SUBSTANCE ABUSE

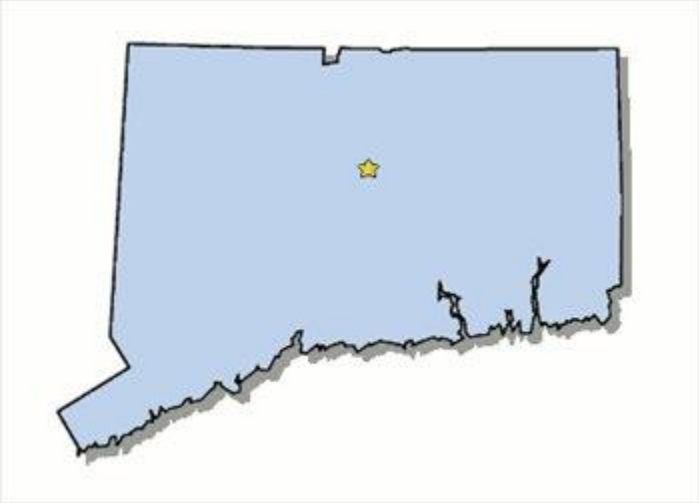
PREVENTION AND TREATMENT

BLOCK GRANT

ALLOCATION PLAN

FEDERAL FISCAL YEAR 2017

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES



August 2016

STATE OF CONNECTICUT
SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

FFY 2017 ALLOCATION PLAN
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1. Overview of the Substance Abuse Prevention and Treatment Block Grant

A. Purpose

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is administered by the United States Department of Health and Human Services (DHHS) through its administrative agency, the Substance Abuse and Mental Health Services Administration (SAMHSA). The Connecticut Department of Mental Health and Addiction Services (DMHAS) is designated as the principal agency for the allocation and administration of the Block Grant within the state of Connecticut.

The SAPT provides grants to states to plan, establish, maintain, coordinate, and evaluate projects for the development of effective alcohol, tobacco, and other drug abuse prevention, treatment, and rehabilitative services. Funds can be used for alcohol and other drug abuse prevention and treatment programs, and services for identifiable populations, which are currently underserved and in the greatest need.

B. Major Use of Funds

Services provided through this Block Grant include the major categories of:

Community Treatment, Residential, and Recovery Support Services – Substance abuse treatment, rehabilitation, and recovery supports provide a range of services designed to meet the client's individual needs. Services provided through the SAPT Block Grant include residential and ambulatory detoxification; intensive, intermediate, and long-term residential care; outpatient treatment; and opioid replacement therapy. A variety of community support services are also funded such as case management, vocational rehabilitation, transportation, and outreach to specific populations in need of treatment.

Prevention and Health Promotion Services – Funds are applied to effective programs and strategies serving the needs of diverse populations with different levels of risk for developing substance abuse problems. Resources are allocated according to Institute of Medicine population classifications. These include **Universal** targeting for the general public; **Selective** targeting for individuals or a population subgroup at risk of developing substance abuse; and **Indicated** targeting individuals in high-risk environments who are pre-disposed to substance abuse. The following six strategies of activities prescribed by the Center for Substance Abuse Prevention (CSAP) are funded:

- **Information Dissemination** – This is characterized by one-way communication from the source to the audience.
- **Education** – This is characterized by two-way communication that involves interaction between the educator/facilitator and participants. Education aims to affect critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities.
- **Alternatives** – These are alternative constructive and healthy activities that can offset the attraction to or otherwise meet the needs usually filled by the use of alcohol, tobacco and other drugs.
- **Problem Identification and Referral** – These strategies aim to identify those who have indulged in illegal and/or age-inappropriate alcohol or tobacco use or who have indulged in illicit drug use for the first time. The goal is to assess if the behavior of the target group can be reversed through education.

- **Community- Based Processes** – These processes aim to help the community provide alcohol, tobacco, and other drug use prevention and treatment services more effectively.
- **Environmental Strategies** - These strategies seek to establish or change community standards, codes, and attitudes that influence the incidence and prevalence of alcohol, tobacco, and other drug use in the general population. There are two categories of environmental strategies: legal and regulatory initiatives and service and action-oriented initiatives.

The SAPT Block Grant also requires states to maintain expenditures for substance abuse treatment and prevention services at a level that is not less than the average level of such expenditures for the two-year period preceding the fiscal year for which the state is applying for the grant. Due to a legislative action which reallocated funding to the Department of Social Services (DSS) as part of the Affordable Care Act and Medicaid expansion, solely evaluating the DMHAS budget would not depict an accurate representation of the state's commitment. As a result, DMHAS has requested a determination of material compliance from SAMHSA based on other relevant factors such as the state's expenditure history, the number of persons served, and the state's future funding commitment which would more accurately demonstrate the state's compliance.

C. Federal Allotment Process

The allotment of the SAPT Block Grant to states is determined by three factors: the Population at Risk, the Cost of Services Index, and the Fiscal Capacity Index. The Population at Risk represents the relative risk of mental health problems in a state. The Cost of Services Index represents the relative cost of providing mental health treatment services in a state. The Fiscal Capacity Index represents the relative ability of the state to pay for mental health related services. The product of these factors establishes the need for a given state.

D. Estimated Federal Funding

The proposed FFY 2017 SAPT Allocation Plan is based on estimated federal funding provided by SAMHSA of $18,212,225 and may be subject to change when the final federal appropriation is authorized, including any changes brought about by the Budget Control Act of 2011. The FFY 16 award increased from an estimated $17,596,352 to an actual $18,212,225 post-allocation plan submission.

E. Total Available and Estimated Expenditures

The total SAPT Block Grant funds available for FFY 2017 are $19,562,606 which is based on estimated federal block grant allocation of $18,212,225 and DMHAS carry over funds of $1,350,381. The estimated federal block grant allocation remains the same as the previous year, and is greater than the originally anticipated FFY 2016 block grant allocation of $17,596,352. The estimated federal funding is subject to change when the final federal appropriation is authorized.

DMHAS estimates that all of the FFY 2017 Block Grant award ($18,212,225) will be fully committed and expended within the federally required time frame of two years. Regarding proposed allocations for FFY 2017, the plan outlines DMHAS' proposal to spend the total funds available. Any changes within the program service categories have been made to ensure continued adherence to federal set-aside requirements.

F. Proposed Allocation Changes from Last Year

Proposed FFY 17 expenditures remain level funded compared to FFY 16 estimated expenditures. The entire Block Grant expenditure plan is intended to maintain and enhance the overall capacity of the full substance abuse service system. DMHAS' overarching goals for 2016-2018 are to improve quality of services and supports; increase stakeholder and community partnerships; develop the workforce across the system of care; and promote integration and continuity of care. Within the realm of substance abuse services, the focus of DMHAS is on responding to the opioid epidemic at all possible intervention points.

G. Contingency Plan

This allocation plan was prepared under the assumption that the FFY 2017 Block Grant for Connecticut will be funded at the level of $18,212,225. In the event that anticipated funding is reduced, DMHAS will review the performance of programs in terms of their utilization, quality, and efficiency. Based on this review, reductions in the allocation would be assessed to prioritize those programs deemed most critical to public health and safety.

Any increases in Block Grant funding will ensure that the current level of obligations can be maintained. Currently, DMHAS' obligations depend, in part, on funding carried forward from previous years. Therefore, any funding increase will first be reviewed in light of sustaining the level of services currently procured via the annual, ongoing award. Second, if the increase is significant and allows for expansion of DMHAS' service capacity, the department will review the unmet needs for substance abuse prevention and treatment services identified through its planning process and prioritize the allocation of additional Block Grant resources.

H. State Allocation Planning Process

Various methods to determine the deployment of substance abuse services were utilized, including: 1) surveys of key informants, 2) development of estimates extrapolated from valid primary surveys or other analytic methods, 3) analysis of service data from DMHAS' management information system, and 4) input from regional and statewide advisory bodies.

Assessment of Prevention and Treatment Need

DMHAS currently, and in past years, has been successful in receiving federal funds for studies to determine the need for substance use prevention and treatment services within the state. The *DMHAS Research Division*, 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 addiction fields. Studies have encompassed areas such as supportive housing, homeless families, criminal justice diversion, co-occurring mental health and substance use disorders, consumer-operated services, trauma-informed care, substance abuse treatment outcomes, the needs of veterans, the concerns of young adults and implementation science. These studies inform decision-makers at both local and national levels about the effectiveness of treatment, prevention, and community-based interventions.

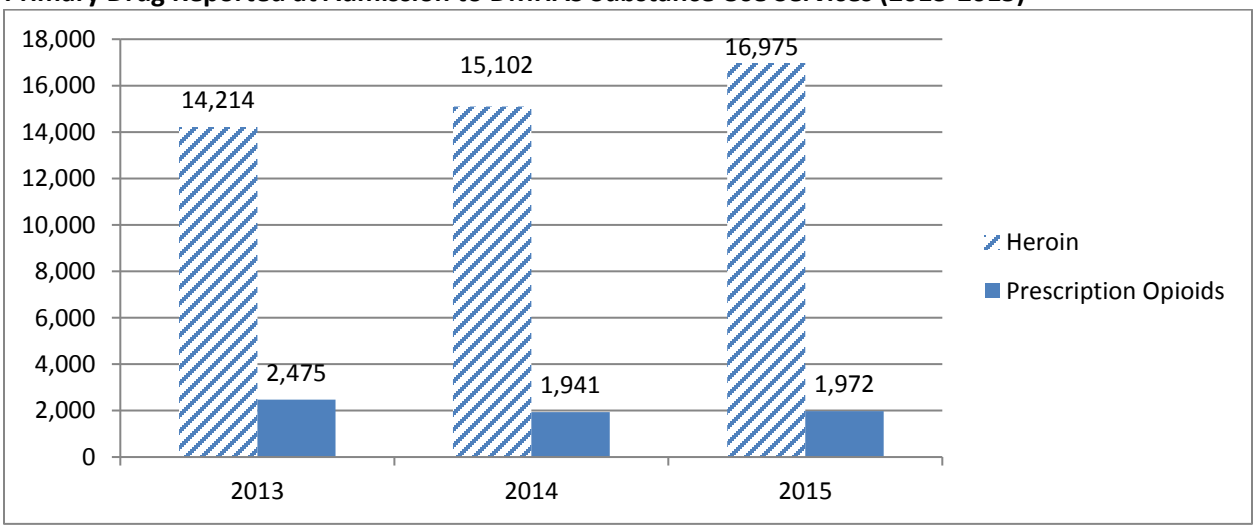
The *DMHAS Prevention and Health Promotion Division* has a statewide system of services and resources designed to provide an array of evidence-based universal, selected, and indicated (based on Institute of Medicine classification) programs to promote increased prevention service capacity and infrastructure improvements to address prevention gaps.

The *DMHAS Prevention and Health Promotion Division* works with the 13 Regional Action Councils (RACs) to determine the prevalence of substance use within their sub-regions and the resource capacity to address the identified problems, identify gaps in the substance use service continuum, and identify changes to the community environment that will reduce substance use. Within their communities, the RACs work with diverse stakeholder groups to contribute additional data and information, assist in interpreting available data/information, and participate in the priority setting process.

DMHAS utilizes both internal and external sources to assess the need, demand, and access to substance abuse treatment services. In addition to DMHAS information management system data, a sampling of various school surveys of middle and high school students' substance use practices from across the state was reviewed. The total number of students surveyed over the 2013-2015 period was 15,129. Data from SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH) was also utilized. This annual survey of more than 67,000 civilian non-institutionalized Americans 12 years of age and older provides national percentage estimates and supplies the data for the state-based reports on substance use included in the 2015 Connecticut Behavioral Health Barometer.

According to the most recent data available, there are three primary substances of concern: opioids (heroin and prescription pain relievers), marijuana, and alcohol. Based on admissions to DMHAS substance abuse services as well as increases in drug-related deaths, heroin usage appears to be on the rise in Connecticut, which is also in line with national trends.

Primary Drug Reported at Admission to DMHAS Substance Use Services (2013-2015)

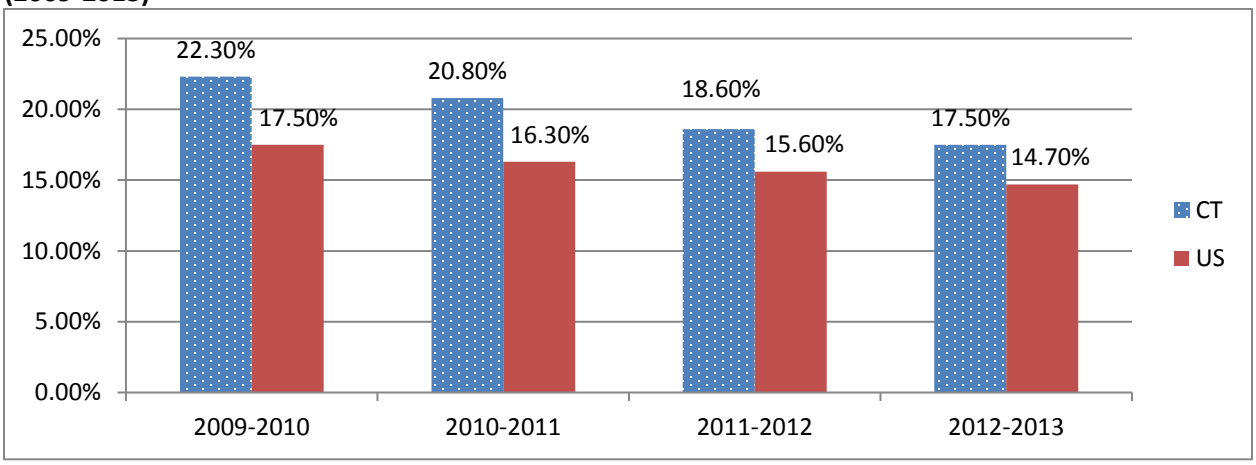


In the last month, 4% of Connecticut adolescents reported misuse of prescription pain relievers which serve as a gateway to heroin use which is similar to the national average and has remained stable since 2010. According to school surveys, 5% of 6 – 12th graders reported nonmedical use of any prescription medications in the last 30 days.

Marijuana continues to be the primary illicit substance used across the country. Most adolescents perceive little risk associated with monthly use of marijuana, both in Connecticut and nationwide. In Connecticut, estimates of marijuana use in the past month among adolescents declined from 2012-2013 (8.57%) to 2013-2014 (7.91%) based on the NSDUH, but are similar to national estimates for 2014 (7.4%).

Young adults (18-25) in Connecticut reported the greatest amount of past month drinking (69%) of all age groups as well as the highest rates of past month binge drinking (47%). Connecticut's percentage of underage (12-20) binge drinkers (18%) continues as it has for several years to exceed the national percentage; however, the trend has been noticeably declining since 2009. Past month reporting of heavy drinking among those 21+ in Connecticut was 6%, which is similar to the national average.

Past Month Binge Alcohol Use among People Aged 12 – 20 in Connecticut and the United States (2009-2013)



DMHAS also conducts ongoing analysis of the treatment system through its internal data management information system – *the Enterprise Data Warehouse (EDW)* - comprised of the Web Infrastructure for Treatment Services (WITS) for state-operated services and the DMHAS Data Performance DDaP system for state-funded services. These systems contain information on all licensed and state-operated addiction services providers within the state. Client data obtained both at admission and discharge is analyzed to determine shifts in drug use patterns by demographics, geographic areas, client outcomes, and service system performance. Provider and program level data are made available quarterly on the Department's website in "report card" formats which are easily comprehended and provide transparency: http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=489554. Additionally, statewide data from the system is organized into an Annual Statistical Report available at: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.pdf. DMHAS is in the process of developing reports to determine the extent to which there are healthcare disparities in the system, which is a SAMHSA initiative.

DMHAS is committed to supporting a comprehensive, unified planning process across its operated and funded mental health and addiction services at local, regional, and state levels. The purpose of this planning process is to develop an integrated and ongoing method to: 1) determine unmet

mental health and substance use treatment and prevention needs; 2) gain broad stakeholder input on service priorities and needs, including persons in recovery, consumers, advocates, family members, providers, and others; and 3) monitor ongoing efforts that result in better decision-making, service delivery, and policy-making.

DMHAS' priority setting initiative, designed to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state, began in December 2001. Fundamental to this process are Regional Mental Health Boards (RMHBs) and RACs which are statutorily charged to determine local and regional needs and service gaps. Both of these entities, working collaboratively, facilitate a process in each of the five DMHAS regions to assess the priority unmet service and recovery support needs across the mental health and addiction service systems. Since inception in 2006, DMHAS has conducted its priority setting process every other year (in even-numbered years). In the intervening years (odd-numbered years), the RMHBs and RACs provide updates to inform DMHAS of progress made in addressing the identified unmet needs and to alert the department to any emerging issues. As part of this process, RMHBs and RACs use aggregate profile data provided by DMHAS to describe usage of services within their region, provider survey results based on a DMHAS generated on-line survey asking for responses about the DMHAS service system, and other sources of information from local needs assessments/surveys and activities. Armed with this information, RMHBs and RACs orchestrate key informant constituency groups (consumers/persons in recovery, family members, providers, referral agencies such as shelters and criminal justice representatives, and local professionals, law enforcement, and town officials) to participate in community conversations, focus groups, and/or structured interview sessions asking about service system barriers, gaps, and concerns.

This process results in Regional Priority Reports across the behavioral health continuum. These reports are presented to DMHAS leadership at regional meetings, providing an opportunity for dialogue between the department and regional stakeholders. From the regional reports, a synthesized statewide priority report is created that examines cross regional priorities and solutions: http://www.ct.gov/dmhas/lib/dmhas/eqmi/priorityservices.pdf. The statewide report is shared and discussed with the Adult State Behavioral Health Planning Council and the Commissioner.

DMHAS also provides representation and collaborates in data sharing with the *State Epidemiological Outcomes Workgroup (SEOW)* chaired by University of Connecticut researchers. Representatives from across states agencies meet to share information, identify data gaps, and discuss ways to link datasets to maximize their usefulness and better address the needs of Connecticut citizens.

While DMHAS functions as the lead state agency for substance abuse treatment, other state agencies including the Department of Children and Families (DCF), Court Support Services Division (CSSD), Department of Public Health (DPH), Department of Consumer Protection (DCP), Department of Education (DOE), Department of Veterans' Affairs (DVA), and Department of Social Services (DSS) share in state efforts to address substance abuse. These efforts are reflected in the legislatively mandated *Triennial Report – 2016* available at: http://www.ct.gov/dmhas/lib/dmhas/publications/triennial_sareport2016.pdf . This Triennial Report contains the state substance abuse plan, including goals, strategies, and initiatives to direct the focus for 2016-2018 which are outlined below:

- Strategy 1: Prevention and Education: Achieve quantifiable decreases in substance use/abuse and suicide/suicide attempts statewide through the skilled delivery of timely,

efficient, effective, developmentally-appropriate, and culturally sensitive evidence-based prevention strategies, practices, and programs.

- Strategy 2: Treatment: Expand access to a broad spectrum of substance abuse services and increase the use of evidence-based practices.
- Strategy 3: Recovery: Increase the use of peers and natural supports and maintain recovery supports.
- Strategy 4: Criminal Justice: Implement criminal justice reforms to increase diversionary options and the availability of substance abuse treatment in jails and prisons and decrease barriers and adverse consequences faced by prisoners when they are released from prison or jail.
- Strategy 5: Collaboration and Cost-Effectiveness: Increase interagency coordination and collaboration in order to more effectively prevent and treat substance use disorders.
- Strategy 6: Accountability and Quality Care: Ensure that providers deliver high quality services and use data to improve care throughout the system.

I. Grant Provisions

The October 2000 Children's Health Care Act reauthorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and enacted changes in some of the provisions which were required by the 1992 Block Grant reauthorization. The most notable changes were:

- The Block Grant requirement that states maintain a $100,000 revolving fund for group homes for recovering substance abusers was made optional so that states can continue such services or use funds to reduce waiting lists for treatment of other services. As part of its vision for a recovery-oriented system of care, DMHAS requested from the federal Center for Substance Abuse Treatment (CSAT) approval to use the revolving fund dollars to support the development of recovery/sober housing in Connecticut. CSAT granted approval in 2004.
- The set-aside requirement for specific (discrete) alcohol and drug treatment expenditures was eliminated.

There remain, however, a number of mandates from the 1992 Block Grant reauthorization. The following represents the major requirements that must be met by the state in the use of Block Grant funds:

- Obligate and expend each year's SAPT Block Grant allocation within two federal fiscal years;
- Maintain aggregate state expenditures for authorized activities that are no less than the average level of expenditures for the preceding two state fiscal years;
- Maintain a minimum level of state-appropriated funds for tuberculosis (TB) services for substance use treatment clients;
- Expend not less than 20% of the allocated funds for programs providing primary prevention activities;
- Expend not less than 2%, but up to 5%, of the allocated funds for existing treatment programs to provide early HIV intervention services including: a) pre/post-test counseling; b) testing for the AIDS virus; and c) referral to therapeutic services if the state has an HIV rate greater than 10 per 100,000. In CY 2014 (the most recent figures available from the Centers for Disease Control and Prevention), Connecticut's HIV infection rate was 6.2, below the threshold for mandatory allocation of funds. However, in consultation with SAMHSA, it was

decided to continue with current efforts to address HIV/AIDS for the next year to ensure that the rate continues to decline before making changes.

- Maintain the availability of treatment services for pregnant and parenting women, spending 10% of the Block Grant award above the FFY 1992 level;
- Make available prenatal care and childcare to pregnant women and women with dependent children who are receiving treatment services under the program expansion funds;
- Assure that preferential access to treatment is given to substance using pregnant women;
- Require that substance using pregnant women denied access to substance use treatment services be provided with interim services, including TB and HIV education and counseling, referral to TB and HIV treatment, if necessary, and referral to prenatal care;
- Establish a management capacity program which shall include notification of programs serving injecting drug users upon reaching 90% capacity;
- Require that those individuals on waiting lists who are injecting drug users be provided interim services, including TB and HIV education, counseling, and testing, if so indicated;
- Ensure that programs funded to treat injecting drug users conduct outreach to encourage such persons to enter treatment;
- Submit an assessment of statewide and locality-specific need for authorized SAPT Block Grant activities;
- Coordinate with other appropriate services, such as primary health care, mental health, criminal justice, etc.;
- Have in place a system to protect patient records from inappropriate disclosure;
- Provide for an independent peer review system that assesses the quality, appropriateness, and efficacy of SAPT Block Grant-funded treatment services;
- Require SAPT Block Grant-funded programs to make continuing education available to their staff; and
- Enforce the state law prohibiting the sale of tobacco products to minors through random, unannounced inspections, in order to decrease the accessibility of tobacco products to those individuals under the age of 18. Connecticut's Synar retailer violation rate was 9.1 % in 2015.

SAMHSA, in response to Congressional interest, established National Outcome Measures (NOMs). The NOMs include a wide range of both prevention and treatment measures designed to determine the impact of services on preventing or treating substance abuse. NOMs reporting became mandatory with the submission of the FFY 2008 SAPT Block Grant application. The required NOMs include:

- Employment Status – clients employed (full-time or part-time) during the prior 30 days at admission vs. discharge
- Homelessness – client homeless during the prior 30 days at admission vs. discharge
- Arrests – clients arrested on any charge during the prior 30 days at admission vs. discharge
- Alcohol Abstinence – clients with no alcohol use during the prior 30 days, regardless of primary problem at admission vs. discharge
- Drug Abstinence – clients with no drug use during the prior 30 days, regardless of primary problem at admission vs. discharge
- Social Support of Recovery – client participating in self-help groups, support group (e.g., AA, NA) during the prior 30 days at admission vs. discharge

II. Tables

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Table A

Substance Abuse Prevention and Treatment Block Grant

Recommended Allocations

PROGRAM CATEGORY	FFY 15 Expenditures	FFY 16 Estimated Expenditures	FFY 17 Proposed Expenditures	Percentage Change FFY 16 to FFY 17
Community Treatment Services	$4,604,586	$3,507,810	$3,507,810	0%
Residential Treatment Services	$6,523,784	$7,437,096	$7,437,096	0%
Recovery Support Services	$2,609,975	$3,108,974	$3,108,974	0%
Prevention & Health Promotion	$3,858,014	$4,658,345	$4,658,345	0%
TOTAL	**$17,596,359**	**$18,712,225**	**$18,712,225**	**0%**
	Sources of FFY 15 Allocations	**Sources of FFY 16 Allocations**	**Sources of FFY 17 Allocations**	**Percentage Change FFY 16 to FFY 17**
Federal Block Grant Funds	**$17,596,359**	**$18,212,225**	**$18,212,225**	**0%**
Carry Forward Funds	**$1,850,381**	**$1,850,381**	**$1,350,381**	**-27%**
TOTAL FUNDS AVAILABLE	**$19,446,740**	**$20,062,606**	**$19,562,606**	**-2%**

Table B1

Substance Abuse Prevention and Treatment Block Grant

Community Treatment Services Program Expenditures

Community Treatment Services	**FFY 15 Expenditures**	**FFY 16 Estimated Expenditures**	**FFY 17 Proposed Expenditures**	**Percentage Change FFY 16 to FFY 17**
Number of Positions (FTE)				
Personal Services				
Fringe Benefits				
Other Expenses				
Equipment				
Contracts				
Grants to:				
Local Government				
Other State Agencies				
Private Agencies	$4,604,586	$3,507,810	$3,507,810	0%
TOTAL EXPENDITURES	**$4,604,586**	**$3,507,810**	**$3,507,810**	**0%**
	Sources of FFY 15 Allocations	**Sources of FFY 16 Allocations**	**Sources of FFY 17 Allocations**	**Percentage Change FFY 16 to FFY 17**
Federal Block Grant Funds	**$4,604,586**	**$3,507,810**	**$3,507,810**	**0%**
Carry Forward Funds	**$1,850,381**	**$1,350,381**	**$850,381**	**-37%**
TOTAL FUNDS AVAILABLE	**$6,454,967**	**$4,858,191**	**$4,358,191**	**-10%**

Table B2

Substance Abuse Prevention and Treatment Block Grant

Residential Services Program Expenditures

Residential Services	**FFY 15 Expenditures**	**FFY 16 Estimated Expenditures**	**FFY 17 Proposed Expenditures**	**Percentage Change FFY 16 to FFY 17**
Number of Positions (FTE)				
Personal Services				
Fringe Benefits				
Other Expenses				
Equipment				
Contracts				
Grants to:				
Local Government				
Other State Agencies				
Private Agencies	$6,523,784	$7,437,096	$7,437,096	0%
TOTAL EXPENDITURES	**$6,523,784**	**$7,437,096**	**$7,437,096**	**0%**
	Sources of FFY 15 Allocations	**Sources of FFY 16 Allocations**	**Sources of FFY 17 Allocations**	**Percentage Change FFY 16 to FFY 17**
Federal Block Grant Funds	**$6,523,784**	**$7,437,096**	**$7,437,096**	**0%**
Carry Forward Funds				**0%**
TOTAL FUNDS AVAILABLE	**$6,523,784**	**$7,437,096**	**$7,437,096**	**0%**

Table B3

Substance Abuse Prevention and Treatment Block Grant

Recovery Support Services Program Expenditures

Recovery Support Services	**FFY 15 Expenditures**	**FFY 16 Estimated Expenditures**	**FFY 17 Proposed Expenditures**	**Percentage Change from FFY 16 to FFY 17**
Number of Positions (FTE)				
Personal Services				
Fringe Benefits				
Other Expenses				
Equipment				
Contracts				
Grants to:				
Local Government				
Other State Agencies				
Private Agencies	$2,609,975	$3,108,974	$3,108,974	0%
TOTAL EXPENDITURES	**$2,609,975**	**$3,108,974**	**$3,108,974**	**0%**
	Sources of FFY 15 Allocations	**Sources of FFY 16 Allocations**	**Sources of FFY 17 Allocations**	**Percentage change FFY 16 to FFY 17**
Federal Block Grant Funds	**$2,609,975**	**$3,108,974**	**$3,108,974**	**0%**
Carry Forward Funds				**0%**
TOTAL FUNDS AVAILABLE	**$2,609,975**	**$3,108,974**	**$3,108,974**	**0%**

Table B4

Substance Abuse Prevention and Treatment Block Grant

Prevention and Health Promotion Program Expenditures

Prevention and Health Promotion	**FFY 15 Expenditures**	**FFY 16 Estimated Expenditures**	**FFY 17 Proposed Expenditures**	**Percentage Change from FFY 16 to FFY 17**
Number of Positions (FTE)				
Personal Services				
Fringe Benefits				
Other Expenses				
Equipment				
Contracts				
Grants to:				
Local Government				
Other State Agencies				
Private Agencies	$3,858,014	$4,658,345	$4,658,345	0%
TOTAL EXPENDITURES	**$3,858,014**	**$4,658,345**	**$4,658,345**	**0%**
	Sources of FFY 15 Allocations	**Sources of FFY 16 Allocations**	**Sources of FFY 17 Allocations**	**Percentage change FFY 16 to FFY 17**
Federal Block Grant Funds	**$3,858,014**	**$4,158,345**	**$4,158,345**	**0%**
Carry Forward Funds		**$500,000**	**$500,000**	**0%**
TOTAL FUNDS AVAILABLE	**$3,858,014**	**$4,658,345**	**$4,658,345**	**0%**

Table C

Substance Abuse Prevention and Treatment Block Grant
Summary of Service Objectives and Activities

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 15	Performance Measures
Community Treatment Services	To ensure that treatment services are available in the community and are consistent with the needs of the individual seeking treatment in order to reduce the negative consequences of alcohol and other drug abuse.	**Opioid Replacement Therapy and Ambulatory Drug Detoxification**: Persons addicted to heroin or other opioids are given medication, counseling services and management of withdrawal (ambulatory detoxification) in a non-residential setting.	**15,031**	Number of unduplicated clients served = 15,031 Percent of clients staying in treatment at least one year = 61% (goal = 50%)
		Alcohol and Drug Outpatient: Provided in or near the community the individual lives in, these programs provide a range of therapeutic services including individual, group, and family counseling. Some outpatient programs are designed to treat clients with special needs such as parenting women or those with co-occurring mental health problems. Most often, these specialty programs provide more intensive outpatient services.	**23,373**	Number of unduplicated clients served = 23,373 Percent of clients with either abstinence or reduced drug use= 59% (goal = 55%) Percent of clients with maintained or improved functioning as measured by GAF score = 58% (goal = 75%)

Substance Abuse Prevention and Treatment Block Grant
Summary of Service Objectives and Activities

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 15	Performance Measures
Residential Services	To significantly impact levels of dysfunction due to substance use via the provision of remedial health care, and psychosocial and supportive services appropriate to the needs of substance users, their families and significant others. To ensure that a continuum of substance use treatment services is available throughout the state. This continuum must be consistent with the needs of the individual seeking treatment, providing the appropriate level of residential care needed to promote a sustained recovery.	**Residential Detoxification**: Alcohol and opioid dependent individuals whose severity requires medical supervision are best treated in a residential program. Detoxification is sometimes seen as a distinct treatment level of care, but is more appropriately considered a precursor of treatment, as it is designed to deal with the acute physical effects of drug use. Upon treatment completion, these persons are most often referred to other treatment services to continue their recovery.	**7,254**	Number of unduplicated clients served = 7,254 Percent of clients completing treatment = 71% (goal = 70%) Percent without readmission within 30 days = 87% (goal = 85%)
		Alcohol and Drug Residential Care: Residential treatment services are conducted in a 24-hour structured, therapeutic environment for varying lengths of stay from a few weeks to months. Treatment focuses on helping individuals examine beliefs, self-concepts, and patterns of behavior which promote drug-free lives. Some residential programs provide or have referral linkages to other support services (e.g., job training, housing).	**5,525**	Number of unduplicated clients served = 5,525 Percent of clients completing treatment = 77% (goal = 80%) Percent of clients without readmission within 30 days = 80% (goal = 85%)

Substance Abuse Prevention and Treatment Block Grant
Summary of Service Objectives and Activities

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 15	Performance Measures
Recovery Support Services	To provide clients with supports and services to be able to live successfully in the community and achieve optimal quality of life	**Case Management** involves case managers collaborating with persons in the community to identify needs, enhance self-management, self-advocacy, and coping skills, and learn to access and use services and supports. Specialized programs include services for dually diagnosed clients, seniors, Latinos, and substance abusing parents of children involved with child protective services.	**1,428**	Unduplicated clients served = 1,428 Percent of clients completing treatment = 48% (goal = 50%) Percent of clients involved in self-help= 66% (goal = 60)
	To assist individuals to prepare for, obtain, and maintain employment.	**Vocational Rehabilitation** services include conducting vocational evaluations, functional assessments, vocational counseling, job search assistance, and development of skills related to locating, obtaining, and maintaining employment.	**221**	Unduplicated clients served = 221 Percent of clients employed = 46% (goal = 35%)
	To assist persons with accessing treatment.	**Transportation** to and from detoxification/treatment programs including recovery houses, shelters, sober houses, hospitals, VA/Veteran centers and Alternatives to Incarceration Centers (AIC).	**NA**	NA
Prevention and Health Promotion	To deliver timely, efficient, effective, developmentally appropriate, and culturally sensitive prevention strategies, practices, and programs, through a network of skilled service providers and use of evidence-based practices.	Conduct activities focusing on the prevention of community problem substance misuse or abuse utilizing the five-step Strategic Prevention Framework (SPF) through **The Best Practices Initiative.**	**2,642,520**	14 providers and 15 programs Maintained a 21.2% reduction in past 30-day alcohol use among high school students

Substance Abuse Prevention and Treatment Block Grant
Summary of Service Objectives and Activities

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 15	Performance Measures
		Develop and implement municipal-based alcohol and other drug prevention initiatives through **Local Prevention Councils.**	**46,976**	225 services provided
		Educate tobacco merchants, youth, communities and the general public about the laws prohibiting the sale of tobacco products to youth under the age of 18 through the **Tobacco Merchant & Community Education Initiative**.	**24,737**	24,737 retailers served by *Be Part of the Crowd or Do the Right Thing* online training and certification or media campaigns 13.3% Synar (inspections) retailer violation rate
		Disseminate information via print and electronic media on substance abuse, mental health and other related issues through the **Connecticut Center for Prevention, Wellness and Recovery**.	**61,497**	56 services provided
		Support prevention efforts within the state by building the capacity of individuals and communities to deliver alcohol, tobacco and other drug abuse prevention services directed at schools, colleges, workplaces, media and communities through the **Governor's Prevention Partnership.**	**19,442**	810 services provided
		Assist providers/local communities in assessing prevention needs and coordinating resources to address these needs through **13 Regional Action Councils**.	**44,116**	2,048 services provided

Substance Abuse Prevention and Treatment Block Grant
Summary of Service Objectives and Activities

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 15	Performance Measures
		Deliver training and technical assistance to substance abuse and mental health practitioners through the **Training Collaborative**.	**350**	16 prevention training workshops 350 participants
		Enforcing state laws that prohibit youth access to tobacco products by inspecting retailers across the state in order to maintain a retailer violation rate at or below 20% through the **Synar Program.**	**3,158**	13.3%synar retailer violation rate 15 media events 462 citations and 264 fines assessed
		Provide training and technical assistance on implementing and coordinating multicultural and diversity awareness, education and advocacy, and programs through the **Multicultural Leadership Institute**.	**111**	21 services provided

III. Proposed Expenditures by Program Category

Substance Abuse Prevention and Treatment
List of Block Grant Funded Programs

Title of Major Program Category	FFY 15 Actual Expenditures (including carry forward funds)	FFY 16 Estimated Expenditures (including carry forward funds)	FFY 17 PROPOSED Expenditures (including carry forward funds)
Community Treatment Services	$4,604,586	$3,507,810	$3,507,810
Residential Treatment	$6,523,784	$7,437,096	$7,437,096
Recovery Support Services	$2,609,975	$3,108,974	$3,108,974
Prevention & Health Promotion	$3,858,014	$4,658,345	$4,658,345
TOTAL	**$17,596,359**	**$18,712,225**	**$18,712,225**
Community Treatment Services			
Outpatient	$3,433,414	$3,252,752	$3,252,752
Methadone Maintenance	$1,171,172	$255,058	$255,058
TOTAL	**$4,604,586**	**$3,507,810**	**$3,507,810**
Residential Treatment			
Residential Detox	$1,527,803	$1,433,338	$1,433,338
Residential Intensive	$751,653	$391,080	$391,080
Residential Long-term Treatment	$3,988,622	$4,533,260	$4,533,260
Shelter	$255,706	$1,079,418	$1,079,418
TOTAL	**$6,523,784**	**$7,437,096**	**$7,437,096**
Recovery Support Services			
Case Management and Outreach	$2,492,280	$2,523,765	$2,523,765
Vocational Rehabilitation	$60,635	$539,899	$539,899
Ancillary Services	$57,060	$45,310	$45,310
TOTAL	**$2,609,975**	**$3,108,974**	**$3,108,974**
Prevention & Health Promotion			
Primary Prevention	$3,858,014	$4,658,345	$4,658,345
TOTAL	**$3,858,014**	**$4,658,345**	**$4,658,345**