Connecticut Children's Behavioral Health Plan

Executive Summary

Overview

As many as 20%, or approximately 156,000, of Connecticut's children have mental health needs that would benefit from treatment; yet many of these children are not able to access services.[1] Families experience a number of barriers to treatment including a highly fragmented system in which access varies according to such factors as involvement in child welfare or juvenile justice, insurance status, race and ethnicity, language, and geographic location. In addition, the continuum of care lacks sufficient inclusion of supports for all children and families that promote nurturing relationships and environments and foster mental wellness. A comprehensive plan is required to guide the efforts of multiple stakeholders in developing a children's behavioral health system that builds on existing strengths and addresses the many challenges that exist.

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children's Behavioral Health in fulfillment of the requirements of Public Act 13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012.[2] The legislation called for development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." This Plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and promote healthy development for all our children.

Public Act 13-178 directed DCF to include in the implementation plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

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;
D. Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;
E. Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;
F. Establishing results-based accountability measures to track progress towards the goals and objectives;
G. Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;
H. Improving the integration of school and community-based mental health services;
I. Enhancing early interventions, consumer input and public information and accountability by: (i) in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes; (ii) in collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program; and (iii) in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

> *A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.* [3]

The Institute of Medicine (IOM) framework aligns services and resources along a continuum that includes universal services for all children to promote optimal social and emotional development; selective services (e.g., early identification, early intervention) for children at high risk for developing a behavioral health condition; and indicated services for treating those with serious and complex disorders. The continuum of care is used to organize the planning and implementation of a system that will meet the needs of all youth and their families.

The theory of change driving this plan is that a children's behavioral health system based on the system of care core values and principles will result in improved health outcomes. Three core values drive the development of a system:

- **Family-driven and youth guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally and linguistically appropriate**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and mechanisms for care coordination, with families and youth as full participants in the governance of that system.

How the Plan Was Developed

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR, Inc., family advocates from the African Caribbean American Parents of Children with Disabilities, Inc. (AFCAMP), and consultants from Yale University took lead roles in input gathering activities, in partnership with CHDI staff. A Steering Team and an Advisory Committee oversaw the process. The core elements of the input gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth

- Open Forums held in six locations and attended by 232 individuals
- Facilitated Discussions on 12 specific topic areas, attended by 220 individuals
- Website input forms submitted by over 60 individuals and groups
- A review of background documents and data pertaining to the children's mental health system in Connecticut

The process yielded the identification of seven areas that will result in significant improvements to the children's mental health service system in Connecticut:

A. System Organization, Financing and Accountability
B. Health Promotion, Prevention, Early Identification, and Early Intervention
C. Access to a Comprehensive Continuum of Care
D. Pediatric Primary Care and Mental Health Care Integration
E. Disparities in Access to Culturally Appropriate Care
F. Family and Youth Engagement
G. Workforce Development

The Plan presents a set of goals and key strategies for each of the seven areas, which are summarized below. Readers are encouraged to reference the full report for more detailed information that includes background information and summarizes the findings that inform each of the goals and strategies.

Implementation Plan: Goals and Strategies by Thematic Area

A. System Organization, Financing and Accountability

Implementing an enhanced children's behavioral health system of care will require a significant re-structuring with respect to public financing, organizational structure, integration of commercial payers, and data reporting infrastructure. Each of these areas is described below.

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

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

1. Establish a process to guide the redesign of the publicly financed system.
2. Identify existing spending on children's behavioral health.
3. Determine opportunities for re-alignment of funds or more efficient funding approaches.
4. Identify mechanisms for pooling funding across all state agencies.
5. Identify a full continuum of services and supports that will comprise the children's mental health system of care.

Goal A.2. Create a network of "care management entities" to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" can improve outcomes for children and lower costs of behavioral health services.[4] Care management entities have the potential to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies, and reduce costs by disseminating information on behavioral health services, connecting families to services, and providing ongoing care coordination. This will help improve the family's experience of a culturally and linguistically appropriate system with a single point of access that helps families access information and navigate care. Strategies include the following:

1. Design and implement a care management entity to implement with fidelity an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.
2. Develop a family support clearinghouse to increase access to information about available mental health services and improve supports for mental health system navigation, consistent with legislation in Public Act 14-115.

Goal A.3. Systematically examine the major areas of concern regarding commercial insurance for children's behavioral health.

Given that insurance companies and self-insured employers currently cover approximately 70% of children and youth, their participation in the children's behavioral health system of care is critical. Concerns about behavioral health services for children and families with commercial insurance arose in the majority of meetings held to gather input into Plan development. Those concerns can be categorized in the following five areas: adequacy of coverage for selected services; adequacy of coverage for selected conditions; appropriateness of medical necessity criteria and utilization management procedures; adequacy of the provider networks; and perceived cost shifting to individuals and the state.

Based on the redesign of the publicly financed system, the incorporation of a care management entity, and the demonstration of outcomes and cost savings, the commercial insurance sector will be incentivized to participate in the children's mental health system of care. Strategies include the following:

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

Goal A.4. Develop an agency and program wide integrated behavioral health data collection, management, analysis, and reporting infrastructure across an integrated mental health system of care.

A core element of PA 13-178 is an emphasis on data and incorporation of results-based accountability. Implementation of the behavioral health system of care requires full attention to the development of data infrastructure for the purposes of monitoring and improving access to services, service quality, outcomes and costs. At the practice level, the collection, analysis, and reporting of data is already an element of evidence-based treatments; yet many other behavioral health services do not currently benefit from systematic data collection, analysis, reporting, and quality improvement activities. Successful approaches in the state include the Performance Improvement Center model,

which has not yet been taken to scale to support all service categories. Specific strategies in this area include the following:

1. Convene a Data-Driven Accountability (DDA) committee grounded in new legislative authority to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.
2. Utilize reliable standards to guide the new data collection, management, and reporting system.
3. Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing children's mental health services.
4. Increase state agency staff capacity to analyze data and report results to the system, providers, and youth and families.

B. Health Promotion, Prevention and Early Identification

Goal B.1. All children will receive age appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

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

1. Provide training and financial incentives for pediatric primary care, education (including early education), and home-visiting service providers to use standardized screening measures and to document results and communicate findings with relevant caregivers and providers.
2. Connect all children who screen positive for developmental and behavioral concerns to further assessment and intervention, using existing statewide systems to identify appropriate resources when needed.
3. Expand use of the Ages and Stages Questionnaire: Social Emotional (ASQ-SE) to assist parents to promote social and emotional development and identify mental health needs and concerns for their young children.
4. Align screening efforts and strategies with the emerging strategies of the State Innovation Model (SIM) and the Early Childhood Comprehensive Systems (ECCS) initiative.

Goal B.2. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in partnership with families, recognizing risk factors and early signs of social-emotional problems and mental illness, and connecting all children to services appropriate for their stage of development.

Providers who work with children need to have specific and developmentally appropriate competencies to assist in mental health promotion and prevention, and to recognize and respond to early warning signs of concerns. As those who work with young children need very specific training and have the opportunity to make the biggest difference in setting children on the right developmental trajectory, the Plan suggests beginning with this group of providers. In addition, there is a wealth of expertise and programmatic efforts in Connecticut to train early care and education and school personnel on the promotion of social and emotional development and identification of mental health

concerns in school settings that could benefit all children if taken to scale statewide. The following key strategies are recommended:

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

2. Review current education-based efforts to increase the ability of providers/teachers to promote healthy social and emotional development in early childhood environments for children birth to five, and in schools for grades K-12, and develop plans to coordinate these efforts to take them to scale to meet the need statewide.

C. Access to a Comprehensive Continuum of Care

Goal C.1. Build and adequately resource an array of behavioral health care services that is appropriate to child and family needs, accessible to all, and equally distributed across all areas of the state.

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

Stakeholders identified the following services as needing expansion:

- Promotion, prevention and early intervention services including social and emotional skill development and promotion of nurturing family and community environments;
- Non-traditional, non-clinical services that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, mental health symptoms;
- Outpatient care provided at Child Guidance Clinics;
- Crisis response services including Emergency Mobile Psychiatric Services (EMPS) and crisis stabilization units;
- Intensive treatment options including Extended Day Treatment, Intensive Outpatient, and Partial Hospitalization Programs;
- Child and adolescent psychiatric evaluation and medication management;
- Services and supports for children with autism;
- Substance abuse services;
- Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches.

Strategies in this area include the following:

1. Conduct ongoing needs assessment at the local and regional level to identify gaps in the service continuum.
2. Create and implement a service development and financing plan to guide the build-out of the full continuum of services in the system of care.

Goal C.2. Expand crisis response and treatment services to address high utilization rates in emergency departments.

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

1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services.
2. Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services.
3. Connect expansion of EMPS with an expansion of crisis respite beds throughout the state.

Goal C.3. Strengthen the role of schools within the array of behavioral health services to address the mental health needs of students.

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

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

Strategies in this area include the following:

1. Develop and implement a plan to expand and finance school-based mental health services.
2. Develop and implement a mental health professional development curriculum for school personnel.
3. Require formal collaborations between schools and the community.

D. Pediatric Primary Care and Mental Health Care Integration

Goal D.1. Strengthen connections between pediatric primary care and mental health services.

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

1. Support co-location of mental health providers in child health sites by ensuring public and commercial reimbursement for mental health services provided in primary care without requiring a definitive mental health diagnosis.
2. Support the development of educational programs for mental health clinicians interested in co-locating in pediatric practices.
3. Require child health providers to obtain Continuing Medical Education (CME) credits each year in a mental health topic (similar to the requirement for child abuse).
4. Ensure public and private insurance reimbursement for care coordination delivered by pediatricians, mental health clinicians, or staff from sites working on behalf of medical homes.
5. Reform state confidentiality laws to allow for sharing of mental health information between health and mental health providers.

E. Disparities in Access to Culturally Appropriate Care

Goal E.1. Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Families and other stakeholders in the children's behavioral health system identified a number of concerns regarding disparities in access to culturally and linguistically appropriate services. At the broadest level, families expressed a lack of awareness of and access to culturally and linguistically competent services and supports in the existing mental health care system. Families requested an expansion of the workforce and the service continuum to include staff that are from the same community and speak the same language as the families they serve, as well as enhanced access for families in the most rural areas of the state. Culturally specific marketing, stigma reduction, and related materials are needed, along with training provided to all mental health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs) of each family, in accordance with Culturally and Linguistically Appropriate Services (CLAS) standards.[5] Although specific strategies are offered in this section, additional attention to disparities and cultural and linguistic competence are addressed in other sections of the report. Specific strategies in this area include the following:

1. Conduct needs assessments at the statewide, regional, and local levels to identify gaps in culturally and linguistically appropriate services.
2. Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.

3. Require all service delivery contracts to reflect principles of culturally and linguistically appropriate services.

Goal E.2. Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of the population across the service continuum.

Specific strategies in this area include the following:
1. Enhance training and supervision in cultural competency.
2. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.
3. Integrate cultural competence into professional credentialing processes for providers.
4. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

F. Family and Youth Engagement

Goal F.1. Include family members of youth with behavioral health needs, youth and family advocates as paid members in the governance and oversight of the behavioral health system.

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

1. Increase the number of family advocates and family members who serve as paid members on the statewide governance structures of the children's behavioral health system.
2. Expand the capacity of organizations providing family advocacy services at the systems and practice levels.
3. Increase the number of parents who are trained in the "Agents of Transformation" curriculum to ensure that families develop the skills to provide meaningful and full participation in system development.
4. Provide funding to support community conversations, public forums and the Plan website to ensure ongoing feedback into system development.

G. Workforce Development

The topic of the workforce emerged from almost every discussion held as part of the planning process. The concept of workforce is used broadly in Connecticut with respect to children's behavioral health. It includes but is not limited to: licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care

and peer support. Concerns related to workforce included: shortages of key professionals or skills in the current workforce; lack of training capacity, including ongoing coaching, monitoring, and reinforcement in order to maintain skills; sufficient access to information for parents; and the lack of adequate knowledge among every sector of the workforce about children's behavioral health conditions and resources to address these conditions. Goals and strategies related to workforce development are reflected in 11 strategies across most of the thematic categories in the Plan so are not called out separately here.

Implementation

In order to turn this Plan into reality, legislative action is highly recommended to fully authorize DCF and other key agencies and systems to ensure that the most urgent plan components are implemented in the short term and a detailed work plan, financing strategy and timeline are in place to implement the longer term strategies. We recommend the creation of a Children's Behavioral Health Implementation Team to guarantee integrated, coordinated efforts as well as full transparency and meaningful engagement of all stakeholders, including families and youth. Each core initiative will be documented on a searchable web site with clear goals, progress benchmarks, and reporting of all actions and results. These individual component reports will be "rolled up" into a Children's Behavioral Health Dashboard that will clearly report progress on a range of system and outcome measures.

Conclusion

Children and families in Connecticut currently experience significant barriers to achieving mental wellness and accessing quality behavioral health care. Throughout every element of the information gathering process, it was clear that Connecticut can and should do better to meet those needs. The process for developing the Plan yielded a comprehensive set of goals and strategies that will require a significant commitment of time and resources with the full participation of all key partners in the public and private sector and a deep commitment from state government, communities, families and youth to reach full implementation over the next five years.

[1] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[2] Connecticut PA 13-178 State Mental Health Planning Initiative. See www.plan4children.org.

[3] Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[4] Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[5] U.S. Department of Health and Human Services, Office of Minority Health (2013). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* Washington, DC: U.S. Government Printing Office.