%	88.5%	92.8%	92.8%	90.9%	82.2%	79.1%
2013	90.6%	86.9%	92.3%	92.3%	90.6%	82.7%	79.2%
2014	90.4%	86.9%	92.2%	92.2%	90.5%	82.5%	80.4%



The percentage of consumer satisfied with services has remained relatively stable over several years with only small increases or decreases noted.

With the interest in differences across groups, one of the limitations of the MHSIP is that it was standardized for use with consumers receiving mental health treatment only, not the broader sample in the Connecticut survey which includes those receiving substance abuse and co-occurring services, in addition to those receiving mental health services.

Group disparities of interest from the 2014 survey results include:

- More women reported satisfaction with services in the Access, Appropriateness, General Satisfaction, Participation in Treatment and Respect domains, while more men reported satisfaction with services in the Outcome domain
- In the Access, Outcome and Recovery domains, more Black consumers were satisfied than those in the White category
- In the Access, Appropriateness, Outcome, General Satisfaction and Recovery domains, more Hispanic consumers were satisfied with services than those in the Non-Hispanic category (this pattern has held since 2010)
- Consumers 55+ were more satisfied with services in the Access and General Satisfaction domains than those in younger age categories
- Regarding Appropriateness and Participation in Treatment domains, more consumers age 25+ were satisfied with services than those age 24 and younger

During FY 2014, DMHAS suggested that providers voluntarily administer the WHOQOL-BREF Quality of Life (QOL) instrument, which is a widely used, standardized quality of life tool developed by the World Health Organization. The original instrument, the WHOQOL-100 was lengthy and so the WHOQOL-BREF or abbreviated form was developed. This shortened version is a 26 question tool

that measures consumer satisfaction with the quality of his/her life in the following domains: physical, psychological, social relationships, and environment. Individual questions are scored on a scale from 1 – 5, with 1 being the lowest score and 5 being the highest score possible. Domain scores are transformed to a scale of 1 – 100, with higher scores indicating more satisfaction with quality of life.

In FY 2014, DMHAS received 2,472 individual responses to the QOL instrument (defined as the number of clients who answered at least one question). The consumers who responded to the QOL survey are a subset of those who responded to the Consumer Survey.

Physical	Psychological	Social	Environmental	General QOL
65.2	65.9	64.0	65.2	68.1

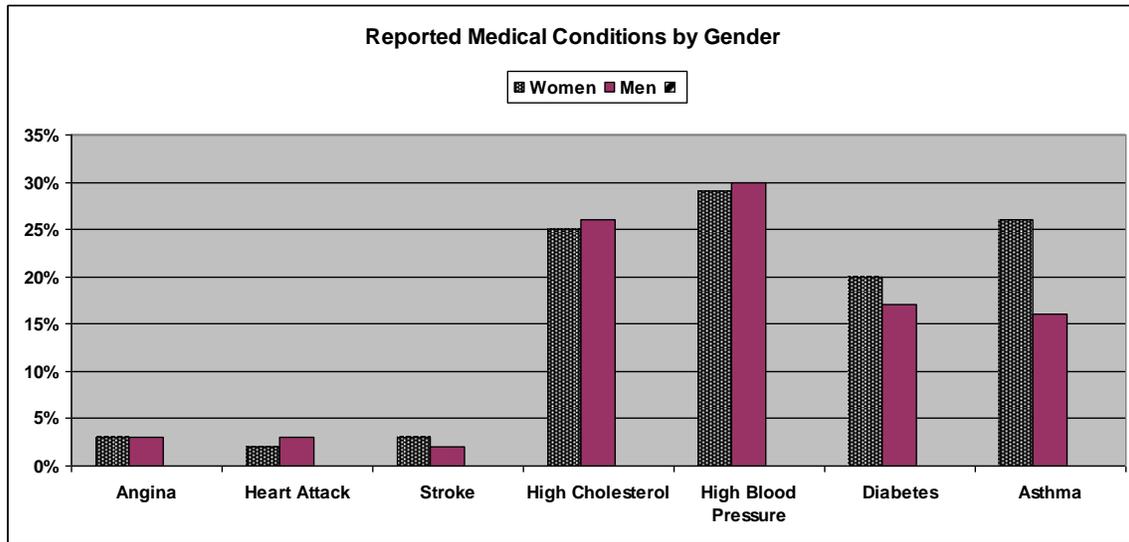
- In the Physical, Psychological, and General QOL domains, men reported better QOL than women
- In the Psychological, Social and General QOL domains, Black consumers reported better QOL than White consumers
- There were no differences in QOL domains by Ethnicity
- For the Physical and Social domains, clients who were 34 years of age or younger reported better QOL than clients who were age 35+. Likewise, in the Psychological domain, clients who were age 24 years or younger reported better QOL than did clients in older age categories

As part of the FY 2014 Consumer Satisfaction Survey process, DMHAS providers had the option to administer an eight question Health Outcomes survey. The questions in this survey were taken from the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in all fifty states. The survey was available in English and Spanish. The questions covered the topics of body mass index (BMI), cardiovascular/respiratory/diabetes disease, overall health from physical and psychological perspectives, and smoking and drinking habits. A total of 3200 surveys were completed (i.e., at least one question answered). Some surveys had height or weight values that were outside of the reasonable range set by the BRFSS and these outlier values were converted to missing data.

BMI could be calculated for 74% (2379) of the respondents. The average BMI for clients was 30.2 ( $\pm$  7.9) with the women’s average at 30.9 ( $\pm$ 9.0) and the men’s average at 29.6 ( $\pm$ 6.8). The results are similar to those reported for FY 2013. According to the Centers for Disease Control and Prevention (CDC), based on BMI scores:

Underweight or Normal BMI	Overweight BMI	Obese BMI
23.4%	33.7%	42.9%

Respondents endorsed the following list of medical conditions:



Despite the medical conditions reported, consumers rated themselves with respect to their overall general health as follows:

Excellent/Very Good General Health	Good General Health	Fair/Poor General Health
31%	39%	30%

### Recommendations

Following are recommendations based on all the qualitative and quantitative data collected and reported in this needs assessment. For some of these recommendations, efforts are already underway to address them. For others, they are perennial issues (such as housing) which are continually being worked on. Some will be reflected within the priorities which follow.

#### Service Access/Outreach:

- Reduce stigma, raise awareness, and educate the public about behavioral health using all forms of social media so that behavioral health issues can be recognized, normalized, and responded to appropriately, including connecting/referring to appropriate care.
- Address the rise in prescription painkiller misuse/heroin abuse by coordinating state efforts, raising public awareness of the dangers, and engaging prescribers in prevention efforts including use of the prescription drug monitoring program.
- Raise awareness of Connecticut's elevated marijuana use and binge alcohol use which exceed national averages.

- Confusion continues related to implementation of the Affordable Care Act (ACA), so further efforts to reach out to and educate the community about the ACA are needed.
- Psychiatrist refusal to accept insurance/Medicaid makes such services unattainable for most clients.

#### Service Expansion:

- To counter the identified workforce shortage of psychiatrists, reflected in extended wait times for an appointment (which can lead to a lapse in prescription refills and a psychiatric crisis for the client), more psychiatrists are needed as are more extended hours and making services available on-line.
- Create long-term therapeutic residential programs without time limits for those persons who will always require a congregate living situation with supervision, but don't meet the medical necessity for a nursing home.
- Transitioning from a higher to a lower level of care is a risky time for a client who might benefit from social and recreational programs, an intermediate level of care, drop-in center/respice/other support group, and more thorough discharge planning and follow up by providers to make sure that the person makes a successful transition. Lengthy wait times for services during these transition periods can result in crises for clients.

#### Service Coordination:

- The success of Middlesex County's Community Care Team (CCT), in which ten local providers meet regularly to collaborate on care management of high-risk clients, should be replicated across the state. The 132 clients that have been part of the CCT caseload for 6 months or more have had a 63% reduction in combined emergency department and inpatient visits.
- The Behavioral Health Home (BHH) model, designed as a cost-effective approach to facilitate access to an interdisciplinary array of behavioral health and medical care, along with community-based social services and supports, should be supported by creation of collaboratives and training of providers.

#### Recovery Supports:

- Every region of the state identified the need for more safe, affordable housing options at all levels of care for those with behavioral health concerns.
- Homeless shelters could better assist clients if the staff received training on how to support clients in their recovery and if staff obtained releases of information, evaluated clients for behavioral health conditions, assisted clients in benefit enrollment, provided social, recreational and support groups, and provided case management services.
- For those without private transportation, public transportation can be a lengthy and circuitous experience deterring their progress. Sharing

- transportation resources and supporting client-owned and operated transportation services were recommended strategies.
- A limited number of DMHAS clients receive supported employment services which follow the Individual Placement and Support (IPS) model. Exploring models other than IPS, arranging for small grants to support consumer-operated businesses, dispelling misconceptions of potential employers, addressing job *maintenance* and not just skills for acquiring jobs, offering behavioral health services on evenings/weekends to accommodate working clients, and addressing client fears about losing entitlements if employed were all suggested.
  - Connecticut can be proud of its efforts with respect to educating and finding positions for persons in recovery (paid and volunteer) as peer advocates/specialists and recovery coaches. Creating opportunities for persons in recovery to share their success stories raises awareness and reduces stigma. Arrangements should be made for peer support at critical junctures for clients, such as those new to treatment, recently released from incarceration, in shelters, with isolated seniors, and with teens and students.
  - Encourage holistic/wellness efforts which consider the whole person. Clients deserve not only respect, but they should be informed of all options, including non-pharmaceutical and non-traditional activities such as yoga, meditation, music/art therapy, and diet and exercise. Clients should be empowered to advocate on their own behalf, taking their preferences and lifestyle choices into account.
  - To assist clients in need of support, greater availability of social and recreational activities at drop-in or community centers, along with more support groups and sober clubs, were recommended.

Population-specific services:

- DMHAS Young Adult Services (YAS) are tailored to young adults to provide an essential transition between youth services provided by DCF and DMHAS and are considered a “gem” of the system. Recommendations for YAS included enhancing provision of skills training and sharing what works in YAS with other providers.
- General recommendations for young adults included, depression screening, expanding school-based health centers, reaching out to academic institutions to educate faculty/staff about behavioral health issues and accessing resources, and providing social support.
- For older adults, training family members and caregivers to identify behavioral health issues and understand resources was suggested. Older adults could also benefit from screening for depression and substance abuse. More seniors need outreach to increase social engagement and decrease isolation. Seniors need age-specific programming and could benefit from creation of a “warm line” managed by them and for them.
- Seniors face complexities around housing issues. Often they can’t remain in their homes because of physical limitations, but facilities won’t accept

them because of their behavioral health issues. Medical issues can make them too much for a residential program, but not enough to qualify for a nursing home, which are also of limited capacity. They may not have the financial resources to afford medications or transportation. Expansion of the “Gatekeeper” program was recommended as this referral program maintains daily contact with seniors and refers professionals to seniors in the community as needed.

- Statewide concern was expressed for the incarceration of person with behavioral health issues and expansion of diversion programs was recommended as a strategy to address this problem. Educating judges about the benefits of jail diversion and placing persons with behavioral health expertise in police departments were encouraged. The community needs to be educated about calling 211 (info-line) instead of 911 for behavioral health concerns so the right kind of help responds.
- Crisis Intervention Training (CIT), which many police departments have taken advantage of, can be expanded to include clergy and other community leaders. It was suggested that CIT become standard training for all new police academy cadets.
- Greater care in discharge planning of inmates from incarceration could reduce recidivism through the following strategies: more computer skills training of inmates, working with potential community employers to create jobs for those exiting jail, utilization of skill building and family reunification to improve community reintegration, more training/legal/community supports to help those being released successfully transition into society, and more thorough discharge planning (identification cards, reinstatement of benefits, housing, etc.).
- The Latino population is challenged by discrimination, lack of health insurance and unemployment. At the same time, Latino youth are reported to have higher rates of substance use, suicide and eating disorders. Ensuring cultural competency and making more Spanish speaking staff available were recommended.
- There is a lack of visibility of gay-affirming providers and concern that those who consider themselves gay-affirming may not have the training or cultural competence needed. It was recommended that gay-straight alliances and events be supported.
- Continuing efforts to integrate care for clients with co-occurring mental health and substance use disorders are needed. Cross-training of staff is needed as is a “no wrong door” approach, so that regardless of how someone with co-occurring conditions enters treatment, all of their behavioral health needs are met.
- It was postulated that staff burnout could contribute to insensitivity toward clients. Greater awareness of signs of staff burnout were recommended along with re-training or re-assigning staff as needed. Staff should be educated on relationship-based care, trauma-informed care, motivational interviewing, and other models that increase sensitivity and understanding. Likewise, staff should be supported, recognized for good

work, earn decent wages/benefits, and be provided communication and supervision.

## **Children's Plan Step II**

### ***Identify the unmet service needs and critical gaps within the current system***

Connecticut has just over 800,000 or 23% of its population are children and youth under the age of eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, 7.1% or over 56,000 is the estimate of children in need of Mental Health Services in Connecticut. 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 a highly 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.

As the result of the tragedy in Newtown in December of 2012, 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 core elements of the input-gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth;
- Open forums held in six locations and attended by 232 individuals;
- Facilitated discussions on 12 specific topic areas, attended by 220 individuals;
- Website input forms submitted by over 175 individuals and groups;
- A review of background documents and data pertaining to the children's behavioral health system in Connecticut.

The process yielded the identification of the following seven thematic areas and specific goals that Connecticut will 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.

**Goal 1.-A.** Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

A core finding from a number of sources is that the children's behavioral health services are, at times, fragmented, inefficient and difficult to access for children and families. Those issues would be substantially improved by integration of public funding that brings together multiple payers and streamlines eligibility, enrollment, service arrays, documentation, and reimbursement mechanisms. Strategies in this area include the following:

- i. Identify existing spending on children's behavioral health services and supports across all state agencies.
- ii. Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.
- iii. Explore mechanisms for pooling funding across all state agencies.
- iv. Identify a full array of services and supports that will constitute the children's behavioral health system of care
- v. Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.
- vi. Identify and address workforce development needs in the children's behavioral health system of care.

**Goal 1.-B.** Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" can improve outcomes for children and lower costs of behavioral health services. A Care Management Entity has the potential, as a model, to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies and accountability, and reduce costs by disseminating information on behavioral health services, connecting families to services, and providing ongoing care coordination. This will help improve the family's experience of a culturally and linguistically appropriate system with a single point of access that helps families access information and navigate care. Strategies in this area include the following:

- i. Design and implement a Care Management Entity to create an effective care coordination system based on proven Wraparound and child

and family teaming models, with attention to integration across initiatives and training.

- ii. Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.

**Goal 1.-C.** Develop a plan to address the major areas of concern regarding how commercial insurers meet children’s behavioral health needs.

Given that insurance companies and self-insured employers currently cover approximately 56% of children and youth in Connecticut, their participation in the children’s behavioral health system of care is critical. Concerns about behavioral health services for children and families with commercial insurance arose in the majority of meetings held to gather input into Plan development. Those concerns can be categorized in the following five areas: Coverage for selected services; adequacy of coverage/services for selected conditions; medical necessity criteria and utilization management and review procedures; adequacy of provider networks; and perceived cost shifting to individuals and the State.

Based on the redesign of the publicly financed system, the incorporation of a Care Management Entity, and the demonstration of outcomes and cost savings, the commercial insurance sector will be incentivized to participate in the children’s behavioral health system of care. Strategies include the following:

- i. Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions.
- ii. Apply findings from the process described above to self-funded/employee-sponsored plans.

**Goal 1.-D.** Develop an agency- and program-wide integrated behavioral health data collection, management, analysis, and reporting infrastructure across an integrated public behavioral health system of care.

A core element of the plan is an emphasis on data and incorporation of results-based accountability. Implementation of the behavioral health system of care requires full attention to the development of data infrastructure for the purposes of monitoring and improving access to services, service quality, outcomes and costs. At the practice level, the collection, analysis, and reporting of data is already an element of evidence-based treatments; yet many other behavioral health services do not currently benefit from systematic data collection, analysis, reporting, standardized training and practice development and quality improvement activities. Specific strategies to be implemented in this area include the following:

- i. Convene a statewide Data-Driven Accountability (DDA) committee to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.
- ii. Utilize reliable standards to guide the new data collection, management, and reporting system.
- iii. Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.
- iv. Increase State capacity to analyze data and report the results.

## **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.

**Goal 2.A.** Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders for children and youth of all ages. Connecticut has a wealth of expertise and programmatic efforts to train early care, education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. However, they reach different audiences and have not been taken to scale to reach children of all ages. (See also Strategy 3.-C. regarding professional development for school personnel in behavioral health).

The key strategy in this area is:

- i. Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the statewide need.

**Goal 2.-B.** All children will receive age appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Screening and early identification are important steps toward avoiding more severe behavioral health challenges over time and deeper involvement in the behavioral health system, this is true for young children and adolescents alike. In addition to the children's behavioral health system; parents and other child-serving systems play a critical role in this effort. Key strategies in this area include the following:

- i. Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life allowing for improved coordination of care.
- ii. Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

**Goal 2.-C.** Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

Providers who work with children and youth need to have specific and developmentally appropriate competencies to assist in behavioral health promotion and prevention, and to recognize and respond to early warning signs or concerns. As those who work with young children need very specific training and have the opportunity to make the biggest difference in setting children on the right developmental trajectory, the Plan suggests beginning with this group of providers. Training for providers working with older children is covered as part of the implementation of specific interventions and through training of school personnel (Goal 3.-C). The following strategy is recommended:

- i. Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

**Goal 2.-D.** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Focus on promotion and universal prevention strategies including continued support for statewide suicide prevention activities, to reduce risk factors and promote protective factors.

### **3. Access to a Comprehensive Array of Services and Supports**

**Goal 3.-A.** 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.

The current array of services is insufficient for meeting child and family behavioral health needs, as manifested in lack of knowledge about the service array, long waitlists for some services and high emergency department utilization. In addition, the proposed expansion of screening to identify behavioral health needs will likely increase the number of youth in need of care, and must be accompanied by an expansion of services to meet those needs. There are currently wide variations in access to and utilization of the array of services among families as the result of such factors as: Past and current child welfare and juvenile justice system involvement; insurance coverage; race, ethnicity and language; and geographic location. De-linking those factors from a family's ability to access a full array of services and supports will go a long way towards meeting the behavioral health needs of all children and families. The use of evidence-based, evidence-informed practices together with innovative and customized services, is highly recommended.

Service expansion in the following areas:

- Early childhood interventions with emphasis on an array of evidence-based interventions from low to high intensity, delivered in a variety of settings;
- Non-traditional/non-clinical services that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, mental health symptoms;
- Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches;
- Behavioral health treatment options including: outpatient care; intensive treatment models; child and adolescent psychiatry; substance use services; and services and supports for children with autism;
- Crisis response services and school-based behavioral health services are also recommended for expansion, which are described in more detail below.

Specific strategies in this area include the following:

- i. Establish an ongoing needs assessment protocol, across local, regional, and statewide levels.
- ii. Finance the expansion of the services and supports within the array that have demonstrated gaps.

**Goal 3.-B.** Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

High utilization of EDs can be addressed through expansion of crisis-oriented services, as well as other elements of the service array. Emergency Mobile Psychiatric Services (EMPS) Mobile Crisis is a proven service that helps divert youth from entering the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission, and providing linkages for families to community-based care. Connections between EMPS and a statewide network of crisis stabilization beds will also help address the current crisis in ED settings. Strategies in this area include:

- i. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services including the expected MOA's between EMPS and local school districts.
- ii. Enhance partnerships between EMPS clinicians and EDs to facilitate effective diversions and linkages from EDs to community-based services.
- iii. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

**Goal 3.-C.** Strengthen the role of schools in addressing the behavioral needs of students.

School-based behavioral health is a key area for expansion of the behavioral health service array that can positively impact all children and should result in substantial overall cost savings through early identification and early intervention. Stakeholders across the state consistently identified schools as playing a critical role in identifying and delivering behavioral health services and supports. The input- gathering process made it clear that the primary mission of schools is to educate students; however, it was widely recognized that students are best prepared to learn when they are healthy and equipped with social, emotional, and behavioral regulation skills and competencies. The state should provide support to schools to address students' behavioral health needs.

Efforts to expand school-based behavioral health services should include co-location of community- based clinicians in schools, additional school-employed behavioral health staff with adequate numbers of behavioral health clinicians, and expansion of School Based Health Centers. All efforts to expand school-based behavioral health care must be coordinated with community-based agencies so that children and families who are identified and/or treated in schools have access to the full array of services offered at community-based clinics, and are assured continuity of care during the summer months. Schools must also closely collaborate with EMPS and with police. School-based behavioral health efforts should pay particular attention to ensuring that youth with behavioral health needs are not disproportionately excluded from the learning

environment due to behaviors that may lead to arrest, expulsion, and out-of-school suspension.

Strategies in this area include the following:

- i. Develop and implement a plan to expand school-based behavioral health services.
- ii. Create a blended funding strategy to support expansion of school-based behavioral health services.
- iii. Develop and implement a behavioral health professional development curriculum for school personnel.
- iv. Require formal collaborations between schools and the community.

**Goal 3.-D.** Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Improve coordination and access to a full service array of suicide prevention activities to support families with children and youth in an acute crisis.

#### **4. Pediatric Primary Care and Behavioral Health Care Integration**

**Goal 4.-A.** Strengthen connections between pediatric primary care and behavioral health services.

Pediatric primary care provides a unique opportunity to screen for and address children's behavioral health needs from a family-based perspective. Child health providers, through the medical home model of care, are an important community-based resource for delivery of health and behavioral health services, as many youth and families access a range of services through their pediatrician. Connections among pediatricians, schools, community-based behavioral health agencies, and other settings, however, need to be strengthened. Connecticut has several initiatives and models in place for improving these connections including the State Innovation Model (See below), Access Mental Health, and Enhanced Care Clinics (See above). These models can be considered when determining how best to address this goal. Strategies in this area include the following:

- i. Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.
- ii. Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices.

- iii. Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.
- iv. Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health, or staff from sites working on behalf of medical homes.
- v. Reform state confidentiality laws to allow for sharing of behavioral health information between health and behavioral health providers.

## **5. Disparities in Access to Culturally Appropriate Care**

**Goal 5.-A.** Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Families and other stakeholders in the children’s behavioral health system identified a number of concerns regarding disparities in access to culturally and linguistically appropriate services. At the broadest level, families expressed a lack of awareness of and access to culturally and linguistically competent services and supports in the existing behavioral health care system. Families requested an expansion of the workforce and the service array to include staff that are from the same community and speak the same language as the families they serve, gender-specific interventions, and enhanced access for families in the most rural areas of the state. Culturally specific marketing, stigma/discrimination reduction, and related materials are needed, along with training provided to all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs) of each family, in accordance with Culturally and Linguistically Appropriate Services (CLAS) standards. Although specific strategies are offered in this section, additional attention to disparities and cultural and linguistic competence are addressed in other sections of the report. Specific strategies in this area include the following:

- i. Conduct an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.
- ii. Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.
- iii. Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

**Goal 5.-B.** Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

Specific strategies in this area include the following:

- i. Enhance training and supervision in cultural competency.

- ii. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.
- iii. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

## **6. Family and Youth Engagement**

**Goal 6.-A.** 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.

Multiple stakeholders, including families, confirmed that a critical element in the development and implementation of a children’s system of behavioral health care is the ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services. At the systems-level, numerous stakeholders, including families, strongly urged that youth, family members, and family/youth advocates have “a seat at the table” in the governance and oversight of the service delivery system and that these roles be paid positions. At the service delivery level, family-advocacy as well as parent and peer support groups were highlighted as important elements of the workforce and the service array. Stakeholders highlighted the importance of opportunities for regular family and youth input and feedback into service delivery at the local and regional level. Strategies in this area include the following:

- i. Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children’s behavioral health system.
- ii. Expand the capacity of organizations providing family advocacy services at the systems and practice levels.
- iii. Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.
- iv. Provide funding to support at least annual offerings of the Community Conversations and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.

## **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.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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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.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## Children's Plan

### Quality and Data Readiness Narrative

1. Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).

Behavioral health providers contracted by DCF report client-level data into an internet-based system known as the DCF Provider Information Exchange (PIE). (Formally known as Programs and Services Data Collection and Reporting System or PSDCRS). Each contracted service (referred to as a Program) has its own customized data collection model, though many data elements are shared across Programs, in which data that is necessary to identify clients and their attributes, services delivered to the clients, and specified outcomes of service delivery.

Data is collected along a combination of points during service delivery, and for some Programs either/both 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.).

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 the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?

The PIE system and the DCF SACWIS system currently under development will give Connecticut added abilities 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 measures?

Connecticut is committed to enhancing and upgrading all data gathering platforms in order to improve the Department's internal ability to track client level outcomes and to eventually meet the requirement of the mental health block grant.

## 1617 Narrative 1 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).**

Connecticut Department of Mental Health and Addiction Services (DMHAS) allocate a portion of Block Grant funding to our sister agency, the CT Department of Children and Families (DCF). We currently report client level data (CLD) for the child services and DMHAS just completed TEDS for mental health for FY 14. We have 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. We do collect data at each of the levels described above: client, program, and provider.

DMHAS developed a data system to capture information from our private providers (DDaP) and we use a commercial system, WITS to capture data from our 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. The child system collects data in multiple systems and does not currently have the ability to provide data beyond the CLD.

- 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 collection and for what populations (e.g., Medicaid, child welfare, etc.)**

As indicated above, the adult information systems 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. Child welfare information is captured by DCF along with behavioral health data pertaining to their clients. Additional behavioral health data is collected by the state's Medicaid authority (Department of Social Services - DSS). That information is not readily accessible and where available, must be governed by inter-agency data sharing agreements.

**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 is capable of providing data at the individual level and is currently reporting TEDS data for both mental health and substance abuse. The child system collects data in multiple systems and does not currently have the ability to provide data beyond the CLD.

**4. If not, what changes will the state need to make to be able to collect and report on these measures?**

DCF, our sister agency that serves children 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 their current systems in order to report TEDS data.

# Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1  
Priority Area: Trauma-informed and Gender-responsive treatment for women  
Priority Type: SAT  
Population(s): PWWDC

Goal of the priority area:

To offer trauma-informed and gender-responsive treatment to PWWDC at all DMHAS specialized providers.

Objective:

To assess the extent to which DMHAS specialized providers are providing trauma-informed and gender-responsive treatment to PWWDC based on fidelity assessment.

Strategies to attain the objective:

Use a recently developed Trauma and Gender fidelity scale to assess all specialized programs and identify areas of improvement.

## Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Completed fidelity reviews indicating the extent to which specialized programs are trauma-informed and gender-responsive  
Baseline Measurement: 2 programs have been assessed.  
First-year target/outcome measurement: Completed reports for 50% of specialized providers.  
Second-year target/outcome measurement: Completed reports for 75% of specialized providers.

Data Source:

Trauma and Gender Fidelity Scores.

Description of Data:

Data based on the Trauma and Gender Fidelity Scale is qualitative and quantitative by domains, including recommendations.

Data issues/caveats that affect outcome measures::

Trouble scheduling fidelity reviews.

Priority #: 2  
Priority Area: Identify and Decrease Healthcare Disparities  
Priority Type: SAT, MHS  
Population(s): SMI, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Using the DMHAS data management system, develop the capability to be able to stratify data by categories to allow comparisons.

Objective:

To be able to determine if health disparities are present in residential treatment outcomes by race/ethnicity and develop a plan to decrease any identified disparities.

Strategies to attain the objective:

DMHAS will develop mechanisms using their data management system to be able to stratify data by categories to allow comparisons. Based on the results, DMHAS will work with providers to decrease any identified disparities.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Residential treatment outcomes by race/ethnicity  
Baseline Measurement: To be established  
First-year target/outcome measurement: Establish baselines for residential treatment outcomes by race/ethnicity  
Second-year target/outcome measurement: Develop a plan to decrease any identified health disparities based on the findings (e.g., program-specific vs. systemic)

Data Source:

DMHAS Enterprise Warehouse Data (EDW)

Description of Data:

DMHAS EDW data is comprised of state-operated program data and private not for profit program data.

Data issues/caveats that affect outcome measures:

Problems with data system development.

Priority #: 3  
Priority Area: Appropriate law enforcement response to persons in behavioral health crisis in the community.  
Priority Type: SAT, MHS  
Population(s): SMI, Other (persons with substance use issues who come to the attention of law enforcement in the community)

Goal of the priority area:

To increase the number of Crisis Intervention Team (CIT) trained officers and the number of police departments with at least one trained officer.

Objective:

To appropriately divert persons with behavioral health needs from incarceration into treatment.

Strategies to attain the objective:

Crisis Intervention Team (CIT) is a pre-booking program for police, in collaboration with behavioral health professionals, to divert individuals with behavioral health conditions at the time of initial contact with law enforcement. DMHAS has funded 5-day, 40-hour CIT training for police officers and related professions since 2004. DMHAS funds the CT Alliance to Benefit Law Enforcement to conduct the training and support police departments in developing CIT programs.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of new police departments with at least one police officer trained in CIT.  
Baseline Measurement: As of 3.30.15, 99 police departments have at least one police officer trained in CIT.  
First-year target/outcome measurement: Two police departments that have not had CIT training will send at least one officer to training, bringing the total to 101.  
Second-year target/outcome measurement: Two police departments that have not had CIT training will send at least one officer to training, bringing the total to 103.

Data Source:

Reports from the CT Alliance to Benefit Law Enforcement which conducts training and supports police departments in developing CIT programs.

Description of Data:

Number of police departments with a CIT policy based on reports from the CT Alliance to Benefit Law Enforcement.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: Number of new CIT-trained police officers

Baseline Measurement: As of 3.30. 15, 1,561 police officers attended CIT training.

First-year target/outcome measurement: 100 police officers will attend the training, bringing the total to 1,661.

Second-year target/outcome measurement: 100 police officers will attend the training, bringing the total to 1,761.

Data Source:

Reports from the CT Alliance to Benefit Law Enforcement which conducts the training and supports police departments in developing CIT programs.

Description of Data:

Number of police officers trained based on reports from the CT Alliance to Benefit Law Enforcement.

Data issues/caveats that affect outcome measures::

None.

Priority #: 4  
Priority Area: Reduce risk of opioid overdose  
Priority Type: SAT  
Population(s): IVDUs, Other (persons at risk of opioid overdose)

Goal of the priority area:

To reduce the risk of opioid overdose.

Objective:

To educate as many providers, first responders, and lay persons as possible about naloxone/narcan.

Strategies to attain the objective:

Maintain webpages on DMHAS website about opioid use and naloxone/narcan.  
Conduct training on naloxone/narcan as requested.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: number of persons trained on naloxone/narcan

Baseline Measurement: As of 4.1.15, 800 persons had been trained on naloxone/narcan

First-year target/outcome measurement: Train 50 persons on naloxone/narcan, bringing the total trained to 850

Second-year target/outcome measurement: Train 50 persons on naloxone/narcan, bringing the total trained to 900

Data Source:

DMHAS trainer data collection on naloxone/narcan presentation which includes: number of training sessions conducted, number of attendees at training, audience being trained, location of training and date of training.

Description of Data:

Count of persons in attendance/sign-in sheet from naloxone/narcan presentation.

Data issues/caveats that affect outcome measures::

Passage of legislation which may negate the need for training by DMHAS since it would allow pharmacists to prescribe, educate, and dispense naloxone/narcan upon request.

Priority #: 5  
Priority Area: Early intervention with HIV  
Priority Type: SAT  
Population(s): HIV EIS

Goal of the priority area:

Earlier treatment for HIV/AIDS and reduced transmission.

Objective:

To provide quicker HIV test results earlier in the conversion process so that treatment can begin sooner and likelihood of further transmission is reduced.

Strategies to attain the objective:

Educate HIV program staff about a new test protocol for HIV and implement at all HIV programs.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: New test protocol implemented  
Baseline Measurement: No HIV programs are using the new protocol.  
First-year target/outcome measurement: All HIV programs have been educated about the new HIV testing protocol.  
Second-year target/outcome measurement: All HIV programs have implemented the new HIV testing protocol.

Data Source:

DMHAS infectious disease reports.

Description of Data:

HIV program reports at quarterly meetings of staff which will include information on staff training and implementation of the new testing protocol.

Data issues/caveats that affect outcome measures::

None.

Priority #: 6  
Priority Area: Referrals for TB follow up care  
Priority Type: SAT  
Population(s): TB

Goal of the priority area:

Optimal care for persons testing positive for TB.

Objective:

To ensure that all persons testing positive for TB receive a referral for follow up care.

Strategies to attain the objective:

Staff working within programs testing for TB will be reminded about the importance of follow up care for clients testing positive. Data will be collected and reported back to programs at least quarterly on staff compliance with referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of persons testin gpositive for TB that receive a referral for follow up care.

Baseline Measurement: 20 persons tested positive on preliminary TB testing in FY 2014

First-year target/outcome measurement: 95% of persons with positive preliminary test results will be referred for follow up care.

Second-year target/outcome measurement: 100% of persons with positive preliminary test results will be referred for follow up care.

Data Source:

DMHAS data collection of infectious disease care statistics.

Description of Data:

Data table which includes: number of persons testing positive for TB and number referred for follow up care.

Data issues/caveats that affect outcome measures::

None.

Priority #: 7

Priority Area: Prevention of prescription opioid misuse

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Through community prevention efforts, reduce misuse of prescription opioids.

Objective:

Reduce the number of prescription opioid-involved overdose deaths among 18 - 25 year olds.

Strategies to attain the objective:

Community level outreach efforts, including raising awareness, education, media campaigns, and forums.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of prescription opioid-involved overdose deaths among 18 - 25 year olds

Baseline Measurement: There were 44 prescription-opioid involved overdose deaths among 18 - 25 year olds in CY 2014

First-year target/outcome measurement: Reduce the number of prescription-opioid involved overdose deaths among 18 - 25 year olds by 2, reducing the total to 43.

Second-year target/outcome measurement: Reduce the number of prescription-opioid involved overdose deaths among 18 - 25 year olds by 2, reducing the total to 41.

Data Source:

Data from the Office of the Chief Medical Examiner for Connecticut.

Description of Data:

Data includes demographics about the overdose victim, including age, gender and race as well as information about cause of death

and types of substances involved.

Data issues/caveats that affect outcome measures::

Late or missing data from the Office of the Chief Medical Examiner.

Priority #: 8  
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:

5. Objective:

1. Increase the number of mental health agencies in CT that provide 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. It is anticipated that MATCH can effectively serve up to 75% of CT children and youth who need mental health services
2. Increase the number of clinical staff trained in providing MATCH services to children, youth and their caregivers.

Strategies to attain the objective:

6. Strategies to attain the objective:

1. DCF, the Child Health and Development Institute of Connecticut (CHDI), and Harvard University (HU) have partnered to implement the MATCH model in CT through systems development and staff training.
2. Train clinical staff in outpatient clinics in the MATCH model.
3. MATCH dissemination will be facilitated through a Learning Collaborative (LC) implementation model that includes:
  - Building providers' capacity to implement MATCH 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 the number of mental health agencies in CT that provide the evidence based MATCH for children, youth and their caregivers  
Baseline Measurement: Four agencies trained to provide MATCH.  
First-year target/outcome measurement: Train an additional six agencies in MATCH.  
Second-year target/outcome measurement: Train an additional six agencies in MATCH.

Data Source:

The Child Health and Development Institute of Connecticut (CHDI).

Description of Data:

CHDI will provide data on the numbers of agencies being trained to provide MATCH.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2  
Indicator: Increase the number of clinical staff trained in providing MATCH services to children and youth.  
Baseline Measurement: Baseline of 50 clinicians trained in providing MATCH.  
First-year target/outcome measurement: Train an additional 25 clinicians in providing MATCH. Total 75  
Second-year target/outcome measurement: Train an additional 25 clinicians in providing MATCH. Total 100 clinicians

Data Source:

The Child Health and Development Institute of Connecticut (CHDI)

Description of Data:

CHDI will provide data on the numbers of clinicians being trained to provide MATCH.

Data issues/caveats that affect outcome measures::

The number of clinicians trained may be affected by the agency retention of clinical staff for the time frames cited.

Priority #: 9  
Priority Area: Prevention of Mental Illness  
Priority Type: MHS  
Population(s): 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:

6. 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 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).  
See attached "State of Connecticut Suicide Prevention Plan 2020"

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Distribution of social marketing materials throughout the state of Connecticut  
Baseline Measurement: 40,000 items distributed  
First-year target/outcome measurement: 60,000 items to be distributed in the first year  
Second-year target/outcome measurement: 80,000 items to be distributed in the second year

Data Source:

CT SAB, 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::

N/A

Indicator #:

2

Indicator:

Increase the number of individuals receiving suicide prevention/crisis response training

Baseline Measurement:

548 individuals trained

First-year target/outcome measurement:

575 individuals trained

Second-year target/outcome measurement:

600 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::

N/A

Priority #: 10

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

Indicator #:

1

Indicator:

Increase number of faculty trained in the curriculum

Baseline Measurement:

28 faculty trained at this time

First-year target/outcome measurement:

2 additional faculty trained

Second-year target/outcome measurement: 2 additional faculty trained

Data Source:

Report from Provider - Wheeler Clinic

Description of Data:

Number of faculty trained

Data issues/caveats that affect outcome measures::

N/A

Indicator #:

2

Indicator:

Increase the number of students that receive certificates of completion

Baseline Measurement:

68 students received certificates

First-year target/outcome measurement:

75 students to receive certificates

Second-year target/outcome measurement:

85 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::

N/A

Priority #: 11

Priority Area: Family engagement

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To increase family voice

Objective:

To assure that the voices, perspectives and input of family members are included in developing, planning and overseeing the statewide behavioral health system

Strategies to attain the objective:

- a) Support Family System Managers (FSMs) positions 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

Indicator #:

1

Indicator:

Increasing the Number of families interfacing with the family system organization and then participating in follow up activities.

Baseline Measurement:

5400 points of interface with families

First-year target/outcome measurement:

5500 points of interface with families

Second-year target/outcome measurement: 5600 points of interface with families

Data Source:

PIE (formally PSDCRS) and FAVOR reports

Description of Data:

Totals of participants at training, support groups and outreach activities

Data issues/caveats that affect outcome measures::

Integrity of PIE data source and other data tracking methods

Footnotes:

# Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Activity	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	\$25,147,572		\$0	\$14,024,888	\$288,261,659	\$0	\$21,394,252
a. Pregnant Women and Women with Dependent Children*	\$6,003,892		\$0	\$0	\$4,522,556	\$0	\$0
b. All Other	\$19,143,680		\$0	\$14,024,888	\$283,739,103	\$0	\$21,394,252
2. Substance Abuse Primary Prevention	\$8,285,496		\$0	\$10,548,550	\$6,415,620	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$1,759,636		\$0	\$0	\$534,506	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$0		\$0	\$0	\$23,333,536	\$0	\$0
13. Total	\$35,192,704	\$0	\$0	\$24,573,438	\$318,545,321	\$0	\$21,394,252

\* Prevention other than primary prevention

\*\* It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

# Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Activity	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. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$348,035,512	\$0	\$6,274,596
6. Other 24 Hour Care		\$217,848	\$0	\$27,805,514	\$377,168,526	\$0	\$969,592
7. Ambulatory/Community Non-24 Hour Care		\$10,461,304	\$0	\$13,512,048	\$953,728,392	\$0	\$12,497,722
8. Mental Health Primary Prevention**		\$200,000	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$476,542	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$40,000	\$0	\$0	\$73,683,180	\$0	\$0
13. Total	\$0	\$11,395,694	\$0	\$41,317,562	\$1,752,615,610	\$0	\$19,741,910

\* Prevention other than primary prevention

\*\* It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

# Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$	\$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$	\$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$	\$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$	\$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$	\$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$	\$
Total	\$0	\$0

Footnotes:

# Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$12,573,786
2 . Substance Abuse Primary Prevention	\$4,142,748
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	\$879,818
5 . Administration (SSA Level Only)	
6. Total	\$17,596,352

\* Prevention other than primary prevention

\*\* 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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for 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 does not meet the AIDS case rate threshold for the fiscal year involved. 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 be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

# Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$1,191,342
	Selective	\$366
	Indicated	\$27,180
	Unspecified	\$0
	Total	\$1,218,888
Education	Universal	\$175,441
	Selective	\$54
	Indicated	\$4,003
	Unspecified	\$0
	Total	\$179,498
Alternatives	Universal	\$165,563
	Selective	\$51
	Indicated	\$3,777
	Unspecified	\$0
	Total	\$169,391
Problem Identification and Referral	Universal	\$15,806
	Selective	\$0
	Indicated	\$366
	Unspecified	\$0
	Total	\$16,172

Community-Based Process	Universal	\$2,306,816
	Selective	\$708
	Indicated	\$52,631
	Unspecified	\$0
	Total	\$2,360,155
Environmental	Universal	\$96,414
	Selective	\$30
	Indicated	\$2,200
	Unspecified	\$0
	Total	\$98,644
Section 1926 Tobacco	Universal	
	Selective	\$100,000
	Indicated	
	Unspecified	
	Total	\$100,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$4,142,748
Total SABG Award*		\$17,596,352
Planned Primary Prevention Percentage		23.54 %

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:



# Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$3,285,199	
Universal Indirect	\$763,923	
Selective	\$1,243	
Indicated	\$92,383	
Column Total	\$4,142,748	
Total SABG Award*	\$17,596,352	
Planned Primary Prevention Percentage	23.54 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

# Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date:  Planning Period End Date:

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	b
Heroin	b
Inhalants	b
Methamphetamine	b
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	b
LGBT	b
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	b
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

# Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$548,842	\$0	\$0	\$548,842
2. Quality Assurance	\$0	\$0	\$0	\$0
3. Training (Post-Employment)	\$138,912	\$0	\$0	\$138,912
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$0	\$0	\$0	\$0
7. Information Systems	\$0	\$0	\$0	\$0
8. Total	\$687,754	\$0	\$0	\$687,754

Footnotes:



# Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015    Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	\$40,000
Total Non-Direct Services	\$40000
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

# Environmental Factors and Plan

## 1. The Health Care System and Integration

### 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>26</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>27</sup> It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.<sup>28</sup> Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices<sup>29 30</sup> that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse 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>31</sup> Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.<sup>32</sup> In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.<sup>33</sup> Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.<sup>34</sup> Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.<sup>35</sup> In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health 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>36</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>37</sup> Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health 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 mental and substance abuse treatment 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 electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.<sup>38</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 behavioral health prevention, care, 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>39</sup> and ACOs<sup>40</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health 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.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.<sup>41</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>42</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>43</sup> Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>44</sup> SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.<sup>45</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.<sup>46</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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 ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.<sup>47</sup> It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.<sup>48</sup>

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>49</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.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, 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>50</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.<sup>51</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 illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
  - Regular screening with a carbon monoxide (CO) monitor
  - Smoking cessation classes
  - Quit Helplines/Peer supports
  - Others \_\_\_\_\_
11. The behavioral health providers screen and refer for:
  - Prevention and wellness education;
  - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
  - Recovery supports

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

<sup>26</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

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 1617 Narrative 1 The Health Care System and Integration

**1. Which services in Plan Table 3 of the Application will be covered by Medicaid or by QHP as of January 1, 2016?**

Physical health, outpatient, some engagement (assessment), medication services, intensive services, acute services, and some out-of-home services are currently in the CT Medicaid Plan. Some other services are covered for specific populations under waivers such as community, recovery, and habilitative supports. The implementation of Behavioral Health Homes (BHH) will add the following as covered services for eligible individuals: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support and referrals to community services.

**2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHP and Medicaid?**

DMHAS is a partner agency of the CT Behavioral Health Partnership (BHP) with the Departments of Social Services (State Medicaid Authority) and Children and Families. The CT BHP is responsible for overseeing the behavioral health portion of the Medicaid program. DMHAS currently has clinical oversight of the adult portion of this program and will continue to be very involved in the operations, including access to services.

**3. Who is responsible for monitoring access to M/SUD services by QHPs? Briefly describe the monitoring process.**

Access Health CT (AHCT) is responsible for monitoring access for plans sold on the exchange. The Office of the Healthcare Advocate (OHA) monitors access through complaints received and the clearinghouse. From a managed care perspective, the CT Insurance Department (CID) has oversight over insurer's plan design, network, formulary and regulatory compliance for fully insured plans. The Department of Labor's (DOL) Employee Benefits Security Administration regulates the remainder of the commercial plans.

**4. Will the SMHAS and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?**

Many entities are involved in this review and receive complaints, including DMHAS, CID, and OHA. There are many on the private side that receive and manage complaints as well.

**5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?**

DMHAS currently plans to fund many recovery support services that are not offered as part of the Medicaid or EHB package. However, coverage in the EHB is not as robust as what is covered in the state's Medicaid program, and DMHAS will need to keep funding those treatment services for the uninsured and for services not covered by other plans (e.g., Medicaid).

**6. Is the SSA/SMHAS involved in the various coordinated care initiatives in the state?**

DMHAS has invested much time and effort becoming thoroughly familiar with health home models across the country. Specifically, after having devoted significant attention to studying the feasibility of implementing Behavioral Health Homes in CT for individuals diagnosed with serious and persistent mental illness (SPMI), we are beginning the implementation of Behavioral Health Homes. Our Health Home Team, including staff from DMHAS, Department of Children and Families (DCF) and the Department of Social Services (DSS, CT's State Medicaid Authority), have worked with designated public and private providers to educate, prepare, and staff-up for implementation in the coming year.

As background, in August 2012, CT's legislatively mandated oversight council on behavioral health (CT Behavioral Health Partnership Oversight Council), in conjunction with DMHAS, formed a workgroup as a vehicle to develop a Behavioral Health Home (BHH) model and implementation plan. This stakeholder workgroup consisted of DMHAS, DSS, DCF, consumers, providers, advocates, family members, and other partners. With this stakeholder input as the foundation, the state partners have drafted a State Plan Amendment (SPA) which includes both operational and fiscal components. Conversations with CMS regarding the specific components are on-going.

In the meantime, designated providers are participating in bi-monthly implementation sessions, receiving both group and individual technical assistance and participating in other training to ensure a successful launch of BHH and systems transformation. Additionally, a contract with an Administrative Services Organization (ASO) is in the final stages; the ASO will assist in implementation, reporting and on-going support of BHH. Also, data collection and reporting components are being designed and tested. DMHAS plans for full implementation in October 2015.

DSS currently leads the design of the Medicare Medicaid Dual Eligible Demonstration in CT; however, DMHAS continues to partner with DSS to help to bring behavioral health to the forefront within this model as 38% of the population has a serious mental illness. As a partner, DMHAS meets with DSS regularly and sits on the stakeholder group and the legislative sub-committee which includes advocates and providers from many disciplines. DSS is presently negotiating a Memorandum of Understanding with CMS in regard to the Duals Project.

DMHAS is a participant in the State Innovation Model (SIM) design and implementation project. The state of Connecticut was one of 11 states selected to receive SIM Test Grant Awards. Connecticut will receive up to \$45 million to implement a number of initiatives designed to improve population health, strengthen primary care, promote value-based payment and insurance design, and obtain multi-payer alignment on quality, health equity, and care experience measures. DMHAS staff are included on the Steering Committee and multiple subcommittees as CT moves toward promoting health equity, tying provider payment to

consumer experience, and more builds through the effective use of health information technology.

Many DMHAS-funded agencies have also been awarded SAMHSA Primary and Behavioral Health Care Integration (PBHPI) grants and are at various stages of implementation. These agencies are included in our stakeholder groups and are informing CT's integration process on the projects listed above. Additionally, Local Mental Health Authorities and other large multi-service DMHAS providers are pursuing co-location with primary care providers and a few have been or are in process of becoming FQHC look-alikes.

**7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?**

Yes, DMHAS is a member of the CT Medicaid Oversight Council which includes members of the FQHC trade association, primary care associations, hospital associations, etc. These organizations are informing the Duals Demonstration process and are working with behavioral health providers in the process. Many of our state-operated and private nonprofit mental health agencies have also begun to forge relationships with FQHCs/CHCs in their local areas as they are working on PBHPI grants or have partnered within the Department's Integrated Care Initiative. Moreover, DMHAS has forged a relationship with the FQHC association as part of our Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant.

**8. Are state behavioral health facilities moving toward addressing nicotine dependence on par with other substance use disorders?**

All state-operated facilities assess individuals for nicotine dependence and offer a variety of smoking cessation programs and pharmacologic aids. Wellness programs offered provide education to both staff and individuals served. Many campuses are smoke-free.

**9. What agency/system regularly screens, assesses, and addresses smoking amongst your clients? Include tools and supports (e.g., regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.**

All substance abuse treatment programs and all department funded mental health programs are required to include nicotine use in their mandatory reporting of client data into the department's client database. Many of these programs have initiated services ranging simply from offering written educational materials (pamphlets, etc.) all the way to offering groups, classes and/or medication specifically for quitting smoking. In addition, DMHAS is currently providing assessment and brief intervention for smoking cessation via the SBIRT grant at Federally Qualified Health Centers across the state. Screening and treatment of nicotine dependence will be included in the Department's Behavioral Health Home Initiative.

Each DMHAS operated facility screens and assesses individuals upon admission and periodically thereafter using facility specific tools. Individuals are offered numerous options at the facility and in the larger community for education, support and assistance.

**10. Indicate tools and strategies used that support efforts to address nicotine cessation.**

Connecticut has a quit-line sponsored by the Department of Public Health (DPH). Connecticut Medicaid pays for: NRT Gum, NRT patch, NRT nasal spray, NRT lozenges, NRT inhaler, Varenicline (Chantix), Bupropion (Zyban), Group Counseling, and Individual Counseling.

**11. The behavioral health providers are screening and referring for:**

- **Prevention and Wellness Education**
- **Health risks such as heart disease, hypertension, high cholesterol and/or diabetes; and**
- **Recovery Supports**

All individuals admitted to a DMHAS operated inpatient unit receive a physical exam upon admission and routine laboratory studies are conducted to identify any of the above conditions. In outpatient settings, Health Screenings are conducted to identify individuals either with these conditions or at risk to develop them. DMHAS operated Local Mental Health Authorities (LMHAs) work closely with Federally Qualified Health Centers in their area to coordinate and integrate behavioral health and primary care. Some state facilities also utilize clinical or pharmacological protocols to ensure periodic laboratory studies or other assessments are conducted for those individuals prescribed medications that place them at higher risk for metabolic syndrome and other health conditions.

Regarding DMHAS funded community providers, two of the six core services of Behavioral Health Homes are prevention and wellness, and referrals to community and social supports. Also, included in the outcome measure for Behavioral Health Homes are the following:

- Tobacco Cessation Intervention
- Adult Body Mass Index (BMI)
- Controlling High Blood Pressure
- HbA1c Level Screening
- Improving Cardiovascular care for individuals with Coronary Artery Disease (CAD)

## **Children's Plan 1. The Health Care System and Integration**

The CTBHP is a Partnership between the Department of Children and Families (DCF), Department of Social Services (DSS), Department of Mental Health and Addiction Services (DMHAS), Value Options (ASO) and a legislatively mandated Oversight Council. Expanded in 2011 to include DMHAS, the contract is designed to create an integrated behavioral health service system for our members, Connecticut's Medicaid populations, including children and families enrolled in HUSKY Health and DCF Limited Benefit programs. CTBHP monitors access, quality of care and addresses any issues related to MHPHEA.

As part of the changes made to the state's Essential Health Benefits package, effective January 1, 2015 Medicaid expanded coverage for evaluation and treatment of services for children with Autism Spectrum Disorder (ASD) already available under non-Medicaid QHPs.

**State Innovation Model (SIM):** Connecticut and DCF have a strong commitment to the integration of medical and behavioral services. In 2014, the Center for Medicare and Medicaid Innovation (CMMI) awarded Connecticut a four-year, \$45 million State Innovation Model (SIM) Test Grant to test state-led, multi-payer health care payment and service delivery models focused on improving health system performance, increasing quality of care, and decreasing costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and for those covered under private pay health plans. SIM establishes a whole-person-centered health care system promoting value, eliminating health inequities for all of Connecticut, and improving affordability. Implementation of the model is underway and includes integration of primary care, behavioral health, oral health, population health, with consumer engagement and community support. The SIM seeks to improve health care quality while reducing costs, increases the state's commitment to workforce development and health information technologies that provide continuous analysis, performance, communication and data usability across public and private health plans alike.

**Elm City Project Launch (ECPL):** ECPL, funded by a federal grant, 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.

**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.

**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 provided a trauma-informed collaborative network of care to address adverse childhood experiences. The network will involve 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.

**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.

**Care Management Entity (CME):** CME 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.

**Connecticut Network of Care Transformation (CONNECT):** CONNECT, is a statewide federally funded SAMHSA System of Care grant initiative, that creates a partnership between youth, families, state agencies, and service providers at the local, regional and state levels. The enhanced partnership supports children, youth, and families' access to the services they need in a timely and effective manner via an integrated network of care that are family/youth driven and culturally and linguistically appropriate. The ultimate goal of CONNECT is to provide a fully developed structure for a network of care created by its stakeholders and is community-specific.

**Department of Developmental Services (DDS)/Department of Social Services Autism Waiver (ASD Waiver):** Effective January 1, 2015, DSS extended coverage for Autism Spectrum Disorder (ASD) evaluation and treatment services for children covered by Medicaid. The private payer system in CT has historically covered these services for their enrollees leaving the state's most vulnerable population to seek services for ASD directly from DCF. As statewide coverage becomes more available, medical and behavioral health providers are more likely to identify children who would benefit from early intervention. Connecticut has identified youth with ASD as high-utilizers of emergency room departments and are committed to addressing the lack of community supports for this population through the implementation of PA 13-178.

**Health Home Models:** In January 2012, the implementation of the Person Centered Medical Home Model (PCMH) allowed for increased access to family-centered, community-based, culturally sensitive services to families and children within their communities. With the recent implementation of Public Act 13-178, Connecticut has committed to strengthening the connections between pediatric primary care and behavioral health systems by supporting co-location of behavioral health providers in child health sites. The Act also supports the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices, requires child health providers to obtain Continuing Medical Education credits each year in a behavioral health topic, ensures public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health, or staff from sites working on behalf of medical homes and reforms state confidentiality laws to allow for sharing of behavioral health information between with other health providers.

**Educating Practices in the Community (EPIC):** One of our partners, the Child Health and Development Institute of Connecticut, Inc. (CHDI) has assisted nearly two-thirds of Connecticut's pediatric practices through an initiative known as Educating Practices in the Community (EPIC). CHDI assists providers to access care coordination for their patients, implement family-centered care, incorporate developmental surveillance and screening in their well-child services, and address behavioral health concerns. This initiative has contributed to a nearly twenty-fold increase in the number of children who are screened for developmental and behavioral health issues in Connecticut since 2008.

# Environmental Factors and Plan

## 2. Health Disparities

Narrative Question:

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>52</sup>, [Healthy People, 2020](#)<sup>53</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>54</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures 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, and people living with HIV/AIDS or other chronic diseases/impairments) 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 standards).<sup>55</sup>

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the 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 top Secretarial priority in the Action Plan is to "[a]ssess 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>56</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.<sup>57</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>58</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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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 population 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

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<sup>52</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>53</sup><http://www.healthypeople.gov/2020/default.aspx>

<sup>54</sup><http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

<sup>55</sup><http://www.ThinkCulturalHealth.hhs.gov>

<sup>56</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>57</sup><http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

<sup>58</sup>[http://www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## **1617 Narrative 2 Health Disparities**

### **1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?**

Prior to July 1, 2015, admission data collection included gender, race, preferred language, ethnicity and age, but not sexual orientation nor did it specifically ask concerning vision and hearing problems. As of July 1, 2015, all state-operated programs will be utilizing a new data collection tool for admissions. The new tool will collect information on gender, race, ethnicity, preferred language, sexual orientation, and vision and hearing problems. While this new tool will be a requirement for state-operated programs, its use will also be encouraged for state-funded programs as well.

### **2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.**

The process of addressing health disparities involves different divisions of DMHAS including Evaluation, Quality Management and Improvement (EQMI), the Office of Multicultural Healthcare Equality (OMHE), Information Technology (DOIT), and Education and Training to collect data and identify problems related to access, service use, and outcomes of various populations while at the same time working with staff to ensure cultural competence.

The Three-year OMHE Strategic Plan from 2013 has the following objectives:

1. Infuse multiculturalism in DMHAS services
2. Identify healthcare equality and disparities through data
3. Ensure multiculturalism and cultural competency is ingrained in the DMHAS culture
4. Empower and support regional Multicultural Action Councils (MCACs)

DMHAS is a member of the Connecticut Commission on Health Equity (CHE) which was established through legislation of the Connecticut General Assembly to improve health outcomes of residents based on race, ethnicity, gender and linguistic ability. In establishing CHE, it was acknowledged that “(1) equal enjoyment of the highest attainable standard of health is a human right and a priority of the state, (2) Connecticut residents experience barriers to the equal enjoyment of good health based on race, ethnicity, national origin and linguistic ability, and (3) that addressing such barriers requires data collection and analysis and the development and implementation of policy solutions.” More on CHE is available at: <http://www.ct.gov/cche/site/default.asp>.

### **3. Are linguistic disparities/language barriers identified, monitored, and addressed?**

Yes. The DMHAS data collection process begins at admission and includes information about each client’s preferred language. For clients preferring to use a language other than English, arrangements are made through interpreter services (including sign language). Use of translation services is tracked and reported.

**4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.**

Each of the DMHAS regions has bilingual staff. Some of these bilingual staff have been trained as medical interpreters. There are phone translation services and in-person sign language services for the Deaf and Hard of Hearing.

**5. Is there state support for cultural and linguistic competency training for providers?**

Yes. There are 5 ways in which this is accomplished:

1. Multicultural Training Cohort: an 18 – 20 session training lasting 9 months which DMHAS employees can participate in on a voluntary basis
2. Project for Addiction Cultural Competence Training (PACCT) designed for counseling staff with the hours counting as part of certification requirements
3. Education and Training offerings
4. Department of Administrative Services course offerings
5. Multicultural Enhancement Project: an agency self-assessment to identify strengths/weaknesses related to cultural competence with the goal of reducing disparity and enhancing competency. Training is offered to address findings.

## **Children's Plan 2. Health Disparities**

DCF is a multicultural agency providing support to a diverse population of races, ethnicities, creeds, sexual orientations, gender identities, and linguistic ability.

Health disparities identified by DCF include:

- A need for additional staff who are from the same community and speak the same language as the families seeking services;
- A need for a culturally specific social marketing campaign within specific ethnic minority communities to reduce stigma among families seeking behavioral health services;
- Lack of awareness of and access to culturally and linguistically competent services and supports in the behavioral health system of care;
- A need for training among all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs, sexual orientation, gender expression) of each youth and their family;
- A need for training for school personnel, school resource officers (school-based police) and behavioral health providers to reduce implicit biases that lead to disparities in youth of color being overrepresented in CT's juvenile justice system and underrepresented in CT's behavioral health system;
- Limited access to the closest available care for families in rural communities and areas along the state borders, as appropriate care is often across state lines and not reimbursable by insurance; and
- A need to reduce the underrepresentation of youth of color in CT's behavioral health system and their overrepresentation in CT's juvenile justice system. Requiring that all internal service delivery contracts reflect principles of culturally and linguistically appropriate services.

DCF tracks access or enrollment in some types of services, (including language services) received and outcomes by race, ethnicity, gender, and age via the Provider Information Exchange (PIE) data system. PIE tracks numbers served and outcomes by race, ethnicity, age, and gender. PIE provides "real time" web-based data reporting from DCF's network of providers throughout the state. Additionally, CTBHP or ASO for children and adults receiving mental health services through Medicaid tracks similar, robust data on diversity, utilization and access to mental health services. This data is then analyzed by CTBHP and trends are identified for system change and intervention.

The upcoming update to DCF's PIE data system will include five categories for gender identity including male, female, Male-to-Female Transgendered, Female-to-Male Transgendered and Non-Binary.

The state has also made a commitment to ensure that all data systems and data analysis approaches are culturally and linguistically appropriate and formally address gaps through corrective action plans and ongoing monitoring. The goals are:

- Develop, implement, and sustain standards of culturally and linguistically appropriate care by conducting an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services by ensuring that all data systems and

data analysis approaches are culturally and linguistically appropriate; and, requiring that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

- Enhancing availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse population by enhancing training and supervision in cultural competency; ensuring that all communication materials for service access and utilization are culturally and linguistically appropriate; and providing financial resources dedicated to recruitment and retention to diversify the workforce.

Connecticut has initiated a needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services. The assessment will include an appraisal of the current workforce and make recommendations towards recruitment and retention of a diverse staff that reflect the cultural and linguistic characteristics of the specific service area. Additionally, DCF will continue to ensure that all internal service delivery contracts reflect principles of culturally and linguistically appropriate services. Under the Department's behavioral health plan, behavioral health providers will receive support to formally review, plan, achieve and maintain culturally and linguistically appropriate services.

Connecticut has planned and implemented some programs to address and reduce disparities in access, service use and outcomes for the above subpopulations. By utilizing the available data in the current system to inform program development, contractual language and workforce development Connecticut has begun to address the ethnic and racial disparities.

Additionally, DCF currently monitors linguistic and cultural differences via data management in PIE DCF's internal data system. All contracted providers are mandated to collect and provide the identical data to DCF for all services provided. During procurement for contracted services, DCF mandates that each provider delineate the linguistic disparities and language barriers and must provide a plan for addressing these disparities and barriers in their request for funding of all programs.

As part of the behavioral health plan, DCF is committed to completing an assessment of the current workforce and make recommendations with respect to recruiting and retaining a staff that reflects the cultural and linguistic characteristics reflective of the children and families they serve. Additionally, many of the contracted services are currently required to implement and report on their workforce trainings that strengthen cultural and linguistic competency.

# Environmental Factors and Plan

## 3. Use of Evidence in Purchasing Decisions

### Narrative Question:

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There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP<sup>59</sup> is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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>60</sup>, The New Freedom Commission on Mental Health<sup>61</sup>, the IOM<sup>62</sup>, and the NQF.<sup>63</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>64</sup> SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. 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 Protocols (TIPs)<sup>65</sup> are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) 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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)<sup>66</sup> was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, 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 mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
  - 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 incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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<sup>59</sup> [Ibid, 47, p. 41](#)

<sup>60</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>61</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>62</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>63</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>64</sup> <http://psychiatryonline.org/>

<sup>65</sup> <http://store.samhsa.gov>

<sup>66</sup> <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

### ***3. Use of Evidence in Purchasing Decisions - DMHAS Adult Services***

#### **1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices?**

DMHAS established a Director of Evidence-Based Practices in 2010. This position resides in the Office of the Commissioner and the EBP unit includes three managers. Several DMHAS divisions participate in activities related to tracking and disseminating information regarding evidence-based and best practices. The Commissioner's EBP Governance Group, which includes members of the Executive team and other senior managers, meets on a quarterly basis.

#### **2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?**

DMHAS has used information regarding evidence-based practices in a number of ways:

- Developed webpages on the DMHAS website for several EBPs to inform providers, consumers and families;
- Developed an EBP "catalog" to organize information about the EBPs that DMHAS funds and supports;
- To design and purchase services; and
- Incorporated into monitoring tools to improve the quality of services.

DMHAS is purchasing the following levels of care/programs based on the evidence-based fidelity scales disseminated by SAMHSA (i.e., the content of the fidelity scales are in DMHAS contract language):

- Assertive Community Treatment (ACT)
- Supported Employment
- Supported Education

Based on evidence-based and best practices, DMHAS developed a fidelity scale for Community Support Program (CSP) services and the DMHAS-developed service called Recovery Pathways (RP). This fidelity scale is also translated to contract language for purchasing that level of care.

DMHAS purchases two co-occurring enhanced residential treatment programs, based on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.

DMHAS purchases supportive housing services based, in part, on the SAMHSA Supportive Housing Toolkit/fidelity scale.

The SAMHSA evidence-based toolkits/fidelity scales are very helpful.

#### **3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?**

Yes. For example, the CT Medicaid agency asked DMHAS a couple years ago which EBP we should collaboratively promote through the CT Medicaid Enhanced Care Clinic (ECC) initiative. Subsequently, the two agencies collaborated on developing an integrated care policy, heavily informed by SAMHSA's Integrated Treatment for Dual Disorders toolkit/fidelity scale. Currently, all ECCs have to adhere to this policy in order to continue receiving their 25% rate increase for Medicaid outpatient behavioral health services.

#### 4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

For the most part, the DMHAS EBP unit is focusing on the implementation of practices that have a strong evidence based behind them and have been named by other entities as an “evidence-based practice” (e.g., NREPP). In terms of choosing emerging, promising or best practices to implement, we rely on consensus-based guidelines and recommendations from the field at large and within DMHAS. DMHAS has a Research Division affiliated with the University Of Connecticut School Of Social Work. Several DMHAS services and new practices are rigorously evaluated by that team or other research teams (e.g., Yale Program for Recovery and Community Health – PRCH).

#### 5. Which value based purchasing strategies do you use in your state:

Connecticut uses the Medicaid Enhanced Care Clinic (ECC) for Medicaid-funded outpatient behavioral health services where ECCs are required to meet certain access and quality standards in order to continue receiving their 25% rate increase for those services. Value Options, in collaboration with Department of Social Services (DSS), Department of Children and Families (DCF) and DMHAS, has an evaluation process to determine if ECCs are meeting the standards.

**a. Leadership support, including investment of human and financial resources** – Leadership training by Yale faculty through the Connecticut Women’s Consortium, including DMHAS funding

**b. use of available and credible data to identify better quality and monitored the impact of quality improvement interventions** – DMHAS quality reports include client outcomes for all levels of care

**c. use of financial incentives to drive quality** – as mentioned above, ECCs are required to meet certain standards in order to receive a 25% rate increase for those services

**d. provider involvement in planning value-based purchasing** – providers are part of the Behavioral Health Partnership Oversight Council and subcommittees. Providers were also involved in the development of the ECC standards and the corresponding monitoring process.

**e. gained consensus on the use of accurate and reliable measures of quality** – DMHAS managers, staff, and providers have been part of the ongoing review and development of the DMHAS quality reports. DMHAS EBP unit includes providers in discussions regarding the use of fidelity review measures and how they are used.

**f. quality measures focus on consumer outcomes rather than care processes** – DMHAS uses measures that focus on consumer outcomes and on care processes. DMHAS emphasizes the importance of both types of measures.

**g. development of strategies to educate consumers and empower them to select quality services** – DMHAS has posted the DMHAS quality reports on its website, largely so consumers can be empowered to select quality services from the array offered.

**h. creation of a corporate culture that makes quality a priority across the entire state infrastructure** – That DMHAS’ culture views quality as a priority is obvious given the multiple initiatives focused on quality including:

- Opportunity for public use of the DMHAS Quality Reports which highlight data quality, processes and client outcomes
- Annual DMHAS Consumer Satisfaction Survey including more than 25,000 DMHAS clients which is posted on the DMHAS website
- Creation of the EBP unit at the Office of the DMHAS Commissioner
- Ongoing fidelity reviews to assess and improve the implementation of EBPs and Best Practices

**i. the state has an evaluation plan to assess the impact of its purchasing decisions** – There are multiple ways that DMHAS and its partners assess the impact of its purchasing decisions as described above.

## *Use of Evidence in Purchasing Decisions – DCF Children Services*

### **1) Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?**

Within the Clinical and Community Consultation and Support Team, the administrator, managers and program leads that oversee behavioral health services have a responsibility to be informed about evidence-based and promising practices and to keep abreast of the latest research including outcomes for emerging effective treatments and interventions. This commitment is consistent with one of the Department's cross-cutting themes - a learning organization. Further, the Academy for Family and Workforce Knowledge and Development remains committed to identifying and implementing the most effective training curriculums.

### **2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?**

Yes. One example is a period of research and discussion that occurred over the course of several months in partnership with providers, families, developers and others about the most effective evidence-based treatments that might become a part of the menu of services at outpatient psychiatric clinics for children. The goal was to find effective treatments that would address the most common childhood disorders that are seen at outpatient clinics. The multidisciplinary state/provider/family group reviewed the recommended evidence-based treatments using national registries, in partnership with outpatient clinic providers to identify the

#### **a) What information did you use?**

The multidisciplinary state/provider/family work group reviewed the recommended evidence-based and promising treatments using national registries.

#### **b) What information was most useful?**

Most helpful was the national and other registries that provide specific treatment description, target population, results of clinical trials, costs, child/family outcomes, etc. It was also helpful to review websites specific to each treatment modality.

### **3) How have you used information regarding evidence-based practices?**

#### **a) Educating State Medicaid agencies and other purchasers regarding this information?**

#### **b) Making decisions about what you buy with funds that are under your control?**

There are several forums to share and discuss evidence-based practices and the pros/cons of disseminating within the service delivery system in Connecticut. Examples include: CT Behavioral Health Partnership; Children's Behavioral Health Advisory Council; Joint Behavioral Health Planning Council; CT Community Providers Association; and Provider-Specific meetings.

### **Children’s Plan 3. Use of Evidence in Purchasing Decisions**

Within the Clinical and Community Consultation and Support Division, the Administrator, Managers and Program Development and Oversight Coordinators oversee behavioral health services. They hold primary responsibility to be informed about evidence-based and promising practices and to keep abreast of the latest research including outcomes for emerging effective treatments and interventions. This commitment is consistent with one of the Department's cross-cutting themes - a learning organization. Further, the Academy for Family and Workforce Knowledge and Development remains committed to identifying and implementing the most effective training curriculums.

DCF will allocate the FFY 2016 CMHS Block Grant for the purpose of supporting services and activities that are to benefit children with SED and complex behavioral health needs, and their families. These funds are used to support community-based service provision, with a focus on “enhanced access to a more complete and effective system of community-based behavioral health services and supports, and to improve individual outcomes”.<sup>1</sup>

Allocations and the services planned for the CMHS Block Grant are based upon input from and recommendations of the Children’s Behavioral Health Advisory Committee (CBHAC). This committee serves as the Children’s Mental Health Planning Council (CMHPC) for Connecticut. Representation on this council includes at least 51% parents of children with SED, other state agencies, community providers, DCF regional personnel and advocacy groups. In addition, one of the co-chairs for the CBHAC must be a parent of a child with SED.

Contracted community services for children and youth are regularly reviewed and monitored by DCF through data collection, site visits and provider meetings to ensure the provision of effective, child and family-centered culturally competent care. DCF's behavioral health information system, known as the Program Information Exchange or PIE (formally PSDCRS), is used to collect monthly data. At a minimum, regular reports, including RBA report cards are generated using these data to review utilization levels and service efficacy.

Competitive procurement processes (e.g., Requests for Proposals (RFP) and Requests for Applications (RFA)) typically include broad participation from DCF staff, parents of children with SED and other community members. This diversity allows for multiple perspectives to be represented to inform service award and final contracting. In particular, this multidisciplinary review process ensures that the proposed program adheres to the following standards:

- The services to be provided are clearly described and conform to the components and expectations set forth in the procurement instrument (e.g., RFP) and include, as pertinent, active membership in the System of Care-Community Collaborative by the applicant agency.

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<sup>1</sup> *Developing an Integrated System for Financing and Delivering Public Behavioral Health Services for Children and Adults in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 01-2 JSS (Section 49) and Public Act 01-8 JSS.*

- The services are appropriate and accessible to the population, and consistent with the needs and objectives of the State Mental Health Plan.
- The number of clients to be served is indicated, supported by inclusion of relevant community demographic information (e.g., socio-economic, geographic, ethnic, racial and linguistic considerations).
- The service will be administered in a manner that is responsive to a mechanism for routine reporting of data to DCF.
- Performance measures and outcomes are included with a defined mechanism for routine reporting of data to DCF.

After a submitted application has been selected for funding, a contract is established. Thereafter, the contractor provides program data and fiscal reports/information related to the activities performed in meeting the contract's terms, objectives and service outcomes. Standard provider contract data includes variables pertaining to client demographics, service provision, and outcome values. DCF program managers regularly analyze, distribute and use these data to implement service planning and/or engage in contract renewal or modification.

Local geographical areas and/or statewide meetings are convened with contractors to monitor service provision, and discuss needed modifications related to service provision. The agency's Central Office behavioral health staff are heavily involved in contract monitoring with respect to the department's behavioral health service programming. These efforts include addressing child-specific treatment planning and systems/resource issues. Central Office staff's contract oversight activities are further enhanced through collaboration with DCF Regional Administrators, Office Directors, Systems Development and Clinical Directors, and Regional Resource Group staff, and the membership of the local System of Care-Community Collaboratives and members of local networks of care.

The above mentioned mechanisms and processes join to provide DCF with a broad and diverse array of stakeholder voices to inform program planning and allocation decisions. Moreover, through the monthly meetings of the CBHAC/CMHPC and quarterly joint meetings with the Adult Mental Health Planning Council, a regular and established forum to obtain community input regarding the children's behavioral health service system is in place.

***Which mechanisms does the State of Connecticut utilizes for value based purchasing strategies?***

- a. Leadership support, including investment of human and financial resources.
- b. Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions.
- c. Use of financial incentives to drive quality.
- e. Provider involvement in planning value-based purchasing.
- f. Gained consensus on the use of accurate and reliable measures of quality.
- g. Quality measures focus on consumer outcomes rather than care processes.
- h. Development of strategies to educate consumers and empower them to select quality services.

- i. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- j. The state has an evaluation plan to assess the impact of its purchasing decisions

In some targeted performance goals DCF uses: **C** “financial incentives to drive quality.”

# Environmental Factors and Plan

## 4. Prevention for Serious Mental Illness

Narrative Question:

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SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.<sup>67</sup> The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.<sup>68</sup> In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.<sup>69</sup> The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.<sup>70 71</sup> This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

\*\*\*\*It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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<sup>67</sup> Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

<sup>68</sup> Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

<sup>69</sup> Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

<sup>70</sup> van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

<sup>71</sup> McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 1617 Narrative 4 Prevention for SMI

Block grant funds designated for prevention come solely from the SAPT block grant, not the CMHS block grant. However, within DMHAS, multiple efforts are underway to prevent mental illness or at least attempt to minimize disability and maximize recovery.

Five percent of the CMHS block grant funds are directed toward early psychosis and prevention of acute symptoms from becoming chronic conditions. Please refer to Narrative 5 for additional information.

The Regional Mental Health Boards (RMHBs) are funded in part by the CMHS block grant as grassroots organizations focused on planning, prevention and advocacy efforts related to mental health. RMHBs exist within each of the 5 state regions and serve on the State Behavioral Health Planning Council and the State Board. Working with DMHAS, and at times jointly with the Regional Action Councils (RACs), they create and deliver or collaborate in the delivery of awareness-raising and informational campaigns within their communities across the state. These campaigns include, but are not limited to the following, all of which include some element of prevention:

- Navigation assistance related to enrollment in the Affordable Care Act
- Screening, Brief Intervention and Referral to Treatment (SBIRT) training of health care providers for depression or other behavioral health concerns
- Development and distribution of regionally-based resource guides to inform and assist the public with identifying and accessing mental health services
- Conducting SAMHSA promulgated Community Conversations on Mental Health
- Development of [www.TurningPointCT.org](http://www.TurningPointCT.org); a website developed by and for young adults with behavioral health concerns to gain answers, guidance and support
- DMHAS and other mentored Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training to teach the public how to identify and respond to the most common mental health concerns
- Question, Persuade and Re-direct (QPR) training – a suicide prevention model
- One Word, One Voice, One Life – media campaign for suicide prevention
- Smoking cessation efforts as behavioral health populations evince high rates of nicotine dependence which can lead to multiple health-related conditions

Connecticut also has Community Care Teams (CCTs) which involve regular meetings of local providers to manage high risk clients in a coordination fashion, benefitting the client and the agencies involved. In Middlesex County, where they have been using this strategy the longest (approximately 4 years), and anchored by Middlesex Hospital, there are 132 clients which have been part of the caseload for at least 6 months. For this cohort of client there has been a 63% reduction in combined Emergency Room and Inpatient visits. The success of the Middlesex CCT has resulted in attempts to replicate this model in other parts of the state.

Another strategy embraced in Connecticut and supported by DMHAS is the training of police officers in Crisis Intervention Teams (CITs). This approach teaches officers to recognize when mental health issues exist in a person they are called to respond to, strategies for managing the person, and options for services and assistance other than incarceration. The CIT training, in conjunction with the Jail Diversion program, are managed by the forensic arm of DMHAS and seek to direct persons with mental health conditions to more appropriate care and services.

The Suicide Prevention plan, created jointly with Department of Children and Families (DCF) and operating statewide, is another prevention piece which is addressed more fully in Narrative 21.

The Governor's Prevention Partnership (GPP) is a statewide public-private alliance (including DMHAS) focusing on the youth of Connecticut. The GPP provides:

- Mentoring
- Training and Events
- Prevention of bullying
- Prevention of underage drinking and substance abuse

Training on Prevention topics is also provided by DMHAS. To view a training catalogue go to: <http://www.ct.gov/dmhas/lib/dmhas/prevention/preventiontraining.pdf>.

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. YAS established the young parent's 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. The goals of this service are to support staff and young adults in the

areas of making informed choices, forming healthy relationships, education in sexuality, and parenting.

#### **Children's Plan 4. Prevention for Serious Mental Illness**

The Connecticut Department of Children and Families (DCF) has statutory authority to provide for all children's mental health services in CT. In this capacity DCF has implemented a broad array of services for children, youth and their families for the prevention of serious mental illness. The Department provides and/or funds a continuum of early identification and early intervention services in the community and in facilities.

These services include family advocacy, intensive case management, in school and after school programs, respite care, emergency mobile psychiatric services, extended day treatment programs, outpatient child guidance clinics, therapeutic foster care, therapeutic group homes, psychiatric residential treatment facilities (PRTF) and inpatient psychiatric treatment. Children and families can access state-operated or state-funded services directly or through referrals from providers in the behavioral health system. The following are specific programs for the early identification, intervention and prevention of serious emotional disturbance and serious mental illness (please refer to the section Connecticut Children's Behavioral Health Service Array for detailed descriptions of each program pages 14-30):

- Care Management Entity (CME)
- Caregiver Support Team
- Child Abuse Pediatricians (CAP)
- Child First Consultation and Evaluation
- Community Support for Families
- Connecticut ACCESS Mental Health
- DCF-Head Start Partnership
- Early Childhood Consultation Partnership (ECCP)
- Elm City Project Launch (ECPL)
- Extended Day Treatment
- Juvenile Review Board (JRB)
- Mental Health Consultation to Childcare
- Positive Youth Development
- Therapeutic Child Care

**Connecticut Suicide Advisory Board CTSAB:** Since January 2012 CT has implemented a statewide initiative to address suicide prevention and response across the lifespan (with a special emphasis on children and youth.) This has included providing educational and resource information to make individuals of all ages aware of what can be done to prevent suicide. In recognition that identification and intervention by family and peers is critical for suicide prevention Connecticut has developed a social marketing campaign "**1 Word, 1 Voice 1 Life "Be the one to start the conversation."**

The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion. The CTSAB seeks to reduce and eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.

## Environmental Factors and Plan

### 5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

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P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.<sup>72</sup> SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)<sup>73</sup>, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

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<sup>72</sup> <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

<sup>73</sup> [http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm\\_source=rss\\_readers&utm\\_medium=rss&utm\\_campaign=rss\\_full](http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## **Children's Plan 5. Evidence-Based Practices for Early Intervention (5 % set-aside)**

### **1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.**

CBITS, Cognitive Behavioral Intervention for Trauma in Schools is an evidenced based treatment model for children suffering from post-traumatic stress symptoms as a result of a traumatic experience in their lives. CBITS is designed for student's grade 4 through grade 12 with elevated symptoms that impact daily functioning including learning. CBITS provides timely and effective early identification and intervention for children exhibiting traumatic stress to improve children's well-being and their functioning at school, home and their community. CBITS addresses the long term impact of untreated trauma that interferes with a child's development and has lasting effects for physical health, behavioral and mental health, cognitive development, psychological well-being, and social relationships. Early identification and treatment in a school based setting can eliminate the negative and adverse consequences of traumatic experience.

### **2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.**

CBITS was implemented in the City of Bridgeport in February 2015 through Optimus Health Center for 4 state funded FTE clinicians to implement CBITS in 4 school settings which were identified by the Bridgeport School District. Clinical trainings were conducted and in early June the first pilot group was started prior to the end of the school year. The CBITS group was successfully completed. The plan is to fully implement CBITS in all 4 Bridgeport Schools starting in September 2015. Expansion of CBITS was recently funded and an RFQ will be issued to expand CBITS to an additional 24 clinicians statewide that will start with the new school year beginning September 2015 through June 2016. Clinical training for the expansion of the CBITS model is scheduled for the end of September for the 24 clinicians. The Bridgeport initiative clinicians will join the expansion and participate in a yearlong learning community supported by the CBITS model developers and DCF. The implementation effort will include a total of 30 clinicians (10 clinical teams including 2 clinicians and a clinical supervisor) and be supported through clinical training on the model, 6 learning community sessions in the new school year to support implementation, consult calls, fidelity monitoring, data collection, as well as any other support necessary for successful implementation of CBITS. Further expansion and sustainability efforts will take place in the third year.

### **3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures. Insert information from childhood trauma:**

Childhood trauma without early prevention and intervention can result in life long adverse consequences for children that effect health, wellbeing, disrupt development, lead to problematic social and learning outcomes. CBITS provides an opportunity for early recognition of children with trauma stress reactions through screening that identifies trauma exposure and trauma symptoms, intervention through the CBITS evidenced based intervention model for students that can change the course for children with traumatic stress and improve wellbeing.

Finally CBITS can be preventative as educational professionals develop trauma awareness and a trauma informed approach in the school setting where children are seen daily. Exposure to trauma is high in the general population where it is estimated that 71% of all children are exposed to at least one traumatic event and often multiple events. By the age of 17 years, 15% of children have experienced at least 6 different traumatic events. Children served in the Child Welfare system have a higher rate for trauma exposure than the general population. Trauma exposure can disrupt brain development, result in Post-Traumatic Stress Disorder, increased risk for behavioral and mental health problems, disruptive behavior, delinquency, academic problems and is linked to psychiatric disorders in adolescents. The primary goal for CBITS is reductions of trauma symptoms and improved wellbeing which will result in improved school attendance, grades and functioning and improve emotional and behavioral health.

CBITS is listed under priority area Childhood Trauma and all of the above information is listed there.

**4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.**

The MHBG funds are added to the State dollars to fund the CBITS initiative in Bridgeport, Connecticut and to expand CBITS state wide so the children across Connecticut will have the opportunity for early identification and treatment in as many school settings as possible. The set aside for year one was \$72,000 and the state addition was \$274,020. The states annualized funds for the next two years are \$1,100,000 and includes the PSA with the model developer, POS for Bridgeport FTE's and funding for statewide expansion.

**5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.**

DCF is working with CHDI to create a CBITS data base that will measure:

- The number of students that are screened in aggregate and at each site
- Percentage of students that present with clinical symptoms (at least 1 reported traumatic exposure and clinically significant PTSD symptoms)
- Percentage of students with clinical symptoms that enroll in CBITS
- Percentage of students that are enrolled that complete the CBITS group
- Percentage of students enrolled that do not complete the group (and why)
- CBITS is evidenced based, students will be measured for change in symptoms via measures specific to PTSD and over all problems and functioning.

## **1617 Narrative 5 Evidence-Based Practices for Early Intervention (5 percent)**

### **1. An updated description of the state's chosen evidence-based practices for early intervention (5% set-aside initiative) which was approved in its 2014 plan.**

The **Potential Program** continues to function as a specialized component of the Young Adult Program at the Institute of Living targeting early psychosis in young adults 17 – 26 years of age. A multidisciplinary team approach is used to provide individual and group psychotherapy, medication management, family education and support services, and cognitive remediation. Regular family meetings are held for planning and support. The Vocational Counselor and the Vocational Therapist are engaging clients and working with them to gain work skills and work confidence. The Peer Counselor is providing outreach and engagement, services which have been heavily utilized. The case management role of the Peer Counselor is expanding to work with the LGBTQ population which struggles with interpersonal challenges in addition to behavioral health issues. Each month outreach events are held to provide an opportunity for safe connections to be made between young adults facing similar concerns. Generally these events are organized around on-site and off-site social activities, some of which include family members. The leadership of the program described how isolation and alienation of this young adult population delays treatment involvement and recovery and how critically important outreach and engagement efforts are in combatting these delays.

The **STEP program** continues to deliver the package of empirically supported treatments that it has since 2006: family education, low dose antipsychotic prescription, cognitive-behavioral therapy based groups, case management, and supported education and employment services. The 5% set-aside funds were used to expand vocational services within the established model of care that has reported trial results with high rates of vocational engagement. The 5% set aside funds supported the hiring (with additional staffing contract dollars) of a full complement of 3 primary clinicians from social work, nursing, and psychology who all work closely with supported education and employment services as part of the clinical team. The Supported Employment Specialist, supported by DMHAS Employment Opportunities grant funds, was able to expand her hours and assume responsibility for providing supported education and employment services to improve vocational engagement that had previously been carried by other members of the team. The Supported Employment Specialist was trained in the IPS (Individualized Placement Services) model which has been adapted for working with the young adult with early psychosis population.

### **2. An updated description of the plans' implementation status, accomplishments, and any changes in the plan.**

All aspects of the **Potential Program** are fully engaged. Case management services provided by the Peer Counselor are heavily utilized and will be expanded in two ways. First, peer services will be expanded toward addressing the LGBTQ population. Second, peer services will be expanded in terms of service hours provided in an effort to meet the case management demands of the young adult population. This is based on the program's belief that the key to working with persons early in their psychosis is to combat their isolation and alienation through outreach and engagement which can bring the person into treatment sooner than traditional models and in a way the person can tolerate. For its efforts, the Association for Ambulatory Behavioral Health Care awarded the Potential Program as Program of the Year at a ceremony in San Diego, California in July 2015.

At the **STEP program**, all aspects of the program are implemented. In February 2015, an NIH grant-funded research project was launched in the form of a campaign to improve access to early psychosis intervention services using 3 approaches:

- Professional outreach and detailing to 8 community stakeholder groups (clergy, police, colleges, mental health agencies, etc.) to participate in informational sessions for the purpose of referring young persons that they come into contact with who demonstrate early signs of psychosis to the STEP program
- Media campaign using social and mass media to provide messaging about early psychosis directly to potential clients and their families and make them aware of STEP Program services
- Performance improvement practices designed to assess the time between initial contact for services and entry into treatment with the goal set at one week

The Director of the STEP Program is interested in implementing a population-health-based approach and has been asked to facilitate a webinar within the next few months.

**3. The planned activities for 2016 and 2017, including priorities, objectives, implementation strategies, performance indicators, and baseline measurements.**

The **Potential Program** plans to hire a second Peer Counselor to provide additional case management services. Otherwise, they plan to continue with their current efforts which, based on their ongoing review, they find to be very effective at bringing persons with early psychosis into their program.

The **STEP Program** hopes to shorten delays in access to care via the NIH project mentioned above. To this end they are collecting data on Duration of Untreated Psychosis (DUP) as an outcome measure. They are also collecting demographic data, clinical and functional information, and additional outcome (social, vocational, etc.) measures. They also hope to expand services and be able to treat clients from a wider geographic area.

**4. A budget showing how the set-aside and additional state or other supported funds, if any, were used for this purpose.**

The **Potential Program** receives a grant of approximately \$400,000 from DMHAS for its Young Adult Program, of which the Potential Program is a part. The 5% set-aside represents less than 20% of their overall budget, at \$84,216. Given the small amount, it is used for the vocational and case management hours as initially planned and outlined in Question 1 above.

The **STEP Program** used the set-aside funds (\$84,216) to support the hiring (with additional staffing contract dollars) of 3 primary clinicians (social worker, nurse, and post-doctoral psychology fellow) who work with the Supported Employment Specialist as members of the clinical team. The funds allowed for shifting of supported education and employment services to the Supported Employment Specialist, thus allowing more clinical time to the other primary clinicians. The Supported Employment Specialist is paid from DMHAS Employment Opportunities grant funds.

**5. The states' provision for collecting and reporting data, demonstrating the impact of this initiative.**

The **Potential Program** functions as a specialized component of the Young Adult Program at the Institute of Living and the data they report to DMHAS is likewise merged into a common data set. Data collected

includes admissions, discharges, service hours, treatment completions, and national outcome measures (social support, stable living situation, and employment status). The program also maintains its own data on events that they conduct and the number of clients and family members attending.

The **STEP program** submits the same data as the Potential Program, but also reports on additional measures (completion of mental health and substance abuse screening, whether 2 or more services were provided within the past 30 days, etc.) Also, in contrast to the Potential Program, the STEP program's data reflects only that program's performance. In addition, the STEP program collects a significant amount of data which is used internally and not submitted to DMHAS, such as DUP, vocational engagement measures, clinical and functional data, Quality of Life data, and other outcome measures.

# Environmental Factors and Plan

## 6. Participant Directed Care

Narrative Question:

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As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

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Footnotes:

## 1617 Narrative 6. participant Directed Care

DMHAS service recipients only have access to financial choice in self-directed care through the Mental Health Waiver. The Community Support Clinician, staffed by DMHAS or under contract with DMHAS, will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial Recovery Planning process and during reviews and updates to the plan. If the individual elects to direct their own services, they will be referred to the fiscal intermediary to provide employer related services. These include:

- Identifying and recruiting individuals that can provide Recovery Assistant and Overnight Recovery Assistant Services;
- Maintaining a registry of individuals that provide Recovery Assistant and Overnight Recovery Assistant Services;
- Providing an enrollment packet for individuals that will provide Recovery Assistant and Overnight Recovery Assistant Services;
- Performing background checks on prospective individuals who will provide Recovery Assistant and Overnight Recovery Assistant Services;
- Providing information and training materials to assist in employment and training of workers;
- Facilitating the meeting with the Participant and the individual providing Recovery Assistant and Overnight Recovery Assistant Services;
- Managing, on a monthly basis, all invoices for Recovery Assistant and Overnight Recovery Assistant Services against the amount of Recovery Assistant and Overnight Recovery Assistant Services authorized in a Participants Recovery Plan and .
- Developing fiscal accounting and expenditure reports.

## Children's Plan 6. Participant Directed Care

The Connecticut Department of Children and Families (DCF) fully supports families, children and youth having increased access to care, and having a significant role in the development of their individualized treatment planning and the selection of services they receive. Services for children and families involved with DCF are generally fully funded through the department, ensuring that both service access and choice are not restricted due to a family's financial means. The broad array of community and congregate based services available to families through DCF includes: Family/peer advocacy and support services, intensive case management, care coordination, in school and after school programs, respite care, emergency mobile psychiatric services, extended day treatment programs, outpatient child guidance clinics, crisis stabilization programs, therapeutic group homes, psychiatric residential treatment facilities (PRTF) and inpatient psychiatric treatment. DCF Initiatives that support participant directed care include the following:

**Child and Family Teaming:** Children, youth and families involved with DCF learn about the array of available services and programs at the time of initial intake and referral. DCF has implemented the process of "Child and Family Teaming" as the primary strategy that defines and supports a purposeful, respectful and supportive engagement and partnership with families who become involved with DCF. Family Teaming is used to involve families (birth, extended, foster and adoptive), professionals and DCF staff in a collaborative process of service planning and decision making. Child and Family Teaming ensures that the voice of the child, youth and family is fully heard and integrated in all aspects of their treatment/service planning. Child and Family Teaming is built on the understanding that when families are directly and fully involved in their treatment/service planning and decision making, their outcomes are improved.

With the delivery of services DCF also ensures the empowerment of the child, youth and their family while working with the service provider. This begins with a collaborative and careful assessment process that results in a highly individualized service plan for the family. The service provider seeks to understand the reason(s) for the child, youth and family's referral, their expressed and felt needs, and the outcomes they desire. The child and family's strengths and skills are acknowledged and valued in the planning process. The family is viewed in the context of their culture, ethnicity, religion, gender and other unique qualities. All of these elements are considered in planning the right mix and frequency of services for the child, youth and family, with the child, youth and family serving as the main designer of the plan through the Child and Family Teaming shared decision-making process. Treatment providers may recommend particular treatments and a schedule of appointments to address individualized needs, but the child, youth and family ultimately decide if these recommendations will meet their unique needs.

**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. One component of their work is the delivery of advocacy services to selected families. The primary goal is to empower these families to advocate for their own needs and services. The programs provided by FAVOR to families include the following:

- The FAVOR Family Peer Support Program provides direct family advocacy services to families with children who have medical, mental, or behavioral health challenges. Family peer support providers furnish assistance to families who need to navigate the special education, juvenile justice, and mental health care service systems. Services can include education on caregiver and child rights and responsibilities, and attending school and Child and Family Teaming meetings. Working collaboratively with families, children and youth, schools and other service providers, Family Peer Support Providers empower families and help them participate fully in the development of their child's treatment and service plans.
- The FAVOR Family System Manager Program works at the system level to help families, children and youth become active and equal partners in Connecticut's Network of Care. Working with both families and service providers, family systems managers offer education, technical assistance, and mentoring to assist in the development of family-driven, youth-guided policies and practices and to facilitate family participation in all levels of system activity and policy development.
- The FAVOR CT Medical Home Initiative assists families to access family-trusted pediatric care and the medical and non-medical services that are needed to help children and their families achieve their maximum potential. Through five regional centers and numerous pediatric practices around Connecticut, the Medical Home Program connects qualifying applicants to appropriate resources, and this family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent care is achieved.

**Care Coordination:** DCF has implemented a system of care coordination as a service to partner with and support families in their planning and receiving services. Care coordination services are provided primarily to non-DCF involved children and youth with a serious emotional disturbance involving complex behavioral health needs requiring intensive coordination of multiple services to meet those needs. Care coordination services are also available to other children and youth with complex service needs with priority given to those children and youth who are at imminent risk for more restrictive residential or hospital levels of care or who are returning from these levels of care.

Care coordination involves direct contact with families, children and youth by a trained coordinator with clinical knowledge, who does not function as the clinician for family members. The Care Coordinator, in partnership with the family, supports the development of the family service plan, drawing on their clinical and community systems knowledge. They serve as advocates for the family and provide support in obtaining, coordinating and monitoring the implementation of the service plan. DCF currently funds eighty (80) care coordinator positions across the state.

**Care Management Entity (CME):** DCF funds a Care Management Entity to coordinate care for children and youth with complex behavioral health challenges who are involved in multiple systems, and their families. The CME serves children and youth, ages 10 to 18, with a serious emotional disturbance who are returning from congregate care or other restrictive treatment settings (e.g. emergency departments, in-patient hospitals, etc.) or who are at imminent risk of removal from their home or community. The CME, through direct service delivery and

administrative functions provides: (1) a youth guided and family-family driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; (3) home- and community based services and peer supports as alternatives to costly residential and hospital care for children and adolescents with serious emotional disturbance. The goals of the CME include the following:

- Improve child, youth and family access to appropriate services and supports
- Engage youth and their families as partners in care decisions to improve their experience
- Improve clinical and functional outcomes
- Foster resiliency in families and youth
- Reduce unnecessary use of costly services (e.g., out-of-home placements and lengths of stay)

# Environmental Factors and Plan

## 7. Program Integrity

### Narrative Question:

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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 behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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 USC § 300x- 55, 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 to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Client level encounter/use/performance analysis data; and
  - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 1617 Narrative 7 Program Integrity

### 1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

The state has practices across units to ensure fiscal and programmatic program integrity. DMHAS' Community Services Division (CSD) monitors contracted behavioral services for program "integrity" through data analysis and on-site visits with "integrity" defined as contract compliant, consumer-focused services and demonstrated positive outcomes. The DMHAS Contract Unit generates and executes contracts as well as reviews fiscal reports and audits. The DMHAS Internal Audit Unit conducts reviews, including on-site reviews of internal controls of agency operations, policies/procedures and business practice on a routine basis. The Internal Audit Unit also conducts reviews in response to allegations of fraud triggered from internal or external sources. The DMHAS Budget Unit tracks federal funds and prepares federal expenditure reports.

### 2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

DMHAS' practice is for all contracts with providers to include standard language concerning expectations for programs receiving SAPT and/or CMHS funds. Included within this standard contract language is:

Scope of Services and Contract Performance: This section states that providers of reimbursable services will provide the service to adults who are medically indigent, which is defined as having no private or public health care coverage that will pay for the services to be provided by the contractor and no access to, or eligibility for, such coverage.

Federal Fund Requirements: This section states that any contractor in receipt of federal funds through DMHAS must comply with the associated CMHS, SAPT, and other block grant requirements which are described.

Reporting: This section states that the purposes of required reporting include determining the contractor's compliance with program performance standards and outlining which reports and audits are due, when they are due, and penalties for late reporting. The required fiscal reports include an 8 month Interim Fiscal Report, an Annual Financial Report (AFR), and an Annual Audit. Programmatic performance data required includes: Admission and Discharge Reports, Service data, Monthly Substance Use Disorder Treatment Reports, Daily Census Report for Substance Use Disorder Treatment, Targeted Case Management Reports, Critical Incident Reports, and Client Satisfaction Surveys.

Budget: This section states that the contractor will adhere to the approved budget, addresses allowable variances and returning of unexpended funds to DMHAS.

The DMHAS contract also specifies programmatic expectations based on each program type or level of care. Included in this standard contract language are target population, length of stay, service delivery expectations (i.e., intake, screening, bio-psychosocial evaluation, treatment and discharge planning) and performance measures (i.e., reporting requirements, utilization).

**3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:**

- a. Budget review** – Creating an approved budget with contracted providers begins in the Budget Office with a projected amount based primarily on actual expenditures from the previous fiscal year. Working with the Contracts Unit, providers build a proposed budget specifying how they plan to spend the funds. These proposed budgets are reviewed for appropriateness by the Contracts Unit Monitors. Once approved, the Contracts Unit sends the Budget Office a Summary of Funding document. The Budget Office conducts a second check of the appropriateness of the planned spending and updates the spending plan, which reflects all state and federal dollars, in the Access Database. The Summary of Funding is added to the provider contract.

The Budget Office monitors the payments made against the Block Grant to the providers, authorizes the payments, and submits required federal financial reports. At the end of the fiscal year, the Budget Office will use the information from payments made to providers to generate the necessary fiscal reports required in Block Grant reports.

An OPM initiative went into effect July 1, 2014 called the Uniform Chart of Accounts (UCOA) for all human services contracts across state agencies. It is the first phase of an effort to standardize the format of contracts and require them to be submitted electronically.

- b. Claims/payment adjudication** – DMHAS' procurement method is through flat grant funding contracts, not fee-for-service contracts and therefore there are no claims or payment adjudication. However, based on fiscal reporting and audit reviews; unexpended funds, material weaknesses and/or management letter concerns have the potential to result in payment adjudication.
- c. Expenditure report analysis** – As spelled out in the providers' contract, there is an Interim Fiscal Report due at 8 months (March 31<sup>st</sup>) covering income and actual expenditures for the first 8 months plus projections of income and expenditures for the remainder of the fiscal year. This report is reviewed to determine if spending is occurring as expected based on the budget and to identify any unexpended funds. Additionally, the Annual Fiscal Report (AFR) is due September 30<sup>th</sup> on actual income and expenditures for the full fiscal year. The actual income and expenditures are compared to budget projections. Failure to submit either report within 30 days results in a standard letter being sent to the provider reminding them of the expectations and financial penalties for late reporting. The DMHAS Contracts Unit has dedicated staff assigned to each of the 5 service regions to review these expenditure reports. All data related to these reports is maintained and tracked electronically.

- d. Compliance reviews** – The Internal Audit Office conducts both routine and “for cause” compliance reviews of all state-operated agencies. Included in these reviews are all agency operations, policies, procedures, and business practices. The Director of Internal Audits employs three staff who review all relevant documentation, including medical records, and produce a report of findings.

As far as programmatic compliance is concerned, the expectations established in the contract language are reflected in the report cards. Required data submission per the contract is aggregated and sorted for statewide, provider, and program review of performance. These report cards readily display where programs are meeting expectations and where they may be falling short. Community Services Division (CSD) monitoring staff utilize data found in the report cards when they conduct monitoring reviews of programs. CSD has a Regional Manager assigned to each region of the state as well as other monitoring staff, all of whom conduct reviews of contracted providers. Specific checklists of the contract expectations are reviewed on-site, as well as client and staff interviews. After completion of all reviews, an exit interview is held with provider leadership in which findings, recommendations, and, as needed, correction action plans are discussed. Each contract provider is reviewed every 2 years if in good standing and more often as needed. If corrective action is not accomplished by provider leadership within established timelines, the Board of Directors is contacted for follow up.

- e. Client level encounter/use/performance analysis data** – As mentioned in the section above, Community Services Division (CSD) monitoring staff conduct reviews of all contract expectations, including performance data as reflected in the report cards, client interviews and staff interviews using structured interview forms, and individual checklists based on the particular program type/level of care being reviewed. Findings and recommendations are shared with provider leadership and, as needed, corrective action plans are requested.

- f. Audits** – *Note: Under the State Single Audit Act, entities which expend \$300,000 or more in total state financial assistance received from state agencies shall have a state single audit performed. Per OMB Circular A-133, grantees expending in total \$500,000 or more in federal awards from all agencies shall have a federal single audit performed.* The provider contract requires submission of an annual audit by an Independent Public Accountant (IPA). The audit includes actual income and expenditures for the full fiscal year and produces a report with copies sent to the provider’s Board of Directors, DMHAS Contracts Unit, and the State of Connecticut Office of Policy and Management (OPM). The report may include comments on internal fiscal controls, material weaknesses, questioned costs, management letter concerns, and recommendations. OPM and DMHAS’ Contracts Unit both review the audits. OPM forwards their review findings to the DMHAS

Contracts Unit for inclusion in the DMHAS review. Based on this review process, DMHAS then sends an Audit Review Letter to the provider. Any appeals from the provider in response to the Audit Review Letter are reviewed by DMHAS' Chief Financial Officer, Chief Operating Officer, and the Directors of the Business Office, the Audit Unit, and the Contracts Unit. All activities related to these audits are maintained and tracked electronically.

Concerns stemming from independent audit findings will be reviewed with the Office of Internal Audits and may result in further on-site investigation.

**4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.**

A state receivable account is established from which payments to providers are made. Funds are then drawn down by the Budget Office from the federal government to reimburse the state receivable account. Funds in the state receivable account are based on the expected budget as modified by the Notice of Grant Award. The Fiscal Services Bureau (FSB) of the DMHAS business office is responsible for making the payments to providers.

Funds received by providers are based on the approved budget. Payments are made consistent with federal guidelines and are specified in the provider contract. Providers receive federal funds on a quarterly basis from DMHAS. Providers receive state funds in an initial 4-month payment followed by 2 quarterly payments and then a final 2-month payment. Based on review of the Interim Fiscal Report, if unexpended funds are identified, FSB is notified to withhold funds as appropriate.

**5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?**

The Regional Managers in the Community Services Division (CSD) provide technical assistance on-site during exit interviews as part of their review process. CSD also has Learning Collaborative meetings for providers that focus on a particular topic relevant to those providers (e.g., Medication Assisted Treatment). These Learning Collaboratives focus on improving quality in the shared topic area through discussions about evidence-based practices and presentations. Report cards reflecting performance measures are another vehicle for providing feedback to providers about the quality of their programs. With respect to safety, the Department of Public Health (DPH) conducts site visits as part of the licensing process. The DPH review focuses on safety and program environment concerns. As far as fiscal compliance is concerned, the Monitors in the DMHAS Contracts Unit work closely with providers throughout the year and maintain contact to be able to assist them in terms of timely completion of required reports and audits.

**6. How does the state ensure block grant funds and state dollars are used for the four purposes?**

DMHAS' practice is for all contracts with providers to include standard language concerning expectations for programs receiving SAPT and/or CMHS funds. Included within this standard contract language is:

*Scope of Services and Contract Performance* section states that providers of reimbursable services will provide the service to adults who are medically indigent, which is defined as having no private or public health care coverage that will pay for the services to be provided by the contractor and no access to, or eligibility for, such coverage.

*Federal Fund Requirements* section states that any contractor in receipt of federal funds through DMHAS must comply with the associated CMHS, SAPT, and other block grant requirements which are described.

Contract budgeting and reporting requirements enable the DMHAS Contracts Unit to see all income and expenditures, including federal, state and other.

## **Children's Plan 7. Program Integrity**

Connecticut's State Child Planner is the lead person that oversees the MHBG program integrity plan. In partnership with the Administrator of behavioral health services, statewide program leads, regional system managers, program subject matter experts and fiscal specialists, management and oversight of MHBG funds, activities and outcomes is conducted on an ongoing, consistent basis. The Children's Behavioral Health Advisory Council and the Joint Behavioral Health Council also oversee the state plan. These councils receive periodic updates and data reports relative to progress to date, barriers, and achievements. Also, the Department's proposed MHBG budget is presented before the Appropriations, Public Health and Human Services Legislative Committees each year. This is an opportunity for further review and scrutiny of activities and results.

The state utilizes a variety of program integrity activities to monitor the appropriate use of funds. These include: budget review; claims/payment adjudication; expenditure report analysis; compliance reviews; encounter/utilization/performance analysis and audits.

Connecticut has developed a uniform method of contracting for purchase of service (POS) and personal service agreements (PSAs). The process is administered by the Office of Policy and Management (OPM) and provides uniform policies, procedures, and formats for contracting for services. DCF must follow the OPM contracting requirements. The OPM has issued cost standards for POS contracts that identify cost categories that are allowable or unallowable.

The DCF contracts with approximately 124 provider agencies across 90 service types. The provider POS contract covers a 3-5 year time period. Contracts can be amended during the contract period if the need arises. The contracted community mental health agencies are not-for-profit entities. Funding allocated to the community mental health providers is made on a historical basis in the form of a grant. The contract is the document considered as obligating the funds. The DCF Summary of Funding sheet identifies the State and Federal funds committed to the provider and identifies the amount of CMHS Block Grant funds and the CFDA number. The contract also includes language related to the restricted expenditures from Block Grant funds and an A-133 audit requirement.

The DCF providers are required to submit an 8-month expenditure report and an end-of-year expenditure report (90 days after close of the State fiscal year). The provider is also required to submit an annual A-133 audit to the Department (180 days after close of the State fiscal year). The A-133 audit is reviewed by using a protocol provided by OPM to determine completeness, conditions that may result in funds recovery, and overall fiscal well-being of the provider. Providers must explain any significant differences between the annual audit information and the 12-month expenditure report.

Program Leads now known as Program Development Oversight and Coordinators (PDOCs) are assigned contract responsibility based on the service type of the contract. PDOCS know budgets for each of their programs, and there is some flexibility to move funds within service or expense categories as demonstrated by need. They review reports from PIE, conduct site visits to providers, and intervene when problems are identified. They also meet with provider groups specific to service types on a regular basis.

In addition, the Department employs a variety of means to identify the strengths and needs of its service delivery system. For example, the Department employs a dedicated Program Director level position that leads DCF's Results Based Accountability and performance expectation activities. This manager works with DCF's Contracts Division, ORE and Program Development and Oversight Coordinators (PDOCs) who are assigned to oversee all of the Department's contracted services. This position has worked to support all DCF contracts having outcome measures. A guidance has also been created to direct the development of performance measures for our contracted services. Practice Guides have also been developed for some service types to concretize service and performance expectations that are outlined in the contracts.

In 2009, the Department launched the Provider Information Exchange or PIE (formally PSDCRS). It is a real-time, client level reporting system that allows for program and performance monitoring of DCF contracted services. Reports, dashboards, and data extracts (access to raw data) from PIE allow the assigned PDOCs (and Contracted Providers) to evaluate the quality and efficacy of DCF funded services. PIE data reports are categorized within a RBA framework to allow PDOCs, Systems Directors (managers in each region who oversee the local DCF service array), and contracted providers to understand and view service provision through the lens of ***"How Much, How Well and Is Any One Better Off?"***

Some programs in PIE also collect periodic data (e.g., client data updates ever quarter or six months). Activities or event level data is also collected for select service types in PIE. This level of data allows for the Department to assess information about key service provision (e.g., face to face contact with a client, duration of visits, location of services, participants, etc.). PIE collects post-discharge/aftercare data for some services. An example of aftercare data would be evidence of supporting transition and monitoring stability of a step down from Therapeutic Foster Care to core foster, relative placement or reunification.

The system also collects data on outcomes using a variety of assessment tools. These include the Ohio Scales, which is a normed, clinical assessment instrument, to monitor child functioning and improvements, YSSF for youth and adult as well as the , Parental Stress Index . Some substance abuse programs use the Global Appraisal of Individual Needs (GAIN). In addition, the types and sophistication of data and analysis by the Department is also different than in years past. For example, the Department began constructing forecasts/population projections three years ago. These data aid in determining the likely placement landscape months and often years in advance. This assists the Department in making decisions about the category of services in which it will need to more greatly invest (e.g., congregate versus community-based).

Most recently, the Department has begun to disaggregate these projections by key demographics such as race/ethnicity, gender and age cohorts. This enhanced view of the forecasts allow us to more adroitly develop a service array that will better meet the needs of the children and youth who we expect to serve.

Program Development Oversight and Coordinators (PDOCs) and Regional Systems Directors use these data to assess program effectiveness, performance, and compliance.

Excel Pivot Table training has been provided to these positions as a means to support more complex analyses. It is expected these data are shared and discussed with contracted providers to support positive outcomes and aid with any performance improvement as may be identified.

Pursuant to the PDOC General Role and Expectation guidance, ***“[t]he PDOC is expected to monitor and coordinate the quality and effectiveness of the programs under their purview. They are to work with providers, the Regions and other DCF offices and units with respect to assuring quality, supporting services' sustainability, and facilitating ongoing service improvement.”***

The guidance further states: ***“[t]he PDOC must understand, engage, use and disseminate data, both qualitative and quantitative, about their service(s). These positions should ensure that providers are achieving the outcomes outlined in their [Scope of Services] and work with them to ameliorate areas of challenge and underachievement [and] ... develop strategies for improvement.”***

As a means to provide information exchange and support program oversight, PDOCs are expected to convene regular meetings with DCF contracted providers. The discussion of data is to be a standing agenda item at these meetings. The Department's Senior Leadership also meets regularly with the Provider Associations and convenes Quarterly meetings of all its POS Contracted Providers and Credentialed Services Providers.

Site visits by PDOCs and DCF licensing visits are another means by which the functioning and performance of contracted providers is evaluated. Both site visits and licensing visits typically involve the qualitative review of provider records, including client files. Site visits may range from a half day to two full days on site. The findings from site visits and licensing reviews are shared with providers. If needed, corrective action plans are developed to remediate any identified challenges.

Provider contracts contain language that requires delivery of services for all eligible clients, including those who have no health insurance and those who have no means to pay even on a sliding fee scale. The Medicaid and private insurance status or lack thereof is tracked for every publically funded client through the PIE.

The Department has a long history of utilizing block grant funds to pay for services that are not covered by private insurance and/or Medicaid. Specifically, the majority of these funds (almost \$ 1 million) pays for family advocacy services and respite care that is not eligible for Medicaid or funded by other sources.

# Environmental Factors and Plan

## 8. Tribes

Narrative Question:

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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>74</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 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

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<sup>74</sup> <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 1617 Narrative 8 Tribes

Connecticut has two federally recognized tribes; the Mohegan Tribe and the Mashantucket Pequot Tribal Nation. Both tribes have successfully established gaming enterprises in the state and provide health care coverage (self-insured) to their tribal members, with the result that most of their community members are not eligible for DMHAS operated or funded services. Both tribes are located in the southeastern area of the state.

1. Over the years, DMHAS' Local Mental Health Authority in the southeastern region (Southeastern Mental Health Authority – SMHA) has collaborated with the Mohegan Tribe and the Mashantucket Pequot Tribal Nation regarding coordination of services. Invitations to the tribes to appoint representatives to serve as members of the State Behavioral Health Planning Council have been declined, but cooperative efforts continue.
2. SMHA continues to collaborate with the Mashantucket Pequot Tribal Nation on systems planning, working with the Special Assistant to Tribal Councilor. SMHA is currently participating in the Mashantucket planning process for their 7<sup>th</sup> Annual Children's Mental Health Awareness Day event scheduled for May 2015. Past involvement with their Circle of Care initiative and Mobile Crisis support remains available upon request as needed.

SMHAs and the Norwich Community Care Team are currently working cooperatively with the Mohegan Tribal Nation specifically on homeless outreach and engagement efforts. Mobile Crisis support remains available upon request as needed.

SMHA continues to work with representatives of both tribes to serve collaboratively on Department of Emergency Management and Homeland Security Emergency Services Function 8: Health and Medical.

## **Children's Plan 8. Tribes**

There are two federally recognized tribes in Connecticut - the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. Both tribes are located in the southeastern (Norwich/New London) area of the state. Both medical and behavioral health care are provided to tribal members, funded largely by their successful gaming enterprises that are maintained in the state. The State has maintained open communication with both tribes consistent with previous years.

Most ICWA activity has centered on the State's resident tribes. On occasion there is activity regarding tribes in the neighboring states of Rhode Island, Massachusetts, and New York. Also notable is the practice of both casinos to exercise Native American hiring preference in their gaming and hospitality enterprise; this has resulted in many (and all required) ICWA notices to be filed with Tribes across the nation and BIA.

There is a longstanding Memorandum of Understanding between the State and the Mohegan Tribe. There is no similar agreement with the Mashantucket Pequot Tribal Nation. There are ad hoc meetings scheduled with the Mohegan Tribe. The content of the meetings is oriented to the Memorandum of Understanding. This includes case specific discussion of State interventions with Mohegan Tribe members. The State notifies the Mohegan Tribe of all accepted reports regarding their members. Discussion is held in a confidential meeting at tribal offices. The meetings are also used as an opportunity to advise the Tribe of new State initiatives.

Regarding the Mashantucket Pequot Tribal Nation, while no formal arrangement is in place for regular meetings, there is a well noted single point of contact, their Director of Child Protection. The State continues to have a positive working relationship with the Director.

Other activity with the tribes included a 2015 invite for participation in the development of a Substance Exposed Infant (SEI) and the Fetal Alcohol Spectrum Disorder (FASD) prevention and identification initiative.

Historically, local collaboration between tribal leaders and behavioral health administrators has occurred. Discussion has focused on needs and services as well as the culture of the tribal nations, and an identification of areas for mutual collaboration.

At the state level efforts have been made, and will continue to assure that tribal leaders are represented at various advisory bodies, committees and planning councils. Children's Behavioral Advisory Council newly elected member self identifies as Native American.

# Environmental Factors and Plan

## 9. Primary Prevention for Substance Abuse

### Narrative Question:

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Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
  - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
  - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
  - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
  - a. A statewide licensing or certification program for the substance abuse prevention workforce;
  - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
  - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 1617 Narrative 9 Primary Prevention for Substance Abuse

### 1. Please indicate if the state has an active SEOW. If so, please describe:

- The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
- The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
- The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

The State Epidemiological and Outcomes Workgroup (SEOW) was first convened in 2005 as part of DMHAS' Strategic Prevention Framework State Incentive Grant funded by the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention (SAMHSA/CSAP). The SEOW maintained a system for ongoing surveillance of state and community-level substance-related indicators to track prevalence rates in different population, subgroups and geographic areas.

The state and community level epidemiological data used in needs assessment, strategic planning, and evaluation at the state and community levels came from agencies participating in the SEOW and included, but were not limited to, alcohol and drug related motor vehicle crashes and fatalities, homicides, suicides; alcohol and drug related deaths; DUIs; arrests for property and violent crimes; juvenile and adult drug arrests; liquor and tobacco law violations; substance abuse treatment admissions; hospital admissions; child welfare cases; alcohol and tobacco licenses; and school suspensions, expulsions and dropouts. National sources of data such as the Youth Risk Behavior Survey (YRBS), the American College Health Association National College Health Assessment, Monitoring the Future, the Core Survey of Alcohol and Drug Use on College Campus, and the National Survey on Drug Use and health (NSDUH) were also examined by the SEOW. The SEOW contributed to the analyses and interpretation of these data, tracked data trends over time, and produced information to prioritize, focus and strengthen prevention efforts statewide.

The SEOW has been dormant since 2012 due to staff reassignments and retirements. Lacking the capacity to manage this in-house, the Prevention Unit has issued an RFP for a consultant to manage the SEOW and serve as a clearinghouse for epidemiological and evaluation-related services for prevention. Applications are due on May 29<sup>th</sup> and the award will be made on August 1, 2015 for 5 years.

### 2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

Thirteen (13) Regional Action Councils (RACs) are legislatively created subregional planning councils created to profile needs and response capacity in the communities they serve. Their mandate is to "(1) determine the extent of the substance abuse problems within their subregions; (2) determine the status of resources to address such problems; (3) identify gaps in the substance abuse service continuum; (4) identify changes to the community environment that will reduce substance abuse..."<sup>1</sup> Furthermore, the legislation requires that they

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<sup>1</sup> Connecticut Statute Sec. 17a-671

comprise their membership of diverse members of the community, including, chief elected official, the chief of police and the superintendent of schools of each municipality within the subregion, one representative designated by the Commissioner of Mental Health and Addiction Services from each treatment facility operated by the department and serving such subregion, business and professional leaders, members of the General Assembly, service providers and representatives of minority populations, religious organizations, representatives of private funding organizations and the media.

Using the state and community level epidemiological data from agencies participating in the SEOW, the RACs conduct a needs and response capacity assessment focused on six substances identified as priorities by the SEOW (alcohol, tobacco, marijuana, prescription drugs, cocaine, and heroin), and two high risk behaviors (suicide and problem gambling). Throughout all priority areas, RACs carefully assess needs and response capacity related to major population categories. Local level data for some of these focus areas may not be accessible, manageable, or useful and are typically indicated in the profile and usually described as a need.

The results of the needs and response capacity assessments are presented in a Subregional Prevention Priority Report for each RAC. The purpose of the process and the Subregional Prevention Priority Report is to describe 1) the burden of substance abuse, problem gambling, and suicide in the subregion, 2) prioritize prevention needs, and 3) the capacity of the subregions' communities to address those needs. It is based on data-driven analyses of issues in the subregion, with assistance from key community members. To ensure an inclusive, comprehensive planning process at the local and regional levels, RACs convene Community Needs Assessment Workgroups to participate in the development of the Subregional Prevention Priority Report. The role of the workgroup is to 1) contribute additional data and information; 2) assist in interpreting data and information; and 3) participate in the priority setting process.

Each RAC Director ensures that the Community Needs Assessment Workgroup comprises diverse community stakeholders, including youth; parents; school personnel; staff from youth-serving organizations; researchers; local government officials; healthcare professionals, nonprofit agency staff; and representatives from the business community, law enforcement, faith community, and prevention coalitions. Sub-populations (i.e., those of various racial/ethnic, sexual orientation, gender, language, disability, and culture) and members of historically underrepresented populations are also represented.

The priority setting process involves the following tasks:

1. Compile subregional sociodemographic and indicator data using data provided by the SEOW and additional community-level data and information, such as student survey focus group results;
2. Produce eight one-page subregional epidemiological profiles describing magnitude, impact, and response capacity;
3. Convene their Community Needs Assessment Workgroups to conduct the priority ranking process; and
4. Prepare and submit the Subregional Prevention Priority Report, which includes three sections: (a) Executive Summary of the findings of the assessment process; (b) Subregional Epidemiological Profiles; and, (c) Indicator Data Tables.

The report and accompanying data are used as a building block for state and community-level processes, including capacity and readiness building, strategic planning, implementation of evidence-based programs and strategies, and evaluation of efforts to reduce substance abuse and promote mental health. In addition, these data will form the core of each RAC's data repository. In this role, RACs publicize the availability of town level data on various indicators, engage other organizations (especially schools) in gathering and sharing data, and will inform the community about various indicators via brief reports in newsletters, on websites, etc. At the state level, the report is one of several resources used to inform the development and procurement of SABG prevention services through competitive bidding processes every five years.

**3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?**

On July 1, 2015, a Training and Technical Assistance Service Center (TTASC) will be funded to provide targeted training and technical assistance for substance abuse prevention efforts. The TTASC will replace workforce development activities formerly provided by the DMHAS Prevention Training Collaborative. The services to be provided include workforce development training and technical assistance and cultural competence training and technical assistance. Training will include the provision of information in curricular format. This will include training on the Strategic Prevention Framework, transfer and application of prevention research findings, cultural competence, and topics associated with prevention certification for the prevention workforce as identified in a Needs Assessment and subsequent Workforce Development and Training Plan. Technical Assistance (TA) will include more formalized assistance/consultation meetings of multiple prevention service providers as well as individualized assistance/consultation to providers in the areas of coalition building; evidence-based practices, policies and programs; and other areas as approved by the DMHAS Prevention and Health Promotion Unit. It is estimated that approximately forty (40) percent of the labor hours will be training and the remaining sixty (60) percent will be provision of technical assistance to prevention services providers and coalitions.

**4. Please describe if the state has:**

**a. A statewide licensing or certification program for the substance abuse prevention workforce;**

Certification for Prevention Professionals is offered through the CT Certification Board, an independent entity and member of the ICRC which promotes uniform professional standards and quality for the prevention and substance abuse counseling professions.

**b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and**

See TTASC Description above.

**c. A formal mechanism to assess community readiness to implement prevention strategies.**

Every two years, a Community Readiness Survey is completed. A joint collaboration between the Connecticut Department of Mental Health and Addiction Services (DMHAS), the Regional Action Councils (RACs), the University Of Connecticut School Of Medicine, Wheeler Clinic and the Connecticut Clearinghouse; the survey

assesses each Connecticut town and city's readiness to prevent substance abuse problems among youth and adults by surveying selected community experts and key informants.

The information gathered generates a prevention community readiness profile for cities and towns within Connecticut. The profiles are made available to members of each town represented and the data helps RAC Directors and DMHAS to support future substance abuse prevention planning, program development and funding decisions. Data has also been used in the past to obtain additional funding and resources.

RACs identify key respondents that know their communities and represent important groups in each community. CT Clearinghouse emails the Community Readiness Survey or a paper copy to respondents, and sends a reminder of the survey about 2 weeks after the initial launch. The survey closes approximately 1.5 months after launch whereupon the data is analyzed and disseminated by University of Connecticut Health Center.

**5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?**

Data on substance use consumption patterns, consequences of use, and risk and protective factors is used to make decisions about the allocation of SABG primary prevention funds as described in *Question 2* above.

**6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.**

Below are descriptions of CT strategic plans developed in the last five years that help to inform the allocation of SABG funds for prevention:

*Connecticut SPE 5-Year Strategic Prevention Plan 2012-2016.* This 5-year plan was completed by a consortium comprised of diverse partners from state agencies, Tribal Nations and youth serving agencies. The plan provides a framework to advance multi-partner prevention and health promotion efforts at the state, regional and local levels by improving the statewide ATOD prevention infrastructure. The plan objectives closely align with SAMHSA's Initiative #1: Preventing Substance Abuse and Mental Illness. The plan has 4 objectives: 1) Improve ATOD prevention data collection, analysis and reporting; 2) Collaborate and coordinate efforts across multiple sectors to implement ATOD prevention programming across identified priorities; 3) Maximize the ATOD training and capacity building infrastructure; and, 4) Monitor and evaluate ATOD prevention program performance.

Achieving the plan objectives will result in Connecticut reaching or exceeding benchmarks on ATOD prevention indicators such as: increasing the age of onset for tobacco use; reducing excessive alcohol use (i.e., binge drinking); and reducing ATOD health disparities.

*Live Healthy Connecticut: A Coordinated Chronic Disease Prevention and Health Promotion Plan. April 2014.* This plan identifies ambitious, achievable and measurable objectives in each of 12 priority areas that address chronic

disease with a focus on promoting health equity. The plan addresses root causes and shared risk factors across diseases, and defines strategies for a comprehensive proactive approach in modifying chronic disease risk factors. The 12 priority areas include: Health Equity; Nutrition and Physical Activity; Obesity; Tobacco; Heart Health; Cancer; Diabetes; Asthma; Oral Health; Genomics and Health; Health Care Quality; and Health Care Access.

A comprehensive set of indicators track progress in each of these priority areas. The plan also establishes specific five-year targets to promote accountability and engage partners around common objectives.

Connecticut Safe Schools / Healthy Students Comprehensive Plan. September 2014. This plan was developed by the state substance abuse, mental health, juvenile justice, and education agencies in partnership with three local education agencies (LEAs) to address five elements of the federal initiative:

1. Promoting early childhood social and emotional learning and development
2. Promoting mental, emotional, and behavioral health
3. Connecting families, schools, and communities
4. Preventing behavioral health problems, including substance use
5. Creating safe and violence-free schools

The plan will: improve collaboration across all children, youth and family serving organizations; implement evidence-based programs that reduce school violence and substance abuse and promote health; and, promote wide scale adoption of the SS/HS framework. The SS/HS mission continues to be supporting school and community partnerships in their efforts to develop and coordinate integrated systems that create safe, drug-free, and respectful environments for learning and to promote the behavioral health of children and youth.

**7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

The Training and Technical Assistance Workgroup of the Training and Technical Assistance Service Center (TTASC) planned for July 1, 2015 will be required to establish an Evidence-Based Program Workgroup (EBPW) to operationalize CSAP's 2009 guidance document in identifying and selecting evidence-based interventions for prevention service providers. Representatives on this workgroup will include content experts in prevention science, data collection and evaluation, state agencies with prevention resources (to ensure maximum coordination of prevention activities across the state), as well as community program providers. When necessary, focus groups will be conducted with community members for feedback and guidance on products, policies and practices of the workgroup. The group's responsibilities will 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. EBPW members will be trained by the CAPT on the SPF, the state's substance abuse priorities, community logic models and applying the SAMHSA guidance document. The EBPW will evaluate prevention interventions submitted for

funding and approve or suggest changes. The EBPW will work across state agency funded programs that implement substance abuse prevention strategies to ensure coordination with all state substance abuse prevention and mental health promotion plans. The EBPW will also make recommendations for SAMHSA’s Service to Science program.

**8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.**

The table below reflects the SABG-funded programs, practices and strategies currently implemented in communities across the state. These PPS are implemented by funded providers and are identified via required logic models that detail the goals, objectives, and activities each community will undertake with SABG funds. DMHAS will continue to require the use of logic models to inform the prevention interventions to be funded.

Strategies	Program/Practice (Service Activity)
Information Dissemination	<ul style="list-style-type: none"> <li>• Media campaigns</li> <li>• Brochures</li> <li>• Health fairs and other health promotion, e.g., conferences, meetings, seminars</li> <li>• Speaking engagements</li> <li>• Radio and TV public service announcements</li> <li>• Curriculum Disseminated</li> </ul>
Education	<ul style="list-style-type: none"> <li>• Peer leader/helper programs</li> <li>• Ongoing classroom and/or small group sessions</li> <li>• Ongoing classroom and/or small group sessions</li> <li>• Peer leader/helper programs</li> <li>• Parenting and family management</li> </ul>
Alternatives	<ul style="list-style-type: none"> <li>• Drug free dances and parties</li> <li>• Youth/adult leadership activities</li> <li>• Community service activities</li> <li>• Community drop-in centers</li> <li>• Youth/adult leadership activities</li> <li>• Community service activities</li> </ul>
Problem Identification and Referral	<ul style="list-style-type: none"> <li>• Student Assistance Programs</li> </ul>
Community-Based Process	<ul style="list-style-type: none"> <li>• Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training</li> <li>• Community team-building</li> <li>• Technical Assistance</li> <li>• Multi-agency coordination and collaboration/coalition</li> <li>• Accessing services and funding</li> </ul>

	<ul style="list-style-type: none"> <li>• Monitoring and Evaluation</li> <li>• Systematic planning</li> <li>• Technical Assistance</li> <li>• Accessing services and funding</li> <li>• Systematic planning</li> </ul>
Environmental	<ul style="list-style-type: none"> <li>• Environmental Consultation to Communities</li> <li>• Promoting the establishment, enforcement and/or review of alcohol, tobacco, and drug use laws and policies in schools and communities</li> <li>• Consultation to Communities</li> <li>• Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs</li> <li>• Public Policy Efforts</li> <li>• Consultation to Communities</li> </ul>

**9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?**

DMHAS requires that prospective SABG grantees clearly describe any service needs and gaps consistent with the RACs assessment contained in the aforementioned Subregional Prevention Priority Report. DMHAS also requires that SABG grantees clearly demonstrate their capacity and experience to address the needs and gaps. DMHAS takes steps to ensure geographic coverage of prevention services across the state and that high need communities have resources to address their needs.

**10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state’s prevention system?**

Process data are collected to assess program progress and accomplishments, challenges encountered and technical assistance needed. Corrective action plans are initiated for programs that fail to demonstrate adequate progress. The following process data are collected:

- Substances/problems addressed by funds
- Number of people served by IOM category, six strategies, demographic group and targeted population
- Number, type and duration of evidence-based interventions implemented, by prevention strategies
- Short term outcomes
- The number and percentage Evidence-based programs, practices and policies
- Population demographics: ethnicity, race, gender, age group
- Risk and protective factors addressed
- Geographic service area

**11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state’s prevention system?**

Program and population outcomes will be collected electronically via the Impact Prevention Data Collection System. Outcome data from SABG-funded programs will be used to assess the prevention system’s capacity to address: 1) substance abuse problems; 2) any reductions in alcohol, tobacco, prescription drugs and other substance behavior, attitudes and consequences; 3) contextual factors (e.g. demographic, geographic, and cultural) that may have affected the outcomes; 4) variations in achieving the statewide performance targets; and 5) whether the outcomes were cost beneficial, durable or sustainable.

Following are among the outcome data that will be collected by the electronic data system

- A reduction in past month alcohol use drinking among 12-20 year-olds as measured by local student surveys.
- A reduction in cigarette and other tobacco use rates among 12-17 year-olds as measured by local student surveys.
- Increased enforcement of alcohol, tobacco and other drug laws.
- A reduction in access to alcohol, tobacco and illegal drugs by minors as measured by the Synar survey.
- A reduction in prescription drug and illicit opioid misuse and abuse in 12-25 year-olds as measured by treatment admissions, decreased criminal justice involvement and self-report surveys.

# Environmental Factors and Plan

## 10. Quality Improvement Plan

Narrative Question:

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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.

*In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.*

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

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

# State of Connecticut Department of Mental Health and Addiction Services Continuous Quality Improvement Plan

## 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 (over 18 years of age) 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 105,000 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 will develop a Quality Council comprised of senior representatives of the Department's major Departments or Divisions in FY 16. Membership will also include provider representatives as well. The Council members will likely include 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 monthly 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 do not 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 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 – DMAHS 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.

### **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.

### **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). Each service type or level of care has performance measures that are Providers that are contracted to provide the

same service type are held to the same 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 and are routinely shared with providers and DMHAS monitoring or fiscal staff. 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.
- Annual System Report Card – DMHAS will develop a system-wide report card in FY 2016, with implementation beginning in FY 17. The report card will minimally include performance on measures related to Access, Consumer Satisfaction, Utilization, Treatment Completion, Readmission and Follow-up Care, and National Outcome Measures (NOMS) like stable housing, employment, abstinence, and improved functioning. The System Report Card will separately show performance for the mental health and substance abuse treatment systems.
- 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. Sample Measures for DMHAS System Report Card (to be designed)**

Individuals will live in stable housing

Individuals will be employed

Individuals will improve or maintain functioning

Residential and inpatient services will be well utilized

Consumers will be satisfied with DMHAS services

Individuals will not be readmitted

Individuals will connect-to-care

Individuals will remain in treatment

Individuals will complete treatment

Individuals in SA programs will have treatment exposures greater than 90 days

## Appendix B. 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	November, 2015
Identify annual QI activities	EQMI	August 1, 2016
Approve QI Plan	Council	September 1, 2016
<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	May 1, 2016
Approve annual QI activity "target"	Council	June 15, 2016
Develop work plan	EQMI	July 15, 2016
Approve work plan	Council	August 1, 2016
Distribute to staff and providers	EQMI	August 15, 2016
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 C. Sample Targeted Annual Quality Improvement Work Plan Opiate 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 approximately and has continued to increase in FY 14 and in FY 15 year-to-date. In addition, after a number of years of declining heroin admissions to substance use programs, admissions have significantly increased in FY 13 and 14. 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. However, many doctors are reluctant to prescribe Narcan to individuals that they are not actually “treating”, fearing that this may be a violation of CT standards of practice. DMHAS providers have also been slow to dispense Narcan as a best practice when they are working with opiate involved clients.

Activity	Responsible Dept.	Completion Date
<b>Provider Education</b>		
Analyze OCME data	EQMI	1/1/2015
Disseminate info re overdose deaths	CSD and EQMI	2/1/2015
Compile info re increased opiate admits	EQMI	3/1/2015
Disseminate to providers	EQMI and CSD	4/1/2015
<b>Narcan Training</b>		
Conduct Narcan training for all state-ops	EQMI	4/1/2015
Conduct Narcan training for meth maint. and detox prog.	EQMI	5/1/2015
Develop training video	Training and Ed.	1/1/2015
Create Narcan resource area on DMHAS website	EQMI	1/1/2015
Disseminate and post video to web	Communications	1/15/2015
Provide training to police and EMS	EQMI	ongoing
Develop pharmacist training	EQMI	8/1/2015
Train pharmacists	EQMI	10/1/2015
Develop pharmacist refresher training	EQMI	1/2016
<b>Legislation</b>		
Submit bill allowing pharmacies to prescribe/dispense Narcan	Leg. Liaison	1/1/2015
Provide testimony to Legislature	Commissioner	3/15/2015
Legislation passed	CT Legislature	7/1/2015
<b>Expand Use of Narcan w/DMHAS Providers</b>		
Develop contract language requiring detox and meth maint. providers to prescribe Narcan for all clients	CSD	5/1/2015

Obtain AG approval	Fiscal	5/15/2015
Educate providers about new requirement	CSD	6/15/2015
Modify contracts	Fiscal/CSD	7/1/2015

## **Children's Plan 10. Quality Improvement Plan**

### 2015 Performance Expectations

- Exit from Juan F. Consent Decree
- Ensure that children reside safely with families whenever possible and appropriate
- Achieve Racial Justice across the DCF system
- Prepare children and adolescents in care for success
- Prepare and support the workforce to meet the needs of children and families

Each DCF regional management team, Central Office division management team, and facility management team has identified its role and contribution to the performance expectations, and has developed a set of operational strategies, with performance measures, to achieve the performance expectations. Performance data is presented to the Commissioner's team by each management team on a quarterly basis, and performance is reviewed, and recommendations for improvement are established.

The Department's plan for improvement is an extension of the implementation of our Strengthening Families Practice Model and Differential Response System. Connecticut's Practice Model is implemented through seven core strategies:

- Family Engagement
- Trauma-Informed Practice
- Family Centered Assessments
- Child and Family Teaming
- Purposeful Visitation
- Effective Case Planning
- Leadership, Management and Supervision

Over the past five years, we have made considerable progress implementing these strategies and positively impacting outcomes for the children and families we serve. In the next four years, we will continue to focus on three goals aimed at continuing to achieve the Department's mission that all children will be healthy, safe, smart and strong.

### **Goal 1: Children will be served in their family of origin whenever possible and appropriate.**

#### **Objectives:**

1. The number of children in foster care will be reduced by 25% through continued implementation of Considered-Removal Team Meetings (CRTM).
2. The in-home service array will be expanded and strengthened to support keeping children with their family of origin.
3. Forty percent of all initial placements and 30% of overall placements will be with relatives and kin.
4. An adequate array of foster home placements is available for children who cannot be placed with their own families.

**Goal 2: Timely permanency will be achieved for all youth who enter care.**

**Objectives:**

1. Children entering care will achieve their permanency goal in a timely manner as measured by entry-cohort reports for reunification, adoption and transfer of guardianship.
2. Permanency Teamings will be implemented to improve the likelihood of permanency for all children and to reduce the use of APPLA by 50%.
3. The number of youth aging out of care without legal or relational permanency will be reduced by 50%.

**GOAL 3: Treatment in congregate care will only be used on a short-term basis, with extensive family involvement in the treatment process.**

**Objectives:**

1. The number of children placed in congregate care settings will be no more than 10% of the population of children in placement.
2. All congregate care settings have extensive family involvement as part of the treatment process.

**Strategic Plan and Use of Results Based Accountability**

The Department continues its work on the ongoing strategic plan, utilizing a Results Based Accountability (RBA) framework. The work continues to be aligned with the CTKids Report Card, as required by Public Act 11-109, and includes the nine overarching strategies.

**Result Statement** - All Connecticut children grow up in stable environments, safe, healthy, and ready for success.

**Population-Level Headline Indicators of Child and Family Well-being**

**Safe**

- Child Fatalities
- Substantiated Reports of Abuse and Neglect
- Emergency Room Visits for Injuries
- Referrals to Juvenile Court for Delinquency
- High School Students missing school because they felt unsafe at school, or traveling to or from school

**Healthy**

- Low Birth Weight
- Childhood Obesity
- Children with Health Insurance

- Children with Thoughts of Suicide

### **Stable**

- Chronic Absenteeism
- Parents Without Full-time Jobs
- Families Spending more than 30% of Income on Housing
- Families Without Enough Money for Food

### **Future Success**

- Kindergarteners Needing Substantial Support
- Third Graders at or Above Grade Level in Reading
- On-Time High School Graduation Rate
- Children Living in Households Below the Federal Poverty Line

### **DCF's Results Statement:**

***“Working together with families and communities for children who are healthy, safe, smart and strong.”***

Since 2011, the Department of Children and Families has undergone a substantial transformation aimed at improving outcomes for the children and families we serve. This transformation is driven by seven cross-cutting themes:

- Implementing strength-based family policy, practice and programs;
- Applying the neuroscience of early childhood and adolescent development;
- Expanding trauma-informed practice and culture;
- Addressing racial inequities in all areas of our practice;
- Building new community and agency partnerships;
- Improving leadership, management, supervision and accountability; and
- Becoming a learning organization.

**In addition to these seven cross-cutting themes, nine overarching strategies have been developed and continue to be utilized.**

- Increase investment in prevention and health promotion
- Apply strength-based, family-centered policy, practice and supports agency-wide
- Develop or expand regional networks of in-home and community services
- Ensure appropriate use of Congregate Care
- Address the needs of specific populations
- Support collaborative partnerships with communities and other state agencies
- Support the public and private sector workforce
- Increase the capacity of DCF to manage ongoing operations *and* change
- Improve revenue maximization and develop reinvestment priorities and methods.

# Environmental Factors and Plan

## 11. Trauma

Narrative Question:

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**Trauma**<sup>75</sup> is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful 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 behavioral health 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, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems<sup>76</sup>. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. 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 behavioral health 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.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.<sup>77</sup> This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>78</sup> paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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75 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.

76 <http://www.samhsa.gov/trauma-violence/types>

77 <http://store.samhsa.gov/product/SMA14-4884>

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## ***11. Trauma – DMHAS Adult Services***

### **1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?**

DMHAS has a requirement of all DMHAS-operated and funded providers to administer both a standardized mental health and a standardized substance use screen upon all admissions. This DMHAS website shows the four screens they can choose from:

<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802>

Both of the available mental health screens on this list include questions about trauma history and trauma-related symptoms the person may be experiencing.

Related to the above screening requirement, providers are expected to provide a comprehensive assessment, informed by the person's screening results, and either provide and/or link to appropriate treatment, including trauma-focused therapy.

### **2. Describe the state's policies that promote the provision of trauma-informed care.**

DMHAS released the following Commissioner's policy on Trauma Services in April 2010:

<http://www.ct.gov/dmhas/lib/dmhas/policies/chapter6.5.pdf>

While not a policy, DMHAS continues to sponsor a Trauma and Gender Practice Improvement Collaborative. Each year DMHAS recruits, through a Request for Qualifications (RFQ) process, a cohort of four agencies to participate in a two year change process designed to help them become more trauma-informed and gender-responsive. Selected agencies receive baseline and follow-up services including:

- Trauma and Gender Fidelity Reviews
- Training
- Consultation
- "Mystery Shopper Walk-through" in which Advocacy Unlimited is contracted to conduct unannounced evaluative intake/admission sessions to assess, from a peer's perspective, how trauma informed and gender responsive the agency's intake process is
- "Report Out days" when the selected programs are convened every 6 months throughout the 2 year change process to "report out" their progress, lessons learned, and challenges; and
- Site visits conducted periodically during the 2-year process by contracted consultants in which real time feedback and a written fidelity review report are provided to the program

### **3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?**

For adults, DMHAS-operated and funded mental health and addiction treatment providers routinely offer the following trauma-specific interventions. Not all providers offer all of these, but most provide at least one of these:

- Seeking Safety,
- Trauma Recovery and Empowerment Model (TREM)
- TREM for men (M-TREM)
- Trauma Adaptive Recovery Group Education and Therapy (TARGET),
- Beyond Trauma
- Eye Movement Desensitization & Reprocessing (EMDR)

The DMHAS website for the Trauma Initiative can be found at:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335292>

**4. Does the state provide training to increase capacity of providers to deliver trauma-specific interventions?**

DMHAS funds the Connecticut Women's Consortium on an annual basis to provide a variety of trauma-specific trainings on models for both women and men. The Consortium website can be found at:

<http://www.womensconsortium.org/>

## **H. Trauma – DCF Children Services**

### **1. Does your state have any policies directing providers to screen clients for a personal history of trauma?**

The majority of community -based services are provided by clinicians at outpatient clinics. These clinics are expected to screen for trauma at the time of intake and to conduct further assessment whenever there are positive trauma screens for any referred child.

Effective July 1<sup>st</sup> 2013 the Department will implement universal trauma screening for all children, ages 4 to 17 who become involved with the agency. A standardized CT Trauma Screen has been developed. If there is a positive trauma screen, a referral to a behavioral health provider is required, using a standardized referral form accompanied by the trauma screen. Providers will also receive training on this screen and may chose to adopt this screen instead of their current practice.

### **2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?**

Yes. Effective July 1<sup>st</sup> all DCF-involved children who have a positive trauma screen will be referred to a community provider that is trained in evidence-based, trauma-specific assessment and treatment.

### **3. Does your state have any policies that promote the provision of trauma-informed care?**

During the past 5 to 7 years the Department has been engaged in various activities to make Connecticut's system of care more trauma-informed, especially the child welfare system and to increase collaboration between child welfare and behavioral health providers of evidence-based trauma-specific treatments. The Department has just developed a soon-to-be released Trauma-Informed Care Practice Guide for all employees. The guide covers what trauma is, how it impacts children and families, treatments for recovery and practical interventions that a child welfare worker can take to lessen the impact and find ways to help children and families heal. Further, relevant child welfare and juvenile justice policies are now being reviewed by a multidisciplinary committee to assure that these policies contain trauma-specific language and trauma-sensitive practices.

Between March and June 2013 all frontline staff will receive a 2-day trauma training, using the updated NCTSN Child Welfare Trauma Training Toolkit and a 1-day training on the Connecticut Trauma Screen and Referral for Behavioral Health Services.

### **4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?**

The provider network offers a variety of trauma-specific treatments. These treatments are not available by every provider, and the do vary across regions of the state.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)  
Child and Family Traumatic Stress Intervention (CFTSI)  
Eye Movement Desensitization and Reprocessing Therapy (EMDR)  
Attachment, Self-Regulation, and Competency (ARC)  
Child Parent Psychotherapy (CPP)  
Parent-Child Interaction Therapy (PCIT)  
Trauma Affect Regulation: Guide for Education and Training (TARGET)

Many residential and day treatment providers utilize the Risking Connection model or Sanctuary model as a trauma-sensitive philosophy and approach to services.

**5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?**

Between 2007 and 2013, through a blending of state and federal funds including MHBG funds the Department has disseminated TF-CBT across 22 community mental health clinics using learning collaboratives based on the Breakthrough Series Collaborative model. An additional 6 clinics will receive the same training through a 9 month learning collaborative during SFY 2014, bringing the total TF-CBT teams to 28 across the state.

Beginning in SFY 2015 DCF, through its vendor/coordinating center - the Child Health and Development Institute 6 agencies will be trained in the Child and Family Traumatic Stress Intervention (CFTSI), developed by Dr. Steve Marans at Yale University. This is a short-term acute trauma intervention following the onset of a traumatic event. During SFY 2016 an additional 6 clinics will receive the same training.

The Department continues to explore funding and strategies for disseminating additional trauma-specific evidence-based treatments. Currently, we are researching the possibility of bringing the ChildSTEPS Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct Disorders.

## Children's Plan 11. Trauma

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 22 clinics in Connecticut with more than 250 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.

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.

DCF has been directing its providers to screen children and youth for a personal history of trauma and to connect them to trauma-focused therapy when needed. The use of trauma screening and assessment is gaining prevalence in Connecticut. The majority of community based treatment services are provided by Outpatient Psychiatric Clinics for Children and DCF funds 26 OPCC providers. The OPCC’s serve children from age 4 through age 18. At present 30 clinics and 318 clinicians have been trained through the Learning Collaborative methodology to provide Trauma Focused Cognitive Behavior Therapy, TF-CBT. Also some clinics have been trained in CFTSI, Child and Family Traumatic Stress Intervention. Connecticut is the fortunate recipient for a five year ACF federal grant that has been used for building a trauma informed child welfare system including workforce development, trauma screening, policy change and improved access to evidenced based trauma focused treatments. Outpatient clinics are expected to screen for trauma at Intake and to conduct further assessment with children and families whenever there are positive indicators for trauma events and symptoms. The data collection and analysis program used by DCF with providers includes several questions about traumatic events.

This year, 2015, DCF has embedded trauma screening in the MDE, Multidisciplinary Evaluations that all children receive when they are removed. All children birth through age 17 are screened and recommendations are made for further trauma appropriate assessment and treatment. Through the trauma grant, Connecticut in conjunction with CHDI and Yale University have developed a Connecticut Trauma Screen that has four questions for trauma events and six questions for stress reactions. This tool is being validated for eventual expansion in the Child Welfare arena as well as clinical service array. When the new SACWIS is implemented in 2017 the trauma screen will be incorporated into SACWIS for use based on policy and practice guidelines.

Finally in the Milford Area Office there is a pilot program for a cohort of 120 children in placement prior to the use of the trauma screen in the MDE. These children are screened for further assessment and treatment, the results are being captured in case planning and screening is repeated as needed.

All policy and practice guides are vetted through the CONCEPT (ACF federal grant) trauma policy review work-group so trauma concepts, best practice and language is included in all relevant policy. This is an ongoing process that has been in place for three years and the group has reviewed multiple policies and practice guides, made recommendations for inclusion of trauma informed practice which have been successfully integrated into the policy and practice prior to dissemination.

DCF also has a trauma guide available to all staff. As a state department, DCF has core organizational cross cutting themes that complement the Strengthening Families Case Practice Model. One of the Cross Cutting Themes is "expanding trauma informed practice and culture". All staff have been trained in the NCTSN Child Welfare Training Toolkit to improve knowledge about trauma and promote trauma informed practice. This toolkit training is part of pre service for all new hires as well. Finally through the federal grant there is an ongoing comprehensive assessment of system readiness and capacity to deliver trauma informed care.

Trauma screening, assessment and treatment is family based and includes caregivers and parents. Parents are asked about their traumatic life experiences and social histories as part of an ongoing assessment. Early childhood well-being and infant mental health require parental participation and inclusion with psych-educational and clinical interventions. The state has an array of services that deliver services to children and families with sensitivity to trauma and the connections with the domains of well-being. Caregivers and parents are referred for appropriate trauma interventions once assessed for the need and included in family based treatment models for trauma interventions with their children. The PRAC elements for intervention, psych education, relaxation, affective regulation and cognitive coping are used to support and build protective factors including, nurturing, parental resilience and social connections. Connecticut is aware of the impact of trauma for victims of domestic violence and intimate partner violence, including the need to engage fathers in a trauma informed approach.

Connecticut is providing trainings to increase the capacity of service providers to deliver trauma-specific interventions. The state is currently disseminating CBITS, an evidenced based trauma intervention through state funding and with some funding from the MGBH. DCF is also expanding MATCH across the state with the first of a three year implementation process for up to 18 provider agencies to train their clinicians in the MATCH model. MATCH currently has 4 provider agencies participating in year 2 of an RCT with the Harvard University. Currently DCF is working on embedding trauma screening into the PIE data reporting system. DCF is also in the process of validating the CT trauma screen.

In May of this year DCF funded the 7th annual TF-CBT conference and offered some 28 workshops to the provider community and CEU's. DCF funds a center of excellence for TF-CBT and is adding CBITS and MATCH to the Evidenced Based Practice Tracker (EBP Tracker) used in the center for excellence. This center monitors the number of children served, the quality of the service fidelity and clinical outcomes through specific measures. The center is expanding TF-CBT to the JJ system, is now in year 2 of this effort with TF-CBT.

The center credentials agencies and clinicians for TF-CBT, provides consultation calls, agency performance incentives and ongoing benchmarks. As of February 2015 there were 752 active children and families receiving TF-CBT services, an increase from the year before of 565 children and families being served.

The provider network offers a variety of trauma-specific treatments. These treatments are not available by every provider, and they do vary across regions of the state.

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Child and Family Traumatic Stress Intervention (CFTSI)
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Attachment, Self-Regulation, and Competency (ARC)
- Child Parent Psychotherapy (CPP)
- Parent-Child Interaction Therapy (PCIT)
- Trauma Affect Regulation: Guide for Education and Training (TARGET)

Many residential and day treatment providers utilize the Risking Connection model or Sanctuary model as a trauma-sensitive philosophy and approach to services.

# Environmental Factors and Plan

## 12. Criminal and Juvenile Justice

Narrative Question:

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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 substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>79</sup>

The SABG and MHBG 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. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>80 81</sup> Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths 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>82</sup>

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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 mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

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<sup>79</sup> <http://csqjusticecenter.org/mental-health/>

<sup>80</sup> The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

<sup>81</sup> A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

<sup>82</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 Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## ***12. Criminal and Juvenile Justice***

Connecticut eliminated county governments decades ago and there are no county or local government operated courts, prosecutors, public defenders, jails, prisons, and probation or parole agencies. These criminal justice functions are funded and administered at the state level. Law enforcement is operated by local police and state police; Connecticut does not have sheriffs.

The Department of Correction (DOC) operates all jails, prisons, and Adult Parole. The Bail Commission and Probation are administered by the Court Support Services Division (CSSD) of the Judicial Branch.

### **1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?**

The Judicial Branch's Court Support Services Division (JB-CSSD) has a Memorandum of Agreement in place with the Department of Social Services (State Medicaid Authority) to expedite Medicaid eligibility for individuals who are under adult probation supervision. In addition, JB-CSSD Bail Commissioners who conduct Jail Re-interview services in the Department of Correction also complete expedited Medicaid eligibility screening for pretrial defendants in jail who are being recommended for release and will be participating in substance abuse and mental health services in the community.

In 2013 the National Institute of Corrections (NIC) chose the CT DOC as its pilot site for studying the interaction between the new healthcare reforms and other state systems. NIC provided technical assistance for DOC, DMHAS, the Judicial Branch, DSS, other state agencies and private provider agencies to map the criminal justice process and identify opportunities and strategies to maximize enrollment in Medicaid. This process is continuing.

DOC and DMHAS fund five enrollment specialists who are employed by DSS to spend all of their time processing Medicaid applications for adults in DOC jails and prisons prior to release. The applications target sentenced inmates and jail detainees with mental illness and/or substance use disorders and/or serious medical conditions.

### **2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

#### **Pre-Booking**

#### **DMHAS Crisis Intervention Team (CIT)**

CIT is a pre-booking 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.

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.

CIT clinicians in seven LMHA sites collaborate with CIT-trained police officers in 15 local departments. As of 12/31/14 over 1,750 police officers in 96 municipal, state, federal, and other public safety agencies in CT have attended CIT training as well as 400 others that include mental health staff, probation officers, parole officers, correctional officers, EMS staff, etc. Nearly 50 police departments have an official CIT policy. Of the 1,750 trained police officers about 1,550 were trained with DMHAS funds (including federal grant funds 2004-2007).

### **Post-Booking**

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 mental health jail diversion programming in all criminal courts.

### **DMHAS Jail Diversion Program and Specialty Jail Diversion Programs**

The DMHAS court-based Jail Diversion (JD) program, initiated in the mid 1990s and expanded statewide in 2001, connects defendants with serious mental illness to community services in lieu of incarceration at arraignment. In SFY14 there were 36,111 defendants in custody at the time of arraignment. The JD program conducted clinical screenings at court for 2,752 defendants; 2,238 (80%) were in custody and the court diverted 1,356 (61% of those in custody). Approximately 2/3 of the screened individuals were known to have a serious mental illness. The remaining 1/3 have a lesser or no mental illness. A large majority of all JD clients, with or without mental illness have a substance use disorder. DMHAS also operates specialty jail diversion programs in several of the higher volume courts to serve specific populations including women with significant trauma related needs, persons with addictions, persons who need immediate detoxification services, and veterans. These specialty programs served an additional 547 defendants, of whom 431 were diverted into the programs.

**3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?**

DMHAS implemented all programs for criminal justice involved persons in collaboration with Courts, DOC (jails and prisons), Probation, Parole, Board of Pardons and Paroles and continues to operate the programs with these collaborations. DMHAS is a member of the state Criminal Justice Policy Advisory Commission (CJPAC) which brings together the Judicial Branch and all relevant Executive Branch agencies to develop policy and coordinate activities. DMHAS participates in multiple standing and ad hoc state level committees and commissions that address criminal justice policy and programming.

While DMHAS does not provide behavioral health services in correctional facilities, DMHAS coordinates with DOC for discharge of all sentenced inmates with serious mental illness and has multiple programs that collaborate with DOC for continuity of care for other accused and sentenced inmates with other behavioral health needs. 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 for inmates with mental illness.

DMHAS, DOC, and the Court Support Services Division (Bail and Probation) of the Judicial Branch collaboratively implemented, fund, and manage the ASIST program that serves diverted court defendants, probationers, and parolees to avoid or reduce incarceration and reduce recidivism.

The DMHAS Division of Forensic Services manages the following community programs for adults where a close collaboration between the DMHAS service system and the criminal justice system is needed to maximize diversion and successful re-entry

- Crisis Intervention Teams (CIT)
  - Described in #2 above
- Jail Diversion/Court Liaison Program (JD; statewide)
  - Clinicians in all 20 arraignment courts screen adult defendants with mental illness, most with SMI, many with COD, and can offer community treatment option in lieu of jail while case proceeds through court process. JD makes referral for services, monitor compliance, report compliance to court.
- Woman's Jail Diversion (JDW; NBritain, Bristol, NHaven)

- Offers full services to women with trauma sequelae, most with substance abuse, at risk of incarceration – mostly pretrial, some on parole/probation at risk of violation. Services include clinical, medication, community support, limited temporary housing, client supports.
- Jail Diversion Veterans (JDVets; Norwich, New London, Danielson, Middletown)
  - Targets veterans of the wars in Iraq and Afghanistan as well as older veterans and those active in them military who have current criminal charges. Can offer community treatment option in lieu of jail while case proceeds through court process. Refer clients for clinical services and specialized veteran’s services, monitor compliance, report compliance to court. Expanding to provide statewide consultation to JD staff.
- Jail Diversion Substance Abuse (JDSA; Hartford)
  - Targets adults with substance dependence who need immediate admission to residential detox and/or intensive residential treatment on day of arraignment or rapid admission to IOP. Includes intensive case management, sober house rent, other transitional housing options, client supports, monitor compliance, and report compliance to court.
- Alternative Drug Intervention (ADI; NHaven)
  - Offers full services to pretrial defendants with substance dependence in New Haven court (mostly men; women go into the JD Women’s program). Services include clinical, medication, case management, client supports.
- Pretrial Intervention Program (PTIP; statewide)
  - Per state statute, 1) evaluations for placement recommendation for “first-offender” DUI and drug possession and 2) Alcohol Education groups, Drug Education groups, or referral to substance abuse treatment program.
- 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 people are admitted to CORP.
- Connecticut Offender Re-entry Program (CORP; 5 sites; 4 prisons)
  - Pre-release (6-18 months) engagement, discharge planning, and twice weekly skills groups in DOC by LMHA staff for sentenced inmates with SMI. Post-release support, temporary housing, client supports.
- Transitional Case Management (TCM; 4 sites; 5 prisons)
  - Pre-release (3-4 months) engagement and discharge planning in DOC by PNPs and post-release OP sub abuse treatment, case management, temporary housing for sentenced men with substance dependence.
- Community Recovery Engagement Support and Treatment (CREST; NHaven)

- Day reporting center for adults with SMI under court/probation/parole/PSRB supervision. Includes case management and skills groups. Clinical services by the LMHA.
- Sierra Center Pretrial Transitional Residential Program (NHaven)
  - 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. LMHA provides clinical services and case management. Most clients also attend CREST.
- Advanced Supervision and Intervention Support Team (ASIST; 9 sites)
  - Combines AIC supervision with clinical support (LMHAs and PNPs) and case management for adults with moderate-serious MI under court/probation/parole supervision. Collaboratively funded/managed by DMHAS, CSSD, DOC. Some temporary housing and client supports.
- Forensic Supportive Housing (FSH; 3 sites)
  - 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. Includes temporary housing, temporary rental assistance before RAP is granted, client supports.
- Connecticut Community for Addiction Recovery (CCAR)
  - DFS funds CCAR activities targeting persons with criminal justice involvement. CCAR staff provide outreach to probation and parole offices and to jails and prisons as well as CJ-specific programming at their centers.
- Forensic Housing Assistance Fund (FHAF)
  - FHAF uses funds in the Housing Assistance Fund (HAF) that are allocated for clients of DFS programs.
  - FHAF provides temporary funds to help clients with serious mental illness secure permanent housing prior to receipt of a permanent rental subsidy.
  - FHAF subsidize 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 Department of Children and Families (DCF) is responsible for both juvenile justice and public sector mental health treatment needs of children and youth.

**4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?**

DMHAS provides trainings to behavioral health providers and criminal justice personnel in multiple formal and informal venues.

The DMHAS Division of Education and Training offers trainings on working with criminal justice agencies and criminal justice clients. These trainings are open to DMHAS and private agency behavioral health staff. Criminal justice staff have also attended some of these trainings. DMHAS assisted the CSSD Office of Adult Probation and the DOC Office of Parole in developing and training their specialized mental health units and will be training Adult Probation staff working with probationers who have Autism Spectrum disorders. Probation and parole officers assisted DMHAS in developing Commissioner' Policy Statement Chapter 6.7 DMHAS Staff Interaction with the Criminal Justice System: Probation and Parole, implemented on 6/15/11.

The DMHAS CIT program, described in #2, includes police officers and local providers in the 5-day, 40-hour CIT training and focuses on developing a collaborative relationship. The CIT training also include probation officers, parole officers, and DOC correctional officers. DMAHS has provided formal and informal training to court staff on mental illness, trauma, veterans' issues, gender-specific programming, and addictions.

## **Children's Plan 12. Criminal and Juvenile Justice**

Upon delinquency commitment and initial placement youth are enrolled in Medicaid. When released to the community it is expected the parents' insurance, if any, will become primary. They remain on Medicaid through commitment. Prior to commitment end, parents are encouraged to maintain enrollment.

Youth with mental and/or substance use disorders are provided screening and services prior to adjudication and/or sentencing. Youth referred to Superior Court for Juvenile Matters may be diverted to Child and Youth Family Support Center for services. In addition to the Juvenile Justice Intermediate Evaluation, screenings are done by detention and probation staff for cases being handled judicially. There is a concerted effort to complete a thorough assessment of the identified youth to determine the nature and extent of issues including any mental health or substance abuse problems. Whenever community-based services are appropriate and can be accessed by the youth and family, these referrals are made, provided there are no safety or other risk factors. Community based services may be provided and those providers may conduct additional screening. The below chart explains what evaluations occur and at what point:

**Comprehensive Review of Screening/Assessment Tools**

<b>AGENCY</b>	<b>ASSESSMENT</b>	<b>WHO IS ASSESSED?</b>	<b>WHEN ASSESSED?</b>	<b>INCLUDES:</b>	<b>RESULT</b>
CSSD- Juvenile Residential Services- Detention and CSSD- Juvenile Probation	Massachusetts Youth Screening Instrument (MAYSI –2)	All individuals in detention and All court cases	Upon admission and post- adjudication, conviction, plea agreement, or an SOR has been signed.	Depression/Anxiety, Substance Use, Somatic complaints, Suicide Ideation, Thought Disturbance (boys), Traumatic Experiences	A mental health screening instrument used by juvenile detention and probation officers to screen for and triage children with potential mental/emotional disturbance or distress and suicide monitoring.
CSSD- Juvenile Residential Services- Detention	Suicide Ideation Questionnaire -(SIQ)/Suicide Ideation Questionnaire JR-(SIQ-JR)	All individuals in detention	Upon Admission	Suicide Ideation	Utilized in the decision on suicide monitoring of the juvenile.
CSSD- Juvenile Residential Services- Detention	CRAFFT	All individuals in detention	Upon Admission	Substance Use	Used to determine the need for the completion of the PESQ
CSSD- Juvenile Residential Services- Detention	Personal Experience Substance Use Questionnaire (PESQ)	All individuals in detention- When indicated	Upon Admission if warranted by the results of the CRAFFT	Substance Use	Utilized to determine the juvenile’s need for MI/CBT substance use work with the LCSW.

**Comprehensive Review of Screening/Assessment Tools**

AGENCY	ASSESSMENT	WHO IS ASSESSED?	WHEN ASSESSED?	INCLUDES:	RESULT
<p><b>CSSD- Juvenile Probation</b></p>	<p><b>Court-based Mental Health Evaluations (i.e. psychological, psychiatric, competency, substance abuse, sex offender, Solnit 30-day Inpatient, or Juvenile Justice Intermediate Evaluation)</b></p>	<p><b>To determine the mental health needs of court- involved youth.</b></p>	<p><b>Mental health assessments may be obtained if written permission has been given by the child’s parent or legal guardian, or the child’s guardian ad litem, in lieu of the parent, and also by the child’s attorney if the child is denying the complaint; and/or upon Judicial order</b></p>	<p><b>The Clinical Coordinator will provide guidance and consultation regarding mental health evaluation needs.</b></p>	<p><b>Considerations:</b></p> <p><b>Diagnoses and recommendations of any prior psychological and/or Psychiatric evaluations.</b></p> <p><b>The degree/volatility of the child’s precipitating behaviors resulting in the child being mandated to Court.</b></p> <p><b>The risk/degree of the juvenile’s self- injurious behavior.</b></p> <p><b>The need to have an assessment of the threat the juvenile poses to the community and/or family.</b></p> <p><b>The possible need for residential placement.</b></p>

DCF collaborates with other state agencies in the diversion of youth with mental and/or substance use disorders from entering the criminal and juvenile justice systems. One such initiative The Connecticut School-Based Diversion Initiative (SBDI) is a school-level intervention designed to prevent youth from entering the juvenile justice system by helping schools meet the following goals:

- Enhance knowledge and skill development among key school professionals relating to children's mental health and juvenile justice
- Reduce use of in school arrests, out-of-school suspensions, and other exclusionary disciplines practices
- Increase utilization of school-and community –based mental health services and supports

The SBDI initiative is funded and overseen jointly by the Connecticut Judicial Branch, DCF, State Department of Education, and Department of Mental Health and Addiction Services.

DCF collaborates with other state agencies in providing cross-trainings for behavioral health providers to increase their capacity for working with youth with behavioral health issues who are involved in the juvenile justice system. The Local Implementation Service Teams serve as a resource/clearinghouse for information about trainings. Providers attend CSSD's training academy for contracted providers and can access trainings when space permits. DCF has encouraged cross training in the Family Conferencing model.

# Environmental Factors and Plan

## 13. State Parity Efforts

Narrative Question:

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MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.<sup>83</sup>

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.<sup>84</sup>

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 behavioral health 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. 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. SMHAs and SSAs should collaborate with their state's 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

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<sup>83</sup> <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

<sup>84</sup> Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 1617 Narrative 13 State Parity Efforts

### 1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

Before MHPAEA, Connecticut enacted its own mental health parity law effective January 1, 2000. Within the state, it is the Connecticut Insurance Department (CID) that provides oversight of mental health parity for the commercial insurance market. CID is a state agency statutorily required to regulate the insurance industry. CID issues an annual Consumer Report Card designed to help consumers compare plans in terms of customer satisfaction and benefits usage.

CID has been proactive in ensuring compliance with mental health parity and has developed a robust process of regulation. Connecticut law requests methodology for monitoring carrier compliance with MHPAEA and for monitoring mental health parity compliance under state insurance laws. The Report on Mental Health Parity and Commercial Health Insurance Compliance provides details on CID's regulatory and education approaches related to insurer reimbursement for mental health services in the state.

The State of Connecticut website has information for consumers about MHPAEA at: <http://ct.gov/cid/cwp/view.asp?a=4222&Q=536944>.

Connecticut's Medicaid program, which serves the medically indigent, already has general parity in terms of coverage for mental health services.

The Office of the Healthcare Advocate (OHA) is funded through an assessment on insurance plans sold in the state and situated within CID for administrative purposes only, meaning OHA is completely of CID, but they provide administrative support. The OHA mission is to assist consumers with healthcare issues through the establishment of effective outreach programs and development of communications related to consumer rights and responsibilities as members of healthcare plans, including parity. The OHA website at: <http://www.ct.gov/oha/cwp/view.asp?a=4363&q=519026> has links to information on federal and state parity laws for consumer, employers, and providers.

### 2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

Yes, there are multiple ongoing consumer outreach efforts that incorporate both public and private stakeholders with frequent collaboration.

### 3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related parity laws and to provide technical assistance as needed?

Most of the coordination is among state entities to directly address this issue with insurers. However, private entities/advocates play a key role in identifying and tracking issues and helping to communicate the message about any perceived compliance concerns.

Efforts are underway to coordinate messaging and distribute materials to help explain MHPAEA, including at the national level.

### **Children's Plan 13. State Parity Efforts**

The Department currently utilizes some of the block grant funds to educate and raise awareness about the issue of suicide prevention and treatment resources. Additional funds would be necessary to implement a statewide campaign to educate about the general issue of mental health parity.

DCF has formed a collaboration with the Office of Healthcare Advocate (OHA) to identify gaps in mental health coverage for youth in Connecticut regardless of their insurance coverage. The collaboration has led to work on identifying gaps in mental health coverage for commercially-insured youth versus state-involved youth. DCF is committed to their collaboration with OHA to ensure that all youth regardless insurance status, private, public or otherwise, are afforded the same spectrum of mental health services necessary and allowed under mental health parity. This year the legislature passed a law requiring a higher level of scrutiny of private payers who were regularly denying "medically necessary" treatment for higher levels of care (residential, substance abuse, eating disorder treatment, etc.).

A well-funded, coordinated and broader multi-state agency, public and private partnership would advance awareness and understanding about benefits. The state continues to enhance its existing partnerships such as the CT BHP and joint interagency agreements to further disseminate information about services, benefits, costs, etc. Also, the Department utilizes the services of family advocates, peer specialists and regional family engagement specialists to disseminate information to specific populations.

# OFFICE OF MULTICULTURAL HEALTHCARE EQUALITY\*

## THREE YEAR STRATEGIC PLAN

\* Focus is on SAMHSA TARGET POPULATIONS (SEE LIST)

- SAMHSA TARGET POPULATIONS:**
- ◆ American Indian/Alaska Native
  - ◆ Asian American/Native Hawaiian/Pacific Islander
  - ◆ Black/African American
  - ◆ Hispanic/Latino
  - ◆ Lesbian, Gay, Bisexual & Transgender (LBGT)

Objective	Activities	Person Responsible	Time Frame	Comment/Status
<p>1) Infuse multiculturalism in services funded or delivered by DMHAS</p>	<p>Admin: DMHAS to adopt and implement the revised CLAS standards. Reconcile DMHAS standards w/CLAS</p> <p>Continue building awareness of multiculturalism through educational programs and events</p> <p>Review/revise contract language to strengthen multiculturalism as a DMHAS service system foundation.</p> <p>Ensure inclusion of multiculturalism in DMHAS sponsored peer training programs.</p> <p>System: State Operated (SO) facilities, LMHAs, and identified multi-service funded agencies complete Institutional Assessments re cultural competency</p> <p>SO facilities appoint a Multicultural Champion for the development and infusion of multiculturalism into services delivered in their facility and the local systems. Invite addiction service providers and PNP LMHAs to appoint MCs and participate in the initiatives and activities. OMHE to hold quarterly meetings of Champions.</p> <p>Develop understanding of Privilege and its affect on multiculturalism within DMHAS service system</p> <p>Ensure inclusion of multiculturalism in all elements of the new Electronic Health Record; in screenings, and comprehensive and risk assessments; in all admission materials; in recovery plans and reviews, and in all elements in clinical and administrative records.</p>	<p>Include Recovery Centers</p>		

Objective	Activities	Person Responsible	Time Frame	Comment/Status
	<p>Services: Delivery of culture specific EBP or Promising Practices for identified populations (SAMHSA identified populations)</p> <p>Regional MCACs: Develop initiative related to Small Acts of Inclusion with each person as the 'messenger'</p> <p>Exercise: Delusions &amp; Illusions</p> <p>Exercise: Small Acts of Inclusion</p>			
<p>2) Data elements collected are appropriate to enable identification and analysis of healthcare equality and disparities for identified populations.</p>	<p>Admin: Collaborate w/EQMI to review data elements specific to SAMSHA identified populations and the DHOH.</p> <p>Ensure inclusion of culture related data elements in all sections of the Electronic Health Record, and in clinical and administrative functions to enable review of health care disparities for identified populations. Collect and analyze data to review and identify health care disparities, and improved provision of multicultural services.</p> <p>Collaborate w/EQMI and CSD to develop reports related to healthcare equality in access, service availability and outcomes for SAMSHA identified populations; ensure development of reports that reflect NOMs and other outcome information by cultural disparities categories, i.e., race, ethnicity, sexual orientation, hearing loss and language capabilities.</p> <p>Collaborate w/EQMI to do a comparative analysis of state and national data in an effort to assess current treatment trends and disparities amongst underserved and diverse populations to facilitate plans to address health disparities in mental health and substance abuse populations with Connecticut.</p> <p>Complete data analysis of inpatient data for comparison to system status in 2005 and community services and to set baseline of healthcare disparities.</p>			

Objective	Activities	Person Responsible	Time Frame	Comment/Status
	<p>System/Services: Collaborate w/ CSD to monitor issues related to cultural competence and multiculturalism.</p> <p>Collaborate w/EQMI and CSD to review issues related to recovery indicators.</p>			
<p>3) Ensure multiculturalism and cultural competency is ingrained in the DMHAS culture through training events and technical assistance</p>	<p>Admin: Provide Multicultural Cohort Training, and conduct analysis re: effectiveness</p> <p>Provide PACCT to develop addiction services staff with understanding of cultural competency and its importance to effective treatment and support, and conduct analysis re: effectiveness</p> <p>Explore development of a PACCT-like program for MH staff</p> <p>Explore infusion of multicultural training in DMHAS funded peer training and certification programs.</p> <p>Provide at least 2 annual trainings related to multicultural competence that offer CEUs or CMEs (collaborate w/UCONN and Yale)</p> <p>Collaborate w/EQMI to ensure DMHAS provider report cards review performance measure at agency and program level across multiple domains, including cultural groups identified by SAMSHA.</p> <p>Collaborate w/EQMI to identify 'culture gaps' in services based on healthcare equality reports and EQMI report cards for each region by identified subpopulations.</p>			
<p>4) Empower and support regional MCACs</p>	<p>Increase participation through outreach, training and TA events. Develop 'Institutes' to develop cultural awareness and understanding of privilege and its effect on discrimination</p> <p>Develop forums for regional sharing of best practices and initiatives.</p>			

**SAMHSA TARGET POPULATIONS:** American Indian/Alaska Native;  
Asian American/Native Hawaiian/Pacific Islander;  
Black/African American  
Hispanic/Latino  
Lesbian, Gay, Bisexual & Transgender (LBGT)

**NOTES:**

# Environmental Factors and Plan

## 14. Medication Assisted Treatment

Narrative Question:

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There is a voluminous literature on the efficacy of FDA-approved medications for 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 medication-assisted treatment of these disorders is described in SAMHSA TIPs 40<sup>85</sup>, 43<sup>86</sup>, 45<sup>87</sup>, and 49<sup>88</sup>. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. 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.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

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

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<sup>85</sup> <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

<sup>86</sup> <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

<sup>87</sup> <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

<sup>88</sup> <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 1617 Narrative 14 MAT

- 1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?**

Connecticut currently has 25 Methadone programs covering each region of the state, although most are located in the higher population centers. The DMHAS website's MAT webpages link to the different programs. Data from the *Behavioral Health Barometer for CT – 2014* demonstrates that the state has increased the number of individuals receiving methadone in Opiate Treatment Programs since 2011. As of 2013, Connecticut had 15,509 persons receiving methadone as part of substance use treatment. The same report found that the number of individuals in Connecticut who received Buprenorphine as part of their substance use treatment likewise increased from 855 in 2011, to 980 in 2013.

In a successful effort to improve coordination and eliminate service gaps related to MAT for Connecticut residents, DMHAS instituted an OTP initiative several years ago whereby clients in substance use treatment programs could be initiated and maintained on methadone while in program and have a slot at a community OTP arranged for them upon discharge.

- 2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?**

All DMHAS women and children's programs allow their clients to participate in MAT. Additionally, through DMHAS prevention efforts and jointly with the Regional Action Councils (RACs), there are videos on a number of topics including methadone (<http://ct.gov/dmhas/cwp/view.asp?a=3749&q=438222>) and the Connecticut Clearinghouse raises awareness about methadone through materials, resources and links (<https://www.ctclearinghouse.org/Topics/topic.asp?TopicID=26>).

- 3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?**

All MAT programs in the state are monitored yearly by DMHAS and specific MAT monitoring tools were created for this purpose. As with all other levels of care, program expectations are specified in the contract and then followed up with monitoring through site visits. Within this level of care, any methadone clinic that wants to open in the state must be signed off by DMHAS. Even methadone clinics that are private and do not receive funding from DMHAS are reviewed by DMHAS for compliance. Some of the MAT programs do have peers within their programs in various capacities. Those DMHAS staff who conduct the monitoring visits have all had experience working in such clinics previously. All MAT programs are required to have diversion plans and this expectation is in the contract language. The Learning Collaborative for MAT does

focus on quality improvement through review of evidence-based practices with a recent emphasis on engagement and retention strategies.

**Children's Plan 14. Medication Assisted Treatment**

Please refer to Adult Services portion of the grant - Substance Abuse Prevention. DCF does not receive any Federal substance abuse block grant funds.

# Environmental Factors and Plan

## 15. Crisis Services

### Narrative Question:

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In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders 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 behavioral health crises.

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 behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)<sup>89</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 behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

#### Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

#### Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

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<sup>89</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>

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Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## **16/17 Narrative 15 Crisis Services**

### **Mobile Crisis**

The Department of Mental Health and Addiction Services (DMHAS) provides mobile emergency crisis services to individuals age eighteen (18) or older. Mobile emergency crisis services are defined as mobile, readily accessible, rapid response, short term services for individuals and families experiencing episodes of acute behavioral health crises. Mobile emergency crisis services are delivered with appropriate safety measures in safe settings such as at the Local Mental Health Authority (LMHA), at any provider with a contract with the Department, at walk-in clinics or in other community settings through the use of mobile emergency crisis teams rather than in a hospital emergency department. 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 and stabilization activities which may include: assessment and evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further care and assistance as required. Mobile emergency crisis services can be provided to an individual following telephone screening when that person is experiencing sudden, incapacitating emotional distress or other symptoms. 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 more than 3 dozen crisis services programs statewide and served a total of 9,849 individuals in state fiscal year (SFY) 2014. The array of crisis services includes mobile crisis, respite care, and Crisis Intervention Teams.

### **Crisis Respite**

Primarily utilized as an adjunct service for DMHAS Mobile Crisis Services, DMHAS provides Crisis Respite Services on a statewide basis. These programs provide a structured community bed setting staffed 24/7 by professional and paraprofessional staff, including a licensed prescriber, to individuals age 18 and older. 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 are used as part of the continuum of care in order to stabilize individuals, avert psychiatric inpatient hospitalization, and return persons to their current residence. There are 9 Crisis Respite Services Programs statewide. In SFY 2014, a total of 671 unduplicated individuals received respite bed services and there were a total of 805 persons admitted to Crisis Respite Services Programs.

Overall within the DMHAS mental health Outpatient level of care system of programs, there were 57,467 clients receiving services in SFY 2014. The majority of clients (68%) were served in mental health outpatient programs and crisis services comprised 28% of those served.

### **Crisis Intervention Team (CIT)**

CIT is a pre-booking 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.

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.

CIT clinicians in seven LMHA sites collaborate with CIT-trained police officers in 15 local departments. As of 12/31/14 over 1,750 police officers in 96 municipal, state, federal, and other public safety agencies in CT have attended CIT training as well as 400 others that include mental health staff, probation officers, parole officers, correctional officers, EMS staff, etc. Nearly 50 police departments have an official CIT policy. Of the 1,750 trained police officers about 1,550 were trained with DMHAS funds (including federal grant funds 2004-2007).

## **Children's Plan 15. Crisis Services**

The Connecticut Department of Children and Families (DCF) has implemented a continuum of services and initiatives to prevent crises for children, youth and families and to provide interventions that support their recovery and resilience. These services and initiatives are child, youth and family centered; trauma informed; strength based; culture, gender, race, age and sexual orientation sensitive; and provided by trained mental health professionals. Every effort is made to provide supports and services to children, youth and families in crisis in a timely and thorough manner and in the least restrictive setting in order to reduce the occurrence of another crisis. DCF understands and respects that for a child, youth and their family a crisis is defined by their experience and report, and not by externally pre-defined criteria.

DCF has implemented a number of prevention services that serve to reduce potential crises for children, youth and families. Section Four (4) of the Mental Health Block Grant presents a number of DCF early identification and early intervention services for preventing crises and the emergence of a serious emotional disturbance in children and youth. These include home, community and school based services that serve to prevent traumas including school removal or dismissal, police involvement and arrest and removal from the home, all of which can contribute to child, youth and family crises. The prevention services cited in Section Four (4) are:

- DCF-Head Start Partnership
- School-Based Diversion Initiative (SBDI)
- Early Childhood Consultation Partnership (ECCP)
- Prevent Suicide CT
- Positive Youth Development Initiatives
- Extended Day Treatment (EDT)
- Care Management Entity (CME)

Currently DCF is also involved in a prevention initiative to study and address the use of hospital emergency departments (ED) by children, youth and families in crisis. This is called a Network of Care Analysis, with the goal of identifying community systems for early identification and effective interventions to prevent crisis and the need for ED visits. The analysis includes representation by hospitals and ED's, physicians, schools, the states' administrative service organization, researchers and DCF.

Other services provided by DCF to both prevent and respond to crises include the following five programs described earlier in the Connecticut Children's Behavioral Health Service Array:

- Functional Family Therapy (FFT)
- Emergency Mobile Psychiatric Services (EMPS)
- Outpatient Psychiatric Clinics for Children (OPCC)
- Crisis Stabilization Services
- Short-Term Family Integrated Treatment (S-FIT)

# Environmental Factors and Plan

## 16. Recovery

### Narrative Question:

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The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health 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 behavioral health 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. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- |  |   |  |
|--|---|--|
| • Drop-in centers                          | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators                              | • Peer-run respite services                                      |
| • Peer specialist/Promotoras               | • Peer wellness coaching                              | • Person-centered planning                                       |
| • Clubhouses                               | • Recovery coaching                                   | • Self-care and wellness approaches                              |
| • Self-directed care                       | • Shared decision making                              | • Peer-run crisis diversion services                             |
| • Supportive housing models                | • Telephone recovery checkups                         | • Wellness-based community campaign                              |
| • Recovery community centers               | • Warm lines  |  |
| • WRAP                                     | • Whole Health Action Management (WHAM)               |  |
| • Evidenced-based supported                |   |  |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 1617 Narrative 16. Recovery

**1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?**

Connecticut established a definition of recovery and recovery values in 2003. In October 2012, grassroots stakeholder groups and advocacy organizations were asked to review the general principles and guidelines to see if updating was needed. There was consensus that the definition and core values remain relevant and inclusive. Below are links to DMHAS Commissioner Statements regarding a recovery-oriented system for Connecticut:

<http://www.ct.gov/dmhas/lib/dmhas/policies/chapter6.14.pdf>

<http://www.ct.gov/dmhas/lib/dmhas/recovery/tenets.pdf>

<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335078>

There is a manager at the Office of the Commissioner responsible for Recovery Community Affairs. She is a self-identified person in recovery and she reports to the Commissioner.

A Center for Medicare and Medicaid Services grant awarded in 2009 provided a means to implement person-centered planning in our state-operated facilities. This process was extended to the Connecticut private nonprofit sector as a component of developing the Community Support and Recovery Pathways Program and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the 39 ACT and CSP/RP 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) are participating in a multi-year federal Person Centered Recovery Planning grant with Yale PRCH; Connecticut is one of two states in the grant. LMHAs are receiving training and technical assistance to implement person-centered planning.

At Connecticut Valley Hospital, all clinical staff persons are trained in person-centered care planning by Janet Tandora, Ph.D. from the Yale Program on Recovery and Community Health. Our expectations for patient involvement are clearly delineated in our Treatment Planning Policy and Procedure.

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, Peer Bridging, Certified Recovery Support Specialists (MI) and Certified Recovery Coaches (SA). The state does not currently provide peer crisis or respite services.

In March 2014, Commissioner Rehmer 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 more than 80 staff in DMHAS programs statewide to assist individuals in completing the Advance Directives workbook and following the process to completion of an executed Advance Directive.

**2. How are treatment and recovery support services coordinated for any individual served by block grant funds?**

Treatment and recovery support services are interwoven for those receiving DMHAS services. As individualized needs are identified and recovery plans to address those needs are developed, an array of treatment and recovery supports are incorporated. A recovery-oriented system of care necessitates that client and staff jointly and holistically create a single plan with the needed recovery and treatment support components included.

**3. Does the State's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?**

As part of the Recovery University, the DMHAS funded training academy for Recovery Support Specialists 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, LGBT populations, and families/significant others.

DMHAS provides education, training, advocacy, and policy development on gender-responsive and trauma-informed care through the Connecticut Women's Consortium. DMHAS has peer-run "mystery shopper" project in which peer staff do walk-throughs at agencies and, using a professional protocol, give feedback to the agencies to increase trauma-informed and gender-responsive care.

DMHAS is a sponsor of True Colors, a LGBT advocacy group, and their annual conference. This conference, now in its thirteenth year, is the largest LGBT youth issues conference in America. More than 2,500 LGBT and ally youth, educators, social workers, clinicians, health care providers, family members, and clergy come together to participate in workshops, activities, and programs that celebrate, educate, and advocate for the interests of LGBT youth and their families.

**4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practices and systems, including the role of peer certification programs, or standards for peer-run services? Does the state have an accreditation program, certification program, or standards for peer-run services?**

Yes, training on recovery principles and recovery-oriented practices and systems are interwoven with clinical training along with cultural competency and family support.

During 2014, DMHAS contracted with the Yale Program for Recovery and Community Health to create a curriculum for supervisors of peer support staff. We have conducted that training three times for more than 60 supervisors.

There are also training certification processes for individuals wishing to provide peer support in both mental health and substance use arenas.

**5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative approaches, and services within the state's behavioral health system?**

Within the last year, DMHAS Research Division has been conducting research projects relating to recovery supports, services identification and dissemination of best practices. These include studies of supportive housing, criminal justice diversion, mental health transformation, crisis intervention, safe schools, behavioral health homes, cost analysis, and the potential of utilizing new technology to reach clients. Some of the subpopulations of focus have been adults with SPMI, young adults or transitioning youth with emerging mental health issues, veterans, school children, adults with criminal justice involvement, and the chronically homeless.

DMHAS funds the Connecticut Mental Health Center (CMHC) Citizens Collaborative. This is a research project conducted by the Yale Program for Recovery and Community Health (Yale PRCH) that is delivering citizenship work as a next-stage of recovery implementation in Connecticut. Current projects include the longstanding Citizens Project for DMHAS clients with previous criminal charges, a Young Adults Citizens Project at the West Haven Mental Health Clinic, the Community Action Group with a number of initiatives aimed at facilitating community connections for CMHC clients.

Over the past year, the DMHAS Office of Evidence-Based Practices, the Hispanic Health Council, Career Resources, CMHC, and Capitol Region Mental Health Center have been involved in a research project conducted by Yale PRCH to implement the IPS model of supported employment services to persons of Hispanic origin and/or with a history of criminal justice involvement.

In 2014, DMHAS launched the Hearing Voices Network. As part of this initiative, five international trainers in the Hearing Voices approach and the Maastricht Interview Technique were brought together with voice hearers, family members, professionals and the public. The centerpiece of the initiative has been the training of 88 certified Hearing Voices Network support group facilitators and the creation of a network of peer-run community-based support groups for voice hearers. The Network currently includes 12 support groups throughout the state. One of those groups takes place in an inpatient facility and within the next year, groups will start to be offered to DMHAS clients in the prison system.

Similarly, DMHAS has begun training facilitators to provide a form of community-based peer support for individuals who are experiencing despair and hopelessness. This approach is modeled after the Alternatives to Suicide support groups designed by the Western Mass Recovery Learning Community. Currently, one Alternative to Suicide support group is operating in Connecticut.

**6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).**

Requests for Proposals (RFPs) are not only scored in a manner which gives increased weight/points to those demonstrating involvement of persons in recovery and their families, but persons in recovery are also involved in the awards process. Regional Mental Health Boards, 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.

Connecticut provides funding to the National Alliance on Mental Illness to provide opportunities to address specific individual/family issues and needs concerning the behavioral health service system which is guided by an agency policy on Family Member Involvement.

During 2014, DMHAS created the DMHAS Peer Workforce Advisory Board. This is an advisory group made up of individuals in recovery who either work as peer workers or take part in the training of peers. This body meets regularly to give advice on expanding the peer workforce in the state.

Additionally, the DMHAS Recovery Advisory Group assists the department in a wide array of promoting a recovery-oriented system. Following is a link to the scope and functions of the advisory group:

<http://www.ct.gov/dmhas/lib/dmhas/recovery/advisory.pdf>

Through the person-centered planning policy and process, individuals are supported via individualized treatment planning and family involvement. State-operated and –funded agencies have advisory committees composed of persons in recovery and/or family members to have input on issues affecting them.

DMHAS has contracted with Pat Deegan Associates (PDA) to conduct a year-long Decision Support Learning Collaborative with eight agencies. The project includes training, technical assistance and the use of PDA’s web-based recovery library.

**7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

The state assists these efforts through direct funding and contracts as well as training and technical assistance.

**8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.**

Advocacy Unlimited, a DMHAS-funded, peer-run advocacy and recovery training organization conducts a quarterly meeting with service users peers across the state. As part of that meeting, they gather input to create an ongoing priority list of the top five advocacy and service system concerns of service system users across the state. DMHAS uses that document in our service design planning activities at the level of the Commissioner. We have extremely robust mental health and substance use advocacy and peer networks in this state. System leadership is in excellent and consistent contact with the consumer networks.

**9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.**

Focus on Recovery – United, a DMHAS-funded training academy, has trained staff on WRAP for Wellness that speaks to various health concerns.

During the past year, DMHAS has funded Advocacy Unlimited to create a peer-run wellness center called TOIVO. TOIVO also traveled throughout the state conducting workshops on wellness. They take the approach of promoting positive wellness rather than the cessation approach.

All DMHAS-funded clubhouses offer groups and workshops on weight management and smoking cessation. Many have quite robust physical fitness tracks that are available to clients.

The Department of Mental Health and Addiction Services (DMHAS) began implementing a Behavioral Health Home in March 2015 for individuals with chronic medical conditions and SPMI. DMHAS' health home quality measurement goal is to continuously improve the quality, cost effectiveness and satisfaction of care provided to health home enrollees.

The CMS health home core quality measures include:

- a. Adult Body Mass Index (BMI) Assessment
- b. Ambulatory Care – Sensitive Condition Admission
- c. Care Transition – Transition Record Transmitted to Health Care Professional
- d. Follow-up After Hospitalization for Mental Illness
- e. Plan- All Cause Readmission

- f. Screening for Clinical Depression and Follow-up Plan
- g. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and reduction of tobacco and nicotine use
- h. Controlling High Blood Pressure (Core Adult Measure)

The DMHAS Tobacco Prevention and Enforcement Program works with communities to inform retailers and the public about laws prohibiting the sale of tobacco to minors and support prevention through compliance inspections, education and awareness.

**10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?**

Connecticut has a strong interagency collaborative focused on housing individuals in community-based settings instead of institutional settings. Connecticut's Interagency Committee on Supportive Housing (which includes the Departments of Mental Health and Addiction Services, Social Services, Children and Families, Correction, Veterans' Administration, Developmental Services, Economic and Community Development, Office of Policy and Management, the Connecticut Housing Finance Authority, and the Judicial Branch's Court Support Services Division) work together to create housing options in the community for individuals with disabilities in the least restrictive setting. The Committee's goal is to create community-based housing with the necessary support services to ensure successful integration into the community for individuals and families that need this level of care. Through this collaborative, Connecticut has been able to house over 2,500 individuals and families in supportive housing and keep them from being housed in an institutional, restrictive or homeless situation. In addition, Connecticut has a robust Money Follows the Person program administered by the Department of Social Services. This program has a goal of assisting individuals in a nursing home level of care find their own housing in the community and provides the required level of support to ensure community integration.

Connecticut's Supportive Housing Initiative provides intensive housing-based case management services. The goals of this service are two-fold: one is to ensure success in housing by teaching the residents the skills necessary to ensure lease compliance (paying rent on time and being a good neighbor) and to incorporate the individual or family into the community. Many folks in supportive housing may have been homeless or in restrictive living settings and may not have the skills to integrate themselves into the community. The role of the supportive housing case managers is to teach these individuals how to be engaged in the community by providing resources such as referrals to educational programs, employment programs, social programs and treatment resources. Case managers also assist individuals with some basic living skills that also help integrate them in community activities such as using public transportation, shopping, and accessing recreational activities.

**11. Describe how the state is supporting the employment and educational needs of individuals served.**

For the past ten year, DMHAS has funded up to 30 private non-profit agencies with \$10 million to provide the evidence based Supported Employment Model to 2,700 individuals at any given time. This program serves about 4,000 individuals/year.

DMHAS also funds 5 Supported Education providers in the state. Each has a capacity of about 40 slots. DMHAS is following a modified version of the SAMHSA supported education EBP Toolkit.

### **Children's Plan 16. Recovery**

The Department of Children and Families in conjunction with the Department of Mental Health and Addictions Services is developing a substance abuse and recovery support plan to provide peer support services to adolescents and young adults throughout the state. The plan will include methods to increase community support and methods to alert youth that such support is available. A report is due to the Connecticut General Assembly by January 2016 and grant funding is currently being sought. A pilot study for Recovery High Schools is one consideration in this planning.

# Environmental Factors and Plan

## 17. Community Living and the Implementation of Olmstead

Narrative Question:

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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 substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate 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 behavioral health 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 of 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

Olmstead Section Questions:

**Describe the state’s Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.**

Connecticut does not have a Olmstead Plan. The Olmstead work is integrated into the State Long Term Care Plan. The plan cuts across a number of state agencies and offers a comprehensive array of services focused on assisting individuals to live in the least restrictive community setting. While the state’s Plan addresses issues across populations and age groups, DMHAS’ activities focus on individuals with serious mental illness and include a range of activities designed to support individuals with serious mental illness in the least restrictive setting in the community. These activities include a Nursing Home Diversion and Transition Program, A Medicaid Home and Community Based Waiver for Persons with Serious Mental Illness, a demonstration grant (Money Follows the Person ) coordinated with the state’s Department of Social Services, and OBRA screening conducted as part of a range of services for older adults. The unique services of the waiver focus on rehabilitation and recovery and offer transitional case management, community and in-home support, recovery assistants, peer specialists, and employment supports.

DMHAS also provides a range of community services that are designed to foster independence and support individuals in the least restrictive setting. Some examples of this include a hospital discretionary discharge fund (funds used to support the discharge of clients that have complicated needs), Gatekeeper services that are designed to identify at-risk elderly and link them to treatment, and the typical array of community support services that includes Assertive Community Treatment, residential supports, and psychosocial programs.

**How are individuals transitioned from hospital to community settings?**

DMHAS’ state-run hospitals begin to focus on discharge at the time individuals are admitted into one of the state’s psychiatric hospitals. Typically individuals are referred to the hospital through one of the state’s local mental health authorities (LMHA’s). LMHA’s are responsible for delivering or coordinating a comprehensive range of community services in distinct locales across the state. If somebody is not connected to an LMHA at the time of admission the LMHA responsible for the area the client resides is linked to the client. LMHA staff attend planning meetings and coordinate with hospital staff as patients become ready for discharge. These entities are then responsible for coordinating the community services that may be needed upon discharge. Each state-operated hospital maintains a distinct discharge planning process and there is a statewide initiative that focuses on difficult to discharge clients. DMHAS maintains a discretionary discharge fund that is used to support discharge resource needs for individuals that are difficult to return to the community. The funds are used to purchase additional community supports that enable a return to the community.

**What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**

The state has implemented a comprehensive array of services that address the integration mandate. These activities include the following:

### **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**

DMHAS' Older Adult Services (OAS) unit continues to broaden its statewide partnerships with providers of services to older adults. The Connecticut State Department on Aging has a representative that functions as the co-chair of the DMHAS Older Adult Workgroup. DMHAS is an active member of the Connecticut Association of Area Agencies on Aging Planning Committee for its Annual Conference. OAS offers training on a regular basis to DMHAS staff and grantee-agency providers on caring for older adults with co-occurring mental illnesses and substance use disorders. Additionally, OAS continues to collaborate with the CT Long-Term Care Ombudsman Program on major workgroups that address key issues that impact nursing home residents and staff. Examples of workgroups include managing challenging behaviors and fear of retaliation.

DMHAS OAS currently manages two statewide programs that serve older adults. One is the Senior Outreach Program that serves older adults who abuse substances, primarily alcohol, or are at risk for abusing substances.

Eight agencies in Connecticut that focus on addiction services provide substance abuse outreach and treatment programs to older adults, including a weekly age-specific support group. The other program is the Gatekeeper Program, an evidence-based practice for identifying older adults in the community in need of some level of service. The Gatekeeper Program trains people in the community to recognize changes in the behaviors or condition of older adults and refers them to appropriate services. One of the goals is to avoid long-term institutional care. In May 2015, OAS is collaborating with one of the program agencies to present the first National Gatekeeper Conference, highlighting nationally-known speakers on topics such as suicide, hoarding behaviors, and Screening, Brief Intervention, Referral and Treatment (SBIRT) as they relate to older adults.

Through collaboration with DMHAS-funded agencies, the Nursing Home Diversion and Transition Program (NHDTTP) 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. Staff includes Nurse Clinicians and Case Managers, two of whom are bilingual to assist clients who are primarily Spanish-speaking. The NHDTTP works in conjunction with the state's Money Follows the Person Demonstration Project, and also operates parallel to the Medicaid Home and Community-Based Services (HCBS) Waiver for Persons with Mental Illness. Persons who may not meet criteria for the waiver, or may not want wrap-around waiver services, may be served by the DMHAS NHDTTP.

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

A recent 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. DMHAS receives comprehensive admission data from ASCEND that enable staff to track, treat, and discharge individuals who improve and do not continue to meet Nursing Home Level of Care.

#### **Medicaid Home and Community-Based Waiver for Persons with SMI**

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 520 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. During the same time period, under the NHDTP, approximately 1,000 clients have been transitioned from Nursing Homes into the community.

#### **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 then referred to the appropriate community provider for services. Through the Mental Health Waiver and the Nursing Home Diversion and Transition Program, DMHAS staff works with the DSS MFP Demonstration Grant to effectively discharge clients back into the community in a clinically safe manner. DMHAS meets with DSS (the MFP awardee) on a regular basis to identify individuals, specifically those in nursing homes, who may be eligible for MFP and then move onto the Home and Community-Based Waiver. DMHAS staff is an active member of the MFP Steering Committee, the 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 is working with both University of Connecticut and DSS to define a continuum of care strategy for aging clients with chronic conditions.

#### **Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved.**

While the Department of Justice has not been involved in Olmstead-related litigation in Connecticut, three state agencies were named in a lawsuit that focused on individuals with serious mental illness who were residing in three distinct nursing facilities. The parties involved in bringing the lawsuit included the Connecticut Office of Protection and Advocacy and the Bazelon Center. The lawsuit alleged that three CT agencies, the Department of Social Services, Department of Mental Health and Addiction Services, and the Department of Public Health violated federal law by administering a system of care where individuals with mental illness resided in nursing homes when they could be living in the community.

The parties reached a settlement agreement in April 2014 as an alternative to a costly court process. The state agencies are currently involved in a range of activities related to that settlement. One of the nursing facilities originally named in the lawsuit closed so the settlement currently applies to two nursing homes.

**Is the state involved in a partnership with other state agencies to address community integration?**

As highlighted in sections above, the department is involved in a number of activities with multiple state partners including the state's Medicaid authority, Department of Social Services, Department on Aging, Department of Public Health, the Office of Policy and Management, and the Connecticut Long-Term Care Ombudsman.

**Children's Plan 17. Community Living and the Implementation of Olmstead**

The department has shown a commitment that children and youth, including those with behavioral health needs, belong in the least restrictive environment as evidenced in the investment of in home services, reduction of children in congregate care and the utilization of kin placements whenever possible.

# Environmental Factors and Plan

## 18. Children and Adolescents Behavioral Health Services

### Narrative Question:

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MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>90</sup> Most mental health 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>91</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death.<sup>92</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>93</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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.<sup>94</sup>

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care<sup>95</sup>:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- 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 behavioral health 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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<sup>90</sup> Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

<sup>91</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>92</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>93</sup> The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>94</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 <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

<sup>95</sup> Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

**Children's Plan 18. Children and Adolescents Behavioral Health Services**

Please refer to the Behavioral Health Assessment and Plan Planning Steps for a comprehensive review of Children and Adolescents Behavioral Health Services.

# Environmental Factors and Plan

## 19. Pregnant Women and Women with Dependent Children

Narrative Question:

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Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

### ***19. Pregnant Women and Women with Dependent Children***

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Please consider the following items as a guide when preparing the description of the state’s system:

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

***If a pregnant woman or other referring agent contacts one of the DMHAS funded Women and Children’s Specialty Residential Programs for admittance, the program must provide priority access for the woman to the program. If the facility contacted does not have an opening, the program is responsible for providing the woman or referring agent with the name and number of the Women’s Behavioral Health Services (WBHS) Utilization Manager at 860-704-6297. The Women’s Behavioral Health Services Utilization Manager or her designee will contact the woman or referring agent with the information regarding vacancies at all of the seven DMHAS funded Women’s and Children’s residential programs. The Women’s Behavioral Health Services Utilization Manager has the most up to date count of current openings at the DMHAS funded Women’s and Children’s residential programs. The Women’s Behavioral Health Services Utilization Manager will work with the woman and/or referring agent and the residential programs to insure that a woman has immediate access. If at the time of the request there are no openings at any of the DMHAS funded Women’s and Children’s residential programs, the WBHS Program Manager will contact Frances Fallon at 860-418-6637, to inform her of the current situation and status of the woman.***

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

***The DMHAS funded Women's and Children's residential programs prioritize admission for pregnant women and admit them within 48 hours when there is an opening. There is currently in place an electronic census that is sent out by the Clinical Care Coordinator of the Women's Behavioral Health Services Program. This electronic census has reduced the wait time for admission significantly and is currently being distributed to agencies and providers at their request.***

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

***If there are no beds available at any time at any of the DMHAS funded Women's and Children's residential programs the woman is provided with the names and phone numbers of PHP (partial hospital programs) and IOP (intensive outpatient programs) in her area. If a woman is at a facility and there are no beds available then the staff, Women's Recovery Specialist or the WBHS manager Gate keeper will review the electronic census and assist the client in contacting the facility where the bed is located and assist the woman in obtaining that bed. If there are no beds in the state then the Women's Recovery Specialist will work with the woman while she is in the community to continue to assist her in obtaining services for admittance into SA services, and offer support until a bed opens up and the woman is placed in residential services.***

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

***The Women's Behavioral Health Specialist program completes a report in January and July which records the number of calls, the date of the call, and the date the woman was admitted to a program. This report is given to DMHAS by the Women's Behavioral Health Services program manager. Additionally a monthly utilization meeting is held between DMHAS and the WBHS Manager.***

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)

***There are seven DMHAS funded women and children's residential programs in Connecticut, all of these programs can accommodate women on medication assisted treatment. These programs are geographically scattered around the state so there are no areas that are not adequately served.***

a. How many of the programs offer medication assisted treatment for the pregnant women in their care? ***All Women & Children's programs offer and accept women on medication assisted treatment.***

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they? **NA**

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)

***There are seven DMHAS funded women and children's residential programs in Connecticut, all of these programs can accommodate women on medication assisted treatment. These programs are geographically scattered around the state so there are no areas that are not adequately served.***

***There are three Specialty Women's Outpatient programs where women can bring their children and can be accommodated with medication assisted treatment.***

a. How many of the programs offer medication assisted treatment for the pregnant women in their care? **All**

### **Children's Plan 19. Pregnant Women and Women with Dependent Children**

DMHAS providers' priority access for pregnant women, along with Women's Behavioral Health Case Management. DCF might end up serving a pregnant woman, but only if there was another child who was identified as the index child receiving our services. For example, in our Project SAFE collaboration with DMHAS, we jointly fund and provide Assessment, PHP, IOP, and OP services for adult caregivers with substance use issues. A woman may be pregnant when receiving these services, but would have to also have another child to access the Project SAFE services.

# Environmental Factors and Plan

## 20. Suicide Prevention

Narrative Question:

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In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).<sup>96</sup>

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

---

<sup>96</sup> [http://www.samhsa.gov/sites/default/files/samhsa\\_state\\_suicide\\_prevention\\_plans\\_guide\\_final\\_508\\_compliant.pdf](http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

# 1 WORD VOICE LIFE

Be the 1 to start the conversation

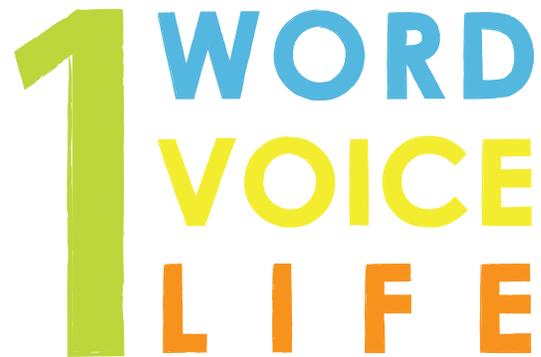
## STATE OF CONNECTICUT SUICIDE PREVENTION PLAN 2020





## DEDICATION

*This plan and the many prevention efforts associated with it are dedicated to the Connecticut residents, families, friends and communities who are affected in profound ways by suicide.*



Be the 1 to start the conversation

# **STATE OF CONNECTICUT SUICIDE PREVENTION PLAN 2020**



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**The State of Connecticut**  
**Department of Children and Families and Department of Mental Health and Addiction Services**  
**Hartford, CT**

December, 2014

Dear Friends:

We are pleased to present the new Connecticut Strategic Plan for Suicide Prevention (PLAN 2020), the result of a collaboration of many stakeholders committed to suicide prevention. While acknowledging the complexity of the personal and situational factors associated with suicidal behavior, a public health approach is regarded as the one most effective to reduce suicide attempts and deaths.

Although Connecticut has one of the lowest rates of suicide in the United States, an average of 351 residents per year over the past five years have died from suicide, almost three times the number of homicides. Suicide deaths are largely preventable, and even one death is too many. Therefore, a concerted force organized around the guiding principles outlined in PLAN 2020 is our best hope for addressing this tragic public health and mental health problem. Connecticut stakeholders must mobilize their resources in a rapid response to prevent further death and disability associated with suicide.

An integrated and coordinated effort with multiple partners is a keystone of the public health approach. Collaboration among public health, mental health, medical, social services, law enforcement, military, political and other community stakeholders is crucial to prevent suicide attempts and deaths. The PLAN 2020 was developed by the Connecticut Suicide Advisory Board (CTSAB). The CTSAB is supported and co-chaired by the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), and is comprised of volunteers and staff representing a variety of state and community sectors. PLAN 2020 establishes five goals and 22 objectives for Connecticut to initiate state prevention activities, and is aligned with the National Strategy for Suicide Prevention and Healthy People 2020. The fact that suicides are preventable calls for organized activation of our resources driven by data and evidence-based best practices to address the goals and objectives in this plan to prevent suicide attempts and deaths. Multiple individuals, including survivors, consumers, advocates, and representatives from state agencies and diverse organizations, contributed input and feedback that shaped this document.

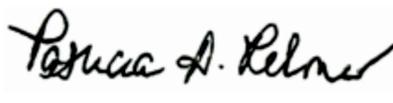
The PLAN 2020 is designed to be accessible to everyone and it is our goal that individuals, communities, institutions and organizations use the plan as their working template to guide their efforts small and large to prevent suicide attempts and deaths and ultimately save lives in Connecticut.

The DCF, DMHAS and CTSAB are committed to the full implementation of the goals and objectives of the PLAN 2020. We hope you find the PLAN 2020 useful, and we thank you for your dedication to working together with us to prevent further suicide attempts and deaths in our state.

Sincerely,



Joette Katz, JD  
Commissioner  
Department of Children and Families



Patricia Rehmer, MSN, ACHE  
Commissioner  
Department of Mental Health and Addiction Services

**Statement from the CTSAB Co-Chairs**  
**Andrea Iger Duarte, MSW, MPH, LCSW and Tim Marshall MSW, LCSW**

The State of Connecticut has a long and proud history of leadership in the development of statewide suicide prevention priorities and programs. In 1989, the State Legislature mandated the creation of the Youth Suicide Advisory Board (YSAB) at the Department of Children and Families (DCF). The Department of Public Health (DPH) developed the Interagency Suicide Prevention Network (ISPN) in 2000 and in 2005 the first Connecticut Comprehensive Suicide Prevention Plan was released. Coordinated prevention efforts and resources increased in 2006 when the Connecticut Department of Mental Health and Addiction Services was an inaugural grantee of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith Grant (GLS), with the YSAB advisory to the Grant, followed by a second successful GLS Grant in 2011.

The Connecticut Suicide Advisory Board (CTSAB) was established in January 2012, and is composed of members from institutions of higher education, state agencies, community organizations and mental health facilities. The board was formed as a merger of the Connecticut Department of Children and Families (DCF) Suicide Advisory Board and the DMHAS/DPH Interagency Suicide Prevention Network to facilitate collaborative efforts among state partners for suicide prevention, intervention and postvention. The CTSAB meets monthly for programmatic and strategic planning to address issues related to suicide across the life span in Connecticut. The membership of the board and the Network of Care has grown steadily since its inception, with 169 members representing 76 sectors including: state and local agencies, profits and non-profits, community and faith-based organizations, hospitals, military, schools, higher education, towns, private citizens, students, survivors and advocates. Importantly, these members are committed and active, as evidenced by meeting attendance averaging 30 and with 60% of members attending six meetings or more per year. This commitment is essential to our:

**Mission:** The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion.

**and our**

**Vision:** The CTSAB seeks to reduce and eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.

Priority areas have included:

- 1) Raise statewide awareness of suicide prevention with the “**1 WORD, 1 VOICE, 1 LIFE...Be the 1 to start the conversation**” initiative;
- 2) Develop a Statewide Network that links state-level with grass-roots local efforts;
- 3) Promote Evidence-Based Best Practices for Suicide Prevention and Response; and
- 4) Revise CT Strategy for Suicide Prevention.

We look forward to partnering with many constituent agencies, communities, survivors and advocates in the implementation of The Connecticut State Suicide Prevention PLAN 2020 (PLAN 2020). It is designed to serve as a blueprint for suicide prevention activities so that we can marshal resources, expertise and political will toward our overarching goal: the reduction of lives lost to suicide.

The CTSAB would like to extend a warm thanks to Professor Nina Rovinelli Heller from the UCONN School of Social Work and member of the CTSAB for agreeing to author State PLAN 2020. In addition to her writing, Professor Heller facilitated the CTSAB activities in developing the priorities of State Plan 2020.

## INTRODUCTION

The Connecticut State Suicide Prevention PLAN 2020 (PLAN 2020) is a living, working document, designed to frame, organize, prioritize, and direct established and emerging suicide prevention efforts throughout the state through 2020. PLAN 2020 was developed through the ongoing efforts of an expanding group of professionals and suicide survivors who meet regularly as part of the Connecticut Suicide Advisory Board (CTSAB), and of the Statewide Network of Care, under the direction of Co-Chairs from the Connecticut Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF).

### The Development of the Connecticut Suicide Prevention Plan 2020

In accordance with recommendations<sup>i</sup> from the Suicide Prevention Resource Center, a national clearinghouse for suicide prevention, the PLAN 2020 is **data-driven** with flexible strategies for prevention. This allows efforts and resources to be directed toward both high risk populations and settings. The plan is also **comprehensive with set priorities**, developed with an understanding of the need for **collaboration across multiple public and private organizations**. The risk factors for suicide are well documented<sup>ii</sup> and mental health issues are prominent; the plan utilizes a **combined mental health-public health approach**, in order to target prevention at both the individual and broader public levels. Suicide occurs **across the lifespan**; the plan is intended to consider the relative risk factors across the lifespan and advocates the development of cohort-specific strategies. Central to the plan is the use of **safety informed communications** at all levels of suicide prevention. Finally, the plan promotes accountability and is designed to be regularly monitored, updated and revised.<sup>iii</sup>

Suicide prevention strategies and plans in the state of Connecticut can best be described as **embedded** and this theme is central to both existing and emerging activities and recommendations. The notion of embedded suicide prevention reflects our commitment to a comprehensive approach that places responsibility for suicide prevention across a wide range of agencies, settings, individuals and communities. The plan is intended to be used by a range of service providers and professional agencies to develop creative, targeted suicide prevention strategies that are responsive to public and client need and to shifting demographic trends in different populations, cohorts and social contexts. Ultimately, **responsibility for suicide prevention**, as well as postvention, must be considered a community responsibility, with the guidance and leadership of the Connecticut Suicide Advisory Board and Network.

The goals, objectives, example strategies, and commitments for implementation and monitoring laid out in the PLAN 2020 involve three levels of intervention in accordance with a public health framework. *Universal comprehensive preventive interventions* address the needs of the *whole population*. An example of this is the **1 Word, 1 Voice, 1 Life** media campaign launched in Connecticut in 2012. This multipronged media campaign was disseminated widely through radio public service announcements, shopping mall media kiosks, movie theater previews and publicity materials available to organizations throughout the state. *Selective interventions* target those groups for whom risk of suicide and related behaviors is elevated. For example, college-aged youth, *as a group*, have an elevated risk; interventions such as those supported by the federally funded DMHAS administered Garrett Lee Smith Grant, to Connecticut campuses, promotes wellness and provided evidence-based interventions chosen specifically for this population that may have an elevated risk. Finally, *indicated preventive interventions* focus on the needs of individuals who show some warning signs of elevated risk. These interventions are often indicated for high risk individuals who may have prodromal symptoms of mental health or substance use conditions. Screening interventions may be implemented with these individuals through primary care offices or college health and disciplinary offices, for example.

Lastly, the PLAN 2020 makes use of the best available data on suicide deaths and suicidal behaviors in the state of Connecticut, to determine a baseline from which we developed measurable and achievable goals for the reduction of suicidal behaviors and the reversal of disturbing trends in Connecticut. These will serve as benchmarks moving forward and will help to direct suicide prevention activities. Annual updates to the plan will allow us to monitor and disseminate our progress toward meeting these benchmarks.

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes specific **targeted outcomes for 2020**.

### The Scope of the Problem

Throughout the world, the suicide rate has been climbing. The World Health Organization reports that each year nearly one million people die by suicide, resulting in a mortality rate of 16 per 100,000, or a staggering death every 40 seconds.<sup>iv</sup> This represents an increase over the past 45 years of 60%, and it is estimated that by the year 2020, suicide will account for 2.4% of the global disease burden. At the same time, it should be noted that, given the impact of stigma, obtaining accurate suicide data is a challenge, resulting in false negatives by underreporting and differences in the mechanisms for investigating and reporting these deaths.<sup>v</sup>

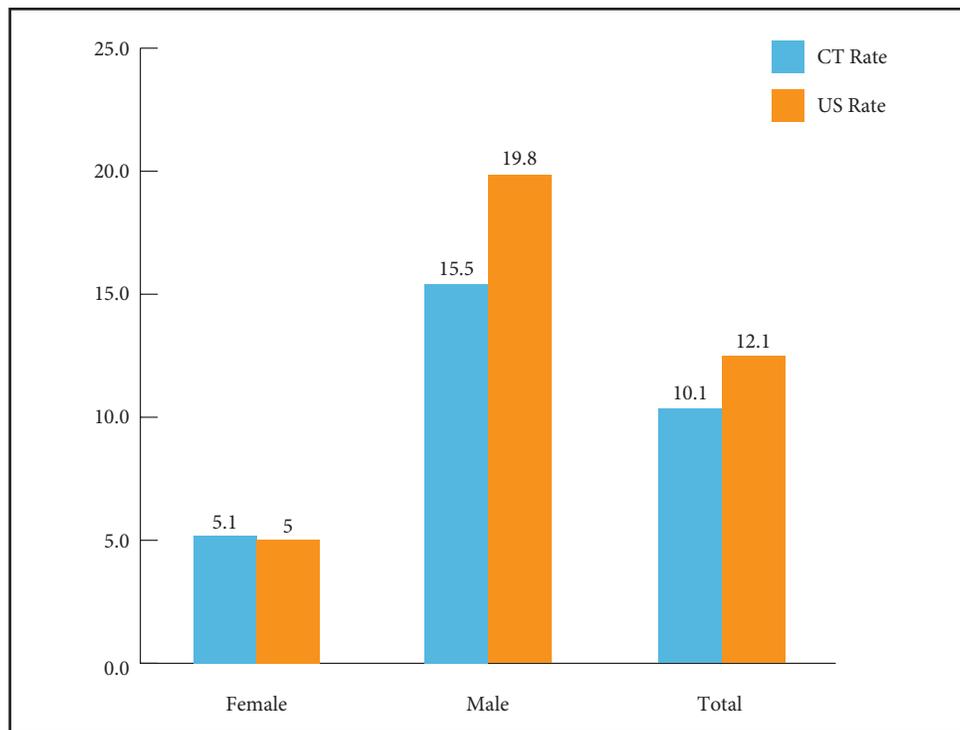
In the United States, suicide and suicidal behaviors have been identified as major public health problems that have far-reaching personal, social and economic implications. In 2012, the latest year for which national data are available, there were 40,600 deaths by suicide. In contrast, during the same year, there were 14,827 homicides (U.S. Department of Justice, 2013)<sup>vi</sup> and 33,561 motor vehicle fatalities (NHTSA, 2013).<sup>vii</sup> Suicide is the tenth leading cause of death and epidemiologists have shown that unlike other causes of death, suicide death rates have been steadily increasing by more than 2% a year (CDC, 2013)<sup>viii</sup>.

In 2011, nearly half a million people presented to hospital emergency departments for self-inflicted injuries. Of these, 224,000 sustained injuries significant enough to require hospitalization.<sup>ix</sup> It is estimated that for every person who dies by suicide, 30 others make an attempt. Furthermore, a prior attempt is one of the strongest risk factors for suicide. The human toll is significant; conservative estimates are that for every death by suicide, there are at least six survivors.<sup>x</sup> Nearly five million Americans became survivors of suicide in the past 10 years, placing some at elevated risk for suicide themselves. In 2010 alone, the number of suicide survivors grew by 230,184 people. In addition to the human toll, it is estimated that 41.2 billion dollars were lost in combined medical and work costs in 2011, due to suicide and related suicidal behaviors.<sup>xi</sup>

There exist significant state and regional differences in suicide death rates, ranging from a rate of 23.2 per 100,000 in Wyoming to 6.8 in the District of Columbia. The Mountain states have the highest rate (18.3) and the Middle Atlantic the lowest at 9.4.<sup>xii</sup> United States and Connecticut comparison total and gender data are presented below (Figure 1.). While Connecticut's total and male rates are substantially lower than the U.S. figures, the suicide rate for females is equivalent.

Figure 1.

### Suicide Rates (per 100,000) Connecticut (2012) and U.S. (2010) Total and Gender



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 2/2/14.

Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Healthy People 2020. US rates based on 2010 data. <http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124>

There are significant age, gender, racial and ethnic group differences in suicide deaths and behaviors. Furthermore, relative risk among age and cohort groups can shift, making timely reporting and analysis critical to understanding current and emerging needs. For example, whereas in the United States in 2010, suicide was the second leading cause of death<sup>xiii</sup> among 25–34 year olds and the third leading cause of death among those aged 15–24, the recent increase in suicides among 45–54 year olds actually represents the highest actual rate of suicide of any age cohort. According to the Centers for Disease Control and Prevention, the annual age-adjusted suicide rate in the 35–64 year old group increased 28.4%, from 13.7 per 100,000 population in 1999 to 17.6 in 2010. The suicide rate for adults over the age of 65 was 14.9 per 100,000 in 2010.<sup>xiv</sup> Gender differences are fairly consistent, with males representing 80% of all suicide deaths, while females have suicidal thoughts and non-fatal attempts at rates consistently higher.<sup>xv</sup> Among racial and ethnic groups, suicide rates are highest for non-Hispanic Whites (14.1%) followed by those for American Indians and Alaskan Natives (11.0%). Rates are much lower for Asian and Pacific Islanders (6.2%), Hispanics (5.9%), and Blacks (5.1%).<sup>xvi</sup>

Those with existing mental health conditions, including substance abuse, are at increased risk for suicidal thoughts, attempts and deaths; it is estimated that 90% of those who die by suicide have at least one diagnosable mental health condition, most commonly a mood disorder.<sup>xvii</sup> Those with anxiety disorders,

borderline personality disorder and schizophrenia are also at elevated risk. Finally, those with a history of prior suicide attempts remain at the highest risk of dying by suicide.<sup>xviii</sup> This has important implications for the need for a broad view of prevention and treatment. The PLAN 2020 addresses the issues of suicidal thoughts and non-fatal attempts as well as suicide fatalities.

### Suicide and Suicidal Behaviors in Connecticut

In Connecticut where the rate of suicide is comparatively low at 45th in the nation in 2010<sup>xx</sup>, there are significant trends and concerns that inform our efforts at the state level. The Office of the Connecticut Chief Medical Examiner (OCME) reported 364 suicide deaths in 2012; 367 in 2011; 342 in 2010; 308 in 2009; 296 in 2008; 250 in 2007; and 257 in 2006. Suicide statistics are typically reported as a suicide rate per 100,000. The suicide rate has pushed upward in the state since 2007, and as with the national rate, as of 2012<sup>xx</sup>, men have a significantly higher rate (15.49) than women (5.05).<sup>xxi</sup> To put Connecticut deaths by suicide in context, when in 2012, 373 people died in Connecticut by suicide, 151 died by homicide.<sup>xxii</sup>

In addition, people who make non-fatal suicide attempts often require hospitalization. Data show the overall rate of hospitalization from self-injury in 2012 was 78 per 100,000.<sup>xxiii</sup> The highest rates of hospitalization for self-injury were observed among youth aged 20–24 and 15–19, with rates declining by age. Among major racial and ethnic groups, Whites were at highest risk of hospitalization (81/100,000). Consistent with self-report data on suicide attempts, women were at higher risk than men. Among counties, the highest rates of hospitalization were observed among New Haven, Middlesex and New London counties. Most common means of self-injury were poisoning by solid or liquid substances, including narcotics (74%), and cutting or piercing (17%). Outcomes of medically serious self-injury: roughly a third of patients were discharged to a psychiatric facility following hospital discharge, 1% died from their injuries in the hospital, and the average length of stay was nearly five days. This length of stay, similar to stays for other significant medical conditions, underscores the need for intensive treatment.

Data sources in addition to the OCME include the Connecticut School Health Survey/Youth Risk Behavior Survey (YRBS) and the 2012 CT Hospital Inpatient Discharge Database (HIDD). The 2009 and 2011 YRSB, a national school-based survey, provided information about percentages of high school students who felt sad or hopeless, considered attempting suicide, actually attempted suicide and who made an attempt that resulted in need for medical intervention. Results for Connecticut indicate differential risk by gender, as expected, and by race and ethnicity. This data has important implications for suicide prevention in a number of settings. The HIDD hospital data<sup>1</sup> provides information about numbers of hospitalizations for self-injury by gender, age, race/ethnicity and county. These data sources taken together provide baseline data that identifies high-risk groups and trends, providing the basis for determining targets for reduction in suicide and suicide related behaviors in Connecticut.

### Connecticut Suicide Facts at a Glance

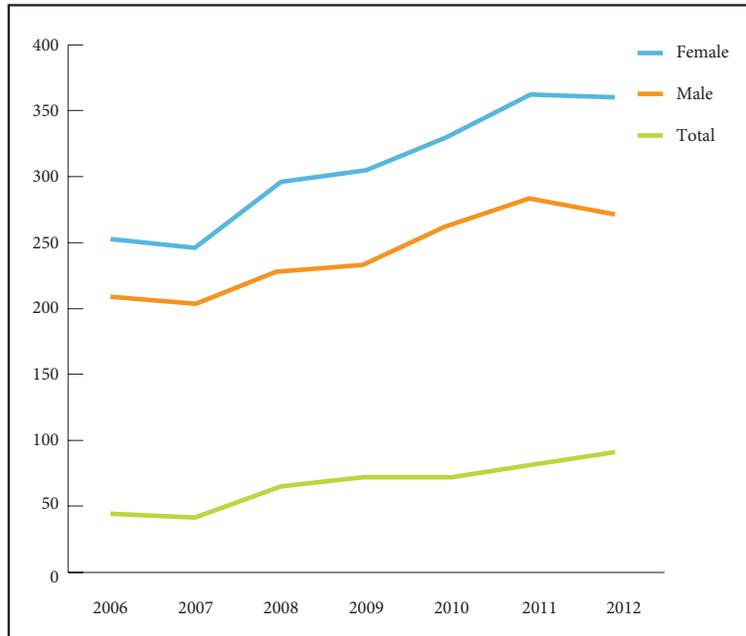
A brief snapshot indicates that certain demographic groups have higher rates of suicide than others; for example, Whites and men, especially ages 35 to 54. There are also regional differences by county. Suicide deaths vary by method of suicide. In 2012, 36.5% of people died by hanging/strangulation, followed by 29.4% by gunshot and 13.7% by substance overdose. The remaining 20.5% involved eight other methods. Method of death also varies by gender and age<sup>xxiv</sup> (Figures 2 and 3).

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<sup>1</sup> See Appendix I

Figure 2.

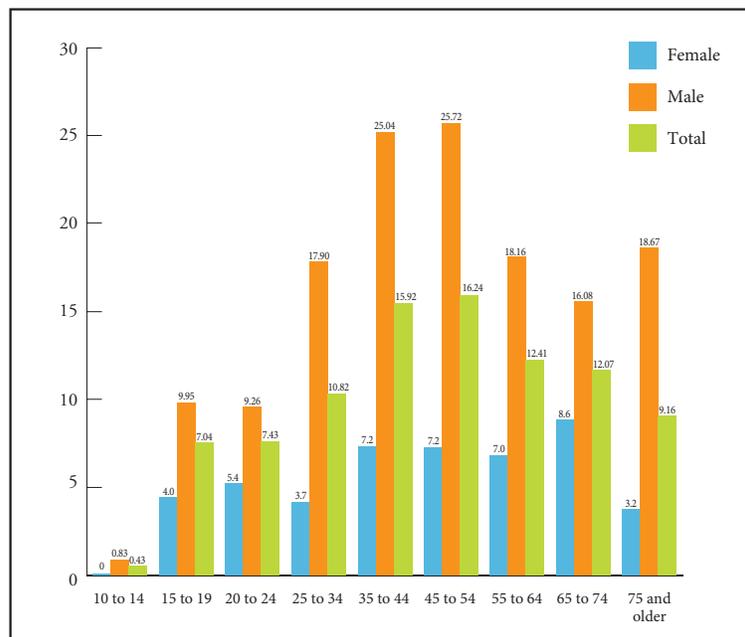
Number of Suicides in Connecticut Total and by Gender 2006–2012



Office of the Medical Examiner Deaths by Suicide 2006–2012  
 Retrieved 5/29/13. [http://www.ct.gov/ocme/lib/ocme/documents/other/07-2011\\_bereavement\\_brochure.pdf](http://www.ct.gov/ocme/lib/ocme/documents/other/07-2011_bereavement_brochure.pdf)

Figure 3.

Suicide Rate in Connecticut by Age and Gender 2012



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.<sup>2</sup>

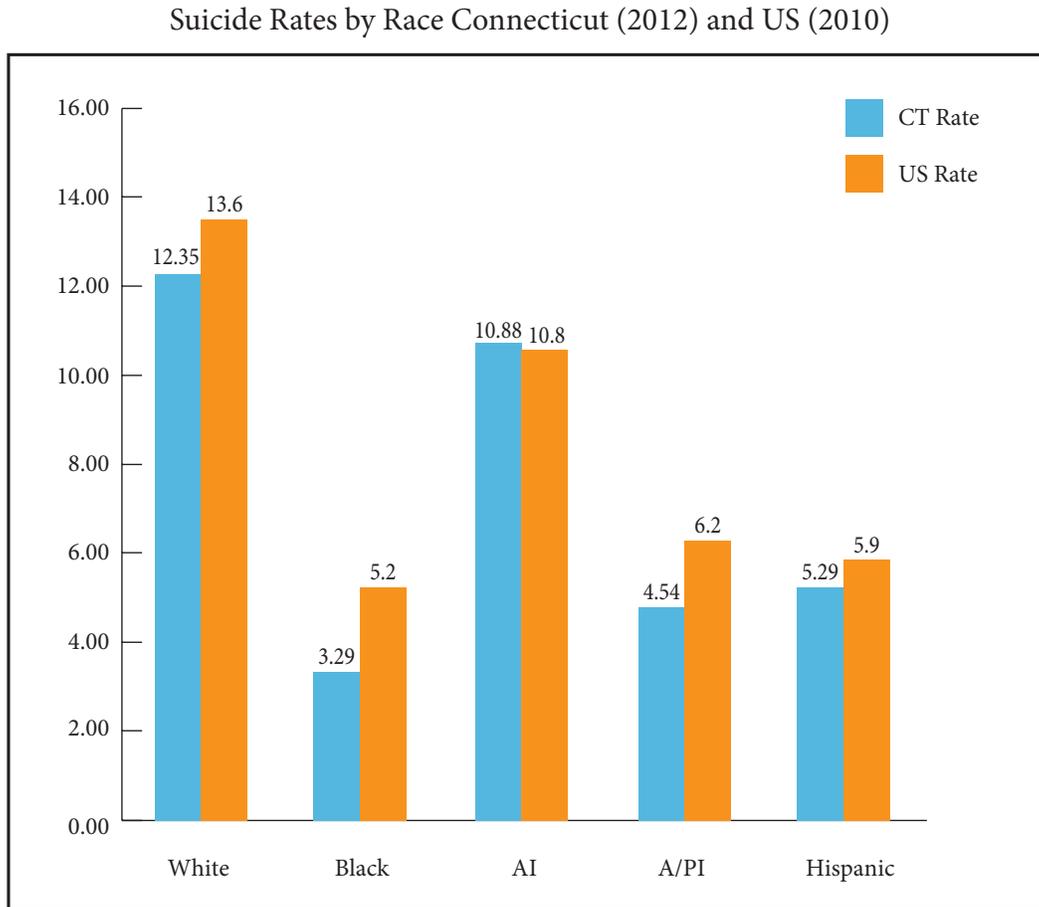
<sup>2</sup> Table with numerical values for age and gender deaths from 2006–2012 appears in the Appendix



## Suicide Rates by Race

Connecticut suicide deaths vary by race; however, this data needs to be considered with caution given the low numbers. For example, Native Americans, who are known to have an elevated risk of suicide nationally, appear as the second highest population in the 2012 Connecticut data. That rate, however, is based on the death of one Native American person in 2012 (Figure 4.).

Figure 4.



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.

Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Healthy People 2020. US rates based on 2010 data. <http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124><sup>3</sup>

<sup>3</sup> Tables with numerical values for race deaths for the years 2006–2012 appear in the Appendix

### Differences by County

There are regional differences in suicide rates in Connecticut by county, ranging from a low of 7.4 in Fairfield County to 15.7 in Middlesex County. This differential is not yet well understood and requires further investigation. (See Table 1.)

Table 1.

Number and Rate of Suicide by Connecticut  
County of Residence 2012

County	n	Population	Rate/100,000
Middlesex	26	165,602	15.7
Litchfield	27	187,530	14.4
Windham	14	117,599	11.9
Tolland	17	151,539	11.2
Hartford	99	897,259	11.0
New London	30	274,170	10.9
New Haven	69	862,813	8.0
Fairfield	69	933,835	7.4
Total	351	3,590,347	9.8

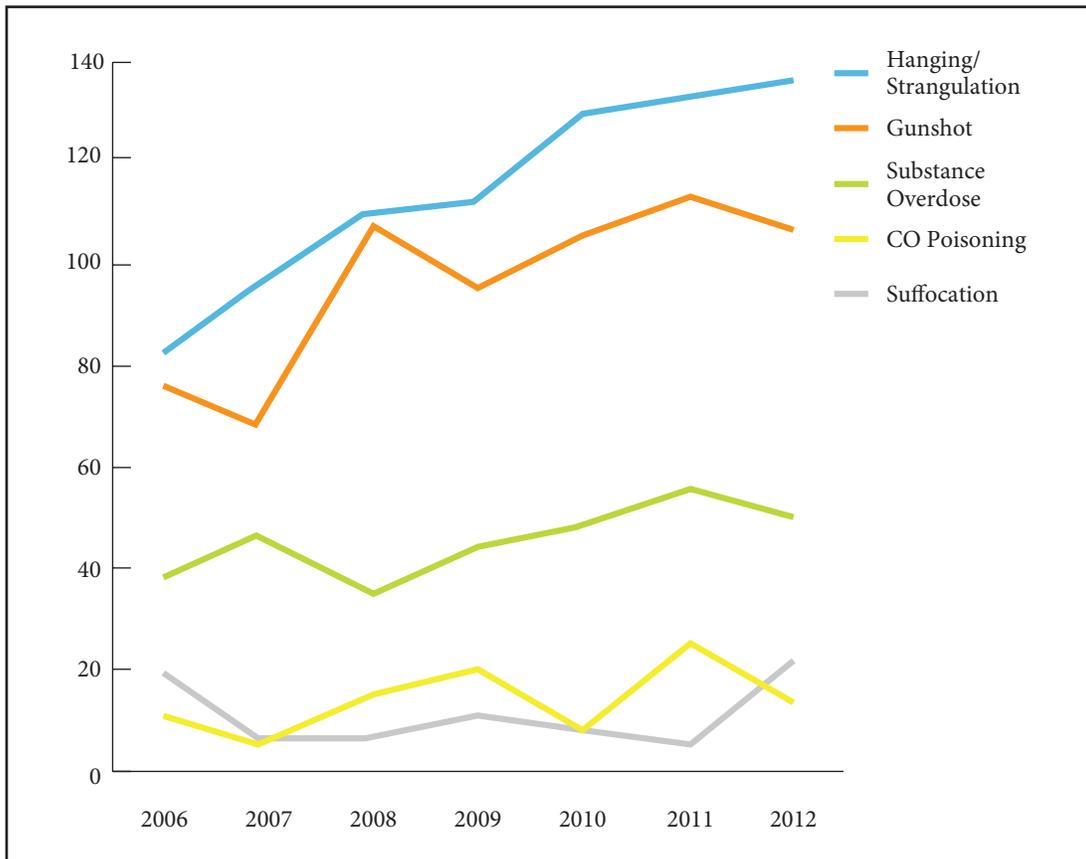
Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

### Methods of Suicide

The method of suicide also varies with hanging/strangulation accounting for more than a third of the deaths, followed by gunshot at almost a third. Nearly three quarters of men die by hanging/strangulation or gunshot, while women are more likely to die by hanging/strangulation and substance overdose. Notably, the method of death has changed from 2006–2012<sup>4</sup> (Figure 5 and 6).

Figure 5.

Primary Methods of Suicide in Connecticut 2006–2012

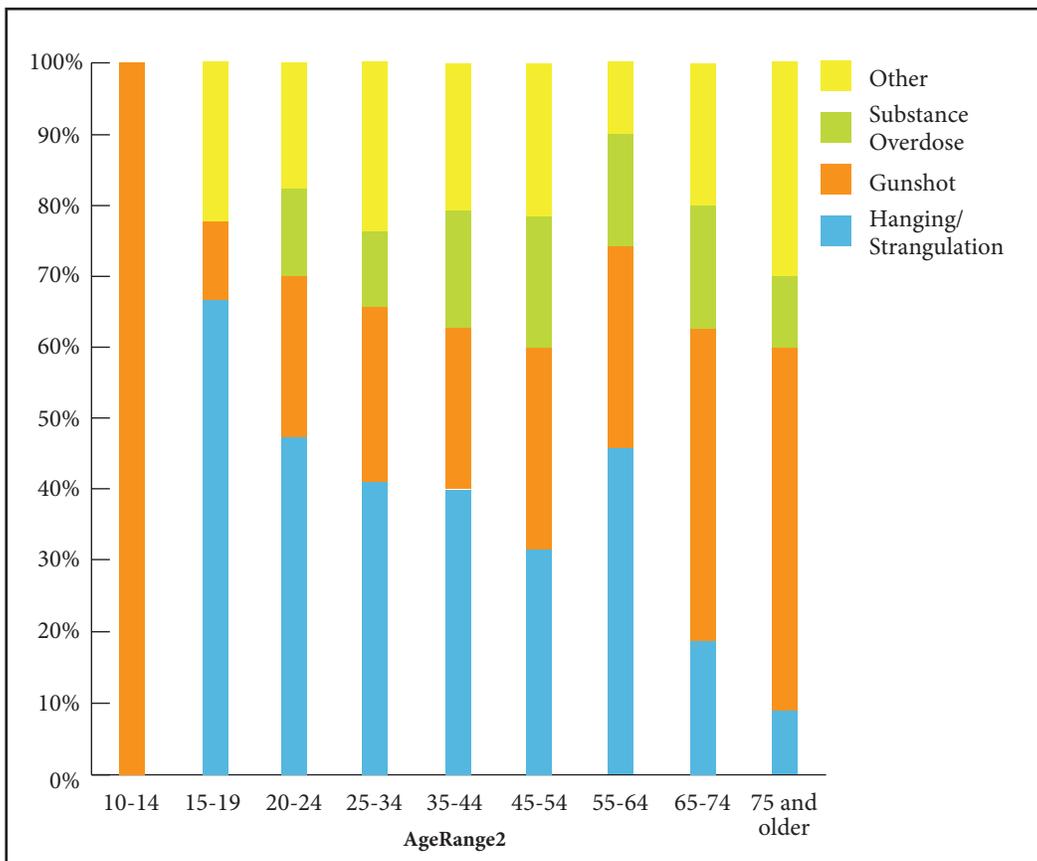


Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

<sup>4</sup> Note: Numerical Values for Primary Methods of Suicide by gender and age and for 2006–2012 in Connecticut are located in the Appendix

Figure 6.

### Primary Methods of Suicide in Connecticut by Age in 2012



Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.



## State of Connecticut Suicide Prevention Goals and Objectives

The State of Connecticut suicide prevention goals, themselves, are derived, in part, from the National Suicide Prevention Strategy 2012 (NSPS), a report of the U.S. Surgeon General, and the National Action Alliance for Suicide Prevention, a public-private partnership. This group developed 13 NSPS goals and 63 objectives, derived from and spanning four strategic directions: 1) Healthy Individuals, Families and Communities; 2) Clinical and Community Prevention; 3) Treatment and Support Services; and 4) Surveillance Research and Evaluation Goals.<sup>xv</sup> The CTSAB endorses each of these NSPS goals, objectives and directions and through a comprehensive, multi-staged process identified five priority goals and related objectives that reflect the priorities for Connecticut suicide prevention efforts. This process included: 1) an online member survey of priorities and current activities and needs; 2) review of all available state level suicide and suicide related data; 3) consensus building discussions at monthly board meetings; 4) triangulation of diverse opinions through small group discussion; 5) consideration of existing initiatives and gaps, and identification of resource capability. In addition, goals were considered in the context of shifting trends and data provided by our consultants. These processes led us to a general consensus about five priority goals.

These goals were presented at the CTSAB 2014 Annual Meeting at which members were asked to generate examples of possible strategies for each of the objectives of the five goals. These collectively derived goals, objectives and examples of possible strategies form the core of the PLAN 2020. Some of the strategies have been enacted, while others emerged from discussions of gaps in suicide prevention activities and knowledge of national best practices. Consumers of the plan are encouraged to use the goals, objectives and strategies as guides to carrying out their respective suicide prevention activities in their own agencies and communities. In addition, we have identified some of these goals, objectives and strategies for monitoring that will serve as the basis for annual review of data and reorganization of priority planning and programming. We have also, in recognition that “one size does not fit all” in suicide prevention, identified, on the basis of Connecticut and national data and the opinions of suicide prevention experts throughout the state, thirteen priority populations at elevated risk for suicide and related behaviors. For each of these populations we highlight current concerns and areas for future attention.

Finally, this report includes targets for improvement in rates of suicidal behaviors, based upon our current data. This will allow for a central component of the plan, the systematic annual review and an updated report of PLAN 2020.

## GOALS, OBJECTIVES AND EXAMPLES OF POSSIBLE STRATEGIES

### Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

#### ➔ Objective 1.1: Integrate, establish and sustain suicide prevention into the values, culture, leadership and work of a broad range of organizations and programs.

**Current Status:** Members of the CTSAB work within their respective agencies and communities to raise the profile of suicide prevention initiatives and they report significant advances since the 2005 Connecticut State Plan. There is strong institutional and leadership support for suicide prevention through the CT Departments of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF) and the Department of Public Health (DPH), as well as designated staff from DMHAS and DCF co-chairs of the CTSAB. Furthermore, networking among agency staff committed to suicide prevention has grown significantly since the implementation of the 2005 plan.

**General Recommendations:** Work to identify and foster attitudes, behaviors and practices within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention. Central to this effort is the institutionalization of **embedded** language, policy and activity in agencies for which suicide prevention may not traditionally be part of the central mission.

#### Examples of Possible Strategies:

- a. Develop contracted language that can be embedded in all relevant departments, such as the Department of Mental Health and Addiction Services, the Department of Children and Families and the Department of Public Health.
- b. Children and Families Behavioral Health (more than 459 district services) requires all DCF contracted behavioral providers to have a suicide prevention education and/or awareness component in the delivery of each service. Develop the same for other state agencies including Department of Mental Health and Addiction Services as appropriate, and review existing contracts for inclusion of this requirement.
- c. Expand state and non-profit agency mission statements to include suicide prevention, when relevant.
- d. Advocate for stronger educational administrative support of measures designed to capture suicide risk at schools, (for example, The Youth Risk Behavior Survey or YRBS).
- e. Support and provide mandatory suicide prevention training for social workers and licensed mental health providers.
- f. Integrate suicide prevention into trainings for domestic violence crisis center volunteers and staff.
- g. Integrate suicide prevention into trainings for staff that provide legal services for immigrant populations.
- h. Integrate suicide prevention training into police agencies, utilizing existing systems.
- i. Partner with faith-based organizations
- j. Continue broad dissemination of the CTSAB media campaign, 1 Word, 1 Voice, 1 Life.

➔ **Objective 1.2: Establish effective, sustainable and collaborative suicide prevention activities at the state/territorial, tribal and local levels.**

**Current Status:** There has been a proliferation of suicide prevention activities, education and training through private and public agencies and community groups in Connecticut since the 2005 State Plan.<sup>5</sup> This has been made possible, in part, through grant funding. Collaborative projects have been developed.

**General Recommendations:** Efforts should be made to identify those activities that have the strongest empirical base and can become sustainable within agencies. Develop creative collaborations among agencies in order to maximize effectiveness, best use of available resources and sustainability.

**Examples of Possible Strategies:**

- a. Work with tribal health councils and related groups to identify representation on the CTSAB and to identify and develop suicide prevention specific to the population.
- b. Compile self-reports on agency programming and prevention activities and include in statewide database through CTSAB.
- c. Establish and utilize subgroups of the CTSAB and broader network according to population and setting focus; for example, youth, corrections, middle-aged adults.

➔ **Objective 1.3: Sustain and strengthen collaborations across state agencies to advance suicide prevention.**

**Current Status:** The rapid and strategic expansion of the membership of the CTSAB has strengthened the collaborative nature of suicide prevention in Connecticut across agencies such as DCF and DMHAS and their contracting providers, and colleges and universities through the Garrett Lee Smith grants.

**General Recommendations:** Continue to use and develop creative collaborations at all levels throughout organizations and agencies.

**Examples of Possible Strategies:**

- a. Bring commissioners of state agencies together to share latest available suicide data, to develop integrated suicide prevention strategies and resources.
- b. Develop a common Memorandum of Understanding that can be used across state agencies for suicide prevention efforts.

➔ **Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.**

**Current Status:** We are at the early stages of identifying public-private partnerships for the development of suicide prevention resources and programs.

**General Recommendations:** Develop a plan to identify possible collaborators representing a wide range of private organizations that share interest in suicide prevention.

**Examples of Possible Strategies:**

- a. Provide funding to private agencies to fund collaboration based on results-based accountability.
- b. Get “star power” for public service announcements.
- c. Publicize public action steps.

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<sup>5</sup> PowerPoint slide from annual report

- d. Pursue collaboration for state, private and federal grants for education awareness and marketing.
- e. Conduct needs assessment for agencies that serve populations at risk.
- f. Work closely with Connecticut firearms manufacturers in a partnership to increase gun safety. Develop suicide prevention material for firearm packaging.
- g. Identify high ranking legislative advocates to advance suicide prevention language into policies and laws at the state level.
- h. Examine existing collaborations and partnerships for member/sector inclusion. Identify non-represented groups and create strategic plan to invite new members to represent them on the CTSAB.

➔ **Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.**

**Current Status:** This is an area for significant growth as the Affordable Care Act takes effect and opportunities emerge for integrated behavioral health care.

**General Recommendations:** Identify potential for the full range of suicide prevention efforts at all levels of care and in all health related settings. Begin to implement population and setting specific recommendations for prevention, intervention and postvention.

**Examples of Possible Strategies:**

- a. Identify key organizations and leaders in the health care community. Engage them in the CTSAB organization and activities.
- b. Identify, recommend, develop and disseminate best practices policies and protocols to be adapted to various components of the health care system.
- c. Educate personnel at all levels in health care organizations in suicide prevention. (For example, doctors, allied health providers, paraprofessionals, organizational staff.)
- d. Ensure adequate and responsive aftercare, especially post-discharge from acute forms of care.
- e. Develop and document organization protocols in the aftermath of suicidal events, including practice drills and annual training.

**Goal 2: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.**

➔ **Objective 2.1: Strengthen the coordination, implementation and evaluation of comprehensive state/territorial, tribal and local suicide prevention programming.**

**Current Status:** Suicide prevention programming and training have been a central focus of efforts by the CTSAB and member agencies and have greatly expanded from 2011 to 2014. For example, the following suicide prevention programs, among others, have been offered in the state during the last year:

- Question, Persuade, Refer Gatekeeper Program (QPR)
- QPR Training of Trainers
- Applied Suicide Intervention Skills Training (ASIST)

- Assessing and Managing Suicidal Risk (AMSR)
- Assessing Suicidal and Self-Injurious Youth (ASSIY)
- TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
- Connect Prevention and Training of Trainers
- Connect Postvention and Training of Trainers
- Mental Health First Aid; Recognizing and Responding to Suicide Risk—
- Primary Care Fresh Check
- SafeTalk
- Survivor Voices Training and Training of Trainers
- Signs of Suicide (SOS)
- Depression Outreach Alliance
- CampusConnect
- Student Support Network; and Active Minds.<sup>6</sup>

**General Recommendations:** The evaluation of existing and emerging suicide prevention programming is essential to ensuring the provision of *effective* suicide prevention activities. Therefore, we recommend continuing cross-agency collaboration and coordination with planned evaluation activities.

**Examples of Possible Strategies:**

- a. Continue to meet within agencies and the CTSAB to identify gaps in programming and to identify resources and strengthen coordination.
- b. Evaluate media campaigns including CTSAB website, social media and mass media placement.
- c. Utilize the CT Healthy Campus Initiative to disseminate information and train college staff to implement evidence-based practices on campuses throughout the state.
- d. CTSAB to make available through their website links to best practices resources through national organizations such as Suicide Prevention Resource Center (SPRC).
- e. Develop and enact legislation requiring suicide prevention training and continuing education for the health, mental health and educational professionals.

➔ **Objective 2.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.**

**Current Status:** The link between mental health and substance use conditions, and suicide and suicide related behaviors is well established. While a small minority of people with mental illness will die by suicide, a large proportion (90%) of those who do die by suicide have struggled with mental health conditions. Community agencies who serve those with mental illness are well positioned to work with those at risk. In addition, other settings whose primary mission and focus are not specifically mental health/illness, such as schools, universities and youth clubs, are well positioned to deliver programs that promote wellness.

**General Recommendations:** Broaden the scope of suicide prevention to include the promotion of wellness and identify those community organizations and agencies that might be well positioned to

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<sup>6</sup> See Appendix J for Trainings by Source and Number Served

develop programs with a focus on wellness, the promotion of protective factors and the reduction of risk factors.

#### Examples of Possible Strategies:

- a. Utilize current infrastructures to enhance/implement suicide prevention/intervention programs.
- b. Promote “Connect Prevention” to communities so they can develop unified language to address suicide prevention.
- c. Promote “Connect Prevention” to communities so they can develop unified language to address suicide prevention.
- d. Use existing campus-community coalitions to provide resources and education to promote wellness and prevent suicide.
- e. Provide training and materials to local community agencies.
- f. Provide training of trainers for evidence-based programs.
- g. Produce suicide prevention curricula for schools.
- h. Identify youth leaders and train them as QPR Gatekeepers to bring safe messaging training back to their own communities and priority populations.
- i. Educate each of DCF’s 25 community collaborations and make recommendations about promoting the implementation of effective suicide prevention and promotion of wellness and recovery.
- j. Develop and implement best practices yoga and wellness programs for youth at risk for anxiety and depression.
- k. Present healthy lifestyles to promote wellness through media campaigns, workshops for groups at elevated risk for suicidal thoughts and behaviors and mental health conditions.
- l. Conduct systematic outreach to key stakeholders to offer training opportunities.
- m. Offer professional development on suicide prevention and risk through the CT Department of Education and track the numbers trained per district.

#### ➔ Objective 2.3: Intervene to reduce suicidal thoughts and behaviors in populations at risk.

**Current Status:** Public and private agencies throughout Connecticut continue to work with people at heightened risk for suicide and suicide related behaviors. Certain demographic groups, however, are at increased risk and may not be sufficiently identified.

**General Recommendations:** Use emerging data to identify those populations, cohorts and settings that have high and/or increasing vulnerability for suicide and suicide related behaviors. Utilize best practices, specific to a particular cohort, to reduce suicidality in populations.

#### Examples of Possible Strategies:

- a. Use recent Connecticut data about suicide related behaviors to identify trends and groups at elevated risk.
- b. Develop programs aimed to ameliorate risk factors in high risk groups.
- c. Continue to assess high risk populations in different settings and demographic groups, particularly those populations that may be marginalized or overlooked. For example, the homeless,

incarcerated, elderly.

- d. Identify the best opportunities by person, setting, and the like for intervening through the analysis of available data.
- e. Engage the community of people with disabilities in order to better understand and respond to suicidality in this population.

### Goal 3: Promote suicide prevention as a core component of health care services.

#### ➔ Objective 3.1: Promote the adoption of “Zero Suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

**Current Status:** The adoption of “Zero Suicides” as an aspirational goal is promoted by the National Strategy for Suicide Prevention and the philosophy is one shared by the CTSAB.<sup>xxvi</sup>

**General Recommendations:** Facilitate discussions among staff involved in suicide prevention and the range of public and private agencies that work with populations at risk about endorsing this stance. Commitment and resources should follow.

##### Examples of Possible Strategies:

- a. Agencies set goals relative to reducing the number of suicides in the populations they serve.
- b. Systematically expand the *1 Word, 1 Voice, 1 Life* campaign to include a “Zero Suicide” message.
- c. Develop and disseminate public service announcements.
- d. Link with community health education professionals at hospitals to incorporate suicide prevention and “zero suicide” messages within all of their health education programming.
- e. Include marketing department/public affairs offices in developing and implementing this message.
- f. Use effective evidence-based care, safety planning, lethal means restriction and follow up care.

#### ➔ Objective 3.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings.

**Current Status:** While individual agencies and trainings promote the delivering of collaborative, responsive and least restrictive settings, there is more to be done in terms of using current research and best practices to inform the development and implementation of these protocols.

**General Recommendations:** Utilize current and emerging research to develop the most responsive, caring and humane responses to the range of human despair that can result in suicidal behavior.

##### Examples of Possible Strategies:

- a. Solicit feedback from survivors of suicide attempts about best responses to suicidal behaviors.
- b. Promote safe messaging.
- c. Include survivors of suicide attempts on the CTSAB.
- d. Include questions related to response to suicidal crises on agency patient satisfaction surveys.
- e. Develop both prototypic and specialized flow charts identifying the process by which agencies will respond to a suicidal client.

- f. Offer assessment services in atypical settings such as recreation centers and houses of worship.
- g. Promote continuity of care and the safety of all patients treated at all levels of the health care system.
- h. Develop innovative “wrap-around” services for people at risk.

➔ **Objective 3.3: Promote timely access to assessment, intervention and effective care for individuals with a heightened risk for suicide.**

**Current Status:** We do not currently have centralized data that tracks all timely access for those at heightened risk.

**General Recommendations:** Encourage agencies to review, develop and implement processes for timely access to these services and to develop means for evaluation and improvement.

**Examples of Possible Strategies:**

- a. Develop recommendations and protocols in agencies for timely access to care and share these among CTSAB member agencies.

➔ **Objective 3.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.**

- a. Develop a presentation using CT data and recruit CTSAB members to develop and present educational materials for hospital emergency room directors and staff.
- b. Develop a database to capture key data elements and to link duplicate/repeat emergency department visits and inpatient admittance. Measure readmission rates.
- c. Ensure that emergency room/department discharges are linked to outpatient providers.
- d. Promote continuity of care and the safety of all patients treated at all levels of the health care system.
- e. Align procedures with those developed by accrediting organizations. Identify where there is room for developing higher standards.
- f. Develop and provide support services for family members of suicidal individuals.

➔ **Objective 3.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.**

**Current Status:** This varies by agency/setting and may be governed by existing accreditation standards. Health care organizations are represented on the CTSAB.

**General Recommendations:** Improvements should occur through individual agencies, accrediting organizations and professional groups. The CTSAB can provide further outreach to health care agencies and encourage the sharing of suicide prevention responses specific to these settings.

**Examples of Possible Strategies:**

- a. Develop a suicide prevention specialized team in health care settings that can in turn provide in-service trainings.

- b. Expand gatekeeper training to staff in health care settings.
- c. Encourage health care professionals to lobby their own professional organizations to increase standards for care of the suicidal client.

➔ **Objective 3.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.**

**Current Status:** This is in progress, in part due to linkages forged through the CTSAB and the CT Garrett Lee Smith Suicide Prevention Initiative, but this is primarily informal at present.

**General Recommendations:** Professional and peer helping relationships can strengthen the support and safety nets for people with suicidal behaviors. Strengthen these through ongoing linkages.

**Examples of Possible Strategies:**

- a. Establish links between providers of mental health and substance abuse services and peer support groups.
- b. Identify current links to community-based services and encourage introductions and collaboration.

➔ **Objective 3.7: Coordinate services among suicide prevention and intervention programs, health care systems and accredited local crisis centers.**

**Current Status:** Suicide prevention activities currently occur in each of these kinds of programs and settings but the degree to which these have been systematically coordinated is unclear.

**General Recommendations:** Continue to identify areas of potential partnership and linkages between these kinds of programs and settings.

**Examples of Possible Strategies:**

- a. Provide links between suicide prevention services and domestic violence crisis centers.
- b. Work with community crisis centers to gather data about referral and coordination patterns, gaps and opportunities.
- c. Engage the Regional Mental Health Boards to participate in the CTSAB.
- d. Consider plans to promote the use of the Columbia Suicide Severity Rating Scale screening tool across state and private agencies.

➔ **Objective 3.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.**

**Current Status:** Some health care agencies are represented on the CTSAB and there are existing collaborations. As the number of people insured in Connecticut rises, patterns of emergency department, crisis units and primary care use may shift.

**General Recommendations:** There is a need, particularly in light of recent health care legislation, to identify the best places for the provision of timely, quality and safe care.

### Examples of Possible Strategies:

- a. Link community clinics to hospitals.
- b. Develop plans of care that direct patients through various levels of care.
- c. Implement evidence-based suicide prevention training into all levels of health care systems.
- d. Discuss and implement safety planning strategies for emergency department patients as a model of evidence-based best practices.

## Goal 4: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

### ➔ Objective 4.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

**Current Status:** We currently have no data on mental health practitioners' routine assessment of at risk clients for access to lethal means. The national data suggest that this is not routinely performed.

**General Recommendations:** There is a great need to publicize the role of lethal means restriction in preventing suicides and to stress that it applies to all potential means of suicide, not just firearms. Given that reducing access to lethal means is an effective prevention strategy, the CT data on method of death by suicide and lack of uniform protocols, this is an important area for education of mental health providers and families and friends of people at risk for suicidal behavior. Education must focus on provider and family attitudes, beliefs and behaviors.

### Examples of Possible Strategies:

- a. Develop a subcommittee of the CTSAB to develop guidelines and educational plans for the training of providers on lethal means counseling.
- b. Develop and disseminate to the public and providers clear statements of what constitutes lethal means, including firearms, poisons, prescription and illegal drugs, and the like.
- c. Consider the socio-legal political climate in the discussion of lethal means restrictions.
- d. Deliver training to primary care physicians and other front-line providers.
- e. Develop an educational public service announcement that educates the public about lethal means restrictions.
- f. Develop provider "cue cards" to ask the necessary questions about lethal means.
- g. Provide links from the CT Suicide Prevention website to Counseling On Access to Lethal Means, <http://training.sprc.org/course/description.php#course3>.
- h. Publicize opportunities (like drop boxes and "take-back" programs) to safely dispose of prescription drugs and poisons.

### ➔ Objective 4.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

**Current Status:** While there has been a model of suicide prevention/firearm dealer collaboration in the state of New Hampshire, there are limited efforts in Connecticut.

**General Recommendations:** Consider bringing stakeholders together to begin discussions about possible collaborations under the auspices of the CTSAB.

**Examples of Possible Strategies:**

- a. Gauge interest among gun dealers to partner with the CTSAB regarding lethal means restrictions.
- b. Develop awareness suicide prevention and lethal means restriction materials for gun shop owners to post and distribute.
- c. Use a similar approach to the CT tobacco merchant education model to collaborate and inform regarding warning signs and opportunities for prevention and intervention.
- d. Recommend policies that require firearm courses to include safe storage and suicide prevention content.
- e. Work toward recommending legislation and local ordinances that would require dissemination of trigger locks at classes and with each sale of arms at stores.
- f. Engage firearm dealers in QPR and other suicide prevention trainings.
- g. Work with police to develop and publicize temporary “safe storage” facilities for lethal means held by individuals at immediate risk for suicide.

➔ **Objective 4.3: Develop and implement new safety technologies to reduce access to lethal means.**

**Current Status:** While safety technologies are available, they are not widely legislated or used.

**General Recommendations:** Consider CTSAB subcommittee to examine research in this area and make recommendations for greater awareness of and utilization of these existing and emerging technologies.

**Examples of Possible Strategies:**

- a. Work with stakeholders to determine current level of safety utilization related to the various lethal means including guns, poisons, and prescription and non-prescription drugs.
- b. Develop recommendations for the implementation of best available technologies to reduce access.
- c. Post crisis number signage at locations where, according to OCME data, people have made suicide attempts (for example, bridges, railways, overpasses, parks).
- d. Support access to and training in the use of Narcan to prevent opioid overdose.

**Goal 5: Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.**

The following objectives are grouped together due to significant overlap of recommended strategies:

➔ **Objective 5.1: Improve the timeliness of reporting vital records data.**

➔ **Objective 5.2: Improve the usefulness and quality of suicide-related data.**

➔ **Objective 5.3: Improve and expand state/territorial, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.**

**Current Status:** The CTSAB contracts with professionals who identify and analyze most recent data related to suicide deaths and attempts in the state of Connecticut. They are able to identify trends and develop benchmarks and priorities for prevention efforts. In a recent survey, CTSAB members reported that while they generally have access to the data they need in their suicide prevention efforts, they would like to have easier access, with one portal for securing it. There are, however, gaps in the data that is available on a timely basis. The complexities in obtaining accurate, timely, consistent data are well identified in the literature but these may be mitigated by the CT Department of Public Health grant award (2014–2019) to participate in the National Violent Death Reporting System (NVDRS).

**General Recommendations:** Develop a clear plan for the timely gathering, analyzing and posting of data related to suicide deaths and attempts in CT. Identify data collection goals, where data can be obtained and what obstacles may exist. Align state reporting systems with those on the national level.

**Examples of Possible Strategies:**

- a. Include on the CTSAB website a regularly updated data page that contains the latest national and state data on suicide related behaviors and deaths in Connecticut.
- b. Strengthen ties between the CTSAB and the Office of the Medical Examiner and local police for the timely access of data related to untimely deaths. This could allow, in the case of suicide, for assistance, support and consultation with affected families and communities.
- c. Obtain a memorandum of understanding with the Office of the Medical Examiner and collaborate on data collection, particularly identifying other field/populations of interest.
- d. Inform and educate hospitals, the public and the judiciary about the importance of reporting timely and accurate suicide data.
- e. Develop quarterly reporting of vital statistics, including deaths by suicide and suicide attempts.
- f. Provide training to those who are in positions to collect data, so that they can reliably recognize, categorize and standardize the data.
- g. Expand the distribution base of entities that receive the “cleaned” data; that is, all 30 hospitals, clinics, and the like.
- h. Improve the usefulness and quality of suicide related data for grants, funding, education and resources, and make available in one central location.
- i. Provide training to health care providers regarding the proper coding of suicide related events.
- j. Provide user-friendly data materials for distribution to agencies and communities. Include trends and concerns for specific areas.
- k. Institute the consistent use of nomenclature for various forms of self-directed violence.
- l. Where feasible, put a “human face” on the statistics, with permission from suicide survivors and family members.
- m. Include suicide data in regional profile development produced by Regional Area Councils.
- n. Use suicide-related data to implement prevention efforts and inform policy efforts and decisions, all related to specific populations.
- o. Use multiple state level data sources such as the CT Health Information Network, Hospital Inpatient Discharge Database and the Office of the Chief Medical Examiner.

- p. Use state level data and national research findings to guide targeted areas and resources and gaps in resources.
- q. Add suicide prevention questions to the CT Health Survey.
- r. Use state level data and the National Action Alliance for Suicide Prevention's *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives* to identify the most immediate needs for suicide prevention research in the state of Connecticut.

## Introduction to the Groups at Elevated Risk

The 2012 National Strategy for Suicide Prevention identified on the basis of multiple sources of data, groups with particularly increased risk for suicide and suicide related behaviors. These include: American Indians/Alaska Natives; individuals bereaved by suicide; individuals in justice and child welfare settings; those who engage in nonsuicidal self-injury; those who have attempted suicide; individuals with chronic medical conditions; those with mental health and substance use conditions; lesbian, gay, bisexual and transgender populations (GLBT); military members and veterans; men in midlife and older men.<sup>xxvii</sup> These priorities are based upon national data and trends and do not necessarily reflect regional differences in populations at risk.

Here in Connecticut, several sources inform our selection of populations for inclusion in this version of PLAN- 2020. First, data collected through the Office of the Medical Examiner, the CT Hospital Database, National Vital Statistics Reports, the CDC Morbidity and Mortality Weekly Report, the CDC Youth Online High School Youth Risk Behavior Surveillance Survey among others have been reviewed and inform our recommendations. Here, we report on groups in three domains: by lifespan; by race and ethnicity; and by special population, which is defined as a group holding a certain status/identification, area of challenge or setting. In addition to using data to determine which groups to highlight at this point in time, we relied on a broad group of Connecticut experts in suicide prevention who have expertise in working with members of at-risk groups. Some of these experts are professional providers; others may be suicide survivors; several identify as both. This process has insured both data-driven and expert-driven approaches, from those who have knowledge of the lived experience of suicide and its impact on individuals, families and communities. As with previous sections of the PLAN 2020, users are encouraged to consider this content as a starting point for developing and implementing their own suicide prevention activities, with particular attention to where those efforts can become embedded in their agency's broader visions.

### Lifespan:

Suicide occurs with different rates and methods across age groups and these trends change over time. Age groups also share common risk factors and have ones that are specific to each. Finally, while many of our prevention strategies are common to all age groups, some we present here are specific, based upon factors such as prevalence, choice of method and risk factors.

### Youth Suicide

Youth suicide is a particularly devastating problem from several different vantage points. The CDC (2012)<sup>xxviii</sup> reports that among those 10 to 24 years of age, suicide is the third leading cause of death, resulting in approximately 4,600 deaths each year. Nationally, the young are most likely to die by firearm (45%), by suffocation (40%) and by poisoning (8%). (Please note: different reporting agencies consider youth to age 19, breaking out 20–24 and 25–29 as young adult; nonetheless, the statistics are troubling.)

Actual deaths by suicide in this age group are not the only concern. Results from the 2011 National Youth Risk Behavior Survey (YRBS) suggest that of US high school students, 16% in a given year reported seriously

considering suicide; 13% reported having a plan for doing so; and 8% actually made a suicide attempt. The data is equivocal; boys die by suicide at significantly higher rates than their girl counterparts; 81% of suicide deaths in this age group are boys; the remaining 19% are girls. However, girls are far more likely to attempt suicide than die by suicide. Nationally, Hispanic youth were more likely to report suicide attempts than their peers.<sup>xxix</sup> The YRBS is a national school-based survey conducted by the CDC and state governments to monitor priority health-risk behaviors among high school students. It is conducted every two years during the spring semester. The national survey samples ninth through twelfth graders in public and private schools. Connecticut samples public high school students.

In the State of Connecticut, the Office of the Chief Medical Examiner reports the following confirmed youth deaths by suicide, by gender and by year.

Table 2.

Connecticut Youth Suicide Frequency and Rate by Age and Gender 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
10 to 14	0	0	1	0.83	1	0.83
15 to 19	5	4.0	14.4	9.95	18	7.04

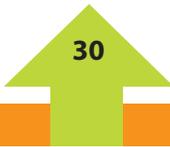
Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 3.

Connecticut Suicide Frequency by Age and Gender, 2006–2012

	Ages 1-9		Ages 10-14		Ages 15-19		TOTALS	
	F	M	F	M	F	M	F	M
2006	0	0	0	1	2	13	2	14
2007	0	0	0	0	1	13	1	13
2008	0	0	3	3	2	12	5	15
2009	0	1	1	0	6	10	7	11
2010	0	0	0	0	2	9	2	9
2011	0	0	0	1	2	12	2	13
2012	0	0	0	1	5	13	5	14

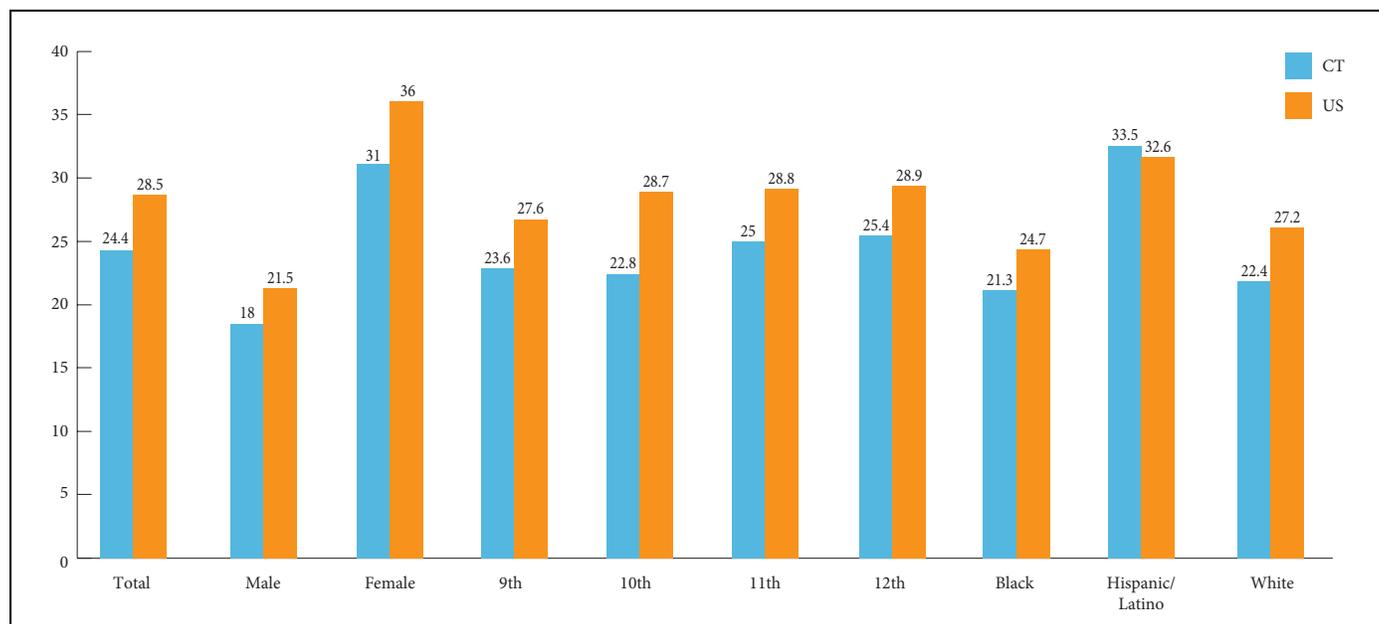
Adapted from Office of the Chief Medical Examiner, State of Connecticut <http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295126>



While youth deaths by suicide are of great concern, equally concerning are the related depressive and suicidal thoughts, plans and attempts. As at the national level, CT youth reported concerning rates of suicide related thoughts and behaviors in the YRBS in 2011.

Figure 7.

Connecticut Youth Suicide Frequency and Rate by Age and Gender 2012



Source: YRBS, 2011 data. <http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=CT>  
 Accessed: March 23, 2014

Additionally, youth reported other serious suicide related behaviors<sup>7</sup>:

- 14.6% of all students reported having seriously considered attempting suicide during the past 12 months (11.9 % of males and 17.3% of females).
- 11 % of all students reported having made a plan about how they would attempt suicide during the past 12 months (9.8% of males and 12.2% of females).
- 6.7% of all students reported having actually attempted suicide one or more times during the last 12 months (5.2% of males and 8.2% of females).
- 2.8% of students reported having made a suicide attempt during the last 12 months that resulted in an injury, poisoning or overdose that had to be treated by a doctor or a nurse (3% of males; 2.5% of females).<sup>xxx</sup>

<sup>7</sup> See Appendix H for additional CT Youth Suicide Related Behaviors

Suicide prevention efforts for youth in Connecticut can focus on micro- and macro-level interventions:

- Broaden suicide prevention efforts to include a focus on prevention of suicide *and* on suicide related thoughts and behaviors that are often precursors to a fatal attempt.
- Provide psycho-education for family members and natural support systems.
- Educate that lethal means restrictions with youth will also include attention to the high-risk method for this population: asphyxia and hanging.
- Provide education and interventions regarding lethal means restriction.
- Increase awareness across the state of risk factors for youth.
- Promote suicide prevention training in all settings where youth congregate (schools, communities, houses of worship, and the like).
- Advocate for legislation and resources to ensure ready access to quality mental health services.
- Embed suicide prevention services and funds in youth programs.
- Develop specialized prevention programs for those youth in foster care and those who have contact with the juvenile justice system. These populations are almost four times more likely to attempt suicide.
- Consider the differences of suicide and related behaviors among youth related to other demographic characteristics such as gender, race/ethnicity and sexual orientation.
- Advocate for legislation that mandates annual suicide prevention training for middle schools and high schools.
- Provide timely outreach to communities after a suicide.
- Promote universal behavioral health screens including substance abuse and depression.
- Consider the development of a suicide prevention conference that addresses youth and young adults, with separate tracks for educators, peers, family members, researchers and direct service providers.
- Train school nurses and other school personnel in Youth Mental Health First Aid.
- Provide Question, Persuade, Refer (QPR) for Youth presentations.

## Young Adult/College Aged

Accurate data for suicide deaths in young adults is difficult to obtain because of the different age groupings used by reporting agencies. For example, the 2010 U.S. Official Final Report aggregates data for the 15 to 24 year old group, obscuring any differences between adolescents and young adults in morbidity and related factors. In Connecticut the OCME does report data for the 15 to 19 year olds and for the 20 to 24 year olds.

Table 4.

Connecticut Suicide Frequency and Rate by Age and Gender, Late Adolescent and Young Adult 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
15 to 19	5	4.0	13	9.95	18	7.04
20 to 24	6	5.4	11	9.26	17	7.43

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

College student data is derived from the American College Health Association/National College Health Assessment (ACHNA/NCHA) Undergraduate Survey (2012). Students reported the following occurrences within the prior 12 months: 44.6% had feelings of hopelessness; 85.2% felt overwhelmed; 56.6% felt very lonely; 59.5% felt very sad; 29.5% felt so depressed it was difficult to function; 49.9% felt overwhelming anxiety; 6.9% seriously considered suicide; 5.5% intentionally cut, burned, bruised or injured themselves; and 1.2% attempted suicide.<sup>xxxi</sup> Additionally, students reported significant difficulty handling academics, finances, intimate relationships and family problems. Furthermore, young adults have the highest rate of treatment for intentional self-injury of all groups. College students with particular needs include those with mental health problems, prior suicide attempts and bereavement by suicide, veterans and active duty students, Hispanic/Latino students and LGBT students.

Programs such as CT Healthy Campuses Initiative, JED Foundation, QPR (Question, Persuade, Refer), Jordan Matthew Porco Healthy Check and the Garrett Lee Smith Grants make it possible to develop programs and provide services for those young adults who are in the educational systems across the state. Young adults who are veterans or active duty military may be identified through DMHAS Military Support Program and Veterans Administration programs. It may be more challenging to reach those young adults who are neither college nor military connected and may have increased rates of unemployment and other challenging life conditions. Pilot data (2002) from the National Violent Death Reporting System found that most 18 to 24 year olds who died by suicide were not students and were as likely to be high school drop-outs or in trouble with the law as to be college students.<sup>xxxii</sup>

Suicide prevention efforts for this population can include, in addition to more universal efforts, the following:

- Involve family members and natural supports in the work with at-risk young adults in ways that are developmentally appropriate.
- Make greater use of social media technology for suicide awareness and referral.
- Encourage young adult participation on the CTSAB.

- Identify particular needs of those youth who are “aging out” of DCF state custody.
- Utilization of the seven strategies referenced in the Jed Foundation Suicide Model for Comprehensive Mental Health Promotion and Suicide Prevention for Colleges and Universities.
- Provide QPR Training (Question, Persuade, Refer) for those working with this age group.
- Encourage the development of peer-run groups on campus, such as Active Minds.
- Develop e-blasts of resources available in CT that address the continuum of services and programs available for young adults to campus leaders.

*Middle-Aged Persons*

National suicide rates for middle-aged men have increased disproportionately since the 1990s and this is currently the highest risk age/gender group. According to the 2012 National Strategy, men in this cohort share universal risk factors, but may have additive risk related to the under-reporting of mental health problems, avoidance of help-seeking, involvement in interpersonal violence, economic hardship related to the recent recession and attendant longer term unemployment, and disruption of intimate relationships.<sup>xxxiii</sup> At the same time, rates for middle-aged women have not shown the same consistent pattern.

Table 5.

Connecticut Suicide Frequency and Rate by Age and Gender for Middle Aged Adults 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
35 to 44	17	7.2	56	25.04	73	15.92
45 to 54	21	7.2	71	25.72	92	16.24
55 to 64	17	7.0	41	18.16	58	12.41

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 6.

Connecticut Suicide Frequency of Middle-Aged Persons  
by Gender, 2006–2012

	Ages 30-39		Ages 40-49		Ages 50-59	
	F	M	F	M	F	M
2006	6	45	15	43	17	48
2007	5	28	14	54	12	40
2008	10	36	17	58	21	50
2009	9	47	0	49	24	58
2010	10	34	23	71	16	63
2011	13	37	21	71	19	68
2012	12	44	19	75	22	54

Source: <http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295126>  
Retrieved 5/22/2014.

Suicide prevention efforts can focus on the following areas:

- Consider public health campaigns targeted to reduce stigma associated with male help-seeking for mental health and substance abuse issues.
- Increase referral and service availability in employer settings.
- Increase training of primary care physicians.
- Develop creative strategies for engaging middle-aged men in treatment.
- Train and counsel professionals, family members and communities for lethal means restriction.
- Greater consideration of the role of job and financial strain as risk factors for suicide, consistent with emerging research.

*Older Adults*

While all age groups share some risk factors for suicide, older adults have several additional or exacerbating factors including: comorbid general medical conditions that significantly limit functioning or life expectancy, and pain and declining role function; for example, loss of independence or sense of purpose; social isolation, inflexible personality or marked difficulty adapting to change; medication abuse or misuse; and impulsivity in the context of cognitive impairment.<sup>xxxiv</sup> Furthermore, their social isolation may make them less likely to be rescued and their most frequent choice of method, firearm (67%), is more apt to result in a fatality. For every completed suicide among older adults, an estimated two to four attempts occur, while in younger adults the ratio of completed suicide to attempts may be as high as 200 to 1.<sup>xxxv</sup> Research has shown that 58% of older adults who die by suicide have seen a primary care provider within the last month of their life.<sup>xxxvi</sup> Specialized training for geriatricians and primary care physicians is essential.



The Administration on Aging and the Substance Abuse and Mental Health Services Administration (SAMSHA) recommend universal, selective and indicated prevention efforts by aging service providers; mental health providers and primary health care providers.<sup>xxxvii</sup> These may include:

- Providing systematic outreach to seniors at elevated risk due to widowhood or social isolation.
- Introducing depression and suicidality screening in non-clinical activities such as senior transportation, senior daycare and senior companionship.
- Providing gatekeeper training to aging service providers and laypersons.
- Routine screening for suicide and mental health conditions in primary care.
- Implementing best practices for diagnosis and treatment for late life depression.<sup>xxxviii</sup>
- Training and counseling for lethal means restriction.

### Race/Ethnicity<sup>9</sup>

There are significant differences among racial/ethnic groups in rates of suicide nationally. In Connecticut, where overall numbers of suicide are relatively low, and numbers even smaller when divided by race and ethnicity, data must be considered with caution. While the 2012 suicide rates range from 12.35 for Whites (N=315), the lowest rate was for Asian/Pacific Islanders (N=7). According to this data, American Indian/Native Americans have a high rate at 10.88, but this is the result of one death in this group in 2012.

Table 7.

Number and Rate of Suicides in Connecticut 2006 to 2012 by Race

Year	White n	White Rate	Black n	Black Rate	American Indian/Native American n	American Indian/Native American Rate	Asian/Pacific Islander n	Asian/Pacific Islander Rate	Hispanic n	Hispanic Rate
2006	228	8.62	10	2.94	0	0	6	4.91	12	3.05
2007	218	8.31	9	2.64	0	0	1	.81	20	4.96
2008	258	9.90	11	3.23	0	0	6	4.78	20	4.77
2009	262	10.09	18	5.20	0	0	6	4.57	22	5.06
2010	285	11.04	17	4.75	0	0	12	8.30	26	5.40
2011	328	12.77	16	4.43	1	11.07	5	3.38	17	3.44
2012	315	12.35	12	3.29	1	10.88	7	4.54	27	5.29

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

<sup>9</sup> Please note: The terms used to describe various ethnic/racial groups reflect the language typically used in national data sets and research. There may be geographic differences in the use of various terms.

## Blacks

In 2010, the suicide rates for Blacks (5.37) was slightly less than half that of the overall United States rate (12.08), was the sixteenth leading cause of death for Blacks of all ages and the third leading cause of death for Black males ages 15 to 24. There are, however, significant differences in rates among age<sup>xxxix</sup> groups in the Black population. For example, Black men ages 25 to 34 have the highest rate at 16.43. Furthermore, the average age of Black suicide decedents is 32, compared to that of White decedents at 44. This has significant impact on the Black community. Black women have historically had the lowest rates of suicide at 1.85 with a range of 2.08 for 15 to 24 year olds and 2.6 for 35 to 64 year olds. The data is complicated by the fact of rates of .77 for women aged 65 to 84 and 1.09 for those 85 or over, both with total numbers of deaths too low for precision.

In spite of relatively low rates of suicide deaths, Black adults 19 and older report similar rates of suicidal behavior compared to other United States adults. There are ethnic differences as well; adult Caribbean Blacks have a higher suicide rate than African-Americans, but among adolescent males, African American Blacks were nearly five times more likely than Caribbean Blacks to make an attempt. There have been attempts to explain the relatively lower rates by which Blacks die by suicide. What is known is that for women, having a strong sense of Black identity appears to confer some protection; religion, social and emotional support seem to play a crucial role for both Black men and women.<sup>xi</sup>

- In Connecticut 10.1 percent of the population (362,296 people) identified as Black or African American in the 2010 Census.<sup>xii</sup>
- Suicide prevention efforts can be tailored to Connecticut's Black population through:
  - Adoption of general prevention strategies.
  - Increasing understanding of ethnic-specific risk and protective factors.
  - Prevention strategies developed with particular attention to strengthening existing protective factors.
  - Co-develop suicide prevention efforts with faith-based communities.
  - Develop culturally congruent practices for prevention and interventions.

## Hispanic/Latino

According to 2010 data, the suicide rate (5.85) for Hispanics of all ages is slightly less than half of the overall U.S. population (12.08), the twelfth leading cause of death for Hispanics of all ages, and the third leading cause of death for Hispanic males ages 15 to 34.<sup>xiii</sup> The highest rate is for Hispanic males age 85 and over (30.58) and the lowest at 10.69 for ages 15 to 24. Rates for Hispanic women range from a high of 8.21 for ages 35 to 64 to a low of 3.27.

There are also ethnic variations in this broad group of Hispanics with Puerto Ricans having the highest rates of suicide attempts. There has been an increase in lifetime prevalence of suicide attempts among 18 to 24 year old Puerto Rican women and Cuban men, and among 45 to 64 year old Puerto Rican men.<sup>xiiii</sup>

Immigration is also implicated in differences related to immigration status. For example, U.S. born Hispanics have higher rates of suicidal ideation and suicide attempts than Hispanic immigrants. Immigrating as a child rather than as an adolescent or adult appears to result in higher suicide risk. Similarly, U.S. born Hispanic adolescents who have U.S. born parents have a higher risk of suicide attempts than their counterparts with

immigrant parents.<sup>xiv</sup> Hispanics who died by suicide had the second highest rate of alcohol use among racial/ethnic groups during an attempt and 28% were intoxicated at the time of their suicide death.

In the U.S. 2010 Census reports for Connecticut, 13.4% of the population (479,087) identified as Hispanic or Latino, making this the highest ethnic/racial population.

In addition to suicide prevention strategies provided universally, suicide prevention strategies for Hispanic populations can include the following:

- Attention to unique protective factors, such as familism, ethnic affiliation, religiosity and moral objections to suicide; and for youth, caring from teachers<sup>xv</sup> and other trusting adults, including parents and family members.
- The development of strategies that target specific risk factors such as alcoholism, underutilization of mental health services and greater likelihood of not seeking or receiving mental health services when needed.
- Develop strategies to address specific risk factors associated with a suicidal crisis: alienation; acculturative stress and family conflict; hopelessness and fatalism; and discrimination.
- Better understand the issues related to relatively high rates of non-suicidal behaviors.

#### *American Indians/Alaskan Natives (AI/AN)*

Nationally, the suicide rate for American Indians/Alaskan Natives (16.93) is much higher than for the total U.S. population (12.08 per 100,00). It is the leading cause of death for all AI/AN and the second leading cause for youth ages 10 to 24.<sup>xvi</sup> Youth are at particular risk, with rates that decrease significantly after early adulthood, in contrast to the overall U.S. population where rates increase with age. The CDC recently (2013) found, however, that AI/AN men and women ages 35 to 64 had a greater percentage increase in suicide rates between 1999 and 2010 than any other racial/ethnic group. Notably, rates increased for women at 81.4% and for men at 59.5%. Rates vary dramatically between tribes.

In Connecticut, in the 2010 U.S. Census<sup>xvii</sup>, .3% of the population (11,256) identified as American Indian or Native American<sup>xviii</sup> and it is unclear how many live within or have strong association with tribes. Given this relatively small population and two reports of suicide deaths by the OCME from 2006 to 2011, it is difficult to make meaningful observations about the suicide rate in this population. Nevertheless, nationwide, several risk factors specific to this population have been identified, including: historical trauma, alienation, acculturation, discrimination, community violence, low patterns of mental health service access and use, and contagion.<sup>xix</sup>

In addition to universal statewide suicide prevention strategies, efforts can be focused in the following ways:

- Actively recruit tribal leaders and tribal mental health and wellness practitioners and youth for involvement in the CTSAB.
- Provide outreach consultation services to tribal leaders.
- Strengthen data surveillance procedures and reporting.
- Use media campaigns that focus on both risk and protective factors for this population.

### *Asians, Pacific Islanders and Native Hawaiians*

Asians (which include persons with origins in the Far East or Southeast Asia) are often combined in the mortality data sets and comprise 4.8% of the U.S. population. The category of Pacific Islanders includes people with origins from Hawaii, Guam, Samoa and other Pacific Islands. This category comprises 0.2% of the U.S. population.<sup>i</sup>

According to the 2010 U.S. Census, in Connecticut, 3.8% of the population identified as Asian, for a population of 135,565. The largest of these groups was Asian Indian at 46,415. Six other Asian groups have populations less than 1.0% and it should be noted that this is a diverse group, with different histories, reasons for immigration or refuge, and cultures.

Asians have a suicide rate approximately one-half that of the overall U.S. rate of 12.08 per 100,000 and suicide was the tenth leading cause of death for Asians/Pacific Islanders and the second leading cause of death for youth ages 15 to 24.<sup>ii</sup> In the U.S. for this population of males, the rate is generally comparable from ages 15 to 24 (10.41 per 100,000) to ages 35 to 64 (11.45 per 100,000). The highest risk group are older adult men at 29.76 per 100,000, but the numbers of death are low, making precision difficult. The lifetime prevalence of suicidal ideation and attempts are lower than in any other ethnic group. Asians who immigrated to the U.S. as children have higher prevalence rates of both suicide and suicidality than those born in the U.S. Further complicating the picture, those who immigrated during adolescence or adulthood have lower yearly prevalence rates of ideation and attempts than either of the previous groups.<sup>iii</sup> Further research is required to fully understand the discrepant rates depending upon age at immigration and what role acculturation and family expectations may play.

Of particular concern are the findings that Asian and other Pacific Islander high school students have reported higher rates of suicidal behaviors than the general population of high school students.<sup>iiii</sup> Asian female students appear to be at increased risk, reporting higher rates of suicidal thoughts and behaviors than their male counterparts and white males and females. Importantly, about 62% of Asians who attempted suicide reported that their first attempt occurred when they were under age 18, highlighting the vulnerability for this group in adolescence.<sup>iv</sup>

There are documented protective factors for Asians and Pacific Islanders, which include: cultural identification and sense of belonging and affiliation, associated with a 69% reduction in the risk of suicide attempts<sup>v</sup> and strong family cohesion, organization and parental belonging. Cohort-specific risk factors include high levels of family conflict, such as witnessing family violence, and among college students, parent-child conflict. Immigrant Asian populations may have problems navigating mental health systems secondary to discrimination and language proficiency issues. Both college students and adults who perceive discrimination report higher rates of suicidal ideation and attempts.<sup>vi</sup>

In addition to universal statewide prevention efforts, the following targeted efforts can be utilized:

- Consider the “model stereotype” mentality (that Asian-Americans are “naturally smart,” wealthy and successful, for example) as a risk factor that may prevent Asians and their families from seeking help—and may prevent providers from accurately assessing their needs.
- Make available translation services at all ends of the prevention services spectrum.
- Provide outreach to the Asian communities with suicide prevention awareness materials that are culturally appropriate.
- Develop practitioner expertise in culturally competent practice.

- Where available, work with community health workers who may have specialized cultural understandings.
- Recruit young adult and adolescents to an advisory board of the CTSAB.

### *Lesbian, Gay, Bisexual, and Transgender (LGBT)*

Estimates of the prevalence of gay, lesbian and transgender people is also imperfect, due in large part to differences in definitions of classification/identification or behavior. Attempts to ascertain the scope of risk for suicide by LGBT persons is hindered by the lack of data sources that include sexual orientation or identity. For example, the U.S. death certificate and the reporting system, NVDRS, do not include this information and we do not know if LGBT people are more likely to die by suicide. Research has then relied on the psychological autopsy, a labor intensive method of gaining an understanding of the reasons an individual died by suicide. There has not, however, been unequivocal evidence from these studies that there was a disproportionate risk of death by suicide.

The data on suicidal thoughts and behaviors is more reliable. There is strong evidence from population based studies that being gay, lesbian or bisexual confers elevated risk for suicide attempts,<sup>lvii</sup> particularly, but not exclusively, for youth. Consider the following results from several meta-analyses of studies:<sup>lviii</sup>

Lifetime prevalence rates of suicide attempts in gay and bisexual male adolescents and adults are four times higher than comparable heterosexuals.<sup>lix</sup>

- Lifetime suicide attempts among lesbian and bisexual females are almost twice those of their heterosexual counterparts.<sup>lix</sup>
- Lesbian, bisexual and gay (LBG) youth were three times more likely than their heterosexual counterparts to report a suicide attempt in the past year.
- LGB youth were three times more likely to report a lifetime suicide attempt and four times more likely to report a medically serious attempt.<sup>lxi</sup>
- 12 to 19% of LGB adults report making a suicide attempt, compared to less than 5% of heterosexual adults.
- 30% of LBG adolescents report attempts, as opposed to 8 to 10% of their heterosexual counterparts.<sup>lxii</sup>

The limited research on suicide and transgender people is even more concerning with 41% of respondents to the 2009 National Transgender Discrimination Survey reporting lifetime suicide attempts.<sup>lxiii</sup>

Specific risk factors for this population may include the effects of “minority status” and discrimination at the personal, institutional and legal levels. It is argued that the elevated risk for suicide attempts is not a function of sexual orientation per se, but of negative responses to it.

Protective factors include family acceptance, a sense of safety, positive identity, connection to caring others, and access to quality and culturally competent mental health treatment.<sup>lxiv</sup>

In addition to general suicide prevention strategies, the following may be useful:

- Recruitment of adolescent, young adult and adult LGBT members to the CTSAB Board and/or Network.
- Develop alliance with True Colors for peer training for suicide prevention.

- Strengthen alliances with local schools regarding stigma and suicide prevention.

### *Military/Veterans*

Suicide rates for members of the military and veterans, historically lower than that of the general population, have been increasing significantly, nearly doubling from 2001 to 2009. As of 2010, the Army National Guard had the largest increase in total suicides, more than doubling the 2009 rate. The CDC now reports that veterans account for 20% of the suicides in the U.S. and are overrepresented in those recently returning from Iraq and Afghanistan and for those who receive Veterans Administration (VA) services.<sup>lxv</sup> In a study of veteran deaths between 2003 and 2008, 69% were caused by firearm, nearly always a fatal method.<sup>lxvi</sup> Half of all people who die by suicide in the Veterans Health Administration have a known mental health condition.

The Department of Defense (DOD) follows active duty/National Guard/Reserves while the VA follows those who have separated from the military. In 2007, the VA initiated an integrated approach to suicide prevention. The DOD developed the Defense Suicide Prevention Office in 2011 to oversee all development and implementation of suicide prevention strategies throughout the military.

The following are risk factors in military personnel, some of which overlap with those for the general population: presence of mental illness, particularly comorbidity; psychological factors such as emotional reactivity; neurocognitive factors such as executive functioning problems such as problem-solving; family history of mental disorders; and childhood adversities.<sup>lxvii</sup> The literature has increasingly focused on the role of deployment and combat exposure on suicide risk, about which there have been some conflicting findings. Future research needs to focus on the circumstances under which deployment raises suicide risk in military personnel and the complex relationships between mental health issues, suicidality and deployment.

Risk factors that may be exacerbated in military personnel include the following:

- The traumatic nature of combat exposure, specifically related to threats of improvised explosive devices.
- Prolonged and repeated deployments and uncertainties about tour extensions.
- New life-saving interventions that promote survival but leave individuals with high distress related to serious health issues and disfigurements.
- Effects of traumatic brain injury.

Specific protective factors may include:

- Social support and cohesion within one's unit.
- Positive contact with family and frequency of contact with spouse.
- Buffering effects of positivity.
- Post-traumatic growth in the aftermath of traumatic events.
- Available, quality, non-stigmatizing mental health treatment.

In addition to general suicide prevention strategies, the following may be useful:

- Collaboration between National Guard/Active Duty and VA services to ensure smooth transitions in care.
- Work to engage with families of active duty/veterans in order to educate about risk factors,

warning signs and how to access help in the various systems.

- Encourage use of peer support resources.
- Development of strategies to reduce stigma related to help-seeking.

### *Criminal Justice*

Suicide in jails and prisons in the U.S. is a significant public health problem. It is the leading cause of death in U.S. local jails and the fourth in state prisons. In 2010, there were 520 suicides in state prisons and local jails, according to the U.S. Bureau of Justice, at rates far above that of the general population. The majority of these deaths occur in inmates age 25 to 34 years of age, though the highest rates are among those 17 or younger and 55 or older.<sup>lxviii</sup>

Despite the lack of privacy and access to weapons, suicide is the third leading cause of death in prisons.<sup>lxix</sup> Corrections settings typically involve high monitoring and restriction to lethal means (sharps and drugs, for example), though the majority of suicides in prison are by hanging. In addition, it is theorized that jail suicides result from two primary factors: that the jail environment is conducive to suicide and that the inmate is in a crisis situation.<sup>lxx</sup>

Among individuals in the juvenile justice system it is reported that suicide rates are four times higher than in the general population.<sup>lxxi</sup> Additionally, it is reported that among suicide attempts reported by youth in juvenile facilities, 60% were violent attempts. Research suggests that more than half of all detained youth experience suicidal ideation and a third have a history of suicidal behaviors.<sup>lxxii</sup> In juvenile detention centers, there are 17,000 suicide related incidents each year; more than half of these juveniles report current suicidal ideation, and a third have a history of suicidal behaviors.<sup>lxxiii</sup>

Those with contact with criminal justice systems share risk factors with the general population, but may also have higher degrees of family discord and abuse, history of prior interpersonal conflict, prior involvement with special education services, legal and disciplinary problems, and prior offenses, among others. Significant relationships were found between suicide risk and traumatic experiences and substance abuse among young people in juvenile detention.

Protective factors among juvenile and adult inmates may include: a sense of control over one's destiny; problem solving and conflict resolution skills; adaptable temperament; support and connections from one's home and community; positive school experiences; religious beliefs that protect against suicide; and housing that is "suicide resistant" and proximal to staff.<sup>lxxiv</sup>, <sup>lxxv</sup> In addition, access to high quality mental health services that provide strong community referrals are protective.

There are different risks and protections afforded inmates in different kinds of settings and prevention efforts should address the continuum from pre-adjudication to incarceration, to probation and parole. Studies by the National Center on Institutions and Alternatives, commissioned by the Department of Justice, have issued a broad and specific set of recommendations for suicide prevention and intervention at the policy and direct services levels. A number of important recommendations, including screening and assessment, reassessment and attention to community reentry, are offered in the Mental Health Assessment in Juvenile Justice: Report on Consensus Conference.<sup>lxxvi</sup>

In Connecticut, where prisons and jails form one integrated system, a screen to determine inmates' level of risk for suicide, the Suicide Risk Assessment (HR-517), is administered to all inmates at intake to a CT correctional facility. Connecticut Department of Corrections (CDOC) direct contact employees are required to receive training in suicide prevention and related topics. In addition, the UConn Health Center

Correctional Managed Health Care policy details procedures for prevention and intervention.

In addition to the general suicide prevention strategies, the following can be recommended:

- Continued specific training for all corrections personnel.
- Strong mental health assessment and ongoing screening for suicidality.
- The availability and resourcing of high quality mental health and substance abuse services.
- “Suicide watch” protocols for those assessed at increased risk for suicide.
- A focus on the continuum from pre-adjudication to incarceration to probation and parole.

### *Mental Health/Substance Abuse*

Between 90% and 98% of people who die by suicide have a diagnosable mental health condition.<sup>lxxvii</sup> The existence of a psychiatric condition is second only to a prior suicide attempt as a major risk factor for dying by suicide. Comorbidity increases suicide risk. The most common mental health conditions associated with increased risk of suicide are depression and bipolar illness, followed by substance use, borderline personality and eating disorders. Those with schizophrenia have an attempt rate of 20 to 40% and 5% die by suicide.<sup>lxxviii</sup> There is a strong association between suicide fatality and post-traumatic stress disorder. It is important to note, however, that despite these risks, of those with a mental health diagnosis, 90% *do not* die by suicide.<sup>lxxix</sup> It then becomes important to identify which people are at the highest risk of suicidal thoughts and behaviors, while providing high quality and prompt treatment for the mental health condition that places them at elevated risk.

Given the strong association between mental health conditions and suicidal thoughts and behaviors, recommendations for suicide prevention mirror those for good mental health and substance abuse treatment:

- High quality and highly accessible mental health and substance abuse treatment.
- Focus on a recovery model that values the individual and optimizes symptom reduction and promotes optimal functioning.
- Ongoing training for mental health professionals and paraprofessionals in all settings.
- Increase in availability of Mental Health First Aid and Youth Mental Health First Aid Training.
- Development of culturally competent services.
- Increase linkages with faith-based organizations.
- Provide wrap-around services that address substance abuse problems.
- Consider alcohol and drugs to be lethal means for some addicted persons and others.
- Follow regional trends in “drugs of choice,” such as heroin, that may be implicated in intentional overdoses, and develop targeted strategies for prevention.

### *People with Chronic Health Conditions and Disabilities*

Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system,

traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.<sup>lxxx</sup> In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality.

Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.<sup>lxxxi</sup>

Until recently, the CTSAB was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities. Peace (2012) writes that “Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live.”<sup>lxxxii</sup> People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

Targeted Recommendations:

- Develop greater scrutiny of someone’s intentions to die.
- Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
- Do not “assume” suicide is a “rational” response to disability.
- Treat mental health conditions as aggressively as with a person without disability.
- CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

## Charting the Future: Measuring Our Progress

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes targeted outcomes for 2020. All targets are derived from the analysis of current data. We are tracking one measure of suicide (deaths) and one measure of medically serious attempts (as measured by hospitalization for self-injury). Both measures can be tracked consistently and reliably annually and by demographic group. We have adopted a target of a 10% reduction by 2020, which is in alignment with the mental health goals of Healthy People 2020. Thus, the 2020 targets for the reduction of deaths by suicide is a reduction from the 2012 rate of 10.14 to a 2020 rate of 9.13. We have determined a target of a 10% reduction of hospitalizations for self-injury from 2014 to 2020.<sup>10</sup>

## Summary and Conclusions

The impact of suicide and suicidal behaviors have far-reaching implications for individuals, their families, friends and communities. In 2012, more than an average of one person per day died by suicide in Connecticut and thousands more were left to mourn and carry on in the face of devastating loss. As staggering as these losses are, there is hope. Globally, the World Health Organization and in the U.S., the National Action Alliance for Suicide Prevention have pioneered comprehensive suicide prevention strategies

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<sup>10</sup> See Appendix I for tables of current hospitalization data

that have mobilized efforts in many domains. Suicide is now being recognized not only as a mental health issue but as a public health challenge.

Here in Connecticut, through Plan 2020, we have highlighted the commitment and priorities of many stakeholders—survivors, providers, and public and private agencies—to come together to reduce both self-injury and deaths by suicide in the state. Our overarching goal and outcome is to realize a 10% reduction in suicide deaths and in non-fatal suicide attempts (as measured by hospitalization rates) by 2020. Through a multipronged and inclusive process, we have prioritized the following areas for coordinated suicide prevention efforts throughout the state:

- GOAL 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.
- GOAL 2: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.
- GOAL 3: Promote suicide prevention as a core component of health care services.
- GOAL 4: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
- GOAL 5: Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

We offer Plan 2020 as a working document. It is our hope that individuals and communities, private and public agencies, schools, universities and community organizations will use it as a framework for developing their own suicide prevention activities. Tailoring these goals and objectives for both special populations and settings ensures a targeted approach, best suited to both general and specialized intervention efforts. As such, we have included with each goal and objective examples of possible interventions.

The Connecticut Suicide Advisory Board (CTSAB), under the direction of Co-Chairs Andrea Duarte of the CT Department of Mental Health and Addiction Services and Tim Marshall of the CT Department of Children and Families, will continue to disseminate best practice knowledge, set priorities for clinical workforce development and address emerging needs for suicide prevention in the state of Connecticut.

The CTSAB believes that **suicide is preventable** through sustained attention, resources, collaboration and commitment from all sectors of our public and private agencies and our communities.

As Tom Steen, who lost his son Tyler to suicide, has written, *“As time went by, I began to recover and decided to honor my son’s memory by helping others who are at risk. I have found that the best way to prevent suicide is through communication and education.”*

Be the 1 to start the conversation.

## APPENDIX A

### Glossary

**Affected by suicide**—All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

**Behavioral health**—A state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support.

**Bereaved by suicide**—Family members, friends and others affected by the suicide of a loved one.

**Best practices**—Activities or programs that are in keeping with the best available evidence regarding what is effective.

**Bipolar disorder**—A mood disorder characterized by the presence or history of manic episodes usually, but not necessarily, alternating with depressive episodes.

**Bisexual**—An adjective that refers to individuals whose sexual orientation or identity involves sexual, physical and/or romantic attraction to both men and women.

**Community**—A group of individuals residing in the same locality or sharing a common interest.

**Comorbidity**—The co-occurrence of two or more disorders, such as depressive disorder and substance use disorder.

**Comprehensive suicide prevention plans**—Plans that use a multifaceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

**Connectedness**—Closeness to an individual, group or individuals within a specific organization; perceived caring by others; satisfaction with relationship to others; or feeling loved and wanted by others.

**Contagion**—A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

**Culturally appropriate**—A set of values, behaviors, attitudes and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services.

**Culture**—The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, faith or social group.

**Deliberate self-harm**—See suicidal self-directed violence.

**Depression**—A constellation of emotional, cognitive, and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

**Evaluation**—The systematic investigation of the value and impact of an intervention or program.

**Evidence-based programs**—Programs that have undergone scientific evaluation and have proven to be effective.

**Gatekeepers**—Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers and those employed in institutional settings, such as schools, prisons and the military.

**Gay**—An adjective that refers to persons whose sexual orientation or identity involves sexual, physical and/or romantic attraction to individuals of the same sex.

**Gender identity**—An individual's deeply rooted internal sense of gender. For most individuals, the sex assigned to them at birth aligns with their gender identity. This is not true for some others, however, who identify as transgender.

**Goal**—A broad and high-level statement of general purpose to guide planning on an issue; it focuses on the end result of the work.

**Health**—The complete state of physical, mental and social well-being, not merely the absence of disease or infirmity.

**Healthy People 2020**—The national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2020.

**Indicated intervention**—Intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

**Intervention**—A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention or reducing access to lethal means among individuals with suicide risk).

**Lesbian**—An adjective that refers to women whose sexual orientation or identity involves sexual, physical and/or romantic attraction to other women.

**Lesbian, gay, bisexual or transgender**—A blanket term that refers to those who identify as lesbian, gay, bisexual or transgender.

**Means**—The instrument or object used to carry out a self-destructive act; for example, chemicals, medications, illicit drugs.

**Means restriction**—Techniques, policies and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

**Mental disorder**—A diagnosable illness characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

**Mental health**—The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

**Mental health services**—Health services that are specifically designed for the care and treatment of persons with mental health problems, including mental illness. Mental health services include hospitals and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services and other intensive outreach approaches to the care of individuals with severe disorders.

**Mental illness**—See mental disorder.

**Methods**—Actions or techniques that result in an individual inflicting self-directed injurious behavior; for example, overdose.

**Minority stress**—The high levels of chronic stress experienced by members of minority populations (including lesbian, gay, bisexual or transgender populations) as a result of the prejudice and discrimination they experience from the dominant group in society.

**Mood disorders**—Persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states. These disorders include depressive disorders, bipolar disorders, mood disorders because of a medical condition and substance-induced mood disorders.

**Morbidity**—The relative frequency of illness or injury, or the illness or injury rate, in a community or population.

**Mental disorder**—A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional, or social abilities; often used interchangeably with mental illness.

**Mortality**—The relative frequency of death, or the death rate, in a community or population.

**Non-suicidal self-injury**—Self-injury with no suicidal intent. Same as non-suicidal self-directed violence (see Centers for Disease Control and Prevention surveillance definitions box at the end of this appendix).

**Objective**—A specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many or how often.

**Older adults**—Persons aged 60 or more years.

**Outcome**—A measurable change in the health of an individual or group of individuals that is attributable to an intervention.

**Personality disorders**—A class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving and thinking of sufficient severity to cause either impairment in functioning or distress.

**Postvention**—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

**Prevention**—A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

**Protective factors**—Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.

**Psychiatric disorder**—See mental disorder.

**Rate**—The number per unit of the population with a particular characteristic, for a given unit of time.

**Resilience**—Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

**Risk factors**—Factors that make it more likely that an individual will develop a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

**Safety plan**—Written list of warning signs, coping responses and support sources that an individual may use to avert or manage a suicide crisis.

**Screening**—Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

**Screening tools**—Instruments and techniques (for example, questionnaires, checklists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

**Selective intervention**—Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

**Self-directed violence** (same as self-injurious behavior)—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either non-suicidal or suicidal.

**Self-inflicted injuries**—Injuries caused by suicidal and non-suicidal behaviors such as self-mutilation.

**Sexual orientation**—An individual's sexual, physical and/or romantic attraction to men, women, both or neither.

**Social support**—Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

**Stakeholders**—Entities including organizations, groups and individuals that are affected by and contribute to decisions, consultations and policies.

**Substance use disorder**—A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

**Suicidal behaviors**—Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

**Suicidal ideation**—Thoughts of engaging in suicide-related behavior.

**Suicidal intent**—When a person intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

**Suicidal plan**—A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time

frame and method. —There is evidence (explicit and/or implicit) that at the time of injury the individual

**Suicidal self-directed violence**—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

**Suicide**—Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

**Suicide attempt**—A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

**Suicide attempt survivors**—Individuals who have survived a prior suicide attempt.

**Suicide crisis**—A suicide crisis, suicidal crisis or potential suicide is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

**Surveillance**—The ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

**Transgender**—Someone whose gender identity or expression is different from the sex that was assigned to him or her at birth. Some transgender individuals take steps to physically and/or legally transition from one sex to another.

**Unintentional**—Term used for an injury that is unplanned; in many settings, these are termed accidental injuries.

**Universal intervention**—Intervention targeted to a defined population, regardless of risk (this could be an entire school, for example, and not the general population, per se).

Source: U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

## APPENDIX B

### Examples of Risk and Protective Factors in a Social Ecological Model

#### ➔ Protective Factors:

##### **Societal:**

- Availability of physical and mental health care
- Restrictions on lethal means of suicide

##### **Community:**

- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization

##### **Relationship:**

- Connectedness to individuals, family, community and social institutions
- Supportive relationships with health care providers

##### **Individual:**

- Coping and problem solving skills
- Reasons for living (for example, children in the home)
- Moral objections to suicide

#### ➔ Risk Factors:

##### **Societal:**

- Availability of lethal means of suicide
- Unsafe media portrayals of suicide

##### **Community:**

- Few available sources of supportive relationships
- Barriers to health care (for example, lack of access to providers or medications, prejudice)

##### **Relationship:**

- High conflict or violent relationships
- Family history of suicide

##### **Individual:**

- Mental illness
- Substance abuse
- Previous suicide attempt
- Impulsivity/aggression

## APPENDIX C

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Changes

### Warning Signs: IS PATH WARM?<sup>11</sup>

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.
- These might be remembered as expressed or communicated ideation. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:

- Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- **Anxiety**, agitation, unable to sleep or sleeping all the time
- Feeling **trapped**, like there's no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking
- Dramatic **mood changes**.

These warning signs were compiled by a task force of expert clinical-researchers and “translated” for the general public. The **origin of IS PATH WARM?**

If you know someone who exhibits warning signs of suicide:<sup>12</sup>

- Do not leave that person alone and remove any objects that can be used in a suicide attempt
- Call the US National Suicide Prevention Lifeline at 800-273-TALK(8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

<sup>11</sup> <http://www.suicidology.org/resources/warning-signs>

<sup>12</sup> 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

## APPENDIX D

### Suicide Prevention Resources

#### **American Association of Suicidology (AAS)**

[www.suicidology.org](http://www.suicidology.org)

AAS promotes research, public awareness programs, public education, and training for professionals and volunteers. It serves as a national clearinghouse for information on suicide, publishing and disseminating statistics and suicide prevention resources. AAS also hosts annual national conferences for professionals and survivors.

#### **American Foundation for Suicide Prevention (AFSP)**

[www.afsp.org](http://www.afsp.org)

AFSP funds research and offers educational programs and resources for professionals, survivors of suicide loss and the public. With the Suicide Prevention Resource Center, AFSP coproduces the Best Practices Registry (BPR) for Suicide Prevention. AFSP's Public Policy Division, SPAN USA, promotes and keeps track of policies and legislation related to suicide prevention. AFSP chapters provide connections to local resources and services addressing suicide prevention. The chapters also organize awareness events.

#### **American Foundation for Suicide Prevention: LGBT Initiative**

<https://www.afsp.org/content/search?SearchText=LGBT+SUICID+INITIATIVE>

This initiative works on suicide prevention among the LGBT population in a number of ways, including producing a conference, funding research grants, working to improve how the media covers anti-gay bullying, helping its chapter volunteers bring understanding of suicide into their local LGBT communities, and creating LGBT mental health educational resources and training tools.

#### **The Jed Foundation**

[www.jedfoundation.org](http://www.jedfoundation.org)

The Jed Foundation works to promote emotional health and prevent suicide among college and university students. The Jed Foundation's programs include: ULifeline, an online resource that gives students access to campus-specific resources and allows them to take an anonymous mental health screening; the Half of Us campaign with mtvU, which uses online, on-air, and on-campus programming to encourage help-seeking; Love is Louder, a movement online and in communities to build connectedness and increase resiliency; and more.

#### **Jordan Matthew Porco Memorial Foundation**

<http://www.rememberingjordan.org/mission/>

Our goal is to help prevent suicide among the college age student population by increasing awareness, identifying resources available to students, helping friends and family recognize the warning signs of depression, encouraging at-risk persons to seek out help, and providing financial support to those organizations and programs dedicated to suicide prevention.

#### **Means Matter, Harvard School of Public Health**

[www.hsph.harvard.edu/means-matter](http://www.hsph.harvard.edu/means-matter)

The mission of the Means Matter campaign is to increase the proportion of suicide prevention groups that promote activities that reduce a suicidal person's access to lethal means of suicide. The website has a wide variety of information to help families, clinicians, suicide prevention groups, local communities, and colleges and universities.

### **National Action Alliance for Suicide Prevention**

[www.actionallianceforsuicideprevention.org/NSSP](http://www.actionallianceforsuicideprevention.org/NSSP)

The National Strategy for Suicide Prevention provides the framework for suicide prevention for the United States. First published in 2001 and then updated in 2012, the National Strategy represents the combined work of advocates, clinicians, researchers, survivors and others. It lays a framework for action to prevent suicide and guides the development of an array of services and programs.

### **National Alliance on Mental Illness**

[www.nami.org](http://www.nami.org)

National Alliance on Mental Illness (NAMI) is a membership organization dedicated to building better lives for Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research. It sponsors awareness events, provides training about mental illness and sponsors the NAMI Helpline—a phone crisis line. NAMI has state organizations and local affiliates across the United States.

### **National Guard/Reserve**

[http://www.army.mil/standto/archive\\_2014-09-18/](http://www.army.mil/standto/archive_2014-09-18/)

The website for the National Guard's suicide prevention program features a six-part film on resilience among National Guard personnel. Other resources include a media gallery, a list of military and nonmilitary organizations with information on suicide, and news stories from National Guard leadership and other branches of the military.

### **National Institute on Alcohol Abuse and Alcoholism, NIH, HHS**

[www.niaaa.nih.gov](http://www.niaaa.nih.gov)

National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems. Alcohol is a significant risk factor for suicide, and the NIAAA publishes studies on how alcohol use interacts with conditions such as depression and stress to contribute to suicide. NIAAA also provides data on alcohol involvement in suicide.

### **National Institute on Drug Abuse, NIH, HHS**

[www.nida.nih.gov](http://www.nida.nih.gov)

National Institute on Drug Abuse (NIDA) funds and publishes studies on the effects of substance abuse on mental health, including suicide, and hosts Suicide Studies Lectures, which review current standards to define, classify, assess and treat suicide-related disorders that sometimes play a role in drug abuse and addiction. NIDA also sponsored a landmark workshop, Drug Abuse and Suicidal Behavior.

### **National Organization for People of Color Against Suicide (NOPCAS)**

[www.nopcas.org](http://www.nopcas.org)

NOPCAS addresses suicide prevention, intervention, and postvention in communities of color. NOPCAS provides professional development and culturally appropriate training for lay and professional audiences as well as sponsoring survivor/bereavement support groups. It also provides the online crisis intervention network entitled "I'm Alive," staffed by certified volunteers, and a speakers bureau.

### **National Strategy for Suicide Prevention**

[www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html)

This is the product of a unique public/private partnership through the National Action Alliance for Suicide Prevention. It outlines the goals and objectives for the national suicide prevention efforts.

### **National Suicide Prevention Lifeline (Lifeline)**

[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

The Lifeline provides immediate assistance 24 hours a day, 7 days a week to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: 1-800-273-TALK (8255). The Lifeline also provides informational materials featuring the phone number, such as brochures, wallet cards and posters.

### **National Violent Death Reporting System (NVDRS) Centers for Disease Control and Prevention (CDC), HHS**

[www.cdc.gov/injury/wisqars/nvdrs.html](http://www.cdc.gov/injury/wisqars/nvdrs.html)

NVDRS is a surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts, including for suicide. NVDRS also pools these data to better depict the scope and nature of violence.

### **Samaritans USA**

[www.samaritansusa.org](http://www.samaritansusa.org)

Samaritans USA provides services to those at risk for suicide, provides support for those who have experienced a loss due to suicide, and educates caregivers and health providers. Crisis lines are the cornerstone of Samaritans USA's services. Samaritans USA also provides suicide prevention education to the public and survivor support groups.

### **State of Connecticut Department of Mental Health and Addiction Services (DMHAS) Suicide Prevention and Mental Health Promotion Initiatives**

<http://www.ct.gov/DMHAS/cwp/view.asp?a=2912&q=335130>

The goal of the CCSPI is to bring sustainable evidence-based, suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher education statewide for students up to age 24. The project is a collaborative effort involving DMHAS and the CT Departments of Children and Families (DCF), Public Health, Higher Education, Veterans Affairs, and the CT State University System, CT Community College System, University of CT Health Center, True Colors, Multicultural Leadership Institute, United Way of CT, Wheeler Clinic and the Veterans Administration CT Healthcare System.

### **State of Connecticut Suicide Prevention**

<http://www.preventsuicidect.org/>

One Word, One Voice, One Life multimedia campaign. This campaign seeks to “start the conversation” with community or campus members about suicide prevention and mental health promotion by engaging them to consider how they would start the conversation with someone they believe is at risk.

### **Substance Abuse and Mental Health Services Administration, HHS**

[www.samhsa.gov](http://www.samhsa.gov)

SAMHSA funds and supports the National Lifeline and Suicide Prevention Resource Center and manages the Garrett Lee Smith grant program, which funds state, territorial and tribal programs to prevent suicide among youth.

### **Suicide Prevention Resource Center (SPRC)**

[www.sprc.org](http://www.sprc.org)

ASPRC is a SAMHSA-funded, national center that helps strengthen the efforts of state, tribal, community and campus suicide prevention organizations and coalitions and organizations that serve populations with high suicide rates. It provides technical assistance, training, a variety of resource materials, a current awareness newsletter (The Weekly SPARK) and a searchable online library.

## **Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)**

[www.sprc.org/bpr](http://www.sprc.org/bpr)

This registry contains approximately 100 suicide prevention programs, including student curricula and peer leader programs, gatekeeper trainings, and trainings for health and mental health professionals. The registry is organized into three sections. Section I: Evidence-Based Programs lists interventions that have undergone evaluation and demonstrated positive outcomes. Most of these are the suicide prevention programs in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

### **TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, 2009**

<http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA09-4381>

#### **Video companion:**

[www.store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50](http://www.store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50)

TIP 50 provides direct practice tools and strategies for identifying those at risk. Also contains information on how substances may affect clinical presentation.

### **Tragedy Assistance Program for Survivors**

[www.taps.org](http://www.taps.org)

Tragedy Assistance Program for Survivors (TAPS) provides information and services to those who have suffered the loss of a military loved one due to any cause. It offers webinar-based courses, six of which concern suicide, for mental health professionals. Other resources include crisis services, online support groups, seminars for survivors, and the Good Grief Camp for children grieving the loss of a loved one in the military.

### **The Trevor Project**

[www.thetrevorproject.org](http://www.thetrevorproject.org)

This national organization focused on crisis and suicide prevention among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth provides a 24-hour, toll-free, crisis intervention phone line (1-866-488-7386); an online, social networking community for LGBTQ youth aged 13 to 24 and their friends and allies; educational programs for schools; and advocacy initiatives.

### **U.S. Department of Defense Suicide Prevention Website**

<http://www.health.mil/Military-Health-Topics/Conditions-and-Treatments/Suicide-Prevention>

This website provides information on recognizing symptoms of those at risk for suicide, links to suicide prevention in each branch of the military, and a list of outside organizations that can provide information and assistance.

### **U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach**

[www.suicideoutreach.org](http://www.suicideoutreach.org)

This website is a resource collection providing access to support hotlines, self-assessments, treatment options, professional resources and forums, and various multimedia tools. It supports all members of the U.S. Armed Forces and reserve components, veterans, families and providers.

### **Web-Based Injury Statistics Query and Reporting System (WISQARS) CDC, HHS**

[www.cdc.gov/injury/wisqars](http://www.cdc.gov/injury/wisqars)

This is an interactive database system that provides customized reports of data from a variety of sources on fatal and nonfatal injuries, violent deaths and cost of injury. The system features a large amount of data on suicide.

## APPENDIX E

### Additional Gender and Age Data

Table 8.

Number of Suicides in Connecticut Total and by Gender 2006–2012

Year	Female	Male	Total
2006	45	212	257
2007	43	207	250
2008	66	230	296
2009	73	235	308
2010	74	268	342
2011	84	283	367
2012	93	271	364

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 9.

Number and Rate of Suicides in Connecticut Total and by Gender 2006 to 2012

Year	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
2006	45	2.50	212	12.40	257	7.32
2007	43	2.40	207	12.13	250	7.14
2008	66	3.68	230	13.47	296	8.45
2009	73	4.05	235	13.68	308	8.75
2010	74	4.03	268	15.40	342	9.57
2011	84	4.58	283	16.22	367	10.25
2012	93	5.05	271	15.49	364	10.14

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 10.

Connecticut Suicide Number and Rate by Age and Gender 2012

Age Range	Female Number	Female Rate	Female Target Rate 220	Male Number	Male Rate	Male Target Rate 2020	Total Number	Total Rate	Total Target Rate 2020
10 to 24	11	3.15	2.84	25	6.77	6.09	36	5.01	4.51
25 to 64	63	6.40	5.76	207	21.95	19.76	270	14.01	12.61
65 and older	18	5.89	5.30	39	17.18	15.47	57	10.70	9.63

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

## APPENDIX F

### Additional Method of Suicide Data

Table 11.

Method of Suicide in CT 2012 (n=364)

Method of Suicide	n	Percent
Hanging/Strangulation	133	36.5
Gunshot	107	29.4
Substance Overdose	50	13.7
Suffocation	22	6.0
CO Poisoning	15	4.1
Incision/Cut	10	2.7
Jump	9	2.5
Drowning	6	1.6
Train	6	1.6
Motor Vehicle	4	1.1
Other	2	.5

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 12.

Method of Suicide in Connecticut 2012 by Gender (n=)

Method of Suicide	n	Percent
Hanging/Strangulation	31.2	38.4
Gunshot	10.8	35.8
Substance Overdose	33.3	7.0
Suffocation	8.6	5.2
Jump	5.4	1.5
CO Poisoning	2.2	4.8
Drowning	3.2	1.1
Incision/Cut	2.2	3.0
Train	1.1	1.8
Motor Vehicle	1.1	1.1
Other	1.1	.4

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 13.

Primary Methods of Suicide in Connecticut 2006–2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
2006	85	78	39	12	19
2007	96	71	46	7	8
2008	109	106	36	16	8
2009	111	95	44	20	12
2010	127	105	48	10	9
2011	130	112	54	25	7
2012	133	107	50	15	22
Total	791	674	317	105	85

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

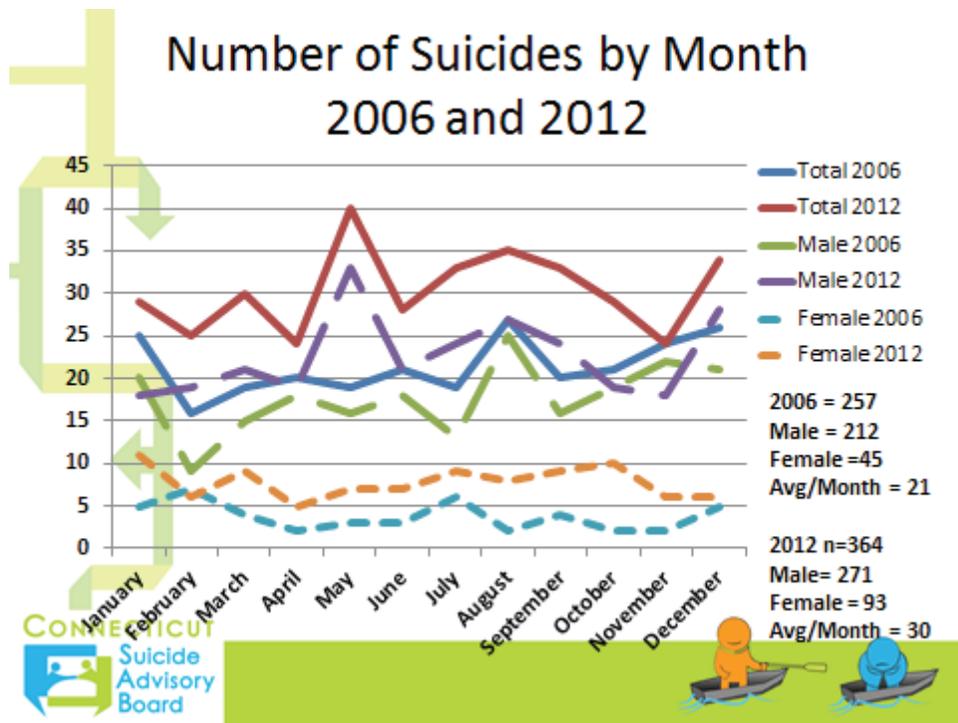
Table 14.

Primary Methods of Suicide in Connecticut by Age 2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
10–14	0	1 (100)	0	0	1
15–19	12 (66.7)	2 (11.1)	0	4 (22.2)	18
20–24	8 (47.0)	4 (23.5)	2 (11.8)	3 (17.6)	17
25–34	19 (40.4)	12 (25.5)	5 (10.6)	11 (23.4)	47
35–44	29 (39.7)	17 (23.3)	12 (16.4)	15 (20.5)	73
45–54	30 (32.6)	26 (28.3)	15 (16.3)	21 (22.8)	92
55–64	27 (46.6)	16 (27.6)	9 (15.5)	6 (10.3)	58
65–74	6 (17.6)	16 (47.0)	5 (14.7)	7 (20.6)	34
75 and older	2 (8.7)	12 (52.2)	2 (8.7)	7 (30.4)	23

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

APPENDIX G



APPENDIX H

Youth Risk Behavior Survey (YRBS) 2009 and 2011

Table 15.

Youth Risk Behavior Survey (YRBS 2011)  
 Percent of students who felt sad or hopeless almost every day for two plus weeks in a row,  
 past 12 months

	CT	US
Total	24.4	28.5
Male	18	21.5
Female	31	36
9th	23.6	27.6
10th	22.8	28.7
11th	25	28.8
12th	25.4	28.9
Black	21.3	24.7
Hispanic/Latino	33.5	32.6
White	22.4	27.2

Figure 8.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who seriously considered attempting suicide during the past 12 months

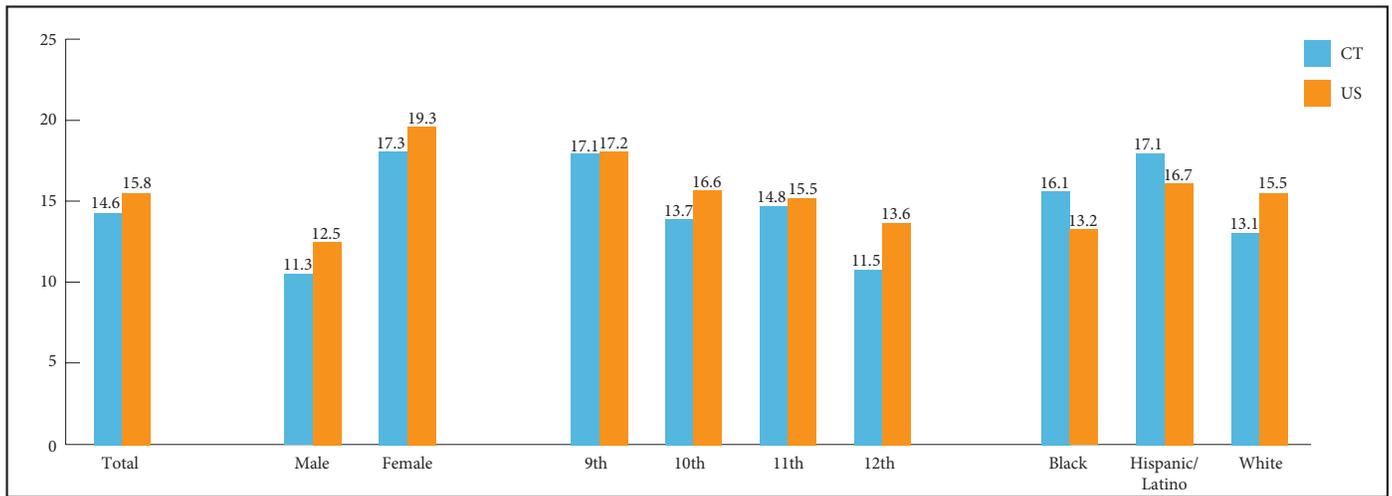


Table 16.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who seriously considered attempting suicide during the past 12 months

	CT	US
Total	14.6	15.8
Male	11.9	12.5
Female	17.3	19.3
9th	17.1	17.2
10th	13.7	16.6
11th	14.8	15.5
12th	11.5	13.6
Black	16.1	13.2
Hispanic/Latino	17.1	16.7
White	13.1	15.5

Figure 9.

Youth Risk Behavior Survey (YRBS 2011)  
 YRBSS 2009 Percent of students who made a plan about how they would attempt suicide during the past 12 months

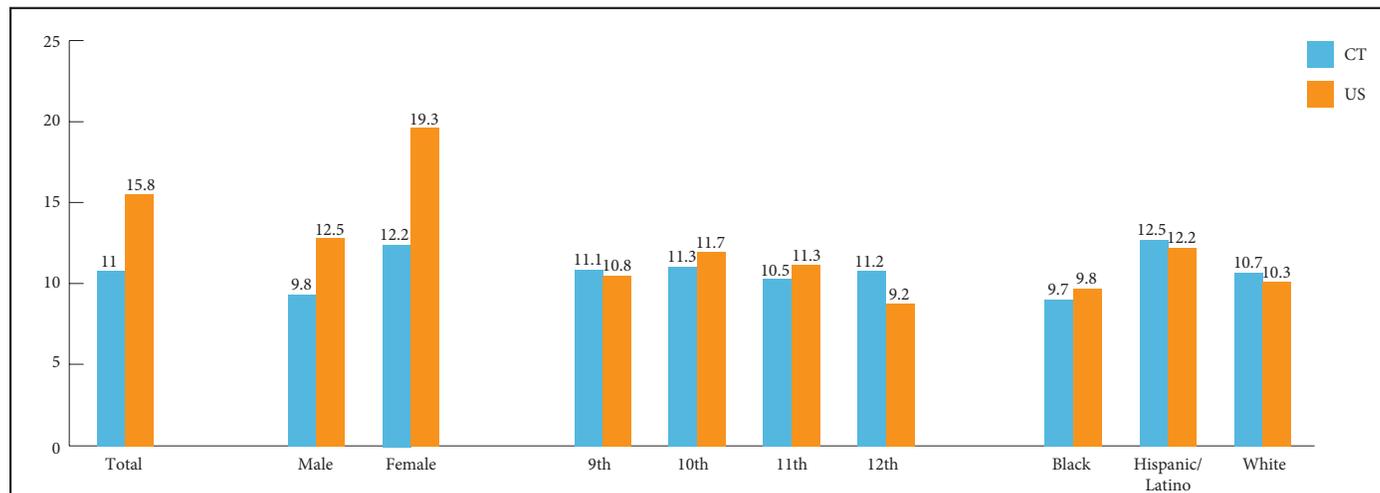


Table 17.

Youth Risk Behavior Survey (YRBS 2011)  
 YRBSS 2009 Percent of students who made a plan about how they would attempt suicide during the past 12 months

	CT	US
Total	11	15.8
Male	9.8	12.5
Female	12.2	19.3
9th	11.1	10.8
10th	11.3	11.7
11th	10.5	11.3
12th	11.2	9.2
Black	9.7	9.8
Hispanic/Latino	12.5	12.2
White	10.7	10.3

Figure 10.

Youth Risk Behavior Survey (YRBS 2011)  
 Percent of students who actually attempted suicide one or more times  
 during the past 12 months

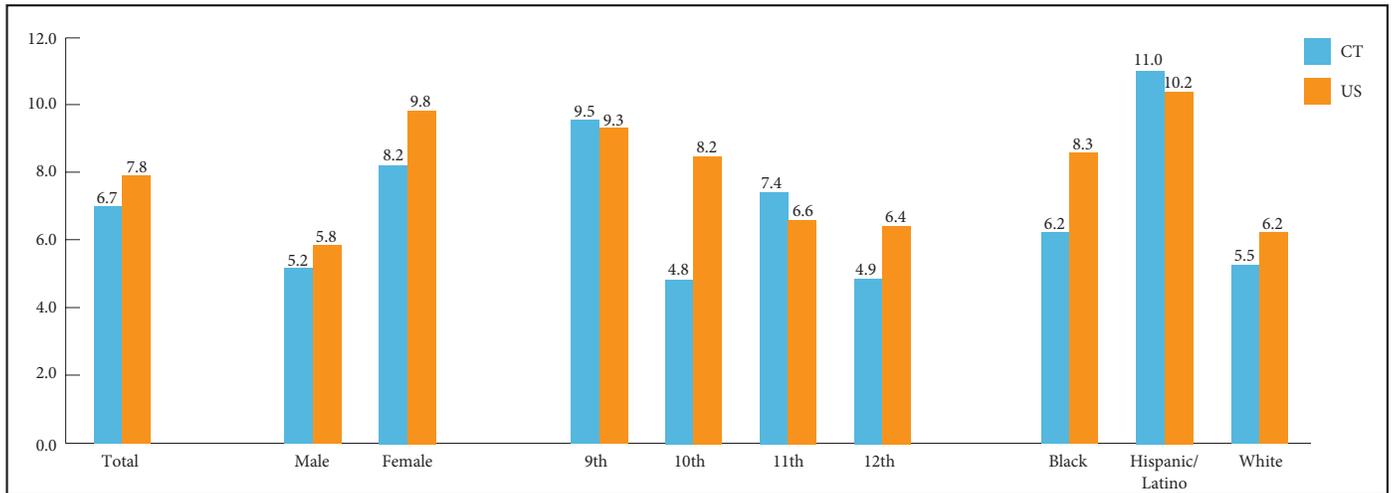


Table 18.

Youth Risk Behavior Survey (YRBS 2011)  
 Percent of students who actually attempted suicide one or more times  
 during the past 12 months

	CT	US
Total	6.7	7.8
Male	5.2	5.8
Female	8.2	9.8
9th	9.5	9.3
10th	4.8	8.2
11th	7.4	6.6
12th	4.9	6.4
Black	6.2	8.3
Hispanic/Latino	11.0	10.2
White	5.5	6.2

Figure 11.

Youth Risk Behavior Survey (YRBS 2009)  
 Percent of students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse

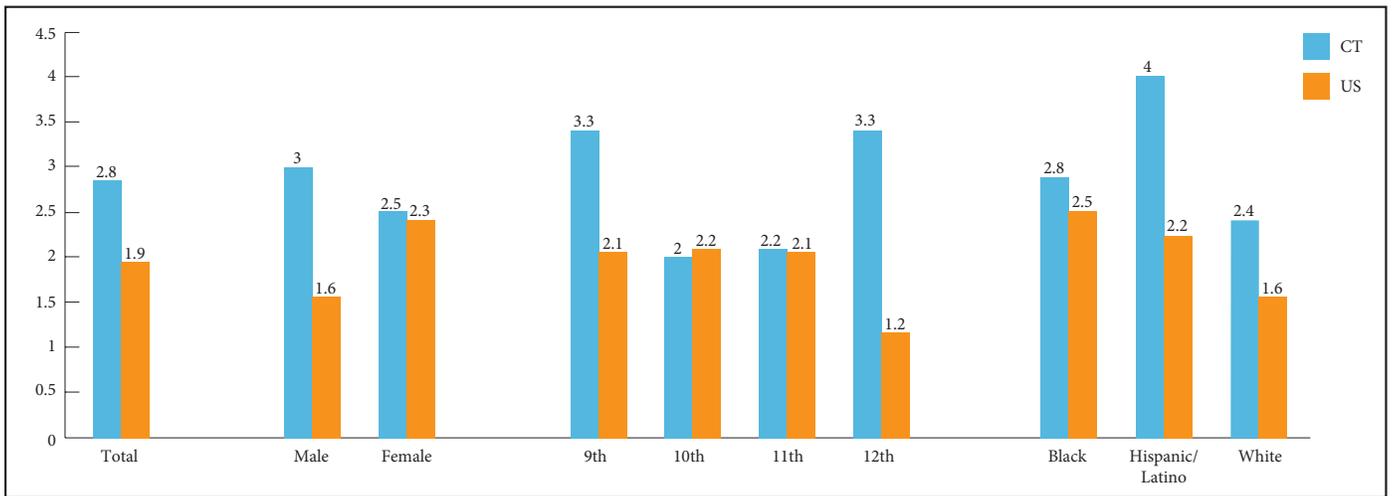


Table 19.

Youth Risk Behavior Survey (YRBS 2009)  
 Percent of students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse

	CT	US
Total	2.8	1.9
Male	3	1.6
Female	2.5	2.3
9th	3.3	2.1
10th	2	2.2
11th	2.2	2.1
12th	3.3	1.2
Black	2.8	2.5
Hispanic/Latino	4	2.2
White	2.4	1.6

## APPENDIX I

### Connecticut Self-Injury Hospital Data

Table 20.

Connecticut hospitalizations for self-injury, 2012 CT Hospital Inpatient Discharge Database (HIDD).

		Number of Hospitalizations	Rate per 100,000
<b>Total Population (10 and over)</b>		2453	78
<b>Age</b>	10 to 14	73	31
	15 to 19	304	119
	20 to 24	308	137
	25 to 34	431	102
	35 to 44	448	92
	45 to 54	508	89
	55 to 64	270	61
	65 to 74	56	22
	75 plus	55	22
<b>Race/Ethnicity</b>	Asian Alone	23	19
	Black or African American alone	210	71
	Hispanic or Latino	311	73
	Other	82	-
	White alone, not Hispanic or Latino	1827	81
<b>Gender</b>	Male	1081	70
	Female	1372	85
<b>County</b>	Fairfield	465	60
	Hartford	594	77
	Litchfield	119	71
	Middlesex	132	89
	New Haven	716	96
	New London	201	85
	Tolland	100	74
	Windham	82	79

Sources: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health; U.S. Census Bureau, 2008–2012 American Community Survey.

Note: Differences by age, race, gender and county were statistically significant at the .05 level.

Table 21.

Means of Self-Injury, 2012 HIDD

	N	%
Poisoning - liquid/solid	1807	73.7%
Poisoning - gas	25	1.0%
Hanging	50	2.0%
Drowning	3	.1%
Firearms	16	.7%
Cutting or piercing	413	16.8%
Jumping	21	.9%
Other	102	4.2%
Late effects of prior injury	16	.7%
<b>Total</b>	<b>2453</b>	<b>100.0%</b>

Source: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health.

Table 22.

Outcomes of self-injury, 2012 HIDD:  
 Percent discharged to a psychiatric facility, percent expired, and length of stay.

	N	Discharged to Psych Facility	Expired	Length of Stay (days)
Poisoning - liquid	1807	37%	0.6%	4.1
Poisoning - gas	25	4%	0.0%	4.6
Hanging	50	18%	16.0%	8.1
Drowning	3	33%	33.3%	3.0
Firearms	16	13%	25.0%	8.9
Cutting or piercing	413	13%	0.2%	6.5
Jumping	21	43%	0.0%	9.6
Other	102	14%	1.0%	7.6
Late effects of prior injury	16	0%	0.0%	5.5
<b>Total</b>	<b>2453</b>	<b>31%</b>	<b>1.1%</b>	<b>4.8</b>

Sources: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health; Annual State Population Estimates, CT Department of Public Health <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>.

Table 23.

Connecticut hospitalizations for self-injury among youth ages 15 - 24 and adults 25+,  
2012 CT Hospital Inpatient Discharge Database (HIDD)

		Youth 15 - 24		Adults 25+	
		Number Hospitalized	Rate per 100,000	Number Hospitalized	Rate per 100,000
<b>Total Population</b>		612	127	1,768	72
<b>Race/Ethnicity</b>	Asian Alone	7	37	15	16
	Black or African American alone	68	110	134	61
	Hispanic or Latino	94	107	205	76
	White alone, not Hispanic or Latino	420	135	1,364	74
<b>Gender</b>	Female	384	166	841	76
	Male	228	93	927	75
<b>County</b>	Windham	26	155	55	69
	Tolland	30	92	69	74
	New London	67	175	127	70
	New Haven	154	129	531	93
	Middlesex	29	139	100	86
	Litchfield	35	152	83	62
	Hartford	152	129	423	71
	Fairfield	103	87	352	59

Source: CT Department of Public Health, 2013

## APPENDIX J

### Trainings by Source and Number Served

#### GLS Grantees:

- Connecticut College
  - 2 Peer Models (38)
  - 1 Connect Prevention (29)
  - 8 Other (406)
- Manchester Community College
  - 18 Question, Persuade, Refer Gatekeeper Program (159)
- Norwalk Community College
  - 5 Question, Persuade, Refer Gatekeeper Program QPR (62)
- Sacred Heart
  - 3 Question, Persuade, Refer Gatekeeper Program (QPR) (22)
  - 2 Connect Prevention (38)

#### Community:

- Wheeler Clinic
  - 9 Question, Persuade, Refer Gatekeeper Program QPR (180)
  - 1 TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (30)
  - 3 Question, Persuade, Refer Gatekeeper Program (QPR) TOT (82)
  - 2 Connect Prevention TOT (45)
  - 1 Connect Postvention TOT (35)
  - 1 Survivor Voices Training TOT
  - 1 Recognizing and Responding to Suicide Risk – Primary Care (48)
  - 3 Applied Suicide Intervention Skills Training (ASIST) (27)
  - 1 SafeTalk (13)
  - 5 Mental Health First Aid (77)
  - 1 Mental Health First Aid Youth TOT (2)
  - 10 Assessing and Managing Suicidal Risk (AMSR) AMSR: 4 DMHAS (8) and 6 EMPS (56)
  - 3 Assessing and Intervening with Suicidal and Self-Injurious Youth (24)
- Veterans Administration
  - 2 Question, Persuade, Refer Gatekeeper Program (QPR) (22)
  - 1 TIP 50 (10)
- Regional Action Councils
  - 32 Question, Persuade, Refer Gatekeeper Program (QPR) (987)
- Department of Children and Families
  - 1 Applied Suicide Intervention Skills Training (ASIST)

## ENDNOTES

- <sup>i</sup>SAMHSA. Guidelines for State Suicide Prevention Leadership and Plans. [http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA\\_State\\_Suicide\\_Prevention\\_Plans\\_Guide\\_Final.pdf](http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA_State_Suicide_Prevention_Plans_Guide_Final.pdf)
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- <sup>vii</sup>National Highway Traffic Safety Association. National Highway Traffic Fatality Report 2012 <http://www.nhtsa.gov/About+NHTSA/Press+Releases+NHTSA+Data+Confirms+Traffic+Fatalities+Increased+In+2012>
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- <sup>xii</sup>McIntosh, J. L., & Drapeau, C. W. (for the American Association of Suicidology). (2012). U.S.A. *suicide 2010: Official final data*. Washington, DC: American Association of Suicidology, dated September 20, 2012, downloaded from <http://www.suicidology.org>.
- <sup>xiii</sup>([http://webappa.cdc.gov/sasweb/ncipc/leadcaus10\\_us.html](http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html))
- <sup>xiv</sup>Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) (2010). [online; cited 2012 Oct 19]. Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).
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- <sup>xxii</sup> <http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295120>
- <sup>xxiii</sup>The State of Connecticut Office of Healthcare Access. *Inpatient Discharge Data and Connecticut Hospitals 2000*. Accessed May 21, 2013. Connecticut Department of Public Health. *Connecticut Health Database Compendium; A Profile of Selected Databases Maintained by The Connecticut Department of Public Health*. Hartford, CT. March 2012.
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- <sup>xv</sup> <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/>
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- <sup>xix</sup> [http://www.cdc.gov/violenceprevention/pub/youth\\_suicide.html](http://www.cdc.gov/violenceprevention/pub/youth_suicide.html)
- <sup>xx</sup>See Appendix H Youth Risk Behavior Survey (YRBS 2011)
- <sup>xxi</sup>CT DMHAS, GLSMA Annual Report FY 13–14. SM 060396
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- <sup>xxiii</sup>U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.
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**1-800-273-8255**  
**National Suicide Prevention Lifeline**

## 1617 Narrative 20 Suicide Prevention

### **1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).**

The State of Connecticut Suicide Prevention Plan 2020 is attached. The Connecticut plan was released in April 2015 and will next be updated in 2020. It was aligned with both Healthy People 2020 and with the National Strategy for Suicide Prevention (2012). Development of the State of Connecticut Suicide Prevention Plan was a joint effort between DMHAS and DCF. A survey and protocol to collect short and long term outcomes related to the goals and objectives in the plan are in development. DCF and DMHAS have contracted with a principal investigator and research assistant to update death and injury data on at least a bi-annual basis.

### **2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.**

The State of Connecticut Suicide Prevention Plan 2020 addresses the following at-risk populations: Youth, Young Adult/College Aged, Middle-aged persons, and Older Adults within a section on Lifespan. Within a section on Race/Ethnicity, it covers: Blacks, Hispanic/Latinos, American Indian/Alaskan Natives, and Asians/Pacific Islanders and Native Hawaiians. In addition, the following populations are addressed: Lesbian, Gay, Bisexual, and Transgender (LGBT), Military/Veterans, Criminal Justice, Mental Health/Substance Abuse, and those with Chronic Health Conditions and Disabilities.

After review of the populations included within the 2012 National Strategy for Suicide Prevention, data specific to Connecticut was considered. This included data from the Office of the Medical Examiner, the Connecticut Hospital Database, National Vital Statistics Reports, the CDC Morbidity and Mortality Weekly Report, the CDC Youth Online High School, and Youth Risk Behavior Surveillance Survey. In addition to using data to determine which groups to highlight, the Connecticut Suicide Advisory Board used a broad group of Connecticut experts in suicide prevention with expertise in working with members of at-risk groups. This process has insured both data-driven and expert-driven approaches.

### **3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention leadership and Plans.**

When the 2014/2015 Block Grant was submitted, Connecticut was still in the process of developing its State of Connecticut Suicide Prevention Plan 2020, which was just released in April 2015. The new plan was developed using the Guidance for State Suicide Prevention Leadership and Plans and progress will be tracked with this document in

consideration. A survey and protocol to collect short and long term outcomes related to the goals and objectives in the plan are in development and will be part of an annual report. DCF and DMHAS have contracted with a principal investigator and research assistant to update death and injury data on at least a bi-annual basis. The plan is attached within this narrative section and is also available at [www.preventsuicidect.org](http://www.preventsuicidect.org).

## **Children's Plan 20. Suicide Prevention**

- 1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).***

The State of Connecticut Suicide Prevention Plan 2020 is attached. The Connecticut plan was released in April 2015 and will next be updated in 2020. It was aligned with both Healthy People 2020 and with the National Strategy for Suicide Prevention (2012). Development of the State of Connecticut Suicide Prevention Plan was a joint effort between DMHAS and DCF. A survey and protocol to collect short and long term outcomes related to the goals and objectives in the plan are in development. DCF and DMHAS have contracted with a principal investigator and research assistant to update death and injury data on at least a bi-annual basis.

- 2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.***

The State of Connecticut Suicide Prevention Plan 2020 addresses the following at-risk populations: Youth, Young Adult/College Aged, Middle-aged persons, and Older Adults within a section on Lifespan. Within a section on Race/Ethnicity, it covers: Blacks, Hispanic/Latinos, American Indian/Alaskan Natives, and Asians/Pacific Islanders and Native Hawaiians. In addition, the following populations are addressed: Lesbian, Gay, Bisexual, and Transgender (LGBT), Military/Veterans, Criminal Justice, Mental Health/ Substance Abuse, and those with Chronic Health Conditions and Disabilities.

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- 3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention leadership and Plans.***

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research assistant to update death and injury data on at least a bi-annual basis. The plan is attached within this narrative section and is also available at [www.preventsuicidect.org](http://www.preventsuicidect.org).

# Environmental Factors and Plan

## 21. Support of State Partners

Narrative Question:

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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 mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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 emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:



Joette Katz  
Commissioner

**DEPARTMENT of CHILDREN and FAMILIES**  
*Making a Difference for Children, Families and Communities*



Dannel P. Malloy  
Governor

June 29, 2015

The Honorable Miriam Delphin-Rittmon, Ph.D.  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4th floor  
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2016-2017 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Children and Families (DCF) will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS) to assist in the implementation of priorities identified in the grant application for adults with mental illness.

Specific activities that DCF will support include:

- Continuing our strategic partnership with DMHAS to assist with implementing priorities that are identified in the 2016-2017 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,

Joette Katz  
Commissioner

STATE OF CONNECTICUT  
Phone (860) 550-6300 - Fax (860) 560-7086  
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Commissioner

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June 1, 2015

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

The Honorable Joette Katz, JD  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

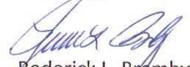
I am pleased to provide a letter of support for Connecticut's FY 2016-2017 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Social Services (DSS) will continue its strategic partnership with the Departments of Mental Health 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 services for those with a serious emotional disturbance or a mental or substance use disorder.

Specific activities supported to 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.
- Working collaboratively through the Mental Health Home and Community Based Medicaid Waiver to return nursing home residents having a psychiatric illness to their communities.

DSS looks forward to advancing the agenda for a comprehensive, effective community-based system of care for those with a behavioral health disorder.

Sincerely,

  
Roderick L. Bremby  
Commissioner

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June 26, 2015

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:

The Connecticut State Department on Aging (SDA) supports Connecticut's FY 2016-2017 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. SDA 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, SDA will continue to collaborate with DMHAS on the Older Adult Behavioral Health workgroup, whose mission is to strive toward an accessible, integrated, multi-disciplinary system of behavioral health care services that promote improved health, wellness and recovery for older adults in Connecticut.

SDA looks forward to advancing the agenda for a comprehensive, effective community-based system of care for those with behavioral health disorders.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth B. Ritter".

Elizabeth B. Ritter  
Commissioner



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**STATE OF CONNECTICUT**  
**DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**  
*A Healthcare Service Agency*

DANNEL P. MALLOY  
GOVERNOR

MIRIAM E. DELPHIN-RITTMON, PH.D.  
COMMISSIONER

June 17, 2015

The Honorable Joette Katz, JD  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106

Dear Commissioner Katz:

I am pleased to provide a letter of support for Connecticut's FY 2016-2017 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 a comprehensive, effective community-based system of care.

Sincerely,

A handwritten signature in cursive script that reads "Miriam Delphin-Rittmon".

Miriam E. Delphin-Rittmon, Ph.D.  
Commissioner

(AC 860) 418-7000  
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134  
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of the Commissioner

June 10, 2015

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

The Honorable Joette Katz, JD  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

I am pleased to provide a letter of support for Connecticut's FY 2016-2017 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 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 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 addressing such disparities;
3. Support activities to strengthen existing school-based health clinics;
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.

The DPH looks forward to advancing a statewide agenda for a comprehensive, effective community-based system of behavioral and primary healthcare.

Sincerely,

  
Jewel Mullen, M.D., M.P.H., M.P.A.  
Commissioner



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Hartford, Connecticut 06134-0308  
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STATE OF CONNECTICUT  
DEPARTMENT OF HOUSING



June 25, 2015

The Honorable Miriam 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 2016-2017 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,



Evonne M. Klein  
Commissioner

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STATE OF CONNECTICUT  
STATE BOARD OF EDUCATION



June 30, 2015

The Honorable Joette Katz, Commissioner  
Connecticut Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106

Dear Commissioner Katz:

On behalf of the Connecticut State Department of Education (CSDE), I am pleased to provide a letter of support for Connecticut's FY 2016-2017 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 of the Judicial Branch, will continue to work collaboratively on school-based diversion of children involved in both child welfare and juvenile justice systems by intervening around mental health crises that might otherwise lead to arrest. 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,

A handwritten signature in cursive script that reads "Dianna R. Wentzell".

Dr. Dianna R. Wentzell  
Commissioner of Education

P.O. Box 2219 ● Hartford, Connecticut 06145  
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Dannel P. Malloy  
Governor

State of Connecticut  
Department of Developmental Services

**DDS**

Morna A. Murray, J.D.  
Commissioner

Jordan A. Scheff  
Deputy Commissioner

June 29, 2015

Joette Katz, Commissioner  
Connecticut Department of Children and Families  
505 Hudson Street  
Hartford, Connecticut 06106

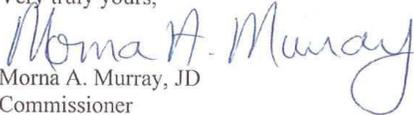
Dear Commissioner Katz:

On behalf of the Connecticut Department of Developmental Services (DDS), I am pleased to provide a letter of support for Connecticut's FY 2016-2017 Community Mental Health Services Block Grant application.

Through this grant, 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 and enhance the coordination of services between DCF and the DDS for clients who are involved with both Departments or may be eligible for voluntary services through DDS. 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,

  
Morna A. Murray, JD  
Commissioner

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001  
460 Capitol Avenue ♦ Hartford, Connecticut 06106  
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Dannel P. Malloy  
Governor

## STATE OF CONNECTICUT DEPARTMENT OF CORRECTION

### OFFICE OF THE COMMISSIONER



Scott Semple  
Commissioner

June 1, 2015

The Honorable Miriam Delphin-Rittmon, PhD  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> floor  
Hartford, Connecticut 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2016-2017 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:

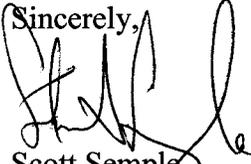
1. Continuing to refer to DMHAS all discharging sentenced inmates who have a serious mental illness (SMI).
2. Supporting Reentry Counselors in their work with offenders being discharged from DOC custody to connect them to resources that may include medical services, mental health and/or substance use services, criminal risk factor treatment, housing, employment, necessary identification papers, and governmental entitlements.
3. Participating in monthly interagency meetings that include Correctional Mental Health Care staff, 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.
4. Continuing to support the Advanced 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.

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)

Page 2

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,

A handwritten signature in black ink, appearing to read 'Scott Semple', written over the printed name.

Scott Semple  
Commissioner

SS/jab

## **21. Support of State Partners**

See Letters of support.

DCF's support of state partners is comprehensive and includes:

- Department of Developmental Services (DDS): Joint planning and coordination of services for clients involved with both DCF and DDS. Activities include: service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice/program evaluation. Additionally, DCF is working closely with DDS regarding the newly legislative mandates around autism services covered under Medicaid.
- Judicial Branch – Court Support Services Division (CSSD): Ongoing evaluation and strengthening the shared service network for youth dually involved or at the risk of involvement with the child welfare and juvenile justice systems. Activities include: shared blended funding for Multi-Systemic Therapy (MST) and Intensive In-Home Child and Adolescent Psychiatry Services (IICAPS); and continued collaboration on state/federally funded initiatives such as the MacArthur Foundation MH/JJ Action Network and State Wraparound Project. See also DOE below and school-based intervention program.
- Department of Public Health (DPH): Ongoing collaboration on the Personal Education Responsibility Program (PREP), the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, and Child FIRST grant application.
- State Department of Education (SDE): Continued collaboration regarding school-based diversion of children involved in both child welfare and juvenile justice systems by intervening around mental health crises that might otherwise lead to arrest. Continued support of DCF's school-based suicide prevention and mental health promotion activities. Implementation of school-based assessments for trauma and a trauma-informed collaborative network based in an inner city school system to address the impact of adverse childhood experiences including care coordination, short term assessment, screening, and direct service for children, trauma informed training and workforce development, and network infrastructure support from DCF.

- Department of Mental Health and Addiction Services (DMHAS): Continue the jointly-managed CT Behavioral Health Partnership to strengthen an integrated behavioral health system for Medicaid eligible children and youth. Work collaboratively to define the criteria for the Welcoming and Engaging Families domain for Enhanced Care Clinics; and continue to work jointly to improve access, quality and outcomes. Ongoing planning, collaboration and facilitation of a more seamless transitioning of DCF youth to adult mental health as indicated.
- Office of the Healthcare Advocate (OHA): Collaboration with the state's insurance advocate's office to ensure that all children in the state, regardless of their insurance coverage, have access to the same levels of care including in-home services, extended day treatment, wrap around services driven by a child and family's need.

## 1617 Narrative 21 Support of State Partners

### 1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

DMHAS partners with a number of other state agencies in the process of fulfilling its mission. Many clients receive services across state agencies or transition between departments as their needs change. Communication and coordination among these state agencies, therefore, is critical to providing efficient and effective care.

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 for children. 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 or 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 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 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, Connecticut's **State Department on Aging (SDA)** collaborates with DMHAS on the Older Adult Behavioral Health Workgroup toward an integrated and multi-disciplinary behavioral health care system that improves the health, wellness and recovery of older adults.

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 build awareness and compel action to address such disparities; support activities to strengthen school-based health clinics; support implementation of a medical home model of care; and 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.

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 clients and client 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 Reentry 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 multi-agency supports in the community.



# State of Connecticut

## JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR  
COURT SUPPORT SERVICES DIVISION  
936 Silas Deane Highway, Wethersfield, CT 06109

June 25, 2015

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

The Honorable Joette Katz, JD  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

I am pleased to provide a letter of support for Connecticut's FY 2016-2017 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 with moderate to serious mental illness and/or substance use disorders.

In partnership with DMHAS and DCF, CSSD will:

1. Continue to strengthen the shared service network developed for those youth that are involved with the child welfare and juvenile justice systems;
2. Continue to share blended funding for the delivery of certain evidence-based treatments such as multi-systemic family therapy and intensive in-home child and adolescent psychiatric services;
3. Collaborate on state and federally-funded initiatives to better integrate care for youth that are involved with the child welfare and juvenile justice system;
4. Continue to collaborate in the Jail Diversion Program that assists the Court in developing community service plans as an alternative to jail for adult defendants with mental illness or co-occurring disorders; and

Telephone: 860-721-2100 Fax: 860-258-8976 E-mail: [Stephen.Grant@jud.ct.gov](mailto:Stephen.Grant@jud.ct.gov)

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5. Continue to fund and manage with DMHAS two programs for adults with mental illness and/or co-occurring disorders, including the Sierra Pretrial Program, a transitional housing facility to pretrial defendants, and the Advanced Supervision and Intervention Support Team (ASIST) program which combines criminal justice supervision with clinical services for pretrial defendants and probationers at risk of violation.

CSSD staff and I 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,

*Brace* (for Stephen R. Grant)

Stephen Grant  
Executive Director

*Connecticut Behavioral Health Planning Council*

---

June 16, 2015

Miriam Delphin-Rittmon, PhD  
Commissioner  
Department of Mental Health and Addiction Services  
410 Capitol Avenue, 4<sup>th</sup> floor  
Hartford, CT 06134

Joette Katz, JD  
Commissioner  
Department of Children and Families  
505 Hudson Street  
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

The Connecticut State Behavioral Health Planning Council met on June 11, 2015 to review and comment on the draft FFY 2016-2017 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The meeting was attended by members of both the Children's Behavioral Health Advisory Council and the Adult Behavioral Health Planning Council, as well as representatives of various state agencies.

After due consideration and discussion, the Council endorses Connecticut's 2016-2017 State Block Grant Plan and Application with comments and recommendations included. Both Departments are commended for their commitment to serving the mental health and substance abuse needs of children and adults in Connecticut.

Sincerely,



Marcia DuFore  
Adult Council Chair



Doriana Vicedomini  
Child Council Co-Chair



David Tompkins  
Child Council Co-Chair

June 26, 2015

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:

The Connecticut Housing Finance Authority (CHFA) supports Connecticut's FY 2016-2017 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. CHFA 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 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, 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. 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 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,



Norbert Deslauriers  
Interim Executive Vice President

# Environmental Factors and Plan

## 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

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Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>97</sup>

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, 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.

*For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.*

*For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.*

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*<sup>98</sup>

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<sup>97</sup><http://beta.samhsa.gov/grants/block-grants/resources>

<sup>98</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.

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

**22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application:**

Children’s Behavioral Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) to the State Advisory Council on Children and Families (SAC) 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 32-member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Protection and Advocacy, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, six members appointed by the leadership of the General Assembly, as well as sixteen members appointed by the chairperson of the SAC. 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 fall delineate spending plans with an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan on May 1, 2015 and June 5, 2015.

**JOINT BEHAVIORAL HEALTH  
PLANNING COUNCIL MEETING**

**AGENDA**

**Connecticut Valley Hospital  
Page Hall Room 217**

**June 11, 2015  
2:00 to 4:00 PM**

Welcome/Introductions – Council Chair

**Children’s Council**

Dave Tompkins  
Doriana Vicedomini

**Adult Council**

Marcia DuFore

1. Minutes: March 12, 2015

Review/Approve

2. Presentation of Block Grant

Susan Wolfe  
Tim Marshall

3. Updates

DMHAS  
DCF

Jim Siemianowski  
Tim Marshall

Other Business

Adjournment

## **1617 Narrative 22 on State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application**

The draft 2016/2017 Combined CMHS and SAPT Block Grant Application and Plan was posted on the DMHAS and DCF websites for a 2-week period along with a notice announcing its availability for review and comment. During the review of the draft Block Grant Application with the Behavioral Health Planning Council, it was announced that this period of posting for review and comment would occur. Additionally, an email notice was sent to all members of the Behavioral Health Planning Council announcing that the draft Block Grant Application had been posted to the DMHAS and DCF website and was available for additional comment.

Connecticut's Joint Behavioral Health Planning Council is comprised of an Adult State Behavioral Health Planning Council and a Children's Behavioral Health Advisory Council. The Adult Council and the Children's Council hold separate meetings throughout the year and come together four times a year for a Joint Council meeting. Membership requirements and Council duties are generally reviewed annually through an orientation session. In addition to meeting the duties as outlined in the Public Health Act, the Council also schedules presentations on topics of interest in behavioral health.

### **1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)**

Throughout the various stages of the planning, development, and review of the Block Grant Application, the Behavioral Health Planning Council has been involved. At each Council meeting, an update is provided on all block grant related activities. Such updates include information about upcoming webinars, opportunities for technical assistance, SAMHSA initiatives, Connecticut budget concerns, progress with respect to selected block grant priorities, and any pending report/application requirements, revisions, and deadlines. Time is allowed for discussion and questions. Council members may ask for additional information and request copies of documents which are either provided in hard copy or are emailed to them.

For the Adult Portion, the Adult Behavioral Health Planning Council includes members from the Regional Mental Health Boards (RMHBs) and the Regional Action Councils (RACs), both statutorily defined planning bodies for the DMHAS system. These RMHBs and RACs were instrumental in conducting the 2014 Priority Setting Process (see the Behavioral Health Needs Assessment section for more details) which informed the priority setting process.

### **2. What mechanism does the state use to plan and implement substance abuse services?**

The Department of Mental Health and Addiction Services, as the name implies, has been a single integrated department since 1995, servicing all behavioral health needs of adults. Connecticut has been submitting combined Mental Health and Substance Abuse block

grant applications since 14/15. The biannual priority setting process is likewise integrated to cover mental health, substance use and co-occurring populations and services.

In October 2012, the State Mental Health Planning Council was expanded to encompass substance use services and was renamed the State Behavioral Health Planning Council. Also at this time, membership was expanded to key stakeholders from the addiction system for both treatment and prevention.

**3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns and activities into its work?**

Council membership includes representation from substance use providers, advocates, and persons in recovery. Fully half of those responding to an anonymous Council member survey in 2014 self-reported that they were advocates for substance use as well as mental health. Orientation for new Council members occurs annually and reinforces that the Council purview encompasses substance use concerns. The biannual Priority Setting Process includes questions related to substance use, mental health, and co-occurring populations/services and recommendations resulting from this process address all of these areas. The State Planner for the Adult portion has a background of more than 25 years working in Addiction Treatment. Updates and presentations to the Council include all manner of behavioral health concerns, including at the April 15, 2015 meeting, a presentation on Opioid Abuse, Overdose and Naloxone (Narcan).

**4. Is the membership representative of the service area population?**

Membership is reasonably representative, although membership recruitment is an ongoing effort to provide a balance of diverse members and block grant requirements. We would like to enhance representation of persons related to substance use, minorities, and LGBT.

**5. Describe 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 Behavioral Health Planning Council is required under the Federal Public Health Services Act and the Community Mental Health Services Block Grant. The Council duties include:

- To review the Combined CMHS and SAPT Block Grant Application and State Plan provided to the Council by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), and to submit to the Commissioners of those departments any recommendations of the Council for modification to those plans;
- To serve as an advocate for adults with SMI, and children with SED and their families, as well as other individuals with mental illness or emotional problems; and

- To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services in Connecticut.

Council representation includes state agencies, other public and private entities concerned with the need, planning, operation, funding and use of mental health and related services, family members of adults and children with SEDs, and representatives of organizations of individuals with mental illness and/or substance use and their families, and community groups advocating on their behalf.

Council business ranges from developing <http://turningpointct.org/>, a website designed by young adults for young adults, to presentations on QPR (Question, Persuade, Refer for Suicide Prevention), Asian Pacific Clients, Autism Spectrum Disorder services, Opioid Abuse, Overdose and Narcan, etc. to a Prevention Subcommittee examining the various state agencies' strategic prevention plans to understand the infrastructure, overlap, and efficacy of the plans.

The Regional Mental Health Boards (RMHBs) and the Regional Action Councils (RACs) which participate in the Adult Behavioral Health Planning Council were instrumental in conducting the 2014 Priority Setting Process (see the Behavioral Health Needs Assessment section for more details). The RMHBs and RACs used information from DMHAS- provided regional client profiles and a DMHAS- managed on-line survey of providers as a starting point from which to conduct their focus groups and "community conversations" to gain qualitative feedback about the behavioral health service system. The RMHBs and RACs combined this data with information garnered from other sources, such as local hospital and school survey data, comments and feedback from meetings with community stakeholders, public forums, evaluations, and interviews, etc., to produce regional priority setting reports. These regional reports were presented to DMHAS leadership and the Behavioral Health Planning Council. Regional reports were organized by the state planner into a single statewide priority setting report which informed the priority setting of the block grant application. Through this approach, the Council plays a vital role of determining the direction of the Block Grant.

**Joint BHPC Meeting  
Meeting Minutes**

<b>Meeting Day/Date:</b>	Thursday, June, 11 2015 - 2:00 PM – 4:00 PM	
<b>Location:</b>	CVH, Page Hall, Room 217	
<b>Attendance:</b>		
<b>Members Present:</b>	Magda Lekarczyk, Carol Meredith, Marcia Dufore, Margaret Watt, Wendi Cook-Fralick, Doriana Vicedomini, Eileen Bronko, Jennifer Gross, Peggy Ayer, Jody Rowell, Laura Watson, Nannette Latremouille	
<b>Staff Present:</b>	Susan Wolfe, Jim Siemianowski, Chris Beauty, Mary Cummins	
<b>Guest</b>	Arnie Trasente, John Hernandez	
<b>AGENDA ITEM</b>	<b>DISCUSSION</b>	<b>ACTION</b>
<b>Introductions</b>		
<b>Review of Minutes</b>	Minutes from March 12, 2015 reviewed and accepted without changes.	Minutes accepted.
<b>Presentation of 2016/2017 Block Grant</b> Susan Wolfe Mary Cummins	<p>Susan Wolfe (DMHAS) shared that the Block Grant application is due September 1, 2015 for 2016-2017 funding. The funding allocations are based on a formula and sent to the states by SAMHSA. The completed application will be posted on the DMHAS and DCF websites for two weeks beginning the end of July for review by council members and the public. Susan shared and elaborated on a summary document regarding the combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant. This included the following information regarding the Block Grant.</p> <p><b>What's the same and what's changed from the 2014-2015 Block Grant Application:</b> Susan and Jim Siemianowski (DMHAS) reviewed what had and had not changed in the current application compared to the 2014-2015 Application. This included the following:</p> <ul style="list-style-type: none"> <li>- The current Block Grant Application has no new set-asides; its descriptions of the services are similar to the previous block grant application, but it has been updated; and the needs assessment process is also similar and was conducted in 2014.</li> <li>- There are changes to the "Quality and Data Collection Readiness" section with SAMHSA now looking for each state's readiness to provide more case-specific data on things like co-existing conditions, medication compliance, completed suicide and depression screenings, etc. to assess each states' service integration, service coverage, and service provision processes. This type of data is consistent with what Medicare/Medicaid is requesting from service providers. The apparent goal is to have each state establish processes and procedures of care that ensure effective care for each individual. Previously, the data requested by SAMHSA was at an aggregate or systems level. CT would need to develop the systems to report on the more individualized data being requested. One of the Council guests raised the question of whether the data currently collected under Title 19 would provide the level of data being considered by</li> </ul>	

	<p>SAMHSA.</p> <ul style="list-style-type: none"> <li>- Quality Improvement, Multicultural and Suicide Prevention plans are now all required for the narrative sections.</li> <li>- New Narrative sections include: 5% set aside for early intervention; prevention of serious mental illness (SMI); participant directed care; medication assisted treatment; crisis services; community living and implementation of Olmstead; and pregnant women/women with dependent children. Jim shared that these new narrative sections reflect areas of interest for SAMHSA, and the information collected through the block grant will be used to assess each state's ability to address each area.</li> </ul> <p><b>DMHAS Block Grant Priorities:</b> Susan provided a handout of the DMHAS priorities for the 2016-2017 Block Grant Application. The priorities include the following:</p> <ul style="list-style-type: none"> <li>- <u>Healthcare Disparities:</u> Using DMHAS data stratify the data based on race/ethnicity and identify disparities, starting with residential treatment outcomes. With established baselines, develop and implement a quality improvement activity (training/technical assistance) to address identified disparities. One of the council guests asked if they could see the DMAHS Multicultural plan for addressing healthcare disparities. Susan offered to provide a copy of the plan to this person and anyone else who wanted it.</li> <li>- <u>Trauma-informed and Gender-responsive treatment for women:</u> using a recently-developed trauma and gender fidelity scale, assess all specialized programs for women and produce a report which identifies how each program is performing, including recommendations for improvement. Data from the fidelity scale used by staff in evidence-based practices at DMHAS will be used.</li> <li>- <u>Law enforcement management of persons in crisis in the community:</u> increase the number of Crisis Intervention Team (CIT) trained officers and the number of police departments with at least one CIT trained officer. Reports from the CT Alliance to Benefit Law Enforcement (CABLE) will be used.</li> <li>- <u>Reducing Opioid Overdoses:</u> educate providers, first responders, and the community about narcan (naloxone), the antidote to an opioid overdose. Data will be based on attendance sheets and will be maintained by DMHAS.</li> <li>- <u>Improved HIV testing:</u> provide quicker HIV test results earlier in the conversion process by implementing a new testing protocol at all DMHAS HIV programs, thereby reducing further transmission. Data will be based on HIV program reports.</li> <li>- <u>TB testing follow up:</u> ensure that all persons with a positive preliminary test result for TB receive a referral for follow-up care. Data will be collected through infectious disease statistics maintained by DMHAS.</li> <li>- <u>Prevention of prescription opioid misuse:</u> through community outreach, awareness and</li> </ul>	
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education reduce the percentage of 18 – 25 year olds admitted to DMHAS substance use treatment programs for prescription opioid misuse, thereby reducing the number of persons that transition to heroin as well. DMHAS admission data will be used. Carol Meredith from DMHAS prevention commented that she was interested in expanding this priority and explained about a related grant to address substance use at the community level.

**DCF Block Grant Priorities:** Mary Cummins (DCF) presented the DCF priorities for the 2016-2017 Block Grant Application which included the following:

- Suicide Prevention: prevent and reduce attempted suicides and deaths by suicide among high risk populations. To enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide.
- Workforce Development: 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. To 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 employment decisions.
- Childhood Trauma: increase the number of mental health agencies in CT that provide 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 causes of trauma. It is anticipated that MATCH can effectively serve up to 75% of CT children and youth who need mental health services.
- Family Engagement: to assure that the voices, perspectives, and input of family members are included in developing, planning, and overseeing the statewide behavioral health system.

**Fiscal Projections:** for both DMHAS and DCF, Chris Beauty reported that the fiscal projections will remain about the same as in the previous grant. The projections and allocations are as follows:

- DMHAS will receive around \$17.6 million dollars for substance abuse services, with 5% needing to be dedicated to HIV and over 20% needing to be dedicated to prevention efforts.
- DMHAS will receive around \$4.8 million dollars for mental health services, with 30% of those funds (around \$1.4 million) going to DCF.
- Both DMHAS and DCF will set aside 5% of the CMHS allocation for the prevention/early intervention with serious mental illness/serious emotional disturbance. This amounts to \$250,000 for DMHAS of which DCF receives about \$73,000. DCF will be using its CBITS program to address this area.

	<ul style="list-style-type: none"> <li>- DMHAS will not be able to achieve the required Maintenance of Effort (MOE) for the grant so they will be requesting a waiver from SAMHSA. The MOE is intended to keep each state's funding for substance abuse and mental health initiatives and services at the same or greater levels, and not just rely on the block grant funding. DMHAS not achieving the MOE is the result of procedures for making expenditures and does not reflect any reduction in its expenditures.</li> </ul> <p><b>Council Membership:</b> The Council is required to have 51% or more of family members/individuals in recovery as opposed to state employees/providers and this may necessitate recruitment of additional members.</p> <p><b>Block Grant Timelines:</b> The plan is to post the completed block grant application to the websites for a two-week period, ideally, July 20 – 21<sup>st</sup>, 2015 for public comment. The following week will be the target for the Governor to sign the certifications/assurances.</p>	
<p><b>Updates</b> Jim Siemianowski</p>	<p><b>Proposed Budget Cuts Restored:</b> Funds that were previously slated to be removed from the DMHAS budget have been restored. This includes cuts scheduled for outpatient services. Apparently, the legislature assumed that funds would be available through the Affordable Care Act, but that was not the case. Around 17 million dollars will be restored to the DMHAS budget.</p> <p><b>Opioid Overdose Intervention:</b> Narcan (Naloxone) will be more widely available to treat and reverse the potentially fatal effects of opioid overdose. In CT, some physicians were reluctant to prescribe the medication due to concerns over the liability of treating a non-patient. CT will be the first state to have pharmacists prescribe the medication so that individuals can obtain it from the pharmacy and give it to family members for opioid overdose. The CT state police have been carrying this medication and providing it to individuals with an opioid overdose, saving around 25 lives since October 2014. The plan is to also make the Narcan (Naloxone) available for fire departments and EMS.</p>	
<p><b>Next Meeting</b></p>	<p>CT Behavioral Health Advisory Council (CBHAC) next meeting is July 10, 2015. Joint Behavioral Health Planning Council next meeting is September 10, 2015.</p>	

# Environmental Factors and Plan

## Behavioral Health Advisory Council Members

Start Year:   
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Margaret "Peggy" Ayer	Parents of children with SED		151 Pond Road North Franklin, CT 06254-1224 PH: 860-642-4348	msayer7@comcast.net
Kristie Barber	Others (Not State employees or providers)	South Central CT Regional Mental Health Board	CT Valley Hospital, Shew-Beers Hall, CVH, P.O. Box 351 Middletown, CT 06457 PH: 860-262-5027 FAX: 860-262-5028	execdir@rmhb2.org
Joan Cretella	Family Members of Individuals in Recovery (to include family members of adults with SMI)		225 Beach Street, Unit 2A West Haven, CT 06516 PH: 203-933-4272	
Jennifer Gross	Parents of children with SED	Eastern Regional Mental Health Board	Eastern Regional Mental Health Board, 401 West Thames Street, Campbell Bdg, Room 105 Norwich, CT 06360 PH: 860-886-0030 FAX: 860-886-4014	kgross@ermhb.org
Marcia DuFore	Others (Not State employees or providers)	North Central Regional Mental Health Board, Inc.	367 Russell Road, Building 34 Newington, CT 06111 PH: 860-667-6388 FAX: 860-667-6390	mdufore@ncrmhb.org
Lorna Grivois	Family Members of Individuals in Recovery (to include family members of adults with SMI)		586 Westchester Road Colchester, CT 06415 PH: 860-267-6083	grivois620@comcast.net
Irene Herden	Others (Not State employees or providers)		49 Bogue Lane East Haddam, CT 06423-1442 PH: 860-873-1999 FAX: 860-873-1999	evherd@comcast.net
Mui-Mui Hin-McCormick, MS, LMLT	Others (Not State employees or providers)	CT Asian Pacific American Affairs Commission	18 - 20 Trinity Street Hartford, CT 06106 PH: 860-240-0080	Mui.Mui.Hin-Mccormick@cga.ct.gov
Lisa Jameson	Parents of children with SED		112 Bell-Aire Circle Windsor, CT 06096 PH: 860-623-5790	lisajameson22@gmail.com
Deron Drumm	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Advocacy Unlimited, Inc.	300 Russell Road Wethersfield, CT 06019-1346 PH: 860-667-0460 FAX: 860-666-2240	ddrumm@mindlink.org
Mary M. Martinez	Family Members of Individuals in Recovery (to include family members of adults with SMI)		7 Mary Shepard Place, Apt 710 Hartford, CT 06120 PH: 860-719-5080	mryadvcomm35@gmail.com
Margaret Watt	Others (Not State employees or providers)	Southwest Regional Mental Health Board	1 Park Street Norwalk, CT 06851 PH: 203-840-1187 FAX: 203-840-1926	mwatt@swrmhb.org

Brian Reignier, MS	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		19 Irving Street Naugatuck, CT 06457 PH: 860-262-5362 FAX: 860-262-5356	Brian.Reignier@ct.gov
Barbara Roberts	Family Members of Individuals in Recovery (to include family members of adults with SMI)		42 School Street Woodbury, CT 06798 PH: 203-263-3250	Barbara114@sbcglobal.net
Janine Sullivan-Wiley	Others (Not State employees or providers)	Northwest Regional Mental Health Board, Inc.	969 West Main Street, Suite 1B Waterbury, CT 06708 PH: 203-757-9603 FAX: 203-757-9603	jsw@nwrmbh-ct.org
Sincilina Beckett	Providers	Wheeler Clinic	322 Garden St Hartford, CT 06112 PH: 860-478-4767	sbeckett@wheelerclinic.org
Josephine Hawke	Parents of children with SED	FAVOR, Inc.	185 Silas Deane Highway, Suite 200 Rocky Hill, CT 06067 PH: 860-563-3232 FAX: 860-563-3961	jhawke@favor-ct.org
Gabrielle Hall	Providers	Clifford Beers Clinic	5 Science Park New Haven, CT 06511 PH: 203-777-8648 FAX: 203-785-0617	ghall@cliffordbeers.org
Mary Held	Parents of children with SED		929 Bank Street Waterbury, CT 06708 PH: 203-441-1887	Heldmary30@aol.com
Marcy Kane, Ph.D.	Providers	Wellmore Behavioral Health	141 Main Street Waterbury, CT 06704 PH: 203-575-0466	mkane@wellmore.org
Debbie McCusker	Parents of children with SED		35 Maywood Street Waterbury, CT 06704 PH: 203-757-7569	jamesmccusker@sbcglobal.net
George McDonald	Parents of children with SED		P. O. Box 2617 Hartford, CT 06146 PH: 860-794-6283	
David Tompkins	Providers	Klingberg Clinic	370 Linwood Street New Britain, CT 06052 PH: 860-832-5511 FAX: 860-826-1739	davidt@klingberg.org
Doriana Vicedomini	Parents of children with SED		9 Kingfisher Lane Suffield, CT 06078 PH: 504-259-4327	DMV35@aol.com
Cara Westcott	Providers	United Community and Family	UCF Health Center, The Meadows Center, 47 Town Street Norwich, CT 06360-2315 PH: 860-892-7042 FAX: 860-886-6124	cwestcott@ucfs.org
Commissioner Jewel Mullen	State Employees	CT Department of Public Health	410 Capitol Avenue Hartford, CT 06106 PH: 860-509-7101 FAX: 860-509-7111	Jewel.Mullen@ct.gov
Magdalena Lekarczyk	State Employees	CT Office of Policy and Management	450 Capitol Avenue Hartford, CT 06106 PH: 860-418-6405 FAX: 860-418-6490	magdalena.lekarczyk@ct.gov
Eileen Bronko	Parents of children with SED	Northwest Regional Mental Health Board	34 Fairfield Court Naugatuck, CT 06770 PH: 203-723-0875	ebronko1@snet.net
Cindy Thomas	Parents of children with SED		162 Saltonstall Avenue Newington, CT 06111 PH: 203-776-3180	cindythomas1370@yahoo.com

c/o LFCRAC, 115-125 Main

Ingrid Gillespie	Others (Not State employees or providers)	Connecticut Prevention Network	Street Stamford, CT 06901 PH: 203-391-7914 FAX: 203-967-9476	igillespie@communities4action.org
Karen Zaorski	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	CT Turning to Youth and Families	92 Head O'Meadow Rd Newtown, CT 96470 PH: 203-879-5526	k.zaorski@comcast.net
Thomas Steen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Capitol Area Substance Abuse Council	3 Barnard Lane Bloomfield, CT 06002 PH: 860-286-9333 FAX: 860-286-9334	tsteen@casac.org
Nannette Latremouille	State Employees	Connecticut Valley Hospital	P.O. Box 351, Silver Street Middletown, CT 06457 PH: 860-262-5970 FAX: 860-262-9334	nannette.latremouille@ct.gov
Commissioner Amy Porter	State Employees	Department of Rehabilitation Services	55 Farmington Avenue Hartford, CT 06105 PH: 800-537-2549	amy.porter@ct.gov
Laura McMenamin	State Employees	Department of Housing	505 Hudson Street Hartford, CT 06106 PH: 860-270-8169 FAX: 860-706-5741	laura.mcmenamin@ct.gov
Wendi Cook-Fralick	Providers	Mental Health Connecticut	61 South Main St, Suite 100 West Hartford, CT 06107 PH: 860-529-1970 FAX: 860-529-6833	wcook-fralick@mhconn.org
Kathy Flaherty	Others (Not State employees or providers)	Connecticut Legal Rights Project	CVH, Shew-Beers Hall, PO Box 351 Middletown, CT 06457 PH: 860-262-5033 FAX: 860-262-5035	kflaherty@clrp.org
Tarsha Galloway	Parents of children with SED		289 Ferry St New Haven, CT 06513 PH: 203-503-1395	ndreams0729@aol.com
Jessica Goodwin	Parents of children with SED		71 Taftville Occum Rd #2 Norwich, CT 06360 PH: 860-237-5424	queenbj7777@gmail.com
Susan Graham	Parents of children with SED		141 High St Thomaston, CT 06787 PH: 860-309-4322	sgraham141@yahoo.com
William "Bill" Halsey	State Employees	DSS	25 Sigourney St Hartford, CT 06106-5033 PH: 860-424-5077 FAX: 860-424-4812	william.halsey@ct.gov
Brenetta Henry	Parents of children with SED		113 Enfield St Hartford, CT 06112	brenetta.henry@yahoo.com
Tim Marshall	State Employees	DCF	505 Hudson St Hartford, CT 06105 PH: 860-550-6531 FAX: 860-556-8022	tim.marshall@ct.gov
Carol Meredith	State Employees	DMHAS - Prevention	410 Capitol Ave, 4th floor Hartford, CT 06134 PH: 860-418-6826 FAX: 860-418-6792	carol.meredith@ct.gov
Jaquita Monroe	State Employees	Court Support Services Division (CSSD)	936 Silas Deane Highway Wethersfield, CT 06109 PH: 860-721-2199	jaquita.monroe@jud.ct.gov
Scott Newgass	State Employees	State Dept of Education (SDE)	25 Industrial Park Rd Middletown, CT 06457 PH: 860-807-2044 FAX: 860-807-2127	scott.newgass@ct.gov
Maureen O'Neill	Parents of children with SED		1811 Mountain Rd Torrington, CT 06790	maureenod65@gmail.com

Alana Parkinson	Parents of children with SED		PO Box 1276 Manchester, CT 06045 PH: 860-836-0382	hillhome57@gmail.com
Nikki Richer	State Employees	DMHAS - Young Adults	CVH, PO Box 351 Middletown, CT 06457 PH: 860-262-6995 FAX: 860-262-6980	nikki.richer@ct.gov
Scott Semple	State Employees	Dept of Correction (DOC)	24 Wolcott Hill Rd Wethersfield, CT 06109 PH: 860-692-7482 FAX: 860-692-7483	scott.semple@ct.gov
Peter Tolisano	State Employees	Dept of Developmental Services (DDS)	460 Capitol Ave Hartford, CT 06106 PH: 860-418-6086	peter.tolisano@ct.gov
Michelle Tournas	Parents of children with SED		96 Alder Street Waterbury, CT 06702	ahaj321@aol.com
Benita Toussaint	Parents of children with SED		45 Niles St Hartford, CT 06105 PH: 860-249-4806	toussassaintbenita@yahoo.com
Ofelia Velazquez	Parents of children with SED		180 Broad St, B1 Hartford, CT 06114 PH: 860-313-9130	ovy4252@yahoo.com
Sarah Gauger	State Employees	State Dept. of Aging (SDA)	55 Farmington Ave Hartford, CT 06105 PH: 860-424-5233	sarah.gauger@ct.gov

Footnotes:

# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	57	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	19	
Vacancies (Individuals and Family Members)	<input type="text" value="1"/>	
Others (Not State employees or providers)	8	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>36</b>	<b>63.16%</b>
State Employees	14	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
<b>Total State Employees &amp; Providers</b>	<b>21</b>	<b>36.84%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="11"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>12</b>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="13"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Throughout the various stages of the planning, development and review of the Block Grant Application, the Behavioral Health Planning Council has been involved. At each Council meeting, an update is provided on all Block Grant related activity. Biannually, the Council identifies needs/problems and strengths of the service system and develops recommendations. These priority setting process results are used for planning and budgeting within DMHAS and inform the priorities selected for the Block Grant. While the entire application is provided to the Council for review (as well as being posted on the DMHAS website for public comment), highlights of the Block Grant Application (changes from the previous application, fiscal projections, and in greater detail priorities) are presented to the Council (at the June 15, 2015 meeting) for discussion and comment. There were no recommendations to change the Block Grant application from the Council and most questions

focused on broader budgetary concerns.

The Council has integrated substance abuse prevention and treatment concerns and activities in its work since 2012 when the Council went from being the Mental Health Planning Council to the Behavioral Health Planning Council. The Council expanded its membership to represent substance abuse, including persons in recovery or family members of persons in recovery and providers/advocates of substance abuse prevention and treatment. The DMHAS state planner since 2012 likewise has over 25 years of experience in addictions treatment. Regional Action Council (RAC) members who are now represented on the Council collaborate with the Regional Mental Health Boards to conduct the biannual priority setting process, which asks about mental health and substance abuse, as well as co-occurring conditions. Likewise, the priority setting process also includes a provider survey asking about mental health and substance abuse; as well as regional profiles of clients receiving both substance abuse and/or mental health services. Activities conducted by the Regional Action Councils include raising community awareness about substance abuse. Each of the 13 RACs held a community forum on opioid abuse in 2014. One of the presentations for the Council in 2015 was on Prescription Drug Use, Opioids, and Narcan (Naloxone).

Both of the vacancies identified are legislative appointments. It is unknown whether the appointments will be from the provider/state employee category or from the individual in recovery/family member/other category. We have attempted to reflect this by placing one vacancy in each category.

Footnotes:

JUL 6 2015

Dr. Miriam Delphin Rittmon  
Connecticut Department of Mental Health  
410 Capitol Avenue, MS# 13 COM  
Hartford, CT 06134

Dear Dr. Rittmon:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Page – 2 Dr. Rittmon

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

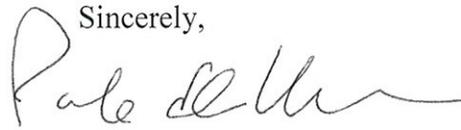
Ms. Virginia Simmons  
Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, Room 7-1109  
Rockville, Maryland 20857  
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons  
Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, 7-1109  
Rockville, Maryland 20850  
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a large initial "P" and a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.  
Director  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration

cc: Susan Wolfe  
Mary Cummins  
Maricia Dufore

Enclosures:  
2016 MHBG Prospective Allotments  
MHBG Project Officer Directory