

# Connecticut Children's Behavioral Health Plan: Progress Report

Prepared pursuant to Public Act 13-178 and Public Act 15-27  
and Submitted to the Connecticut General Assembly

October 1, 2018

Submitted by

The Children's Behavioral Health Plan Implementation Advisory Board and the Department of  
Children and Families

In February 2013, as Commissioner of the Department of Children and Families, I offered testimony to the Sandy Hook Advisory Commission noting that mental illness should be treated as a public health issue not a criminal justice issue. Fortunately the world of behavioral health continues to evolve. We know more today about neuroscience, adolescent brain development, the impact of trauma and the importance of a multigenerational approach to service provision. We also know how important it is to have a comprehensive, integrated, family centered system to best address those needs. Such a system needs to be both proactive and responsive to prevent and reduce the negative impact of mental, emotional, and behavioral health issues for children. The Legislature correctly acknowledged the different but complementary mandates as well as the respective areas of expertise that various state agencies hold, and appropriately expects that a strong partnership will be maintained to tackle this important issue.

Central to the development of the CT Children's Behavioral Health Plan was the feedback from consumers and providers across the state. The Department and all of the state partners benefitted from the courage of families who shared their stories and offered valuable feedback to what was working well and where improvements were needed. The feedback sessions have continued involving another 300 adults and youth. These sessions are essential in allowing us to continuously examine the service system and make necessary adjustments and improvements.

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

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

Reflecting on our collective work to date, this past year saw demonstrable progress building on the foundation of work. As was reported last year, the Department engaged with partners to develop a fiscal mapping template and began utilizing it with a couple of agencies and for finite pieces of work. This year saw a significant enhancement that involved applying fiscal mapping to all twelve agencies named in the legislation. The goal was to operationalize, collect, and develop a financial mapping analysis that specifies expenditures within the behavioral health network of care for children and families in Connecticut. Notably, the majority of funding was spent in the Prevention and Promotion category, with far less in Support and Care. On its face this was promising news; however, additional analysis and information are needed to fully understand what that means for children and families. To that end, the work had limitations and challenges: agencies define the service system differently; access to Medicaid data is inconsistent; and a health equity lens is not uniformly applied to help us understand who is or is not served and who is or is not better off. Despite these limitations, this data, for the first time, provides a much clearer picture of the multiple funding streams and how well they do or do not connect to the broader vision of a comprehensive, integrated children's behavioral system. When we know more we do

better. An example of this comes from last year's submission relative to fiscal mapping. That first effort was completed specifically on substance use services for adolescents and revealed the need for improved substance use screening and recovery supports that had largely been absent from the service system. In response, DCF has implemented Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) in various settings including community-based services and mobile crisis, and has established a Statewide Youth Recovery Support Coordinator and alternative peer and recovery support groups.

Another central issue named by families and providers relates to early identification, and has required us to gain a better understanding of where screening is used and what barriers exist. This new appreciation has led us to increase the use of screening in multiple settings for children and youth. Trauma screening in particular has seen continued growth as has the service system which is better equipped to respond with appropriate and proven trauma responsive interventions.

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

This report highlights a number of examples of state agencies working collaboratively through federal grants and state funding to maximize investments resulting in increased access and service provision. The Department would like to thank all the partners who have contributed to this important work, particularly the Children's Behavioral Health Plan Implementation Advisory Board. The Board has been central to coordinating these efforts across state agencies and serving a critical function to promote, support and advance this work. While there is much to acknowledge, there is still more to do. Evidenced by the growth in the field from the passage of the 2013 legislation to date, it will be incumbent on all of us to remain vigilant in critically examining what is working, identifying the gaps and advocating to make the necessary advancements in health promotion, early identification, treatment and recovery.

Respectfully Submitted by Commissioner Joette Katz, DCF

The Children’s Behavioral Health Plan Implementation Advisory Board (“Board”) submits the following report summarizing initiatives and activities underway to advance the recommendations outlined in the Children’s Behavioral Health Plan (“Plan”), which was originally submitted to the General Assembly on October 1, 2014.<sup>1</sup> This year’s report reflects expanded contribution from all state partners legislatively connected to the Plan as well as evidence of increased coordination among state agencies and departments to improve service delivery for children. Much of this shared activity is highlighted in the updates from each state agency and department that are included as **Appendix A**.

This year’s report also highlights substantial progress made to more deeply understand the foundation of the two critical goals of the Plan that were selected by the Board as areas of primary focus since last year’s report: *fiscal mapping* and *screening and identification*. Several activities have been underway to enrich our understanding of the complexity of the financial foundation to promote and maintain children’s behavioral health. Equally important is the immediate need to improve early detection and facilitate entry into services for children with behavioral health needs.

The Board’s continued conceptualization of the optimal Connecticut children’s behavioral health system increasingly reflects a public health model that considers the social determinants of child and family well-being. The Plan envisions a system that addresses the behavioral health needs of all of Connecticut’s children regardless of demographics such as race, ethnicity, language, geography or income, and regardless of which service system door through which they enter. The findings and recommendations from the Board’s work on implementing the Plan call for a children’s behavioral health system anchored on a foundation of interagency, cross-functional, and multi-sector collaboration that is guided by an integrated view of child and family well-being and an understanding of fiscal and programmatic interdependencies. Meeting the goals of the Plan requires an informed process of decision-making that considers potential implications throughout the system before changes to policy, financing, or programming are made and that leverages opportunities to optimize funding, decrease disparities, and improve outcomes for children with behavioral health needs and their families.

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<sup>1</sup> This Report is mandated by Public Act 15-27. On or before September 15, 2016, and annually thereafter, the board shall submit a report, in accordance with the provisions of section 11-4a of the General Statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to children.

## ***Summary of Progress on the Recommendations from 2017 Advisory Board Report***

1. *Amend the enabling statute to require state agencies and departments to provide data on or before an annual deadline that will enable the Board to generate a complete report to the general assembly. Submitted data must include information about access, financing and scope of impact so that mapping of resources and areas of need can be better identified.*

All twelve state agency partners participated in the submission of data for both fiscal mapping and our inventory of screening and identification tools and activities. As a result, the Board postponed pursuit of this recommendation. As expected and confirmed through the submission process, information about expenditures and other service data varies across state agencies. A focus on identifying a uniform set of definitions and recommendations for required data elements across state agencies will be pursued by a work group of the Board. While the initial review has offered valuable information, this next phase will provide greater clarity about whether, and what kinds of additional legislative support might be necessary to further the work of the Board.

2. *For the Board to choose one to two targeted goals(s) from the plan and remain focused on achieving and monitoring progress and barriers to achieving that/those goal(s).*

As noted above, the Board identified completion of the ***fiscal map*** for FY 2015 and FY 2016 as one of two primary areas for intensified focus (the years in which complete expenditure data was available for all departments and agencies participating in Plan implementation). The second targeted area was ***screening and identification, with a goal of creating an inventory of behavioral health screening tools and practices across different agencies and settings that serve children..*** These two areas of focus were selected because they are of central importance to many other goals of the Plan, Substantial progress was made in both areas.

As Connecticut's public spending resources have been reduced, it is critical to understand expenditures across departments in order to identify opportunities for collaboration to reduce costs and maximize positive impact on children's well-being. It is important to underscore that while the mapping of past years' spending does not provide a *current* snapshot of resource allocation, the process greatly expanded understanding of the contribution of each state department and agency to different aspects of the behavioral health system and will help to arrive at an agreed upon methodology and process that can be adopted on an ongoing basis.

The focus on compiling an inventory of all behavioral health ***screening*** activities and practices for ***identifying*** behavioral health need was driven by the understanding that early detection and intervention is essential to promoting children's well-being and promoting positive outcomes. Earliest detection of need and connection to resources and services are also understood as the way to reduce system costs associated with higher level interventions necessitated by failure to intervene early on.

- 3. To establish a workgroup with representation from departments with a critical role for each target area identified that will meet with more regularity than the full advisory Board to examine implementation strategies, barriers and impact.*

As the intensified focus on completing the fiscal map and inventory of screening tools and practices was underway through individual meetings with each state agency, a workgroup was formed to review and analyze the findings. The workgroup included representatives from several state agencies as well as other stakeholder Board members, and met to review the findings in relation to the overarching goals and objectives of the Plan during those months that the full Board did not convene. From January 1, 2018 to August 1, 2018, 30 individual sessions with state agencies and five workgroup meetings were convened.

- 4. Obtain modest yet sufficient funding to staff the coordinating work of the Board in order to advance the achievement of Plan goals. The Board will explore public and private funding sources and/or engagements with partners who could support the collection, coordination and compilation of information and data.*

Grant funding was obtained through the Connecticut Health Foundation to support the work of the Board in the two areas of the plan identified above. The funding supports a part-time Project Coordinator, hired through the Child Health and Development Institute (CHDI), who has been instrumental in collecting and facilitating contributions from all twelve of the legislatively appointed agencies and departments that are accountable for participating in Plan implementation (see Appendix B). In addition, federal funding through the Department of Children and Families was utilized to contract with Beacon Health Options to obtain technical consultation and assistance with fiscal mapping to facilitate a deeper understanding of the intersecting roles of multiple departments in promoting children's behavioral health and in understanding related Medicaid expenditures. The process of gathering data from each state partner promoted valuable information-sharing in several areas: (i) within each agency as they contributed and categorized content for the plan; (ii) within the work group of the Board that was formed to review this fiscal and screening information; and (iii) within the Board itself at its public meetings. Some of the significant findings derived from the information collected and from the ongoing analysis and discussion are highlighted later in this report.

- 5. Recommend that the joint standing committee of the general assembly having cognizance of matters relating to children convene an annual public hearing on the Plan report, which hearing shall encourage attendance and participation by each of the legislatively-identified state agencies and departments to maintain attention to the collective and individual role each has in promoting children's behavioral health and well-being.*

With the benefit of the Connecticut Health Foundation's funding to staff a project coordinator, we were able to devote individualized attention to each of the twelve partner agencies responsible for plan implementation to assist each with responding to requests for data and information. We believe this facilitated a level of voluntary cooperation that currently addresses the concern that originally gave rise to this recommendation.

### *Findings from Fiscal Mapping:*

- There was variation in how different departments categorized spending for children’s behavioral health and many examples where it was difficult to untangle expenditures that were strictly related to behavioral health (e.g. spending for school readiness, or percentage of personnel expenditures within agencies or departments that provide monitoring to the system to ensure child and family wellbeing.) There was an underlying consensus, grounded in the original Plan, that funding for behavioral health should include expenditures in the domains of Prevention and Promotion, Treatment, Support and Care, and System Infrastructure. Using these broad categories of spending, greater cross-system agreement began to emerge about the proportional spending in each domain that should be allocated in an optimal behavioral health system.
- Many departments initially included spending related to basic needs in their expenditure reports for the fiscal map. This spending was not exclusive or primarily tied to children with behavioral health needs, and resulted in an inflated view of spending attributed to the children’s behavioral health system. It was determined, however, that while not directly funding children’s behavioral health services, such expenditures provide a *foundation of support* critical for the promotion of behavioral health and well-being for *all* of Connecticut’s children.
- It is important to note areas of system improvement since the last fiscal analysis of the children’s behavioral health system in 2000<sup>2</sup> that was the catalyst of a broad system reform. While the methodology for the current fiscal analysis is different than that used in 2000, and other changes to the financing system would discourage direct dollar comparison, three significant advances are readily apparent. Most notable is in the area of proportional spending for community-based behavioral health services versus inpatient and other out-of-home placement. In 2000 70% of Medicaid and DCF behavioral health spending was for out-of-home care and 30% for community-based treatment. In looking at Medicaid and DCF funding in 2015 and 2016, those figures reverse, with 64% in 2015 and 63% in 2016 dedicated to community-based programming and only 36% and 37% respectively for out-of-home care. This can be directly attributed to the wide array of research-supported community-based interventions that have been disseminated in response to the 2000 findings and subsequent recommendations from the Blue Ribbon Commission<sup>3</sup> to expand services to maintain children in their homes and communities. What is also important to highlight, is that whereas in 2000 the fiscal analysis was limited to Medicaid and DCF spending (which is the comparison provided here), the current fiscal analysis incorporates expenditures and conceptual input from 12 state agencies that have direct contribution to our continuously evolving system. Also of note, is the commitment to seeking family input in the review and shaping of the current system. This was a value launched by the original 2000 Blue Ribbon Commission, and must continue to be promoted as we seek to refine

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<sup>2</sup> *Delivering and Financing Children’s Behavioral Health Services in Connecticut* (2000).

<sup>3</sup> *Governor’s Blue Ribbon Commission on Mental Health* (2000).

and update the system to meet the behavioral health needs of children and families and ensure that we have the right distribution of resources at every level of care.

- An identified challenge is that the way different sources of data are collected by several state agencies makes it difficult to connect fiscal expenditures by line items to race and ethnicity. As the first effort to create a combined fiscal map of the children’s behavioral health system including expenditures from each state partner agency, the initial data collection focused on allocation of expenditures to programming or infrastructure for 2015 and 2016 (the two most recent full years of spending that were available for all departments at the time the project was initiated). This initial mapping does not analyze expenditures in relation to how *many* children in need of services received help, or identify whether there were disparities in referral, access, or types of services provided by race, ethnicity, or even geography.
- It was also determined that there currently is no method that will allow identification of services provided to an individual child across different service systems while ensuring adequate protection of confidential and sensitive information. Developing this capacity is integral to being able to monitor who is receiving which children’s behavioral health services and who is not, to identifying gaps or redundancy in the system, and to gauging the overall effectiveness of the children’s behavioral health plan.
- As neuroscience has expanded understanding of the developing brain, we know that “development” does not stop at age 18 and several departments have extended the age range for services provided to match best practices or to meet federal mandates. As a result, although the original Plan identifies a focus on children through age 18, the fiscal mapping for 2015 and 2016 included expenditures for youth up to age 21. The analysis of spending was significantly impacted by whether the mapping went to 18 versus 21 years of age, not only in terms of total spending, but also with regard to the relative proportion of spending across different service levels. There was general consensus, however, that an effective children’s behavioral health system must also attend to supporting the successful transition of youth with behavioral health concerns, known trauma history, and/or early adverse experiences into their adulthood with effective connection to treatment services and ongoing supports.
- It is important to note that the data collected regarding behavioral health treatment expenditures in the fiscal mapping only included state and some federal Medicaid dollars, and not costs covered by commercial insurance programs.

***Additional Finding Related to the Financing of the CT Children’s Behavioral Health System***

- To illustrate the complexity that underlies the financing of our children’s behavioral health system in CT, the Board makes note of recent policy and fiscal decisions that reallocated funding among two state agency partners within this system, the Department of Children and Families and the Judicial Branch Court Support Services Division. The ramifications of those decisions extended beyond the intended population of youth on parole, impacting programming for youth involved in the juvenile justice system as well as non-justice

involved youth and families. For example, resulting reductions in programming financed through braided funding have led to a decrease in resources available to address behavioral health and related needs of at-risk youth. In effect, this is a reduction in services that would help keep youth from entering the justice system in the first place. Such an outcome demonstrates the importance of ensuring that careful analysis of fiscal and programmatic interdependencies is conducted when changes are being considered within a complex service delivery system such as we have in Connecticut for children’s behavioral health.

***Recommendations:***

1. **Continue fiscal mapping using the emerging shared definitions for categorizing expenditures and levels or types of care.** This will provide valuable insights into what is being funded, how it is being funded, and **whether there are additional opportunities to blend, braid or otherwise optimize funding across state agencies.** Further analysis of the children’s behavioral health system that maps services and builds on the pyramid model presented graphically in this report, would provide a clearer picture of the existing continuum of services. This would allow better understanding of where there are gaps, where there is redundancy, where there is interdependence and where there are opportunities to pool funding to serve *needs* rather than maintaining silos that create inefficiencies and work against the “no wrong door” system. This type of analysis is critical to inform and promote fiscal and programmatic policy decisions that strengthen the system and positively impact children, youth, families and communities.

***Progress Measures:***

- a. Create a repository of shared definitions and approaches to categorizing expenditures.
  - b. Identify resources to support ongoing development of a blended financial data set that will enable examination of expenditures and utilization across systems by race, ethnicity and language preference utilizing FY17 data.
  - c. Identify opportunities for blended or braided funding to promote better efficiencies, access and outcomes for youth with behavioral health needs, with particular attention to how this approach can be used to reduce health disparities.
2. **Strengthen data collection, analysis and communication of findings through a health equity lens.** Our children’s behavioral health system must be equally responsive to and accessible for all children in need, regardless of race, ethnicity, town of residence, or other factors. An effective children’s behavioral health system must rest upon a foundation of health equity, meeting the basic needs of children and families, with supports to foster not only their behavioral health needs, but also their physical, social, spiritual, educational, and financial well-being. The Board acknowledges that

we will not achieve our goal of improving children’s behavioral health if we do not also promote physical health, nutrition, housing-security, access to safe social networks and activities, and supports for school and vocational success for each of Connecticut’s children. To this end, the graphic representation (figure 1) of the children’s behavioral health system was developed to provide a conceptual representation of these principles, and will allow flexibility to look at expenditures and programming dynamically and comprehensively. As we move forward with further fiscal and system analysis, data will be represented within the pyramid structure, closely aligned with a conceptual model often seen in public health frameworks. To ensure that Connecticut’s behavioral health system is equitable and promotes wellbeing for all children, it is critical that the Board examine spending, services and outcomes across the system. This will require shared expectations about data collection and terminology that at a minimum allows for analysis by race, ethnicity, gender, primary language and town of residence. It will also require strategies to better follow services provided to an individual child across systems to determine equity in identification of need, access to the full service array and outcomes. Careful consideration of the mechanisms established for following expenditures by child is necessary to ensure that the system protects sensitive information, does not compromise confidentiality and does not create other unintended consequences. Families must maintain control of who is granted access to their personal health information.

***Progress Measures:***

- a. Align efforts with other projects addressing data collection and information exchange, including the Connecticut State Data Plan and the Health Information Exchange, to promote better data collection and information sharing across systems that facilitate system evaluation without compromising privacy and confidentiality.
  - i. Develop shared expectations and technical strategies across state agencies and departments to collect and analyze service data and expenditures at a minimum by race, ethnicity, gender, primary language and town of residence.
  - ii. Explore best practices from other states and comprehensive behavioral health systems for integrating screening, service utilization and outcomes data across child-serving systems. This may include the use of a common identifier or other effective strategies.
- b. Work with state partners to identify behavioral health expenditures that are directly and specifically related to promoting health equity.
- c. Information about system services, expenditures and populations served will be presented through the pyramid model to promote understanding of the

complexities of the system and to assist in communication about status of health equity.

3. **Continue to promote a seamless system of behavioral health treatment for adolescents and young adults that matches services according to developmental presentation and need, rather than by assignment to the child or adult system according to chronological age.** Connecticut's behavioral health system must include procedures and resources to ensure the successful transition of youth with behavioral health conditions, histories of adverse childhood experiences, and developmental challenges that impact emotional development to adulthood with the appropriate supports in place. This requires services that extend beyond the 18<sup>th</sup> birthday for many, and dedicated resources that will manage and support successful transitions to the adult behavioral health system. It also requires effort to identify and eliminate barriers to serving individual youth where their treatment needs will best be met, such as age restrictions due to licensing regulations or difference in authorized services in the adult versus child systems. The development of a system that ensures a seamless transition from youth to adult services must be replicated to serve the commercially insured population as well.

***Progress Measures:***

- a. Identify existing resources and services dedicated to supporting transition from child to adult system.
  - b. Provide recommendations to address systemic barriers to serving youth age 18-21 in programs that are matched to developmental needs rather than determined by chronological age.
4. **Review existing data to advance recommendations for enhanced screening and identification practices throughout the system.** The selection of screening tools must also ensure that there are standardized measures that have been validated for use with different racial /ethnic groups representative of Connecticut demographics, and minimally available in English, Spanish and other languages identified as common in the state. Greater integration across service systems is necessary to facilitate early detection of behavioral health needs through routine screening of children ages 0-21 at critical contact points, including but not limited to primary care, educational settings and juvenile justice. Explicit attention should be focused on identifying screening opportunities across systems that have the potential to promote health equity for diverse populations. Beyond enhanced integration and expanded screening capacity, recommended practices will be required in order to connect children, adolescents and young adults who have identified behavioral health needs to appropriately matched services across a continuum ranging from prevention to intensive services. It is essential that fiscal decisions ensure sufficient resources to meet programming and service demands at each level of care.

***Progress Measures:***

- a. Develop an inventory of recommended standardized and validated tools for behavioral health screening that are validated for use with different racial/ethnic groups representative of Connecticut demographics and available in English and Spanish and other languages identified as common in the state.
- b. Develop and disseminate recommendations for screening practices at critical contact points for infants, children, adolescents and young adults ages birth to 21.
- c. Explore strategies (within Connecticut and elsewhere) for promoting connection from screening to further assessment and/or services where indicated, with rigorous attention to privacy and confidentiality.
- d. Examine whether current service delivery expenditures are sufficient to meet the demand for services that will result from increased screening.

Given the broad scope of the plan, there continue to be many areas for attention beyond the focused recommendations noted above. Although not explicitly included in this year's goals, it will be important to partner with other workgroups that are identifying and addressing related needs, both to monitor progress and to collaborate as may be appropriate to move the work of the plan forward. One potential area for collaboration that has been identified as requiring extensive attention is enhancement of the service array and workforce readiness to address the needs of children with complex developmental disabilities or a diagnosis of autism. As reported by the Office of the Child Advocate (OCA) in its submission for this report (included in Appendix A), these issues are being addressed by the Developmental Disabilities Workgroup of the Medical Assistance Policy Oversight Council (MAPOC). Another potential area for collaboration, is to explore opportunities to coordinate efforts with the Connecticut Chapter of the American Academy of Pediatrics (AAP) Integrated Primary Care Taskforce that is working to identify and address barriers to colocation and integration of behavioral health into primary care settings, and expansion of screening practices to identify children with behavioral health concerns early on.

Similarly, it is important that members of the Board who sit at other tables addressing related needs share with those stakeholders' information and findings from the work of the Board. An example of this type of opportunity would be the continued sharing of information between the Screening and Identification workgroup of the Board and the Diversion Workgroup of the Juvenile Justice Policy Oversight Council (JJPOC) that has been working on developing uniform screening and referral practices for youth referred to Youth Service Bureaus due to truancy.

Finally, as Plan implementation proceeds, it will continue to be important to ensure that there are adequate opportunities for meaningful participation in the discussion and decision-making process by those who are directly impacted by children's behavioral health system policy and programming. This includes the children and families who receive services, or who otherwise engage with the children's behavioral health system, and the providers of those services. Board membership does include family and provider representatives and multiple community stakeholder

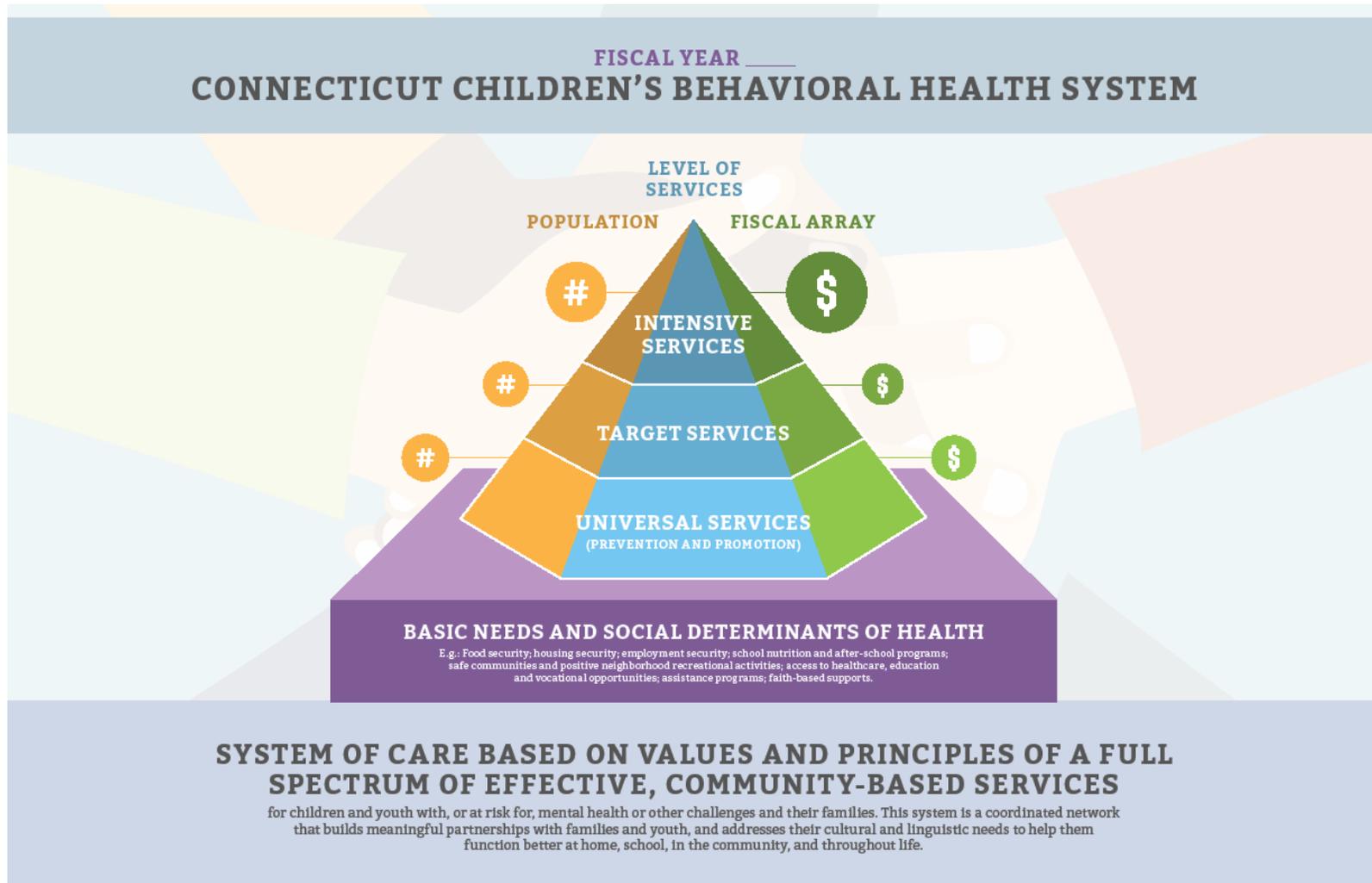
listening sessions have been held, as reported in Appendix\_. The Board will continue to explore ways to achieve ongoing input and participation from these important stakeholders, and will take steps to ensure that the youth voice is heard. Families, youth, young adults, and service providers can offer valuable insights into what is and what is not working well and for whom. Ensuring that the family, youth, young adult and provider perspective is heard can help to avoid harmful and costly decisions, as well as help to bring to light gaps and needs within the system.

We look forward to continuing our work with the Board, the Children's Committee, the General Assembly, the Executive Branch, and the Judicial Branch to realize the vision set forth in the Plan.

Respectfully submitted,

Tri-Chairs: Elisabeth Cannata, Ph.D.  
Carl Schiessl, JD  
Ann Smith, JD, MBA

Figure 1



## Appendix A

### **Partner Organizations and Departments:**

Department of Children and Families (DCF)

Department of Developmental Services (DDS)

Department of Social Services (DSS)

Department of Public Health (DPH)

Department of Mental Health and Addiction Services (DMHAS)

State Department of Education (SDE)

The Connecticut Insurance Department (CID)

The Office of Early Childhood (OEC)

The Office of the Child Advocate (OCA)

The Office of the Healthcare Advocate (OHA)

The Judicial Branch -Court Support Services Division (CSSD)

The Commission on Women Children and Seniors (CWCS, formally Commission on Children)

### **A. System Organization, Financing and Accountability**

Of the twelve reporting agencies, ten agencies provided a response under section A.

**This year a priority area of focus was the completion of the first phase of the behavioral health fiscal mapping process. All partner agencies participated and submitted some level of fiscal data in an effort to begin to analyze Connecticut's investment in children's behavioral health. The fiscal mapping process affords the opportunity for more careful analysis of system expenditures. In order to effectively understand invested behavioral health resources a base-line view was developed that included five categories: 1.) health promotion, 2.) prevention, 3.) support and care, 4.) treatment and 5.) after-care and recovery. Additional alternative fiscal views will be explored including a three stage public health view that includes: universal, selective and intensive service expenditures. These alternative views will allow a more in-depth understanding of Connecticut's investment in children's behavioral health.**

### **DCF Response**

DCF continues to expand, develop and staff the workgroups that support the necessary activities needed to meet the goals of the legislative mandates of PA 13-178. These include:

1. Fiscal Analysis and Mapping
2. Screening and Early Identification
3. Network of Care Analysis
4. Data Integration
5. School Mental Health
6. Workforce Development
7. Implementation of the national CLAS standards and racial justice activities.
8. Family and Youth Engagement
9. Early Childhood
10. Primary Care and Behavioral Health Integration
11. Communication

Each of these workgroups have developed a logic model, vision, goal, key strategies, a work plan, outcomes and each track results and provide routine updates and reports.

DCF continues to maintain eight fulltime Care Coordinators under the Care Management Entity to serve DCF involved youth or non-DCF children being discharged from Psychiatric Residential Treatment Facilities (PRTFs). Capacity is limited at this time, serving approximately 120-160 youth annually.

DCF has continued to contract with Beacon Health Options and staff the development of the behavioral health fiscal map of the partner agencies for expenditures for state fiscal years 2015 and 2016. All state partners participated in varying levels of fiscal details.

DCF continues to work with SDE, Child Health and Development Institute (CHDI) and Connecticut Children's Medical Center-Injury Prevention Center and interested schools throughout the state to utilize the National School Mental Health Census and Performance Measures using the School Health Assessment and Performance Evaluation (SHAPE) electronic self-assessment system. The primary goal of this project is to assist school in meeting the behavioral health needs of their student populations.

### **DDS Response**

DDS continues its commitment to working as a collaborative partner to help construct a strong and sustainable behavioral health system that prevents, identifies, and addresses the behavioral health needs of all children in Connecticut. DDS continues its collaboration with DCF, DMHAS and DSS on complex case reviews and with the Administrative Services Organization (Beacon) staff and by other groups. DDS continues efforts to recruit and retain psychology series staff. To this end, DDS has increased weekly hours for psychologists from 35 to 40. A national recruitment effort video was also completed through Skill Scout.

A DDS committee is working with DSS and other state agencies (e.g., DCF, ABH) on a project that explores the statewide structure for behavioral providers. The committee is looking at stratifying the rates, revising the credentialing process, and determining the impact of BCBA licensure.

With regard to emergency behavioral supports, DDS is in the process of planning for the structuring and staffing of the step-up/step-down unit project. Recent focus has been on establishing the mobile crisis portion (e.g., team leads, hotline, triage, peer supports, etc.). We have an upcoming meeting with DCF to discuss possible integration into the existing Mobile Crisis system and statewide call center.

DDS continues to face challenges in accessing treatment data from outside sources for individuals we support. Last year, DDS worked with DSS to gain access to Medicaid Management Information System (MMIS) claims data. DDS has developed analytical reports to identify when individuals supported by DDS receive treatment for potential critical incidents. Due to the large pool of data and complexity of both business rules and modern claim systems, DDS requested and received support to utilize an analytical software tool procured by DSS for MMIS claims review. The

funding request was submitted to CMS in June and may be approved shortly. Once approved DDS will work with the software developer to create customized analytical reports that are more actionable in identifying treatment for critical incidents to allow for administrative review and follow-up if needed. Recently legislation passed requiring agencies to submit priority data sets to the state's Chief Data Officer at OPM to review for inclusion in the CT Open Data Portal. DDS hired a BI Director to oversee the Open Data initiative, as well as develop the broader Business Intelligence program at DDS.

### **DSS Response**

Beacon Health Options, under the direction of the state agency partners, has improved their capacity to collect, analyze and report healthcare outcomes data, including, but not limited to HEDIS measures. This allows Connecticut to compare itself to other states on validated healthcare measures.

### **DPH Response**

CT DPH continues to support activities identified in the completed HRSA State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders and other Developmental Disabilities to improve access to comprehensive, coordinated health and related services. The grant was a collaborative project between DPH – the state's Title V agency and A.J. Pappanikou Center – the state's University Center for Excellence on Developmental Disabilities (UCEDD). Proposed outcomes of the project included: (1) implementation of the CT State Autism Plan, with activities that strengthen stakeholders' awareness of early signs of ASD; knowledge about and access to evidenced-based, individualized and timely screening; diagnostic assessment and interventions implemented by a competent workforce; (2) engage ASD specific family support and training organizations to provide information and education on ASD; (3) work with the AAP, pediatric primary and family care providers, and the CT Medical Home Initiative for CYSHCN (CMHI) providers to expand practices providing family-centered, comprehensive coordinated health care and related services including screening, linkage to diagnosis, and transition to evidence-based interventions.

Report numbers include the following: training on the importance of developmental screening and supporting materials were provided to 2,441 families and 2,105 professionals for a total of 4,456 trainings; Community outreach activities and distribution of developmental screening materials totaled 6,402; 14 "Learn the Signs. Act Early." products were distributed 16,519 times during the project period; 7 products developed during the period were distributed 9,765 times and six products developed prior to the project were distributed 7,304 times during the project period.

Ann Gionet was selected as the Center for Disease Control and Prevention (CDC's) "Learn the Signs. Act Early" Ambassador for Connecticut. The program aims to improve early identification of children with developmental disabilities including autism to raise awareness of the importance of screening and early identification through the distribution of materials for parents and professionals working with young children. "Learn the Signs. Act Early." trainings were provided to three hundred and seventy-nine individuals comprised of families, early care and education providers and state agency staff and community providers.

The CT DPH Title V CYSHCN Director provided input to AMCHP's State Public Health Autism Resource Center (SPHARC) interactive, self-paced learning module called "Communicating the Value of Developmental Screening." This informational module aims to build capacity of Title V leaders, family members, health professionals and other key stakeholders in articulating the value of developmental screening by helping users: identify the purpose of developmental screening, understand the impact screening has on families and children, recognize the roadblocks and challenges of the screening process, understand the role of Title V in developmental screening and communicate its value, and identify additional resources.

Developmental screening is a priority area for the CT Department of Public Health State Health Improvement Plan Advisory Council and the Maternal, Infant and Child Health Workgroup. The Developmental Screening Workgroup was formed that includes a group of stakeholders committed to developmental screening made up of community providers, representatives from family organizations, state agency representatives, the group meets quarterly. The Developmental Screening Workgroup's Action Agenda contains three strategies.

The first strategy is to conduct an education and awareness campaign that targets families and communities on the importance of developmental screening. The Developmental Screening Workgroup is supporting the Connecticut's Project LAUNCH's media campaign message which includes information on and the promotion of developmental screening, a focus on families & relationships, and the Strengthening Families' Protective Factors. The success of the campaign will be monitored through the counting of several screening and referrals items available through Child Development Infoline and tracking these data points overtime. Ages and Stages Questioner (ASQ) new enrollments 2,296; Ages and Stages Questioner (ASQ) Screenings Completed 2,427 Birth to Three referrals 9,466; Ages and Stages Questioner web hits 3,125; Ages and Stages Questionnaire enrollment from web hits 1,007. Promote awareness and use of Child Development Infoline. Total number of Child Development Infoline and Help Me Grow calls is 3,285, CDI/HMG cases related to monitoring a child's development 749. Expand the number of "Learn The Signs. Act Early." materials distributed statewide to families and community providers 642, "Learn The Signs. Act Early." web hits at Child Development Infoline 145.

The second strategy is to train community and healthcare providers to improve screening rates and coordination of referrals and linkage to services within the state. Success will be tracked through a variety of Educating Practices in Communities (EPIC) including but not limited to Help Me Grow EPIC during July 1, 2016 to June 30, 2017 there were 4 presentations (West Hartford, East Hartford, Manchester, and Bridgeport) to 52 staff of which 93% said they would use the information provided in the module and 83.3% said the information was helpful. Infant Mental Health EPIC had 3 presentations (Niantic, East Lyme and Bloomfield) to 21 staff of which 91% said they would use the information provided in the module and 100% said they information is helpful. CT Association for Infant Mental Health (CT-AIMH) endorsement process had 15 trainings for 243 people and CT-AIMH's infant and toddler trainings were scheduled 8 times and included 547 people. There were 3 Ages and Stages Questioners trainings and 2 ASQ Social Emotional Train the Trainers presentations which resulted in 20 trainers for the state of Connecticut.

The third strategy is to engage in cross system planning and coordination of activities around developmental screening. Members of the Developmental Screening Workgroup will join state level groups in order to support communication among and coordination of statewide efforts around developmental screening and the promotion of healthy development including Connecticut Project LAUNCH's State Level Young Child Wellness Council, the DPH State Level Care Coordination Collaborative, and the Help Me Grow Advisory Council.

CT Project LAUNCH success includes the co-creation of Developmental Screening marketing materials in partnership with the Department of Public Health, Child Development Infoline and Help Me Grow and streamlining family friendly language around developmental screening across agencies. These materials will be linked to a state level conference for the purpose of equipping families, family advocate, and providers to begin regional and community action plans. Communities will be provided Developmental Screening Community Action Planning Tool Kits.

In addition CT Project LAUNCH saw several successes this year including; increased parent participation at the state level young child wellness council; partnering with local schools around initiatives that support family strengthening (ex. Delivering Stress Management 101 Workshop) and negotiated a memorandum of understanding with a fourth pediatric practice to have an embedded clinician on their team.

The MAVEN online reporting system is available to care coordinators within the CT Medical Home Initiative for Children and Youth with Special HealthCare Needs (CMHI) with enhanced fields specifically related to developmental screening. Fields include whether the child received a developmental screening, screening results, confirmation of screening results and referrals made. This mandatory data entry gathered information from parents on developmental screening of CYSHCN under the age of four who are currently served by CMHI contractors.

### **SDE Response**

Through an emerging collaboration with the Department of Social Services, SDE is assisting LEAs with developing improved billing systems to access Medicaid payment for general education student needs

SDE supports 58 Family Resource Centers operate in 41 communities and provide information and referral for developmental, behavioral and mental health issues.

### **CID Response:**

CID is accountable for regulation of the fully insured commercial insurance market. Since the start of the CT Children's Behavioral Health Plan there have been significant changes to Insurance Statutes to address concerns. Specifically, there were changes to the requirements for Utilization review. Connecticut insurance statutes 38a-591 through 38a591n require that insurers utilize clinical peers when issuing a denial of services based on a medical necessity determination. Connecticut now has very specific requirements for behavioral health reviewers in terms of

credentials. Further child reviews must be conducted by a reviewer with expertise and credentials specifically in child and adolescent fields.

Connecticut General Statute 38a-591c defines the Clinical Criteria that an insurer must use when evaluating requests for behavioral health services. These are subdivided by adult vs, child for mental health disorders. (4) For any utilization review for the treatment of a child or adolescent mental disorder, the clinical review criteria used shall be: (A) The most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument., one of the most important aspects of CID's regulatory activities is administration of the External review program. This allows for expedited independent third party determinations regarding medical necessity claim denials by insurance companies. Based on increased focus for Children's Behavioral Health issues, CID has been coding all behavioral health external review cases so that reporting can be broken out by adult vs. child.

External Review coding also allows reporting by where the behavioral health services are delivered such as inpatient services, outpatient services, pharmacy services and Emergency Room. External Review coding also gives reporting by condition: Behavioral Health, Substance Abuse, Behavioral Health Comorbidity and Eating Disorder.

Children's behavioral health levels of treatment are also identified for reporting purposes including: Psychiatric, Acute Care, Substance Abuse Detox, Partial Hospitalization, Intensive Outpatient, and Residential Treatment Center. This coding allows the department to quickly determine any Children's Behavioral Health trends that are occurring in the commercial health insurance marketplace overall or by a specific insurance company.

The Department's annual Consumer Report on Health Insurance Carriers in Connecticut is a comprehensive tool that consumers and public policymakers can use to meaningfully compare health insurers against a number of factors including quality measures. The Department has been publishing the report since 1998 and has greatly enhanced it over the last two years to include quality measures for behavioral health and substance abuse coverage. The 2017 edition was expanded to include data on how insurance companies are doing in providing follow up treatment for mental health and substance abuse care. The Report Card is distributed each October to the Insurance and Real Estate Committee and is available on CID's website.

### **OCA Response**

With regard to the Plan's goal of re-designing the publicly-financed system of behavioral health for children and ensuring adequate allocation of existing or new resources, OCA's ongoing advocacy on behalf of children with disabilities and their families has included examination of the state's continuum of services for children with complex developmental disabilities, including how such a continuum is funded and made accessible to families who are covered by different health care payers. OCA continues as a lead participant on the Developmental Disabilities work group

established through P.A. 16-142, An Act Concerning Recommendations For Services Provided To Children And Young Adults With Developmental Disabilities.

In July of 2017, The Developmental Disabilities Work Group issued its first report. Based on extensive analysis of services for children with developmental disabilities, the report made findings and recommendations on Connecticut's existing system of services and supports. Members found that the current system for Children with Developmental Disabilities has: - inadequate/disparate access to state-funded voluntary services (DCF/DDS), - limited availability of needed services for children with intellectual disability, - a critical need for high-skilled family care coordination, - uneven access to educational services that children are entitled to under federal law. Recommendations were made, which align with the goals of improving service delivery, care coordination, and outcomes.

Throughout the months the group has met, members received significant information regarding families and children that are in crisis due to the lack of timely access to critically needed services. Children with developmental disabilities and mental health needs are disproportionately reliant on emergency room care, and some children become "stuck" in emergency rooms for days and even weeks on end due to the lack of an appropriate discharge plan and the families' need for help. Families in crisis, community-based providers and health care professionals throughout Connecticut shared information with group members regarding their frustration with the lack of a well-coordinated and lead-agency approach to treatment planning for vulnerable children with developmental disabilities.

The Work Group decided to conduct a focused review on children with developmental disabilities who are accessing crisis support and stabilization in local emergency departments. Specifically, the group sought information regarding: 1. Children and families who present to a hospital emergency department for the first time with an acute behavioral health crisis; and 2. Children with developmental disabilities whose care and safety needs are highly acute, resulting in lengthy or repeated ED stays as well as prolonged or repeated inpatient hospitalizations. While acknowledging that the work of this group has not yet been completed, the following key findings and recommendations are based on the entirety of the examination the Work Group has made on children with developmental disabilities.

## **OCA FINDINGS**

1. Based on data provided by Connecticut Children's Medical Center and Yale New Haven, it seemed apparent that children with developmental disabilities spend a longer time in the ED compared to their peers without developmental disabilities.

2. In an analysis conducted by Beacon Health Options (the behavioral health administrative service organization for Connecticut Medicaid), in Calendar Year (CY) 2016, there were 578 Medicaid-enrolled children and youth aged 0 - 21 with an I/DD/ASD diagnosis that were admitted to an inpatient psychiatric hospital. This represents 0.14% of all Medicaid enrolled youth for CY 2016.

3. Also, in CY 2016, there were 42 Medicaid-enrolled children and youth aged 0 – 21 with an I/DD/ASD diagnosis that were delayed in an emergency department with a reported barrier to

discharge related to their diagnosis. This represents 0.01% of all Medicaid enrolled youth for CY 2016.

4. Beacon found that in CY 2016, there were a total of 365 in-state and out-of-state acute inpatient hospitalization (excludes Connecticut State-run hospitals) episodes in where there was an I/DD/ASD diagnosis on the claim for youth aged 0 - 21. These 365 episodes accounted for a total of about \$6.6 million.

5. Previous reporting in Connecticut has found that “youth with an ASD diagnosis stay longer in inpatient care than their peers not identified as having ASD while utilizing the same services.” (See Autism Feasibility Working Group Study, 2013).

6. The odds of a child with an ASD diagnosis going to the emergency department for a psychiatric reason are 9 times larger than the odds of a child without an ASD diagnosis. (Kalb, Stuart, Freedman, Zablostky, & Roma, 2012)

7. Children with ASD are at a greater risk of hospitalization than children with other disorder (Gallaher, Christakis, & Connell, 2002)

8. When there is a lack of appropriate community services, children that exhibit aggressive and self-injurious behaviors have an increased risk of hospitalization (Mandell, 2008)

9. Information from families and hospital providers reveals children with an I/DD/ASD diagnosis who get stuck in emergency rooms are difficult to discharge for reasons related to family crisis, lack of family resources, and lack of 24-7 support for children with complex care and safety needs. As a result, children and families spend excessive time in emergency rooms which is well beyond what is medically necessary.

10. Emergency Department staff have reported difficulty accessing developmentally appropriate, behavioral health treatments and high-skilled care coordination that can assist with discharge, transition, and treatment planning.

11. In conducting a scan of the provider network within Connecticut, there are few in-state hospital beds for a child with complex developmental disabilities and acute mental health treatment needs.

12. The two DCF-operated and three private Psychiatric Residential Treatment Facilities (PRTF) are not staffed to meet the needs of children with a comorbid psychiatric and intellectual disability. Through state funds, two of the three private PRTFs have received support and expert consultation in order to provide services to children with a psychiatric condition and autism spectrum disorder, which has improved their capacity. The project evaluation (BRISC) notes an ongoing need for attention to training and support.

13. There is only one residential treatment facility in the state that is focused on the specialized treatment of children with developmental disabilities. Insurances typically will not cover this service as well as residential treatment is not a Medicaid-funded service. This leaves the state agencies (DDS and DCF) as the only available funders for this level of care.

14. DDS Voluntary Services (called the Behavioral Support Program) is not able to provide services to new, yet eligible, families due to budget cuts.
15. Families and providers have indicated that DCF Voluntary Services frequently denies eligibility for children with developmental disabilities.
16. While the adult service system has some capacity to provide respite to families, there is no current system for providing respite to families as part of a child's treatment plan, even where brief respite is identified as essential to maintaining the child in a non-institutional setting.
17. There is no apparent health care funding stream (other than Voluntary Services) which allows a family, in conjunction with a child's treatment team, to direct treatment and support dollars to where they are most needed for the child and family (e.g., treatment hours, child care support, respite, pro-social support). The lack of flexibility in treatment dollars can result in expensive treatment plans and unsuccessful outcomes.
18. Children are at risk for poor treatment outcomes and unnecessary or prolonged hospitalization unless there is significant investment in capacity building and technical assistance to the provider community to better support children with developmental disabilities and their families.
19. Multiple community-based providers, with the support of DDS and DSS, are piloting innovative treatment models for children with I/DD/ASD and their families, including the provision of intensive technical support to existing programs (CCSN), Hospital for Special Care, Autism Services and Resources Connecticut (ASRC), Southern CT State University, and Suffield School system.
20. Intensive wrap-around care coordination and a whole family approach, within the behavioral health field, may demonstrate positive outcomes for children with I/DD and their families.

## **OCA RECOMMENDATIONS**

1. Pilot an intensive care coordination service for children with I/DD/ASD who present to the emergency department with acute behavioral health treatment needs to support discharge and connection with appropriate community-based supports. This pilot must have an evaluation component that analyzes healthcare outcome measures for the child and family and cost effectiveness of the service.
2. Develop a specialty Psychiatric Residential Treatment Facility (PRTF) that has capacity to serve children with psychiatric conditions and moderate to severe intellectual disabilities. As part of Connecticut's strategy to maximize federal Medicaid reimbursement for children with I/DD/ASD, for those children eligible for Medicaid, the state would assume approximately 41% of the cost related to this service based on current reimbursement
3. Expand access to respite services for families to ensure children with complex I/DD/ASD can remain in their homes and avoid the need for more acute services. If respite services are expanded, evaluate the impact respite has on reducing emergency or institutional care for children.

4. Scale-up capacity-building technical assistance programs, such as the BRISC framework as part of Connecticut's workforce development strategies to serve children with I/DD/ASD. The BRISC model uses locally-based, nationally-recognized experts to assist community based mental health treatment providers with serving children with developmental disabilities.
5. Support the creation of Regional Training Academies to facilitate caregiver and provider training needs. Such training academies would build on successful resource models such as the Southern Connecticut State University Center for Excellence.
6. Develop reimbursement strategies for (a) specialty extended day treatment for children with I/DD/ASD and (b) maximize capacity of Federally Qualified Health Centers (FQHC) to provide in-home services to children with I/DD and their families. This will allow to further develop an appropriate continuum of services for children with I/DD/ASD and their families.
7. Review the cost effectiveness of providing intensive case management/care coordination to children with complex I/DD/ASD and their families as a means to reduce reliance on emergency room and hospital admissions. This should be coordinated among state health care policy makers, the Office of Health Strategies, as well as other relevant agencies.
8. Improve the cost effectiveness of state voluntary services through a systematic approach to third-party payer reimbursement. Expand the scope of OHA reimbursement work for DCF to include other state agencies.
9. The OHS should assist with examining whether provision of state-administered or state funded Voluntary Services reduces the frequency and duration of hospitalization for children with I/DD.
10. The OHS should work with state health care policy makers to examine cost-effectiveness and outcomes achieved by providers who are or could provide "whole family" services where a child has complex I/DD. As an example, Clifford Beers is utilizing a new and innovative model of service delivery for children with ASD and their families that incorporates both intensive care coordination and a whole-family approach to service delivery.
11. Conduct an analysis of the state's return on investment for well-coordinated, flexible and wrap-around service delivery for children with complex I/DD/ASD and their families. The MAPOC subgroup on children with developmental disabilities should work closely with the Office of Health Strategies to assist with this analysis.
12. Examine other states' strategies for financing effective service delivery for children with complex I/DD/ASD and their families that increases individual functioning and reduces reliance on institutional care.
13. Develop a core measure set to evaluate healthcare outcomes and quality of life. Healthcare utilization and outcomes measures should include access to routine preventive services such as primary care and dental care in addition to measures that track utilization of acute services

### **OHA Response**

Under P.A. 14-115, OHA was tasked with the creation and implementation of a comprehensive, online database of behavioral health providers, searchable by carrier, network status, availability, discipline, type of patients served, language(s) spoken, whether they're accepting new patients and more. A robust and sustainable model was developed, however, due to no funding this project is on hold.

For both fully and self-insured plans, OHA actively collects and tracks information about each consumer case, with routine analysis of this data to identify potential trends in access or quality, including mental health parity. Past data is available in the CT Open Data Portal, and analysis of key trends is reported in OHA's annual reports. OHA continues to develop and enhance its data collection and reporting capabilities, seeking greater granularity in the types of issues we see.

### **JB-CSSD Response**

The Judicial Branch participates in the Juvenile Justice Policy and Oversight Committee (JJPOC) that provides guidance to the Legislature, the Governor's Office, and the state agencies on the programs and services necessary to divert children from the juvenile justice system as appropriate and best serves those children who required court involvement.

The Judicial Branch provides regular updates to the JJPOC at the monthly meetings and produces data related to court intake, detention admission, service utilization, and recidivism as requested.

The Judicial Branch has been preparing for the transfer of the DCF Juvenile Justice function to the Judicial Branch effective on July 1, 2018. Given the transfer of function, the Legislature transferred funding from DCF to the Judicial Branch for this purpose. The Judicial Branch is in the midst of developing a network of residential treatment programs and community-based services to replace the Connecticut Juvenile Training School which closed in April 2018.

### **CWCS Response**

CWCS provides information, research, analysis and policy direction to elected officials and the public regarding issues affecting the state's women, children and older adults, without regard to ethnicity or socioeconomic standing. As appropriate, the Commission also seeks to inform – and is informed by – federal policies that have an effect on Connecticut residents. See the [CWCS 2017 Legislative Agenda](#).

CWCS seldom oversees direct service to Connecticut residents, rather, the Commission works to improve the delivery of service by family-serving agencies through legislated systems integration and change and improved collaboration between executive agencies and across branches.

CWCS is the lead legislative agency for Connecticut's [two-generational initiative](#). The two-generation approach is a growing national strategy that seeks to serve children and the adults in their lives together.

## **B. Health Promotion, Prevention and Early Identification**

Of the twelve reporting agencies, eleven agencies provided a response under section B.

**Promoting health, prevention and early identification and screening is always less expensive than providing treatment after a behavioral health issues has developed.. Some of the examples below provide a snapshot of the ways in which the systems can align around essential areas impacting the overall well-being of children. Although there has been significant movement and complimentary efforts, promoting health and well-being and prevention behavioral health issues remains and area of focus.**

### **DCF Response**

DCF continues to support the Infant Mental Health Training Series both statewide and in each of the six DCF regions. Since 2012, over 553 staff have attended the training sessions. The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department will continue to offer two statewide training 8 session training series in this year, inclusive of DCF staff and community providers serving young children.

DCF maintains support to train Circle of Security Parenting (COS P) to DCF staff, DCF-funded programs that served parents, Therapeutic Child Care, Caregiver Support Teams, Therapeutic Foster Care, and Intimate Partner Violence programs. Additionally, DCF remains committed to building capacity throughout the state to offer COS P. This includes offering the training in Spanish and offering trainings utilizing multiple methods.

DCF continues to fund the Early Childhood Consultation Partnership (ECCP) which provides early intervention and prevention mental health strategies and supports the implementation of strategies to prevent the disruption of children from their early care and education settings. The data continues to show that the Partnership is successful at reducing suspension and expulsions from early care and educational settings.

The Connecticut Suicide Advisory Board (CTSAB) continues to be co-chaired by DCF and DMHAS and has added a third Tri-chair representative from a Connecticut private suicide prevention foundation. Additionally, DMHAS, DCF and DPH continue management of the Garret Lee Smith Suicide Prevention award with DMHAS being the lead state agency.

DCF participates in the CHA Neonatal Abstinence Syndrome-Comprehensive Education and Needs Training (NASCENT) initiative to develop standardized approaches to NAS across hospitals and to improve early recognition of substance use disorders in pregnant and parenting women.

The CT Elm City Project Launch or CT-ECPL continues to be funded by SAMHSA.

The work addresses children's unmet physical, emotional, social, behavioral and developmental needs by promoting resilience and collaboration between families, health care and educational settings utilizing five core strategies: 1) screening and assessment in health care and educational settings, 2) integrating behavioral health into primary care settings, 3) home visiting with an emphasis on children's social and emotional well-being, 4) mental health consultation in early childhood education programs, and 5) family strengthening and parenting skills training. The grant

targets the New Haven Dwight Neighborhood with a plan to expand to other communities in the New Haven area.

Partnerships have firmly been established with CT's Help Me Grow (HMG) Advisory Committee and CT's Maternal and Child Health (MCH) Developmental Screening Workgroup to develop strategies for raising awareness of the importance of developmental and mental health screenings, as well as, working to align efforts across early childhood systems to use standardized developmental and social/emotional screenings.

LAUNCH has supported the development of an infant mental health (IMH) 6- day curriculum for home visiting (HV) professionals to increase knowledge of infant social and emotional development. This year, 63 Home Visitors in the New Haven area were trained and 40 families are receiving Trauma- Informed Child-Parent Psychotherapy (CPP) as a result of ECPL's workforce development efforts.

ECPL has partnered with the CT Chapter of the American Academy of Pediatrics to develop a plan to promote behavioral health integration at a system's level.

### **DDS Response**

DDS continues to support implementation of Supporting Families Community of Practice (COP) activities as a vehicle to provide better supports to all families. In the past year, staff from the CT Regional Education Service Centers (RESCS) have been trained by the national COP staff on how to use Charting the LifeCourse planning tools in school systems. In August, a team of stakeholders including family members, students, stakeholders from DORS and DDS, RESC staff and national Charting the LifeCourse technical assistants will meet to develop a plan for sustaining the use of Charting the LifeCourse activities in all 169 of the school districts.

DDS is in the process of filling six of the fifteen vacant transition advisor positions. This will greatly help DDS to complete prevention, promotion, and early identification for the 1500 youth with IDD age 16-21, that are currently receiving services in the CT school districts.

### **DSS Response**

DSS, through its medical Administrative Services Organization (CHN-CT) has incentivized CHN to increase the rate of PCP providers performing annual developmental and behavioral health screens.

DSS is developing the reporting specs to identify children with two consecutive positive screens to determine if they connected to specialized care.

### **DPH Response**

Mental health services are a priority within the SBHCs and experienced adolescent health clinical staff who provide medical, mental/behavioral health services are employed. One focus has been on suicide prevention among adolescents. Title V staff regularly participated in Connecticut Suicide Advisory Board (CT-SAB) meetings. Title V distributes 1 Word 1 Voice 1 Life suicide prevention awareness campaign materials (developed by the CT-SAB) throughout all programs. The Behavioral Risk Factor Surveillance System (BRFSS) in 2016 collected information to assess awareness of the 1 Word suicide prevention campaign Title V participated in the development of

the State Suicide Prevention Plan. Title V collaborated with the president of a local suicide prevention foundation to facilitate the piloting of 4 What's Next, a suicide prevention and mental health promotion event for high school students and plans are in place to expand to other high schools utilizing SBHC partners.

Title V staff provided Question, Persuade, Refer (QPR) suicide prevention training to partners working with adolescents including high schools, SBHCs, DCF foster parents, and numerous care coordination and family advocacy partners. DPH partnered with Child Health and Development Institute and CT Children's Medical Center to promote Educating Practices In the Community (EPIC) training on suicide prevention for pediatric providers, including SBHCs. In addition, DPH partnered with the Department of Mental Health and Addiction Services (DMHAS) to train SBHC staff in the use of the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach to identifying, reducing and preventing problematic substance use disorders in the adolescents served. DPH staff also partnered with the CT-SAB to increase awareness of the SBHC as a resource for suicide prevention and intervention.

### **DMHAS Response**

DMHAS Young Adult Services (YAS) program continues to provide, through funding from the Department of Public Health (DPH), a perinatal support program to young parents engaged in the young adult services program. Over the past year, the YAS Perinatal support program has provided in-home pregnancy/parenting education to 95 families, serving 100 children.

This past year, DPH extended their initial 2 year allocation for an additional year so that YAS could continue to offer training to young adults using the evidenced based curriculum, Be Proud Be Responsible (BPBR). BPBR was developed to give young people the knowledge and skills that they need to reduce their risk of HIV/STDs, increase condom use, and affect their knowledge and beliefs as they relate to sexual behaviors such as frequency of intercourse, multiple partners and contraceptive use. To date, DMHAS YAS has provided 22 trainings to over 190 YAS young adults. This funding has also allowed DMHAS to provide training to the statewide YAS staff on Human Sexuality and Understanding Gender Issues and Transgender terminology.

DMHAS' Young Adult Services program continues to participate in the TANF program. Our focus is to prevent and reduce the incidence of out of wedlock pregnancies by identifying the risk of pregnancy and providing interventions to lessen the risk.

DMHAS participates in a statewide initiative for early detection, prevention, screening and assessment of Fetal Alcohol Syndrome in order to provide prenatal care and services to any child exposed to FASD. DMHAS actively participated in the Early Intervention and Screening Workgroup and the Training workgroup to develop statewide standards.

DMHAS participates in the CHA Neonatal Abstinence Syndrome Comprehensive Education and Needs Training (NASCENT) initiative to initiate standardized approaches to recognition and treatment of NAS across hospitals and improve early recognition of substance use disorders in pregnant women.

DMHAS YAS has been training direct care and clinical staff in the trauma-based **Attachment, Self-Regulation and Competency Model (ARC)** developed by Kristine Kinniburgh and Margaret Blaustein from the Justice Resource Institute in MA. This model is applied across all levels of care and offered to all YAS staff. The **ARC** builds staff competencies needed to better assist individuals in ameliorating the debilitating physiological, behavioral and psychological effects of their experience. DMHAS has provided 4, 10 week training modules over the past year.

DMHAS continues to collaborate with DCF, CSSD and SDE in supporting the School Based Diversion Initiative in an effort to reduce school based arrests and identify and provide alternatives and appropriate interventions to youth.

DMHAS also participates on the Children's Behavioral Health Advisory Committee (CBHAC) and the Joint Planning Council that combines the CBHAC with the Adult Mental Health Planning Council.

DMHAS has been providing Mental Health First Aid trainings to youth and to adults to increase awareness and the ability to intervene. Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. In 2017, 131 Youth Mental Health First Aid training sessions were conducted in Connecticut and over 1,602 persons were trained. Additionally, 305 Adult Mental Health First Aid training sessions were conducted and over 3747 persons were trained in 2017.

In 2015 DMHAS was awarded a five-year youth suicide prevention grant focused on 10-24 year-olds from the federal Substance Abuse and Mental Health Services Administration; it's titled Networks of Care for Suicide Prevention. The CT Departments of Children and Families, Mental Health and Addiction Services and Public Health co-direct the initiative and partner with: the CT Suicide Advisory Board (CTSAB), Community Health Resources; United Way 211, Manchester Public Schools, Manchester Police Department, Manchester Community College; the Eastern CT Health Network; and the UConn Health Center as the evaluator. Through this partnership and the resources awarded, CT is working to establish a statewide Network of Care for suicide prevention, intervention and response, and implement an intensive community-based effort to reduce non-fatal suicide attempts and suicide deaths among at risk youth age 10-24.

The statewide network of care is managed by the United Way of CT and is comprised of five regional coalitions. One community network is located in Manchester, the site of the intensive community-based effort managed by Community Health Resources. The grant works on all levels to promote the state suicide prevention goals and objectives with an emphasis on integration of suicide prevention across multiple sectors and settings; adoption of best practices; quality

improvement of health and behavioral health care; enhanced reduction of lethal means access; and surveillance and use of local and state data.

Some highlighted activities are: support of Wheeler Clinic as a National Suicide Prevention Lifeline provider; workforce development focused on identification, screening and safety planning across many sectors- education, police, healthcare, etc.; engagement of healthcare systems in the quality improvement model- Zero Suicide; the early identification, referral and follow-up of at risk youth; and development of the elementary children's book, curriculum, feasibility study and website for Gizmo's Pawesome Guide to Mental Health ([www.Gizmo4MentalHealth.org](http://www.Gizmo4MentalHealth.org)).

DMHAS continues to administer the four year federally funded Safe Schools/Healthy Students (SSHS) grant by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/center for mental health Services (CMHS).

Administered by the Connecticut Departments of Mental Health and Addiction Services (DMHAS) in conjunction with the State Department of Education (SDE), the grant supports three LEAs - Bridgeport Public Schools, Middletown Public Schools, and the Consolidated School District of New Britain – to implement activities, services and strategies that decrease youth violence and promote healthy development of children and youth. The SS/HS grant encourages solutions to the precursors of violence by focusing on five elements: 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 Substance Use; and 5) Creating Safe and Violence Free Schools. This SSHS Framework is used to expand and enhance improvements in school climate, access to behavioral health and other supports, reduce substance abuse and exposure to violence in students in grades pre-K through 12.

Over the first three years, the grant has established the ground work necessary for launching interventions built around the five SS/HS elements. It has: conducted a thorough needs assessment and environmental scan that identified important gaps and strengths in each of the communities and at the state level; developed a comprehensive plan, which laid out the initial proposals for activities that could be implemented to address the problems identified in the needs assessment and environmental scan; established the Statewide Management Team (SMT) with its diverse stakeholders as the advisory group to focus on increasing awareness of the initiative and expanding and sustaining the initiative's efforts; and, established Community Management Teams (CMT) at the LEA level to provide linkages across elements and identify successful strategies and various supports needed to continue them beyond grant funding.

In year three a number of evidence based trainings and practices were implemented. These included: PBIS, Ruler, and Youth Mental Health First Aid, as well as Boys Town training within Bridgeport's specialized classrooms and therapeutic school. Middletown Public Schools continued to partner with Middlesex Hospital Center for Behavioral Health Family Advocacy program on the early childhood home visiting program, Child First, and elementary mental health screening and referral initiative, ICARE. Middletown Public Schools also contracted with Effective School Solutions, to provide wraparound in-district services for secondary students with emotional and behavioral health needs, and with Rushford, to coordinate prevention-based afterschool activities. In addition, all certified staff have been trained in the Kognito At-Risk for Educators modules to

identify students at-risk of mental health issues. The New Britain LEA hired a new superintendent who has been a champion for the SSHS project. The CMT has decided to merge with the Coalition for New Britain Youths to ensure that supports are in place to allow programs to continue to function.

Year 4 of the grant focused on planning for expansion, sustainability, and completing a request for a No Cost Extension. The Leadership Team, SMT, CMTs and LEAs were all engaged in deciding which strategies, policies, EBPs, and best practices should be adopted widely across the state, and the mechanisms to ensure sustainability. At the state level diffusion and sustainability will take the form of: a 1-day conference with plenaries and breakouts targeting administrators and related services on multi-tiered system and what works; a 2-day learning community for 10 schools on the multi-tiered system with targeted TA and incentives, and; online web hosting of state and LEA SSHS materials. Additionally, a toolkit which includes: a checklist for student supports; a sample MOU between schools and community providers for sharing student information; and, a flowchart to consider prior to administering disciplinary sanctions will be among material distributes at the conference and learning community.

The Bridgeport LEA will continue oversight activities and professional development and support for the Boys Town curriculum, Mental Health First Aid, PBIS, RULER, bullying prevention and restorative practices. The New Britain LEA will use their unspent funds to support professional development through contracts with the Anna Grace Project, Boys Town and East CONN. Funds will also be used for supplies for the pre-K through 1st grade classroom to support intentional play. Having spent their grant allotment, the Middletown LEA wrapped up their grant activities at the close of year 4 and are still contemplating sustainment activities. On-going monitoring and evaluation of the project to determine if the outcomes desired are achieved will continue in the NCE period. The evaluators will also collect and conduct analyses of available state and LEA level data to support the SSHS elements. Additional issues that the evaluation will explore include: the difference state made in the implementation of the initiative; any policy changes at state level; any increased awareness/collaboration; student outcomes from evidence-based programs implementation; whether disparities goals were met at the LEA level; and, any difference made by professional development.

This initiative will end this year.

DMHAS, in collaboration with DCF, continues to administer the federally funded Now is the Time, Healthy Transitions-CT Strong grant. This grant provides wraparound services utilizing a “whatever it takes” approach to engage youth and young adults ages 16-25 who reside in the cities of New London, Middletown and Milford and who have, or are at risk of developing behavioral health disorders.

### **SDE Response**

SDE supports initiatives addressing prevention-oriented activities that include: PBIS, SBDI, RULER and the expansion of trauma-informed practices. The CSDE in collaboration with the OEC, has developed the Social-emotional Learning (SEL) Standards for K-3

CGS 10-16b requires that schools provide to all students instruction on human growth and development, mental and emotional health, suicide prevention and substance abuse prevention among other preventive skills. The Department maintains specific health educator certification standards to ensure fidelity of instruction.

Through the Individuals with Disabilities Education Act (IDEA), Child Find is the primary systematic public effort toward early identification of at-risk children. There are more than 74,000 students in CT who have been identified and are receiving services through IDEA.

All individual school districts comply with ChildFind and each independent, whether magnet, Charter or Approved Private Special Education program all are required to continue assessing student needs to address any disability. Each identified student (74,000+) has an annual review to ensure they are having their needs met.

During the 2016-17 academic year, there were 15,977 referrals for evaluation in CT schools. 11,444 students were found eligible for services (71.6%). SDE participates in the monthly meetings of the CTSAB.

#### **Connecticut Insurance Department Response:**

The Department has been urging reporting of any and all specific children's behavioral health claim issues to CID's Consumer Affairs Division so compliance to State laws can be determined. Consumer complaints to the CID serve as an important first indicator of troubling trends or problems in the marketplace. Insurance examiners are trained in insurance statutes and regulations and are vigilant in ensuring that the insurance companies comply with these requirements when reviewing consumer complaints. The examiners can quickly spot any trends or areas of concern and escalate them rapidly to the Insurance Department's Market Conduct division. The Market Conduct division will work the issues through to a regulatory conclusion including fines and corrective actions.

#### **OEC Response**

In early 2018, OEC launched a year-long outcomes rate card pilot with Social Finance, a nonprofit organization dedicated to mobilizing capital to drive social progress. An outcomes rate card is a procurement tool through which government defines a menu of outcomes it wishes to "purchase" and the amount it is willing to pay each time a given outcome is achieved. OEC is incorporating bonus payments into a cohort of our existing home visiting programs both state and federally funded for achievement of the following outcomes:

- Full-term birth: For families enrolled prenatally before 28 weeks gestation, the child is born at 37 weeks gestation or later.
- Caregiver employment: At the time of measurement, the caregiver is employed, enrolled in education or training, or has recently graduated from an education or training program.
- Safe children: at the time of measurement there are no substantiated cases of maltreatment (other than any reported by provider staff) and no incidents of injury- or ingestion-related visits to the emergency room.

- Family Stability: For families that are identified at intake to have a demonstrated need for child care, health care, or housing, the need is met by the measurement point.

OEC is the first in the nation to pilot rate cards in home visiting.

The Birth to Three System recently moved from a bundled service delivery rate for intervention to a fee for service. This change has had a dramatic impact on Birth to Three providers as they reorganize their business planning and logistical operations. Services for families are not expected to change.

Birth to Three continues to evaluate children with behavioral concerns-and remains committed to training staff state wide on the evidence-based practice of activity-based teaming. Staff are also offered training on trauma informed care.

Over 5000 families received home visiting services in 2017. The majority of services take place in the home and, on average, families received 2 home visits per month. Four evidenced-based home visiting models are offered to families based on need and location. The four models are:

- Parents as Teachers
- Early Head Start
- Nurse Family Partnership
- Child First

Home visitors attempt to screen for developmental delays and social emotional concerns with all household children from 2 months through age five. In a given year, they administer over 6,000 screens, including screens administered at regular, prescribed intervals to the same child. Importantly, the percentage of children enrolled in home visiting who received at least one developmental screen (i.e., ASQ or ASQ SE) has increased from 57% in 2011 to 76% in 2015. Children who screen positively for developmental or social emotional concerns are referred to Birth to Three for an evaluation.

OEC has increased funding to Help Me Grow. Help Me Grow connects children and their families to community services and resources related to child health, behavior, development and learning. They serve pregnant women, parents, caregivers, social service agencies, child health providers, as well as early care and education providers. Working through Child Development Infoline 800 number, care coordinators work with families and community providers to connect them to appropriate referrals. In 2017 Help me Grow connected over 2000 families to over 3000 appropriate services.

In addition, CDI connects children and families to developmental screening if they are being referred to Birth to 3 with NO developmental concerns. DCF referrals for substantiated cases of abuse or the most common cause of this. CDI is central point of intake for all children who screen positive for developmental delays-they are then referred to a Birth to Three contracted program for a full evaluation.

OEC and United Way are partnering to bring Sparkler, a mobile developmental screening tool to Connecticut to increase the number of children under 5 being screened for developmental delays including social emotional/behavioral health issues.

OEC has provided funding to the CT Association of Infant Mental Health to offer clinical supervisors in home visiting and early interventionists at Birth to Three reflective supervision. Reflective supervision is the regular, collaborative reflection between a service provider and a clinical supervisor on the impact the work has on the service provider's thoughts, feelings and values.

### **OCA Response**

With regard to the Plan's goal of improving screening, assessment and service delivery for young children with emerging behavioral health and developmental service needs, in February 2018, the OCA, in partnership with the Center for Children's Advocacy and the Child Health and Development Institute of Connecticut, Inc. published a policy brief *Setting Young Children Up for Success: Decreasing Suspensions by Investing in Social and Emotional Development*. The goal of this policy brief is to provide best practice strategies, including local examples of effective models that will decrease the number of young children excluded from school through recommendations that will also improve children's social-emotional development and capacity to learn.

### **School-Focused Recommendations**

1. Support districts in developing curriculum and implementing CSDE's Early Learning and Development Standards (ELDS) for children up to age 5, and the "Components of Social, Emotional, and Intellectual Habits: Kindergarten through Grade 3"<sup>26</sup>, a blueprint for intrapersonal, interpersonal, and cognitive competence.
2. Adopt National School Climate Standards for all Connecticut schools.
3. Amend Conn. Gen. Stat. §10-233c to include all OEC-funded early childhood programs, including School Readiness, Smart Start, and state Head Start programs, in accordance with OEC's General Policy A-06.27
4. Amend Conn. Gen. Stat. §10-233c to narrow the exceptions to the ban of out-of-school suspensions, and instead add the option of, and provide resources to support, "therapeutic removals" to take place in the school building.
5. Require professional development and ongoing training opportunities around effective intervention strategies that are trauma-informed and developmentally-appropriate. For example, on-site coaching to support teachers in the classroom in putting these principles and interventions to use.
6. Support all districts in implementing multidisciplinary approaches to social and emotional skills-building for children, and in implementing a framework for staff team-building and social-emotional support as well.

7. Provide regional training opportunities regarding a continuum of interventions for young children with a variety of learning needs, cognitive profiles, and behavioral presentations.
8. Implement evaluation criteria for administrators/teachers that includes social-emotional measures/outcomes in order to build capacity among educators to support social-emotional development of young children.

### **Community-Focused Recommendations**

9. Expand Intensive Care Coordination for families, especially wrap-around services that support a continuum of care for families and children.
10. Eliminate regulatory barriers to school-community provider partnerships; permit reimbursement to health care providers for care coordination for children with complex needs (trauma and other identified complex mental health needs).
11. Ensure strategic planning at the state level (including the State Board of Education, CSDE, and the legislature) that includes clear strategies and measurable outcomes to be achieved for young children—attendance, discipline, school-readiness with a focus on social and emotional development, teacher preparation, and professional development. Plan should include consistent receipt of data and input from DSS, OEC, and DCF regarding their efforts to support positive youth development/two-generational<sup>28</sup> work with families who have young children
12. Strengthen and support the two-generational approach to intervention for young children—including home-visiting and Child First. Maximize federal dollar reimbursement to support expanded access to these services.

With regard to the Plan’s goal of developing, implementing and monitoring effective programs that promote wellness and prevent suicide, through OCA’s child fatality review and prevention work the OCA participates in the state’s suicide prevention work and sits on the CT Suicide Advisory Board. The OCA shares its child fatality review data with state and local partners with the goal of reducing and eliminating youth suicide.

### **OHA Response**

P.A. 16-142 created the Developmental Disability Workgroup, developed and championed in collaboration with the Office of the Child Advocate to: identify age-appropriate services and resources available for children and young adults with developmental disabilities; better understand the coordination of the various state efforts to serve this population; identify areas of overlapping services/resources, gaps in services/resources; make policy recommendations as appropriate to facilitate appropriate, cost effective delivery of services. Throughout 2017, the Workgroup invited staff from several state entities to present information about the services they provide, the populations served, and the efforts at inter-agency coordination they undertake. The Workgroup continues to meet on a regular basis, monthly when possible, and to craft a comprehensive map of how these services intersect, overlap and complement each other. The goal is to better understand the service gaps and opportunities to streamline the provision of services to

this complex population, while complying with a myriad of state and federal law and regulations, ensuring that those served received the most efficacious care in the most timely, appropriate and efficient manner.

OHA supports the expansion of the highly successful DCF-OHA collaboration, the primary purpose of which is to maximize the utilization of all available payers for services provided by state agencies to consumer. The DCF-OHA project has facilitated a greater understanding of the importance of insurance coordination of benefits rules, as well as applicable state and federal law concerning the use of government funds, through the efficient identification of consumers receiving services from a state agency with alternate payer sources. This initiative has promoted the timely and effective utilization of these sources to minimize state expenditures. As a result, OHA leadership has initiated discussions with DMHAS, DDS, CSSD and OPM, as well as conversations with the legislature, to expand this effort to identify all opportunities where the state currently pays for services that might otherwise be payable by another party. These discussion have resulted in draft legislative language to promote this expansion to all agencies delivering or paying for clinical services and, while it did not progress through the legislative process during the 2017 session, is expected to be a topic of discussion during the 2018 session.

#### **JB-CSSD Response**

The Judicial Branch participates in many interagency efforts related to health promotion, prevention, and early identification for those children referred to the juvenile court. Participation includes partnership on the following grants: the DCF-led *CONNECT*, *IMPACCT*, and *ASSERT* grants; the DMHAS-led *Now Is The Time/Connecticut Strong*; and the DMHAS/CSDE co-led *Safe Schools/Healthy Students* grant.

The Judicial Branch also participates on the Connecticut Suicide Advisory Board and has implemented the Zero Suicide Initiative, including the use of the Columbia Suicide Severity Rating Scale (CSSRS) in its juvenile detention centers and residential treatment programs. These programs undergo an annual suicide audit and suicide prevention is a focus area for continuous quality improvement.

The Connecticut Legislature has supported many of the recommendations made by the JJPOC through the passing of legislation (PA 16-147, PA 18-31) that requires the implementation of a community-based diversion system and a school-based diversion system to provide access to behavioral health services in the community and schools so that children and families can access needed services which will prevent arrest and referral to juvenile court. While the mandates have been passed, the funding to support these mandates has not been fully allocated. In addition, the Juvenile Review Boards, which service as court diversion programs in over 80 communities, will lose a significant amount of funding in fiscal year 2019.

In attempt to identify children exhibiting behavioral health challenges which have gone unidentified or untreated, the Judicial Branch screens all children referred to the juvenile court for suicidal ideation, other mental health symptoms, and trauma, when legally able to do so (once jurisdiction has been established). The MAYSI-2 and the Connecticut Trauma Screen (CTS) are used by Juvenile Probation Officers for this purpose. The juvenile detention centers screen using

the MAYSI-2 (mental health symptoms), the STRESS (trauma), the CSSRS (suicide risk), and the CRAFFT (substance misuse). Licensed mental health staff (LCSWs, APRNs, and MDs) in the detention centers work with detention staff to establish appropriate intervention plans to provide for the child's immediate mental and behavioral health needs and to develop discharge plans that provide the necessary supports upon return to the community.

The Juvenile Court and Juvenile Probation Officers have accessed to licensed mental health clinicians that provide immediate on-site crisis intervention, screening consultation, and forensic clinical assessments to assist in disposition and case planning.

Children identified as needing follow-up assessment or treatment are referred to appropriate services through the Court Support Services Division's network of contracted programs or through the community behavioral health system.

The juvenile detention centers use Positive Behavioral Interventions and Supports (PBIS) in the education program and throughout the center to support social-emotional learning of the children in detention. The Judicial Branch is moving all its contracted residential treatment programs to use PBIS as well. The detention centers also uses other approaches to promote healthy relationships and prosocial learning (e.g., Boys Council, Girls Circle, Risks & Decisions, TARGET, health groups.)

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

Of the twelve reporting agencies, nine agencies reported activities under section C.

**It is well acknowledged that the needs of children, families and communities is diverse, but all children and families need equitable access to a comprehensive array of services and supports. It is important that the system continue to build and scale up examples of what works well and identify the gaps based on need, geography or coverage.**

**Though there has been demonstrable progress it is important to note that we have not fully realized equity in access. There are many areas of the state without particular services. Additionally, loss of funding has continued to impede some access. Some improvements have been made but there have been also been some setbacks. Inequities based on insurance coverage, geography and school districts still remain.**

### **DCF Response**

DCF provides 82 beds for crisis stabilization and emergency respite services for up to 14 days through Short Term Family Integrated Treatment (S-FIT) providers. Effective access to these 82 statewide beds occurs through Mobile Crisis and Beacon Health Options.

DCF along with SDE, the Mobile Crisis Providers, and school districts throughout the state, has largely fulfilled the requirement in PA 13-178 to execute MOA's between Mobile Crisis providers and the local school districts in their service areas.

DCF continues to expand access to Modular Approach to Therapy for Children (MATCH), an evidence based outpatient treatment intervention that addresses 70% of the most common presenting problems in children seeking mental health outpatient services.

DCF continues to expand access to Cognitive Behavioral Intervention for Trauma in Schools (CBITS); an evidenced based treatment model for children suffering from post-traumatic stress symptoms as a result of trauma experiences in their lives

DCF continued its collaboration with DMHAS to disseminate Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT) throughout the state after the federal funds that launched this effort expired. DCF has continued to support A-SBIRT.

DCF has continued collaborating with DMHAS, CSSD, CSDE, Beacon Health Options, youth and families, other SAMHSA grantees in CT, the CT Alcohol and Drug Policy Council (ADPC), and technical experts.

DCF continues to implement activities related to the ASSERT grant. The ASSERT grant provides funding for CT to implement the IMPACCT comprehensive statewide strategic plan for substance use. This program funds improvements in treatment for adolescents and transitional aged youth (age 12-21 years) with substance use disorders (SUD) and/or co-occurring substance use and mental health disorders by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. It also supports infrastructure improvement and direct treatment service delivery and brings together stakeholders across systems to strengthen an existing coordinated network to enhance/expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices (EBPs), and implement financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment, and recovery support system.

### **DDS Response**

Funding to Behavioral Services Program (BSP) has partially been re-established and there is no longer a BSP waitlist. New individuals are being accepted into BSP services. As of July 30, 2018, DDS supports 377 individuals age 9-21 in BSP.

The DDS/DCF MOA has been updated. This MOU formalizes the departments' mutual commitment to work together to ensure that each child receives appropriate services. A DDS Central Office liaison has been assigned to work with DCF so that there is cooperation and consistency across departments and regions.

DDS staff continue to routinely participates in the following committees, which focus on issues relating to the behavioral health of children:

- Weekly complex case rounds with Beacon Health for children and adolescents
- Quarterly meetings with DMHAS
- Restraint/Seclusion Prevention Workgroup
- Quarterly oversight meetings with Adelbrook, Inc.

- Quarterly meetings with DCF on age-outs
- The DDS central office Director of Family Support Strategies meets with the regional IFS Assistant Regional Directors and managers on a monthly basis (sometimes bimonthly) to deal with IFS issues, BSP, family grants and helpline services.
- Children’s Services Committee to discuss clinical feedback and suggestions on appropriate services that may be available for the most complex children’s cases
- Early Childhood Cabinet
- Multiple autism services-related committees, which often take on topics overlapping with behavioral health issues discussed in other forums
- Connecticut’s Children’s Behavioral Health Plan Advisory group
- Various Birth to 3 groups, DSS committees, family advocacy groups, and various other overlapping committees that address services for children.

### **DSS Response**

DSS is currently developing a specialized Intensive Care Management model for youth with ID and/or ASD who get stuck in the ED or on inpatient unit. This model should be operational in September 2018.

### **DPH Response**

The CT Title V program recognizes the value of providing adolescents with appropriate, comprehensive, timely health care and related services as well as the challenges to both adolescents in respect to access and providers in respect to appropriate prevention and screening. We also recognize the importance of efficacious transition to all aspects of adult life, including health care and related services. In addressing the needs of adolescents, the CT Title V program strategies emphasize supporting Adolescent Wellness

(including comprehensive well child visits) and process improvement for the transition to adult life – inclusive of the identification of primary care providers for Youth with Special Health Care Needs. The School Based Health Centers supported through a state line budget as well as MCHBG funding, were used as an infrastructure in promoting comprehensive adolescent well child visits, inclusive of developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and BMI screening and intervention.

DPH supported 93 school health service sites in 28 communities statewide through a state budget line item as well as federal funds. Included are 82 School Based Health Centers (SBHC) and 11 Expanded School Health (ESH) sites. Eligible students are those that attend the schools in which the SBHC is located. All DPH funded SBHCs provide primary care, mental/behavioral health services and health education/promotion activities designed to meet the physical and psycho-social needs of children and youth within the context of family, culture and environment. In some instances, dental care is also offered. All SBHC and ESH sites offer some level of behavioral/mental health services and/or risk reduction education. All sites provide some form of behavioral/mental health screening, referral, counseling and linkage to additional outside services if necessary. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards.

The school based health service sites serve as the principal vehicle for promotion and improvement of adolescent health services with more than 26,848 students (unduplicated users) receiving one or more service visit per year. The number of visits to the SBHCs total more than 120,874 per year. Numbers of screeners completed is 8,370 with 864 found to be at risk, approximately 10% at risk. Services include, but are not limited to: anticipatory guidance, health assessments, including comprehensive physical exams, health screenings and risk appraisals, individual and group health counseling, diagnosis and treatment of acute illness and injury, management and monitoring of chronic diseases including, but not limited to asthma, obesity and diabetes, administering immunizations, providing age appropriate reproductive health care as appropriate, laboratory testing and prescribing and administering medications, follow-up and referral to community based health providers or medical home for needed services outside the scope of SBHC practice.

Mental/behavioral health services include, but are not limited to: assessment, diagnosis and treatment of psychological, social and emotional problems, crisis intervention, individual/group/family counseling, psycho social education, advocacy and case management, outreach to students at risk and referral to community based providers/organizations to address needs outside the scope of SBHC practice. DPH staff presented at the CT SAB to increase awareness of the SBHCs as a resource for suicide prevention and intervention. CCCM provided a detailed training on the Protective Factors Framework on May 3, 2017 at the annual statewide care coordination forum: Building Networks, Building Stronger Families.

Data is currently being collected from SBHC (available in early 2019) that show the number of student and staff trainings provided with number of participants.

### **DMHAS Response**

The CT Strong grant engages youth and young adults (16-25) who reside in the cities of New London, Middletown and Milford who have or are at risk of developing behavioral health disorders. Utilizing a wraparound services model, the youth and young adults are connected to services and supports. The project coordinates public awareness, outreach and engagement strategies, as well as addresses system wide coordination and policy issues.

DMHAS is collaborating with DCF in developing a comprehensive plan for adolescent substance use treatment over the next two years.

DMHAS has established four ACCESS centers throughout CT that offer services to youth who would not necessarily be identified as needing the intensive level of care provided by Young Adult Services. One of the goals of this service is to connect youth with appropriate treatment and community support services. All of the access centers have exceeded goals for number of youth served and for outreach and community educational initiatives

DMHAS YAS staff participates on the State Personal Responsibility Education Program (PREP) Advisory Board with DCF, DPH, Department of Education and other stakeholders, which focuses on how to deliver education to young people on preventing pregnancies and how to establish healthy relationships. Since 2010, PREP has had a successful history of reducing teen pregnancy and risk taking behaviors in at risk youth in foster care and other high risk populations.

Connecticut's Safe Schools Healthy Students (SSHS) Diffusion Initiative uses a school and community partnership model. These partnerships create safe, drug -free and productive environments across all settings for social and emotional learning and promote healthy physical development and academic success. The SSHS partnership model connects state policy development and implementation of SSHS programs at the school district and community level. The State Management Team (SMT) assembles diverse stakeholders including parents and representatives from education, mental health and substance use, public health, juvenile justice, social services, child and family protective services, family advocacy and youth development. The SMT process supports the wide spread adoption and operation of SSHS programs to extend the benefit beyond Connecticut's three initial SSHS school districts. In support of developing a process for planning services, the SSHS project has developed a template for social workers, psychologists, school psychologists and other professional staff to collect student level behavioral health data within the school setting. SSHS has also developed a template for a MOU between schools and community partners to facilitate individual level data sharing about behavioral and mental health services for children.

### **SDE Response**

Title IV, Part A of the Every Student Succeeds Act (ESSA) requires every qualified district to perform a Needs Assessment to determine the best use of funds, including student support activities – allocation for FY2017-18 is \$3,250,250.

Title IV, Part A will nearly triple its allocation in 2018-19 to \$9,032,214, allowing districts to identify additional funds to address student needs.

Youth Service Bureaus (YSB) provide direct services designed to provide supports and build assets for youth, including special populations, such as justice involved youth, youth with mental health needs, other youth at risk, and youth needing services to enhance their education and career advancement. In 2017, YSBs served 275,718 students through 3,060 programs. *2017-18 State Funding: \$2,545,456.*

Family Resource Centers (FRC) are comprehensive, integrated, community-based systems of family support and child development services located in public school buildings. They operate 58 sites in 41 communities serving 7482 families (9025 children and 7239 adults) and 174 early care and education providers. FRCs provide access, within a community, to a broad continuum of early childhood and family support services that foster the optimal development of children and families. 2017-18 funding \$580,000.

Neighborhood Youth Centers provide athletic and recreational activities, enrichment or tutoring activities, skills training in problem-solving, decision-making, conflict resolution, peer counseling and life skills; parent involvement in planning the grant initially and on an ongoing basis; youth involvement, including, but not limited to, input into the planning and management of the program and youth leadership development activities; and maximum use of existing neighborhood services for youths. *2017-18 funding: \$438,836.*

School Climate Transformation Grant (SCTG): supporting schools' ability and capacity to support students' behavioral health, growth and development, learning capacity, teaching strategies and learning environments: served 178 schools 2015-2018 through the Tiered Fidelity Inventory, including 1420 student interviews and 740 staff participants a no-cost extension year, Safe

Schools/ Healthy Students (SS/HS) served 31,367 students attending 49 schools and programs located in 2 districts.

The Diversion Initiative (SBDI) works to reduce juvenile justice involvement among youth with mental health needs through building connections with community agencies, increasing staff understanding of youth mental health and improving disciplinary responses. It is currently supporting 18 schools in 6 districts, potentially impacting 14, 798 students. Producing 33% decrease in court referrals (statewide decrease is 6%)

Primary Mental Health Program (PMHP) is an evidence based program that helps children in pre-k through third grade adjust to school, gain confidence, socials skills, and focuses on learning. It currently serves 22 schools in 18 districts providing services to approximately 800 pre

Title IV, Part B: After-school programs that include behavioral health components Pre-K to Kindergarten students.

U.S. Department of Education Dual Capacity-Building Framework: expanding school family-community partnerships to improve schools' ability to support students and families for improved academic success and social-emotional health. This parent engagement element is an important component of any comprehensive curriculum.

Mental Health First Aid for Youth training is an option available to schools for professional development.

Mobile Crisis (EMPS) has 198 out of 206 school districts with an MOU in place with their mobile crisis provider.

Schools with SROs are required to have MOUs with their local law enforcement department

### **Connecticut Insurance Department Response:**

Connecticut is widely considered to be a leader in parity. P.A. 13-3, P.A. 15-5, and P.A. 16-158 are laws that have helped Connecticut continue to promote mental health parity and ensure that Connecticut residents have access to these important services.

Network availability for child behavioral health treatment in the commercial insurance market continues to be a concern due to the shortage of health care providers in this field. Further, provider reluctance to become part of networks in Connecticut and throughout the country is well documented.

CGS 38a-472f has given the Department the responsibility to review the adequacy of commercial insurance networks. Carriers are required to maintain adequate arrangements to assure that covered members have reasonable access to participating providers located near the member's home or workplace.

Mental Health Providers for children is one of numerous categories that are reviewed to determine adherence to CMS requirements for Time and Distance standards based on county size and population density.

## **OCA Response**

With regard to the Plan's goal of building an adequate continuum of behavioral health care services that has the capacity to meet child and family needs, the OCA's individual and systems work on behalf of children with complex developmental disability and their families has emphasized the need to improve the available service array. The OCA has underscored the need for families to have access to high-skilled care coordination. The OCA is also working with stakeholders to discuss the need for a more effective crisis-response and care coordination model for families whose children are experiencing their first behavioral-health related crisis and may be presenting to the local emergency department. The state is making progress but many service gaps remain throughout the state for children with developmental disability and co-occurring behavioral health treatment needs. Workforce development remains an urgent area in need of ongoing attention.

With regard to strengthening the role of schools in addressing the behavioral health needs of students, the OCA continues to assess school capacity to meet the needs of children who have experienced significant trauma and/or have mental health needs. OCA advocates both individually for children for whom a concern about the efficacy or quality of education is reported, and systemically to promote classroom and school safety and child well-being. During the past year, OCA has published an issue brief describing concerns with widespread utilization of homebound instruction considered the *most restrictive* educational setting under federal law.

The OCA continues to advocate for improved service delivery for minors served by the state's juvenile justice and adult criminal justice systems. We are in the final stages of producing a report for the legislature on conditions of confinement in juvenile detention centers and Manson Youth Institution (CJTS closed 4/2018).

## **JB-CSSD Response**

The juvenile justice Local Interagency Service Teams (LISTs) serve as planning boards to inform the state agencies of the local needs for those children at-risk or involved with the juvenile justice system. There are 12 LISTs throughout the state, which are connected to a juvenile court/juvenile probation office.

Each juvenile court has access to the same complement of programs contracted by the Court Support Services Division (CSSD) to address the delinquency risk factors and needs of children referred to juvenile court. The continuum of services includes cognitive-behavioral therapies offered at the Child, Youth, and Family Support Centers (CYFSC), Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), psychiatric medication management (HomeCare), Adolescent Community Reinforcement Approach (ACRA), mentors, treatment for inappropriate sexual behavior, and flex funding to support prosocial interests and basic needs. Children and families are also referred to trauma-focused cognitive-behavioral therapy (TF-CBT), Intensive In-home Child and Adolescent Psychiatric Services (IICAPS), and other outpatient services offered by Child Guidance Clinics.

The Court Support Services Division also offers an array of residential programs to provide short-term stabilization (HAMILTON) and residential treatment (TRAC, Intermediate Residential, REGIONS) in order to address delinquency risk factors and needs that require a period of out-of-home care. CSSD also refers children and families to S-FIT programs for stabilization, assessment, and wraparound planning to address psychiatric needs. Court-involved children are referred to

psychiatric residential treatment facilities (PRTF) and inpatient hospitals as needed through the behavioral health system.

CSSD offices and providers will access Mobile Crisis Services as needed and encourage families to do the same.

The Judicial Branch continues to partner with DCF, CSDE, and DMHAS to support the School-based Diversion Initiative (SBDI) to work with high-arrest schools to reduce exclusionary discipline practices and to utilize mobile crisis services, teacher and staff training, and the use of graduated responses and restorative practices to address disruptive school behaviors without the need for police intervention. The Child Health and Development Institute (CHDI) through the SBDI project provides behavioral health training to school personnel to assist in the identification of students in need.

CSSD has implemented the Zero Suicide Initiative in its juvenile detention centers and residential treatment programs to create a culture of suicide prevention. Other disciplines at CSSD (Adult Probation, Juvenile Probation, Family Relations) are learning about the Zero Suicide Initiative in an effort for the agency to become fully informed and embrace a culture of Zero Suicide.

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

Of the twelve reporting agencies, three agencies provided a response under section D.

**The input gathering process for the plan repeatedly acknowledged the important role primary care plays in the lives of children and youth. This section represents efforts to promote and advance greater integration between primary care and behavioral health.**

#### **DCF Response**

DCF continues to contract with Beacon Health Options to oversee ACCESS Mental Health. ACCESS-MH CT provides telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program allows for face-to-face consultations when a telephone consultation with a child psychiatrist and/or clinician is not sufficient to completely address the PCP's questions. Care coordinators and family peer specialists assist in obtaining identified services. The three "hub" providers contracted to provide the services are Wheeler Clinic, The Institute of Living, and Yale Child Study Center.

ACCESS MH has continued to see an increase in utilization. In addition to the direct consultation, the Hub teams provide training throughout the year to further support physicians. Training topics in the last fiscal year included; Screening Tools in Primary Care, Pharmacogenetics, Addressing Vaping and Juuling in Primary care and Bereavement and Fostering Resilience in Children.

To continue to build on the feedback and subsequent recommendation regarding increased support to pediatric practices, key stakeholders have continued to examine the barriers that interfere with

co-location between pediatric and behavioral health care. Such a process will inform actions relative to what, if any, legislative, regulatory or licensing issues need adjustments

### **DDS Response**

DDS Program Review Committee (PRC) process continues to review behavioral health supports provided to the individual and the number of medications that the individual was prescribed, as well as a review of any aversives, including restraints.

### **JB-CSSD Response**

Medical and mental health staff in the detention centers and residential programs meet weekly to review the needs of each child. Services are offered in an integrated manner and every child leaves with a discharge plan for follow-up in the community. The discharge plan is provided to the family and the Juvenile Probation Officer for implementation.

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

Of the twelve reporting agencies, five agencies reported activities under section E.

**This section provides an overview of the ways in which the child and family serving systems individually and collectively are examining service delivery and outcomes through a cultural, linguistic and racial justice lens. In various ways, systems are focusing on this critical issue recognizing the ways there has and continues to be disparate and disproportionate outcomes for children and families of color, those who speak different languages and are from different ethnicities.**

### **DCF Response**

DCF continues to facilitate and oversee the workgroup for the implementation of the national CLAS standards and racially just activities. (see workgroup description above)

DCF continues its commitment to address racial inequities in all areas of practice through multiple concurrent strategies. Much of that work was codified into state law this past legislative session. This includes: reviewing services with a focus on race and ethnicity for those referred, those served and their outcomes associated with their completion of the service. Additionally, DCF is currently utilizing technical assistance from individuals with experience with racially just child welfare and health care practices and the national *Culturally and Linguistically Appropriate Services* standards (*CLAS*).

### **DMHAS Response**

DMHAS Young Adult Services has been working on insuring that youth are included in all aspects of programs development. Youth advisory boards have been established at the young adult program sites. Staff has received and continues to receive training on youth culture and issues that impact youth's access to care.

DMHAS' substance use workgroup has continued to meet every other month over the past year. Membership included YAS OOC Managers, YAS staff from a number of agencies, representatives from CT Strong, the Hartford Dispensary and peer advocates. The meetings followed a "Community Practice" model. Each meeting featured a speaker presenting on an aspect of substance use treatment relevant to young adults. Some of the models presented included: A-CRA, the Seven Challenges, SBRIT and SMART Recovery. There were 2 subgroups that also met.

The Clinical subgroup was tasked with making recommendations for intervention models that would be most applicable to DMHAS YAS settings. This group continues to meet at least every other month with the goal of presenting written recommendations to YAS OOC leadership by 10/18.

The Peer Subgroup included young adults and others involved in peer run organizations who identified settings in the community that were accessible and targeted to young people with substance use issues. The last peer group was held in 5/18.

Young Adult Services has also provided additional funding to Advocacy Unlimited (AU) to develop and implement a Statewide Young Adult Warmline and to hire a Young Adult Recovery Support Coordinator. The Warmline is a phone-based peer support resource for young adults to connect to community resources, find motivation to move forward in life, and gain inspiration through the hope offered by operators who demonstrate the positive outcomes of recovery. Activities and events that are geared to the developmental trends, culturally relevant and generational experience of emerging adults are also offered. The position of Young Adult Recovery Support Coordinator is a dual position that is shared with the Young Adult Services (YAS) Division of the Department of Mental Health and Addiction Services (DMHAS). In addition to carrying out the operations of the Warmline, the overarching goal of this position is to encourage the involvement of young adults in the planning, implementation, and evaluation of programming across the state. This includes working collaboratively with AU emerging adult staff, systems leaders, and DMHAS YAS leadership to strengthen the voice of young people across levels of care.

Connecticut's SSSH initiative leverages the efforts of its Office of Multicultural Healthcare Equality (OMHE) to address health and education disparities and assures that cultural competence is an integral quality of all services provided through the initiative. In support of this goal, SSSH is developing operational guidelines/standards for collecting student level behavioral health data.

### **DPH Response**

DPH contracts have cultural competency language embedded.

SBHC contracts have language to recruit and maintain a culturally diverse staff reflective of the clients served and all staff receive training in the area of cultural competency through presentations, print, workshops, etc., and report data on trainings.

Cultural competency training is a continuing education requirement for licensed mental health clinicians including those working in SBHC's.

SBHC contract language includes policy and procedures for the provision of interpreter or translation services, and non-English client related materials including SBHC forms

### **SDE Response**

Each LEA recipient of Title IV, Part A funding is required to perform a needs assessment. Every LEA receiving more than \$30K must complete a comprehensive needs assessment every 3 years.

Currently, SDE uses analysis of its data to identify LEAs requiring assistance in addressing disproportionality and issues of cultural sensitivity.

Since 2013, the CEEDAR Center at the University of Florida and the CSDE have collaborated with pilot higher education institutions, CCSU and SCSU, to analyze and reform teacher preparation curricula to ensure training in evidence-based practices in literacy (reading and writing), culturally responsive teaching and clinical experiences. When revised curricula are implemented, the pilot institutions must then measure impact of pre-service candidates.

### **JB-CSSD Response**

CSSD is requiring adherence to the CLAS standards in its new residential and community-based contracted programs.

The Judicial Branch has an extensive limited English proficiency (LEP) initiative that works to address the communication needs of clients. Access to interpreters and the use of language-line services is available to all Judicial Branch staff.

CSSD monitors referral activity, program utilization, and service completion rates for clinical assessments, inpatient evaluation, CBT, MST, MDFT, and other services by gender and race/ethnicity to identify disparate access to care or outcomes. The availability of Spanish-speaking service providers, in particular, is continuously monitored and new means to attract and retain such personnel remains a priority and challenge for CSSD.

The Judicial Branch is committed to addressing implicit bias in court personnel's decision making and raising awareness of how unconscious bias impacts interactions with clients, the identification of needs, responses to behavior, access to care, and access to justice. CSSD continues to offer a training series related to cultural competence and responsiveness for all employees and offers additional workshops on understanding and working with specific populations.

CSSD has engaged in an initiative with the Ceres Policy Institute to pilot SOGIE data collection in the two juvenile detention centers and two juvenile probation offices. SOGIE is the collection of data related Sexual Orientation, Gender Identity, and Gender Expression. The initiative will allow CSSD to pilot the inclusion of five questions related to orientation, identity and expression and train staff to work more effectively with children based on their expressed gender orientation and identity.

## **F. Family and Youth Engagement**

Of the twelve reporting agencies, six agencies provided a response under section F.

**Fortunately, there is increased awareness about the benefit of family and youth engagement as full partners in all realms of work, whether that be; obtaining partnership on systems improvements, receiving critical feedback to make the systems better, serving as an advisory board member, participating in policy development or serving as a peer support in a service delivery model. Systems across the state in various ways have embraced the opportunity to more actively and authentically engage family and youth in the scope of their work.**

### **DCF Response**

DCF continues to partner with FAVOR, to support the Family and Youth Engagement workgroup. The goal of the workgroup is to increase mental health awareness by partnering with parents, caregivers, emerging adults, adolescents and youth with the goal of integrating family and youth voice into the statewide Children's Behavioral Health System.

FAVOR completed another round of community conversation throughout the state. 210 adults participated along with 88 youth in 33 separate conversations. The feedback from those community conversations will be developed into a report and reported back to the local communities.

### **DDS Response**

DDS continues to contract with the CT Family Support Network (CTFSN) to provide outreach to families who do not receive waiver services from the department. CTFSN and DDS partnered with FAVOR to implement six Community Conversation meetings aimed at gathering information from DDS families who have a child who experiences behavioral health concerns. We anticipate receiving a final report soon from FAVOR which summarizes the feedback obtained from families during these meetings. DDS has also partnered with CTFSN and FAVOR to develop a new statewide BSP support group for families who want to connect with other families who experience similar challenges. A second support group is in development in the Torrington area.

Three informational videos titled, "Understanding ID", "Understanding ASD", and "Positive Behavior Supports for Developmental Disabilities", are being developed by a team of DDS psychologists. The completed videos will appear on the DDS website and on YouTube for individuals, caregivers, and providers to access.

DDS continues to partner with DCF, DMHAS, Beacon Health and BRISC to offer trainings to EMPS mobile crisis providers on proactive and reactive strategies to use in work with I/DD children and families.

### **DPH Response**

SBHC contract has language for an Advisory Board to include a parent of a student enrolled in DPH SBHC.

CT Medical Home Advisory Council has active parent members including parents who have children and youth with behavioral health needs.

DPH supports parents through the partnership with the CT Family Support Network.

DPH recommends parents to attend the National Conference of the Association of Maternal and Child Health Programs.

### **DMHAS Response**

The DMHAS YAS program continues to support the web based project developed through the South West Regional Mental Health Board called TurningpointCt.org. TurningpointCT.org is a technology based approach to engaging youth and young adults in mental health/recovery services. The web site is youth driven and managed. The result has been a web based resource for adolescents, young adults and families who are looking for answers regarding mental health issues, sharing of stories and resources for help. The number of followers on this site continues to increase.

The Now is the Time-Healthy Transitions, CT Strong grant incorporates a Peer Support and Advocacy component to engage young adults and support family members. Each wraparound team in the grant funded cities of New London, Milford and Middletown has a Peer Advocate and Family Advocate as part of the team. Additionally, the grant funds a Peer Advocacy Coordinator who works with the Project Director and the local teams to bolster and enhance Peer Advocacy efforts throughout the state.

The Youth Advocate and Outreach Specialist for the CT Strong grant has assembled a group of youth leaders from across CT whose vision is to ensure that “Every young person will achieve a healthy transition into adulthood.” The group, Youth Leaders Partnership, is driven by young adults who promote culturally appropriate services by building relationships and bridging systems to enhance outcomes for youth in the community. Young Adult Leaders presented at the Child, Adolescent and Young Adult Behavioral Health Research and Policy Conference in Tampa Florida on diverse strategies for systems to engage youth to create youth driven programming.

DMHAS Young Adult Services has also provided additional funding to Advocacy Unlimited (AU) to hire a Young Adult Recovery Support Coordinator. The position of Young Adult Recovery Support Coordinator is a dual position that is shared with the Young Adult Services (YAS) Division of the Department of Mental Health and Addiction Services (DMHAS). The goal of this position is to encourage the involvement of young adults in the planning, implementation, and evaluation of programming across the state. This includes working collaboratively with AU emerging adult staff, systems leaders, and DMHAS YAS leadership to strengthen the voice of young people across levels of care.

The SSHS initiative offers opportunities for parents to participate in more meaningful ways across the project. Parents are members of the state and community advisory councils and help to identify ways in which the project benefits their families and schools.

### **SDE Response**

The Commissioner's Roundtable is a group of 30 members tasked with advising the SDE on issues and policies related to family and community engagement and recommends effective practices to be adopted by LEAs.

The Parent Trust Fund, overseen by SDE, supports 5 models for developing parent leadership initiatives, including the Parent Leadership Training Institute. 2018-19 allocation is \$267,193.

The Young Parents Program provides day care services for the infants/toddlers of students enrolled in and attending school, as well as parent guidance and family skills for the mothers/fathers.

### **JB-CSSD Response**

CSSD puts much attention on youth and family engagement through its recidivism reduction efforts, particularly through client and family engagement staff training, the use of motivational interviewing, and strengths-based case planning and case management.

CSSD is highly successful in engaging families in Case Review Team meetings, home visits, and discharge planning. Families are surveyed annually by the Juvenile Probation Department and semi-annually by the Juvenile Detention Centers.

CSSD, together with DCF, has committed to family engagement as a priority for the LISTs which work at the local level to raise awareness about the needs of at-risk and court-involved children, youth and families. Each of the 12 LISTs has family member participation and gears efforts and events towards family engagement and education.

CSSD continues to increase family partner involvement at the policy and program development levels, as well. CSSD is working with DCF and other stakeholders to partner with existing statewide youth and family groups to inform policy, program and effective practice.

### **G. Workforce**

Of the twelve reporting agencies, six agencies reported activities under section G.

**Workforce development continues to remain a priority and an important component of sustaining the improvements that have been made. It is essential to strategically support workforce development. Connecticut needs to continue to avoid creating stand-alone training activities without supporting comprehensive cross-training, coaching, and continuous quality improvement. There are multiple examples of the systems shift to enhanced workforce development. This acknowledges that the issues faced by children and families can be multifaceted and complex and as such it is critical to arm teams with specialized supports and knowledge.**

## **DCF Response**

DCF continues to facilitate and support the Workforce Development workgroup. The goal is to ensure that families/caregivers, and youth are full partners in all aspects of the planning and delivery of their own care/services and in the policies and procedures that govern care for all children and youth in their community.

The following training curriculums have been developed and offered throughout the state:

- a. Network of Care - Agents of Transformation*
- b. Persuasive Story-Telling*
- c. Data 101*
- d. CONNECTing Youth*

Additionally, collaboration and partnerships have been developed with organizations who offer other trainings for parents, caregivers and youth; including the following:

- a. Youth Mental Health First Aide*
- b. Parent Leadership Training Institute*
- c. Foster Grandparents Program*

*Future Health Care Professionals*

## **DDS Response**

Three informational videos titled, “Understanding ID”, “Understanding ASD”, and “Positive Behavior Supports for Developmental Disabilities”, are being developed by a team of DDS psychologists. The completed videos will appear on the DDS website and on YouTube for individuals, caregivers, and providers to access.

DDS continues to partner with DCF, DMHAS, Beacon Health and BRISC to offer trainings to EMPS mobile crisis providers on proactive and reactive strategies to use in work with I/DD children and families.

## **DMHAS Response**

DMHAS YAS continued to collaborate with UCONN on a grant from HRSA to provide internships for 18 second year or advanced placement master level social worker’s in young adult programs. This project ended in 2018. UCONN will continue to offer internships in YAS to social work students interested in working with this population. Pre and Post surveys indicate that the students have gained considerable knowledge about this population and feel much more confident working with this age group than they did prior to placement.

## **OCA Response**

The OCA’s work on behalf of families and children with disabilities has led to findings that extensive workforce development needs still exist *across all child serving systems* with regard to the assessment and service delivery for children with complex developmental disabilities. OCA issued findings related to workforce in a recent child fatality investigative report (Matthew Tirado) regarding risk and vulnerability assessment and mitigation across multiple child-serving entities. OCA has subsequently convened an interagency (OCA, DCF, DDS, OEC, SDE, UCEDD and UConn) working group to further assess workforce learning and practice.

OCA is an active member of the Hartford Public Schools Monitoring Advisory Group-established in response to the 2017 report by the OCA of widespread noncompliance with mandated reporting requirements. In addition, OCA's investigatory work has resulted in the district's decision to contract with outside experts to assist them in improving their services to children with complex developmental disabilities.

OCA continues its collaboration with the CT Interagency Restraint and Seclusion Prevention Initiative. The committee has continued to expand to include critical stakeholders such as educators, private service providers, and persons with lived experience. Monthly meetings provide opportunities for information and idea exchange as well as planning for an annual conference.

### **JB-CSSD Response**

CSSD staff receives pre-service and annual refresher trainings on a variety of topics, including but not limited to, adolescent development, behavioral health disorders and effective treatments, the impact of trauma on behavior, and suicide prevention.

A focus of program development and staff training has been related to the transfer of the DCF juvenile justice function and the delivery of services to the previously committed delinquent population. CSSD has developed a residential treatment program model for children presenting with the most serious juvenile delinquency risk factors.

### **CWCS Response**

CWCS also oversees the Parent Leadership Training Institute (PLTI). Below is a sketch of the impact of PLTI in 2017:

- PLTI: graduated 130 parent leaders in 8 communities: Stamford, Danbury, Bridgeport, Milford, Waterbury, West Hartford, Hartford, and Windsor Locks. The parents completed civic community projects in the areas of health, education, and safety.
- Child Leadership Training Institute: graduated 80 child leaders in 4 communities.
- 2Gen Parent Academy: 75 parents from the Hartford region attended.
- A PLTI graduate led an effort to successfully pass [HB 5190](#) regarding custody for care.

## Stake Holder Submissions

### School Mental Health:

#### **Submitted by the Trauma-Informed School-Based Mental Health Task Force**

On behalf of the Trauma-Informed School Mental Health Task Force, the following set of recommendations are presented for consideration by the Commissioners of the Department of Children and Families and the State Department of Education to address and improve trauma-informed school mental health systems and services statewide. The Trauma-Informed School Mental Health Task Force is a collaborative group with a mission of promoting a comprehensive framework for a statewide trauma-informed infrastructure that integrates behavioral health services and school and community supports. Participating organizations include: the Child Health and Development Institute (CHDI), the University of Connecticut Collaboratory on School and Child Health, the Capitol Region Education Council (CREC), Clifford Beers Clinic, the Ana Grace Project, the Injury Prevention Center at Connecticut Children’s Medical Center, the Department of Children and Families, and the State Department of Education. These recommendations have developed over the past year from our work following a “Symposium on Trauma-Informed School Mental Health” in May 2017 at the University of Connecticut that we co-sponsored and attended by over 100 school, mental health, and community leaders from across the state to address childhood trauma, it’s impact on a child’s education, and innovative evidence-based strategies for responding to children who have experienced trauma or have behavioral health needs. We are committed to advancing and supporting these recommendations to support the vision that Connecticut schools and children will be the healthiest in the nation.

#### **Recommendations**

- 1) Implement the School Health Assessment and Performance Evaluation (**SHAPE**) System to support school mental health needs assessment and resource mapping.
  - a. The SHAPE System is a free, web-based tool to support schools and districts in identifying strengths and areas of need with respect to the core domains of school mental health quality and sustainability. All Connecticut school districts should be required or strongly encouraged to complete the SHAPE System assessments to address school climate, mental health needs, and available resources to support schools and communities. Through the collaborative efforts of this team and with technical assistance from the University of Maryland Center for School Mental Health, approximately 20 Connecticut schools/districts have already engaged in the SHAPE System as of July 2018.
- 2) Adopt a statewide **data dictionary** to operationalize terminology such as Social Emotional Learning (SEL), trauma-informed, and school mental health to promote consistency in language and to guide the state in developing a common framework for advancing this work across systems and disciplines.
- 3) Develop a comprehensive, evidence-based, tiered **framework** to structuring, implementing, and evaluating trauma-informed school mental health services and supports, which is required to disseminate a statewide model of care.
- 4) Develop a system of **workforce development** and support across multi-tiered systems for school staff, administration, behavioral health providers, and families to build awareness, knowledge, and skills in trauma-informed practice and self-care.

- a. This system must include additional training, coaching, and on-going support with opportunities to collaborate with others in similar roles and provide an action plan for schools/districts to address system capacity, systems understanding, leadership, and a model of shared accountability and quality improvement to be most effective.
- 5) Develop **policy** at the state level to drive integration, expansion, funding, accountability, and sustainability of trauma-informed school mental health work moving forward.
- a. Leadership support and buy-in across all levels of school administration and support from community partners, legislators, and funders are necessary for developing, financing, and sustaining a common framework for trauma-informed school mental health in Connecticut.

For additional information concerning these recommendations or the Trauma-Informed School Mental Health Task Force, visit <https://csch.uconn.edu/trauma-informed-school-mental-health/> or contact the co-chairs: Jeana Bracey, Ph.D., Child Health and Development Institute ([bracey@uchc.edu](mailto:bracey@uchc.edu)) and Sandy Chafouleas, Ph.D., Neag School of Education, University of Connecticut ([sandra.chafouleas@uconn.edu](mailto:sandra.chafouleas@uconn.edu)).

## **Early Childhood**

### **Submitted by the CT Help Me Grow Advisory Committee**

Connecticut's [Help Me Grow system](#), a model being replicated throughout the country, has been in existence for 15 years. The HMG system ensures that families with young children at risk for negative outcomes have access to information, support and resources. The goal of this Advisory Committee is to build, in partnership with families and entities that have a similar focus, a coordinated early childhood system that supports developmental screening, early identification and linkages to services and supports.

Committee members are experts, from a variety of vantage points, in early childhood. Last year, the Advisory Committee recommended that greater attention be paid to prevention, early identification, and the promotion of development.

Below are our 2018 recommendations as well as our 2017 recommendations with updates on the work that has been accomplished over the past year. We continue to advocate for the CT Children's Behavioral Health Plan to embed and support these recommendations as they are reflective of Public Act 13-178, specifically around: A. Employing prevention-focused techniques, with an emphasis on early identification and intervention; B. Ensuring access to developmentally-appropriate services; C. Offering comprehensive care within a continuum of services.

### **Recommendations 2018**

A Tri-Chair of the CT Children's Behavioral Health Plan Advisory Committee to serve on the HMG Advisory Committee.

In the messaging and promotion of services, acknowledge and address the issue of stigma as a barrier to seeking help. Normalize behavioral wellness and avoid perceived negative labeling.

Utilize technology and other innovative ways to encourage developmental promotion and screening, such as the [CDC's new Milestone Tracker app](#) and the [Sparkler app](#), currently in development.

Offer screenings of the film, *Resilience: The Biology of Stress and the Science of Hope*, as a forum for discussing how to identify and address the impact of toxic stress. For example, the HMG Advisory Committee was awarded a license to offer screenings of the film from Bridgeport Prospers, Bridgeport's Cradle to Career Strive Initiative. With guidance and support from Bridgeport Prospers, the film was screened by the HMG Advisory Committee in May, which created a ripple effect for how the film would be used by Committee members' organizations, which include using it to reach legislators, families, direct service providers, and Board members and management staff of state, municipal and community-based agencies.

## **2017 RECOMMENDATIONS-UPDATES**

Create a marketing campaign on the benefits of early detection that targets both families and providers.

### **Update:**

- In partnership with Project LAUNCH, a new [HMG Developmental Screening brochure](#) has been developed and is being promoted throughout the state. The overall brochure message celebrates how a child grows and develops.
- As indicated on the HMG Developmental Screening brochure, the tagline "Healthy from Day One" is being promoted on messaging materials with the goal of reinforcing a consistency and continuity of early childhood services available to Connecticut families. The CDI website has the [Healthy from Day One](#) brochure and additional Healthy from Day One information for families (and providers) at <https://cdi.211ct.org/healthyfromdayone/>

Increase routine screenings as early as possible.

### **Update:**

- The Norwalk/Child Development Infoline Early Childhood Initiative, using the Ages and Stages Questionnaire (ASQ-3), is establishing a system of developmental screenings for children from birth to age 5 with the goal of ensuring that children enter kindergarten developmentally ready to learn. ASQ screenings are currently being done through the City's School Readiness programs and home visiting services. It is also included as part of the kindergarten registration packet.
- On June 19 the HMG Advisory Committee, in partnership with the Department of Public Health's (DPH) State Health Improvement Plan's (SHIP) Developmental Screening Work Group; the University Center for Excellence in Developmental Disabilities; Project LAUNCH; Wheeler Clinic; Child Development Infoline; and the Office of Early Childhood, sponsored the *Screening to Succeed Conference, An Early Childhood Call to Action for Communities to Promote Developmental Awareness and the Power of Community Connections*. It was a well-attended (by over 100 people) and well received conference. The planning committee is now working on supporting the

communities that are acting on the call to action around promoting developmental screenings and using the Ages and Stages Questionnaire.

Maximize the use of Child Development Infoline (CDI) as the state's centralized access point for identifying children with developmental and behavioral health concerns and connecting them and their families to services as needed. NOTE: CT's centralized intake via CDI/Help Me Grow is featured nationally in the joint report issued in January 2017 by the U.S. Department of Education and the U.S. Department of Health and Human Services entitled *Collaboration and Coordination of the Maternal, Infant, and Early Childhood Home Visiting Program and The Individuals with Disabilities Education Act Part C Programs.*

**Update:**

- All the new messaging materials use CDI as a point of contact for more information and assistance.

Develop mechanisms to track and measure the impact of this work.

**Update:**

- The HMG Advisory Committee and the member agencies represented on the Advisory Committee are working in collaboration with the Developmental Screening Work Group of DPH's State Health Improvement Plan (SHIP), which has a SHIP Objective to increase by 10%, the percentage of parents who complete standardized developmental screenings tools consistent with the American Academy of Pediatrics (AAP) guidelines. To achieve this objective, a range of strategies focusing on families, providers and systems have been developed and many are reflected in the updates within this document.
- Based on the 2016 National Survey of Children's Health, the percent of children, ages 9 through 35 months, who receive a developmental screening using a parent completed screening tool in the past year is 28%. We are working on increasing the percentage of ASQ completed and supporting children and their families by offering tiered interventions designed for children who are developing on track, may need some additional supports or, based on the ASQ score and input from parents, are referred for an evaluation.
- Some of the sources providing the data being used to measure efforts to achieve this developmental screening objective include: Child Development Infoline, the Child Health and Development Institute, the Office of Early Childhood Family Support Services (home visiting programs and Birth to Three) and the State's Act Early Ambassador at DPH. The data are posted on DPH's data dashboard, which serves as a tracking mechanism of DPH's State Health Improvement Plan (SHIP).

Support and advocate for policy (legislative and administrative) identified by the Early Childhood Workgroup that ensures there is adequate awareness about and access to services directed toward prevention, early identification and promotion of development.

**Update:**

- The Norwalk Early Childhood Council established a policy requiring School Readiness programs to include the ASQ as part of their enrollment and re-enrollment process.
- The Norwalk Public School District has included as a requirement for Kindergarten registration a completed ASQ.

**APPENDIX B**

**Early Identification and Screening and Fiscal Mapping Data  
Prepared for the CT Children’s Behavioral Health Plan  
2018 Annual Progress Report**

**Initial Findings Early Identification and Screening Capacity**

Screening Information  AGENCY	Age Range of clients	Evidence Based screening tool	Evidence informed and/or Informal screening	Follow up action steps identified	No screening capacity*
Office of Early Childhood (OEC)	0-5; parents	✓		✓	
Dept. of Education (SDE)	0-21	✓	✓	✓	
Dept. Children & Families (DCF)	0-21; parents	✓	✓	✓	
Department of Public Health (DPH)	0-21	✓		✓	
Dept. Social Services (DSS)	0-21	✓		✓	
Dept. Developmental Disabilities (DDS)	8-21	✓	✓		
Dept. Mental Health & Addiction Services (DMHAS)	15-18	✓	✓	✓	
Court Support Services Division (CSSD)	7-21	✓		✓	
Commission on Women, Children & Seniors (CWCS)	All				✓
Office of the Healthcare Advocate (OHA)	All				✓
Office of the Child Advocate (OCA)	0-21		✓	✓	
CT Insurance Department (CID)	All				✓

*\*No screening capacity means that they do not currently have a mechanism to identify and refer children for potential behavioral health concerns.*

**State Agency Fiscal Mapping Data Collected for fiscal years 2015 and 2016**

Agency	Fiscal Mapping data submitted	Type of data submitted
Office of Early Childhood (OEC)	✓	All programs & services
Dept. of Education (SDE)	✓	Select programs & services
Dept. Children & Families (DCF)	✓	All programs & services
Department of Public Health (DPH)	✓	Select programs & services
Dept. Social Services (DSS)	✓	Paid claims data
Dept. Developmental Disabilities (DDS)	✓	Select programs & services
Dept. Mental Health & Addiction Services (DMHAS)	✓	Select programs & services
Court Support Services Division (CSSD)	✓	Select programs & services
Commission on Women, Children & Seniors (CWCS)	✓	FTE estimate
Office of Health Advocate (OHA)	✓	FTE estimate
Office of Child Advocacy (OCA)	✓	FTE estimate
CT Insurance Department (CID)	✓	FTE estimate

**APENDIX C**  
**Public Comment**

The 2018 Connecticut Children’s Behavioral Health Plan Progress Report was posted for public comment on the [www.plan4children.org](http://www.plan4children.org) website from Friday 9/21/18 to Thursday 9/27/18. No Public Comments were received.