**DCF Senior Administrators Meeting**
**5/28/14**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

Increasing Access to Care and Coordination of Care

- Currently what works well requires DCF involvement which often equates to extreme need. Families shouldn't need to become system involved.
- Increase opportunity and access earlier on for children and families.
- Adequate network, single point of access and quality control.
- Single point of access: Call one place - one location - ASO - not working the way it should.
- Single point of access - who to call - has to be managed well.
- Incentives need to be aligned
- We need an adequate network that matches the population seeking services
- Communication, coordination and access
- We need to increase care coordination
- Need behavioral health service that meet all populations needs.

Structuring and Financing Mental Health Care

- We need to reshape how we operate. Promote multi-state agency collaboration including CSSD and SDE, financially and administratively contributing to one entity
- Structural point of view needed to delineate between public and private operation - we have a balance and not enough discipline between the two. Create fiscal discipline regarding "Pay for Success". People rewarded for good outcomes.
- Structurally delineate roles - (public & private) operational/government, not enough delineation/clarity between the two.
- Wraparound idea = CPSSA. Kansas at ½ of case rate per member. 5% of kids in congregate care. Structures inside state government made it difficult for government to move in right direction. 2.) Structural case management model is not correct model for behavioral health issues that are longer term. Our model works well in short term. Case management model is not our model
- Structurally - case management model to address alleged child abuse and neglect is not designed to meet the long term and chronic needs of children and families. Very different model from a care coordination model
- Involvement of commercial insurers - what is their philosophy.
- Commercial insurance - lack of access to care.

- Small communities need to have a role and a responsibility in the behavioral health system. JRB - not funded. No robust community support. Communities to be motivated and take responsibility for behavioral health and welfare of their residents.

Prevention and Early Intervention

- Prevention needs to be fundamental.
- Earlier intervention
- Prevention – Creativity
- Track better/intervene earlier

Family Engagement and Cultural Competence

- Families need to drive their plans
- Operationalize cultural competency.
- Ask kids themselves what works and what didn't?
- Cultural competence - language issue, look at the needs of Black/African-American families.

Cross-Systems Collaboration

- DCF will not solve everything. Partnerships are needed. People using DCF for cover rather than understanding their role and responsibility - some over reliance
- **Pediatricians** - more emphasis on behavioral health in the medical school curriculums, enhanced training for nurse practitioners, system integration
    - Goal is to see that PCP's are educated and integrate at that level. Allows access to Care
    - Coordination, Birth to Three and child development. Practical ideas needed
    - Integrate care with Primary Care Physicians: start in med school and partnering with other system partners, opportunities for integration
    - Pediatricians/SDE appear to be resistant to partnering
    - PCPs and schools create accountability to behavioral health issues, is their accountability tied to accreditations? They are 1st responders and have a great opportunity and play a critical role.
- Need to ensure accountability with other entities and their mandates and responsibilities.
- More holistic view of all systems impacting families.
- **Emergency Departments.** ED's are not prepared to care for youth with mental health needs. They do not do engagement well. We need to track better and intervene in EDs earlier. ED's are not prepared to adequately assess and coordinate. They don't know what is available and how to coordinate care.
- **Law enforcement** partnership needed - issues relative to overrepresentation of people of color and disproportionality. Who gets behavioral health services vs. who goes down the criminal justice track and how is that determined
- **Early Childhood Care:** Childcare/daycare issues; kids thrown out of daycare; efforts to improve using Behavioral Health consultants; licensing is important consideration

- **Child Welfare.** Mandated report - lack of knowledge about legislative requirements. Public policy issue - what we should be delineating as roles and responsibilities doesn't mean that Child Welfare shouldn't be the "lead organization".

The Role of Schools and SDE

- Improve the role of schools interacting with behavioral health system.
- Role of schools - reflect on their approaches -too much emphasis now on children and "fixing" them vs. teachers roles, contributions and approach. Should obtain surveys from young people
- Schools should be involved. PBIS, what we think children should do, not staff. School climate is important. Gather more information on school climate from students/young people/children on how they see the school. More information and framing on human behavior, behavioral health, kids well being
- Concerns regarding schools. 2000 kids under age of six were suspended. That's a failure. Suspect that behavioral health issues and disproportionate number of kids of color or minority. We are failing. External meetings need SDE at the table. DCF is not the only system who touch children, more school based health clinics needed. Be the norm. We can't go looking for behavior health issues either.
- Need to see SDE as active participant at many tables
- Further support and utilization of School health clinics to help make behavioral health a more normative part of understanding and helping children.
- Region 2 has an opportunity based on new federal award - school based wrap. All too often see pilots but it's unclear how well these pilots are sustained and scaled up.
- SDE is doing their thing, and DCF is too - we need to work together.

Data and Outcomes

- Not enough recognition of what works well.
- Identify and determine which service delivery outcomes are better if delivered through the public vs. the private sectors.
- Develop services by real measureable data.
- Providers need to be held accountable. Nurses, physicians, social workers need to share their information about the kids and families.
- Data on quality are needed, and importance can't be understated - better connections

Public Awareness

- We need to consider a public and social marketing campaign. Describes roles and responsibilities, who does what, and that it's everyone's job. Informing people regarding where to go. Legislature - who had their own struggles with where to go and how to navigate. Need a campaign for money and social marketing plan.
- Separate plan/funds to support message.

Clinical Services

- More diagnostic clarity with release of DSM-V.

- Need to start testing kids on spectrum.  Spectrum disorder - better understanding, the right service types and building capacity.  Service array for kids on spectrum is limited and discussion is needed.
- We may not have trained clinicians to lead "the system".  More trained clinicians needed to drive the system.
- Assessment rooted in short term not long term needs.
- Substance using youth - more services needed.