

Connecticut Children's Behavioral Health Plan

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Connecticut Children’s Behavioral Health Plan

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I. Introduction

A. Legislative Charge: PA 13-178

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children’s Behavioral Health Plan was prepared by 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 2012.¹ 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.” While developed under the guidance of DCF, this Plan reflects extensive public input and discussion over the last eight months and aspires to be the Plan owned by the diverse set of stakeholders who will make it a reality.

There are approximately 784,000 children under age 18 in Connecticut, constituting 23% of the population. Every child deserves the opportunity to achieve mental wellness by growing up in nurturing and supportive homes and in communities and schools that promote optimal social and emotional development. Yet, as many as 20%, or 8approximately 156,000 of Connecticut’s children have a diagnosable mental health symptoms that would benefit from treatment.²³ The lifetime prevalence for any mental disorder for 13-18 year olds is 46.3%, with 21.4% having a “severe” disorder.⁴ Exposure to trauma or Adverse Childhood Experiences (ACE) is a growing concern, with a recent study suggesting that two-thirds of children have at least one adverse childhood experience and 10% have five or more.⁵ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports the prevalence rates for substance abuse by age 17 as more than 30% for marijuana and more than 60% for alcohol.⁶ Additionally, according the DCF’s data, an average of more than 60% of boys in the CT Juvenile Training School (CJTS) over the past three years had a substance use diagnosis.

Yet an estimated half of children who struggle with mental health or substance abuse problems in any given year do not receive treatment. Extensive work remains in our current system to ensure compliance with federal and state mandates regarding promotion, prevention, and early identification, access to care, parity between mental health care and medical care, and access to treatment in the least restrictive environment.

On the whole, the State of Connecticut has made tremendous strides in building a more responsive publicly funded behavioral health service system in recent years that includes an array of school, center and home-based services (See Section III.B and Figure I.1). Ninety-four child guidance clinic locations have been designated as Enhanced Care Clinic sites with increased reimbursement for providers committed to achieving a set of pre-defined service improvements. Twenty-six System of Care (SOC) collaboratives across the state supported by care coordinators work with cross-sector child and family teams to individualize treatment planning for children with SED. State-supported School-Based Health Centers (SBHC) have expanded in numbers to 65 and many more are supported through other means, including hospital and community-clinic partnerships and

Table 1.1 Coverage Status of Connecticut Children Under Age 18

Coverage Category	Percent	Number of Children
Covered by private commercial plans subject to State coverage mandates	31.8%	249,000
Covered by private plans of self-insured employers (not subject to State mandates)	31.8%	249,000
Covered by public plans (HUSKY A, HUSKY B, other)	32.4%	254,000
Uninsured	4.0%	31,000
Total	100.0%	783,000

NOTE: These are estimates based on multiple sources to provide a sense of proportions in each system, not exact numbers. Sources: U.S. Census, American Community Survey, 2012 (denominator); CT Department of Social Services, CT Department of Children and Families.

bringing additional pediatric and family mental health providers and clinicians into Connecticut schools. There is more attention to the behavioral health needs of very young children through such interventions as Early Head Start/Head Start, Birth to Three, the Early Childhood Consultation Partnership, Child First and the Infant Mental Health Endorsement. There is a much stronger presence of family advocacy and family and youth participation in governance and service delivery through strong statewide and community family advocacy organizations. Through the Connecticut Behavioral Health Partnership (CT BHP), resources and services for children enrolled in Medicaid are much more efficiently and effectively managed through an Administrative Services Organization.

Notwithstanding these significant improvements and reforms for children served through the public sector, too many families with children in need of immediate behavioral health services continue to struggle with a fragmented system that is difficult to understand and navigate and lacking in basic capacity across the continuum of services. In this fragmented system, identified roadblocks for accessing care include a diffuse network of payers, differing categorical and financial eligibility criteria, restrictions on covered services, and inconsistent standards for clinical practices. Access issues are compounded by inadequate training for specific diseases and disorders as well as the statewide lack of trained personnel. Policymakers have, in turn, faced a barrage of constituent complaints about the lack of complete and clear data on the current system and a conflicting array of prescriptive actions for remedying the situation.

This Plan provides Connecticut with a unique and timely opportunity to align policy, practice and systems development, building on the strengths in the current system and addressing the weaknesses that exist to ensure that all children have access to effective behavioral health prevention, treatment and support. DCF, as the State's children's mental health authority, was designated as the lead agency to develop and submit this Plan in consultation with families and youth, representatives of the children and families served by the Department, providers of mental, emotional or behavioral health services for children and families, advocates, and others interested in the well-being of children.⁷

Public Act 13-178 directed DCF to include in the implementation plan, at a minimum, 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 outlined in this section and sections 2 to 7, inclusive, of this act;
- 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 behavioral health services; and
- 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.

While this Plan builds on many recent analyses, recommendations, and previous plans (see Appendix B, Bibliography), its main distinguishing factor is that it addresses the entire public and private children's behavioral health system, approached from the standpoint of the families and children who rely on these services. It seeks to build an integrated, comprehensive system that delivers needed services to all children in the most efficient and effective manner, regardless of system involvement, payment source, race and ethnicity, age, geography or any other factors.

Although the State has made great strides in reforming the publicly funded components of the system through the CT BHP,⁸ this Plan recognizes that only about 25% of children in the State are covered by that system (Table 1.1). Further complicating matters, of the estimated 64% of children covered by private plans, only half are in plans that are subject to state-level public mandates related to coverage. Larger companies that are self-insured cover the remaining children. Companies who self-insure their employees are covered by federal law (ERISA) but are subject to limited state oversight.⁹ A shrinking but still significant segment of children, ranging from 2-6% depending on location,¹⁰ remain uninsured due to immigration status or other factors. Families in all three covered categories and the uninsured utilize many of the same providers and systems, with variation in access and services offered.

This plan will address these challenges directly, reflecting a growing determination across sectors to create a behavioral health service system that provides all Connecticut's children the best start in life. The development of the Plan was funded through a public/private partnership including DCF, the Connecticut Health Foundation, the Children's Fund of Connecticut and the Grossman Family Foundation.

B. Plan Structure

Section II provides an overview of the current system as reflected in available data, background and history of selected recent efforts to develop the children's behavioral health system and the main findings from the extensive community discussions and stakeholder input. Section III presents the conceptual framework used in the Plan including the System of Care principles guiding the Plan design. Section IV presents the detailed implementation plan by the seven thematic areas identified through the input gathering process. Section V discusses Implementation and Section VI presents a brief conclusion.

C. Methods

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate the information gathering process and the preparation of the Plan. DCF and CHDI established the Connecticut Children's Behavioral Health Plan Advisory Committee to guide the development of the Plan (see inside cover for membership). A Steering Committee composed of DCF and CHDI staff, a FAVOR family advocate, and experts from Yale University monitored progress, reviewed input, and examined the results of a number of current and recent planning efforts (see inside cover for individuals involved). CHDI developed a Plan website, www.plan4children.org, to share information about PA 13-178, upcoming events and opportunities for input, summaries and notes from the information gathering and Advisory Committee meetings and to allow the public to monitor Plan development and provide feedback on drafts.

The Planning Team gathered input from families, youth, advocates, providers, and recognized experts over the course of three months, from March – June, using the following strategies:

- **Website Input.** Individuals and groups with an interest in the children's behavioral health system were asked for input through a structured feedback questionnaire that could be entered through

the website, completed and emailed, or mailed to CHDI. Forty-five individuals and 19 groups submitted comments on a range of topics.¹¹

- **Open Forums.** Six forums open to the public were held across the state and attended by a total of 232 individuals. The Forums were publicized on the plan website, in the media, and through email blast communications to numerous listserv operated by a variety of stakeholders. Each Open Forum included Spanish and American Sign Language translation as needed by attendees. One or more Advisory Committee members attended each Open Forum.
- **Network of Care Community Conversations.** FAVOR, Connecticut's non-profit Statewide Family Advocacy Organization, and AFCAMP organized a total of 26 family and community meetings on the Plan. These sessions engaged youth with behavioral health needs and their families in large and small cities and towns across the state. These Community Conversations, co-facilitated by FAVOR Family System Managers and family members, involved a total of 339 adults and 94 youth. Community Conversations were held in English and Spanish. The Community Conversations were initially developed as part of the SAMHSA-funded CONNECT System of Care Expansion Planning Grant that was being implemented simultaneously to this Plan's input gathering activities, creating opportunities for synergy.
- **Facilitated Discussions.** A series of Facilitated Discussions was held across the state on various topic areas. A total of 220 individuals participated in these opportunities including invited stakeholders, experts, and family members with specific expertise in the topic. Facilitated Discussion topics included the following:
 - The Juvenile Justice System and Mental Health
 - Infant and Early Childhood Mental Health
 - Crisis Response and Management
 - The Child Welfare System, with the DCF Senior Team
 - The Education System and Behavioral Health
 - Autism Services and Supports
 - Coordination of Care
 - The Role of Commercial Insurance
 - Evidence-Based Practices
 - Substance Abuse and Recovery
 - Law Enforcement and Behavioral Health
 - Keep the Promise Children's Coalition

Crosscutting themes were identified and integrated into the discussions rather than addressed independently. These themes were: 1) cultural competence; 2) access to services; 3) workforce development; 4) family engagement; 5) developing the network of care; and 6) data systems and infrastructure.

- **Review of Background Documents and Data.** The Planning Team reviewed extensive documents from a number of intensive planning processes and ongoing initiatives, which are listed in Appendix C and referenced in Section II.B. The team also reviewed national reports and systems building efforts in other states (e.g. New Jersey, Indiana).

Although it would have been useful, there was not sufficient time or resources in the planning process to conduct surveys of hospitals, child guidance clinics or to update detailed analyses of Medicaid data.

In addition to the input gathering activities above, five Advisory Committee meetings were held to review progress and obtain guidance and feedback on the process, the emerging themes, and the Connecticut context that would further inform the Plan.

Results of the input gathering process were used in developing the Plan and are available at the Plan web site.

II. The Current System

A. Quantitative Description of System

U.S. Census data indicate that Connecticut has 783,945 residents under the age of 18. Data from the CT BHP indicates enrollment of 253,659 youth under age 18, or 32.4% of the population. State employees are Connecticut's largest group of individuals covered by self-insured/employer-sponsored plans. According to the Office of the State Comptroller, in Calendar Year 2013, there were 38,728 children under age 18 covered by the state's health insurance plan. All of these children had behavioral health coverage, and 6,654 (17.2%) used behavioral health services during the year.

Quantitative indicators of mental health service utilization can help inform an understanding of the current children's mental health system and the issues in that system. Utilization of crisis services (e.g., emergency departments), for example, is one way to assess the overall functioning of the children's mental health system. High rates of Emergency Department (ED) utilization for behavioral health concerns suggest a mental health system that is not sufficiently meeting the needs of children and their families. ED utilization is likely influenced by a number of additional factors, including, but not limited to: increased recognition and awareness among families and schools of mental health symptoms; demand for services that exceeds the supply of services; historical patterns of service utilization; lack of information or access to appropriate community-based services; and fragmentation associated with multiple payers and systems that provide mental health care.

National data suggests an alarming increase in the number of youth presenting to EDs for behavioral health treatment, with one study indicating an increase of 26% from 2001 to 2010.¹² A review of Connecticut data indicates a similar trend.

The CT BHP continues to monitor data and utilization of EDs among Husky enrolled youth with behavioral health concerns. A recent study examined information on all eligible Medicaid youth ages 3-17 years in Calendar Years 2011 and 2012. Those data suggested a 30% increase in behavioral health ED utilization between 2011 and 2012. The study found that DCF-involved youth, even though they make up only 2.6% of the state population, accounted for 22% of all behavioral health ED visits.

Data from Emergency Mobile Psychiatric Services (EMPS) also provides insight into overall utilization of crisis mental health services. EMPS is one of the only behavioral health services in Connecticut that is accessible to all children in the state, regardless of system involvement, insurance status, or geographic location. In Fiscal Year 2014, 62% of youth served by EMPS were enrolled in Medicaid and 32% were privately insured. In addition, more than 80% of children served by EMPS in FY 2014 had no DCF involvement. Recent results from EMPS further support a high demand for crisis-oriented behavioral health services. There were 9,455 EMPS episodes of care in Fiscal Year 2011 and 12,367 episodes in Fiscal Year 2014, a 31% increase. Most referrals to EMPS during that timeframe came from families (43.0%) and schools (34.6%).¹³

Current pressures in the statewide behavioral health system are seen in the wait lists at various levels of care; however, data on wait lists are not systematically collected across levels of care or across systems and payers.

These data support the contention that Connecticut is in need of significant reforms that emphasize promotion of social and emotional skills, the ongoing development of a comprehensive service array at all

levels of care, and a number of other supports that reduce the burden of mental health concerns that currently impact children and families across the state. Furthermore, the lack of easily accessible data is a barrier to statewide planning efforts. Systematic data collection and reporting on a common set of system-level indicators will help statewide stakeholders monitor implementation of the children's mental health system and allow for timely responses to issues that negatively affect service delivery for children and families. Ideally, those data should be integrated across insurance types and child-serving systems.

B. Developing Connecticut's System of Care, 1980 to the Present

This Plan builds on a series of efforts over the last four decades to develop a more responsive and effective children's behavioral health system nationally and in Connecticut. This section recounts in a timeline, the highlights of these efforts in Connecticut, which are fully documented in a series of plans and reports that contain a fuller description of each stage in this history.

At the national level, the Institute of Medicine, the Surgeon General, the Robert Wood Johnson Foundation, university-based centers (at Georgetown, UCLA and elsewhere), specialized think tanks (e.g., Zero To Three and ChildTrends), and others have issued a series of plans and reports that have informed Connecticut's work.

Connecticut Milestones in the Development of Children's Behavioral Health Services and Systems

- 1980:** The Department of Children and Youth Services (precursor to DCF) adopted recommendations of a broad based public private working committee that children's mental health services be described and developed according to a Continuum of Care model.¹⁴
- 1989:** Publication of the department's first ever children's mental health plan,¹⁵ including a new mission statement and operating principles.
- 1997:** The Legislature mandated the development of a "system of care" in Connecticut and articulated the guiding principles (P.A. 97-272), the genesis of the 26 local System of Care groups in operation covering all 169 towns in the state.
- 1999:** Young Adult Service Program Launched, a partnership among DCF, DMHAS, DDS, and OPM to assist with transitions from adolescence to young adulthood
- 2000:** Creation of FAVOR, a statewide family advocacy organization.
- 2001:** The Department of Social Services led a planning effort in 1999-2000 that resulted in Connecticut Community KidCare and the formation of the Connecticut Behavioral Health Partnership (BHP).¹⁶ This report identified all public funding sources supporting children's behavioral health and recommended a new structure for improving services through an Administrative Services Organization (ASO).
- 2006:** DSS and DCF launched the BHP, carving out behavioral health services from the HUSKY managed care contracts and blending it with DCF funding through an ASO (ValueOptions, Inc.) retained to manage development of and access to an integrated continuum of services.
- 2008:** Passage of the Mental Health Parity and Addiction Equity Act of 2008
- 2010:** A Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issues Mental Health Care 'Blueprint' for Children in Connecticut in June.
- 2011:** DMHAS joined the BHP, adding management of adult services.
- 2011:** Implementation of Rehabilitation Option in Medicaid allowing for reimbursement for in-home services and expansion of IICAPS (Sec 17a-22q-1)
- 2011:** DCF leadership redirected the agency to work much more closely with families and communities to assure children's health, safety, learning, and success.¹⁷ DCF policy shifted away from congregate care with a concomitant reemphasis on supporting birth families and relative foster family care when a child must be placed out of home.

- 2013:** OHA's January 2013 report, "Findings and Recommendations: Access to Mental Health and Substance Use Services"
- 2013:** PRI Reports on Access to Substance Use Services for Privately Insured Youth
- 2013:** DCF received a planning grant to develop a "Network of Care", which provides the foundation for this Plan and is described in Section III. DCF led a collaborative that applied for federal implementation funds for the **Connecticut Network of Care Transformation (CONNECT)**.
- 2013:** The Office of the Health Care Advocate led a team developing the Connecticut Healthcare Innovation Plan under the State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation (CMMI; Implementation funding application submitted in July 2014).
- 2013:** Passage of Public Act 13-3 – sections 64-79, provisions on Behavioral Health Taskforce, reforms to mental health and substance use utilization review for insurance plans, Access Mental Health and assertive community teams under DMHAS, DMHAS care coordination teams, mental health first aid training.
- 2014:** Connecticut Department of Public Health issues Healthy Connecticut 2020 State Health Assessment and Health Improvement Plan (Focus Area 6 is Mental Health, Alcohol, and Substance Abuse).
- 2014:** Task Force to Study the Provision of Behavioral Health Services for Young Adults, Established Pursuant to Public Act 13-3 (Section 66), issues its report on April 20.
- 2014:** Passage of P.A. 14-115 requires OHA to establish, by January 1, 2015, a behavioral health care provider information and referral service to help residents and providers with resources, timely referrals, and access. OHA is required to report annually on "...gaps in services and the resources needed to improve behavioral healthcare options..." PA 14-115 mandates collaboration with stakeholders, a public awareness and educational campaign and a data-reporting mechanism for measuring effectiveness.
- 2014:** Passage of Public Act allowing co-location of behavioral health providers in other providers' practices.

Notwithstanding all these efforts and some measureable improvements, the goal of an efficient, accessible system that meets family's needs eludes our state. Building on a series of in depth analyses and the work of a number of committees, this Plan identifies the critical system development tasks that represent a growing consensus and have the potential to move the entire system beyond the bottlenecks and fragmentation that have frustrated improvement efforts.

III. Conceptual Framework for the Plan

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing mental health challenges and the Institute of Medicine framework for addressing the full array of services and supports that comprise a comprehensive system (see Figure III.1). 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."¹⁸

The system of care offers states and communities a conceptual and practical framework on which to base system and service development that benefit the behavioral health and wellness of children and their families, and ensures access to services regardless of geographic location, race, ethnicity, agency affiliation (or not), or insurance status.

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 for children at high risk of developing a behavioral health condition to provide early identification and early intervention, and indicated services for treating those with serious and complex disorders.¹⁹ Prevention under this framework aims to reduce risk factors, promote protective factors, and

prevent or reduce the impact of behavioral health conditions. This 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. The three core values driving the development of a system are the following:

- **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 competent**, 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.

Thirteen guiding principles are listed in Table III.1

Table III.1 Guiding Principles of a Network or System of Care

- **Ensure availability and access** to a broad, flexible array of effective, community-based care, services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
- **Provide individualized care** in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, child and family team approach to a care planning process and an individualized Plan of Care developed in true partnership with the child and family.
- Ensure that care, services and supports **include evidence-informed and promising practices**, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
- **Deliver care, services and supports within the least restrictive**, most normative environments that are clinically appropriate.
- **Ensure that families, other 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.
- **Ensure that care, support and services are integrated at the system level**, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
- **Provide care management** or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the network of care in accordance with their changing needs.
- **Provide developmentally appropriate mental health care and supports** that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
- Provide developmentally appropriate care and supports, **to facilitate the transition of youth** to adulthood and to the adult service system as needed.
- **Incorporate or link with mental health promotion, prevention, and early identification** and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
- **Incorporate continuous accountability and quality improvement mechanisms** to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
- **Protect the rights of children and families** and promote effective advocacy efforts.
- **Provide care, services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics**, and ensure that services are sensitive and responsive to these differences

IV. Implementation Plan by Thematic Area

Based on a synthesis of all the information gathered in the planning process, the Plan is organized into six major thematic categories. For each area, the Plan sets from one to three major goals and associated strategies, for a total of 12 goals and 45 strategies. In each area, we provide a brief overview of the findings that are the basis for the goals and strategies and explanations of the strategies. The six thematic areas, and associated goals, are summarized in Table IV.1

Table IV.1 Plan Thematic Areas and Goals

A. System Organization, Financing, and Accountability

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

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

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

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

B. Health Promotion, Prevention, Early Identification, and Early Intervention

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.

Goal B.2 Ensure that all providers and caregivers who work with young children 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 children to services appropriate for their stage of development.

C. Access to a Comprehensive Continuum of Care

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

Goal C.2 Strengthen the role of schools within the continuum of mental health services to address the mental health needs of students

D. Pediatric Primary Care and Mental Health Care Integration

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

E. Disparities in Access to Culturally Appropriate

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

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

F. Family and Youth Engagement

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

G. Workforce

Workforce strategies are distributed across the other thematic sections.

A. System Organization, Financing and Accountability

Findings from the Planning Process

Among the most consistent themes from the input gathering process was the perceived “fragmentation” of the children’s mental health system reported in different ways by family members, providers, and advocates and repeatedly identified in past reports on Connecticut’s and the national children’s mental health systems.²⁰

Goals in this section are designed to move toward a system in which access to services will be de-linked from system involvement, insurance status, geographic location, or other factors. The result is that all children and their families will have access to the system of care based on their needs.

A primary driver of fragmentation is the presence of multiple payers in the mental health arena, each with different eligibility criteria, enrollment processes, service arrays, and reimbursement strategies. Those payers include state agencies, commercial insurance providers, and self-insured/employee-sponsored plans. A partial list of the state agencies involved in funding mental health care for children and youth includes: DCF; The Department of Social Services (DSS); the Department of Mental Health and Addiction Services (DMHAS); the Department of Public Health (DPH); the State Department of Education (SDE); the Judicial Branch’s Court Support Services Division (CSSD); the Department of Developmental Services (DDS); the Department of Rehabilitation Services (DHR); and the Office of Early Childhood (OEC).

Families described the current behavioral health system as one in which the availability of services is linked to one’s system involvement and/or insurance status, with each system/payer purchasing its own array of services. Families also described the system as difficult to understand and navigate, especially for families who are in the midst of a mental health crisis. Others underscored the theme of fragmentation by describing a system that lacks coordination and integration. Some families with commercial insurance reported that they were forced to allow their child to go untreated and decompensate in order to meet medical necessity criteria required to receive services. Others describe being advised to allow their child to be arrested so that they could access needed services that were only available to those involved in the juvenile justice system. Providers cite outdated provider information in commercial plans and their extremely low reimbursement levels as major issues.

In addition to concerns about fragmentation in the state-funded system, there were significant concerns raised by parents, providers and advocates about the commercial insurance system. Concerns about access to services under commercial insurance plans arose in the majority of the meetings held to gather input. The many comments received on this topic yielded concerns that can be grouped into five categories:

1. Lack of coverage for selected services (e.g., intensive, in-home/community evidence-based practices; emergency mobile psychiatric services; other home and school-based services);
2. Lack of adequate coverage/services for selected conditions (e.g., autism, substance abuse);
3. Overly restrictive medical necessity criteria and utilization management procedures (e.g., authorized access to care; time limits);
4. Lack of adequate provider networks;
5. Cost shifting to individuals and to the state.

The Connecticut Insurance Department convened a productive meeting between the CHDI Planning Team and representatives of DCF and major insurance carriers in the state. The representatives of the carriers and DCF acknowledged shared interests in potential collaboration on issues such as utilization of high intensity and crisis services, monitoring and improving service quality, and examining service utilization data. A few carriers acknowledged selected challenges, such as difficulty finding a sufficient

number of child psychiatrists to participate in their networks. By and large however, the carriers questioned what they viewed as inaccuracies about commercial insurance, stating that their networks, covered services, policies on covered conditions, and procedures were of high quality.

The Connecticut Insurance Department, the Office of the Healthcare Advocate, DCF, various state agencies, and others have made concerted efforts to review the behavioral health services that are and are not covered by commercial insurance providers, to investigate complaints, and to intervene in various ways that address identified problems regarding the commercial insurance industry's role in providing behavioral health services. Public education can help to ensure an understanding of the responsibilities of the commercial insurance industry (both commercial plans and self-insured employers); however, the public has numerous, valid concerns about commercial insurance coverage that can be addressed through continued formal reviews, legislative actions, and other focused strategies. Valid, reliable, and objective data will help in the ongoing investigation of all concerns and claims, and those data can be used to devise strategies that effectively address those concerns, with the overarching goal of ensuring that youth who are covered by commercial insurance have access to a full continuum of mental health services and supports.

Implementing an enhanced children's behavioral health system of care will require a significant restructuring 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 mental health care for children to direct the allocation of existing and new resources.

The redesign of the publicly financed system of behavioral health care has the potential to significantly reduce fragmentation, increase access to a full continuum of care, save money, and support better access to care and outcomes. A fully integrated system of care would reduce fragmentation and place Connecticut at the forefront nationally in the funding and delivery of children's mental health services. Participation of the commercial insurance industry in the funding of that system would represent transformational progress in ensuring that all children have access to a full continuum of effective mental health services.

A financial analysis will help to determine the costs of expanding services over the next five years and the potential sources of funding including direct appropriations, grants, and reimbursement through insurance (federal, state, private). The financial analysis should also address the opportunity costs of not providing these services as well as the cost offsets that would result from a comprehensive system of services that would fully meet the needs of all children in the state.

Strategy A.1.1 Establish a process to guide the redesign of the publicly financed system.

A high level task force should be appointed to drive this design process and include representatives from all state agencies that fund children's behavioral health, other relevant state agency representatives, mental health providers, advocates, family members, and youth. The task force will be responsible for establishing a governance structure to guide implementation efforts including many of the strategies identified in this section.

The work of this task force will include the following:

- **Identify existing spending on children's behavioral health services and supports across all state agencies.** Connecticut should identify the total spending on children's behavioral health to generate a baseline understanding of the funding that is available, the services those funds are purchasing, gaps in services, areas of redundancy, and opportunities for creating efficiencies.

- **Determine if those existing funds can be re-aligned or used more efficiently to fund the full continuum of care.** If, as expected, existing funding is not sufficient to implement the full continuum of care, stakeholders will need to implement all relevant strategies to identify sufficient funding (e.g., direct appropriations, pooled state agency funds, re-directed cost savings, federal grant funding, social entrepreneurship).
- **Identify mechanisms for pooling funding across all state agencies.** The task force will identify specific strategies for pooling funding and organizing it under a single entity that will finance and deliver children’s mental health care. It is recommended that the state examine the Connecticut Behavioral Health Partnership as an effective model.
- **Identify a full array of services and supports that will constitute the children’s mental health system of care (See Strategy C.1.1).** The full continuum of care will include a range of services organized across a continuum that includes prevention, early identification, early intervention, treatment, and aftercare, defined more fully in Section C. The pooled funding structure will create a single point of entry into the system of care that will reduce fragmentation for Connecticut’s youth and families. The pooled funding system should be sufficiently flexible to allow for the funding of family-based services that treat children, caregivers, and siblings together as a family unit.
- **Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach.** Contract with a health economist or another qualified professional to conduct a comprehensive cost analysis. It is presumed that there will be significant, long-term cost savings associated with preventing serious mental health problems, avoiding costly and restrictive treatment and placement settings (e.g., congregate care, emergency departments, inpatient hospitalization, detention) when possible, and expanding access to effective home-, school-, and community-based services. Those savings can also be re-invested into developing and sustaining the full system of care. The findings can also be used to justify ongoing participation among state agencies and to attract the participation of other payers and funders, including federal agencies, philanthropy, commercial insurance providers, employee-sponsored plans and social entrepreneurship entities.

Goal A.2 Create a network of regional Care Management Entities (CMEs) to streamline access to and management of services in the publicly financed system of mental 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” will improve outcomes for children and lower costs of mental health services.²¹

Concerns expressed in the planning process regarding the current quality of care coordination include:

- The need for better coordination of services within the mental health sector as well as between mental health and other sectors that serve children (e.g. schools, health care).
- Fragmentation in care and gaps as children move from inpatient to outpatient services, from home visiting programs to school reentry and from screening in primary care medical services to outpatient mental health services.
- Families having several care coordinators, working in different systems and no “coordination among the coordinators.”

Care management entities have the potential to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies, and reduce costs by taking on the functions of a “clearinghouse” that disseminates information on mental health services, affirmatively connects families to services, and

provides ongoing care coordination for children requiring intermediate to intensive services. This will help improve the family's experience of a system as having "no wrong door" with improved ability to access information and navigate care. Regional care management entities will build on Connecticut's recent experience in developing 26 "Systems of Care" Community Collaboratives to localize family and youth engagement efforts and will ensure the implementation of services that are culturally and linguistically appropriate.

While this system would be created initially for families and children in the public systems, the system could be made available as a cost-effective option for private insurers to manage care as well, a development that has occurred with the New Jersey system.

Each of the strategies below must be carried out with focused attention to cultural and linguistic appropriateness to ensure access for all children and families. Parent and youth peer-to-peer networks within care management entities must promote full engagement of youth and families in services and supports (see Section IV.F for detail on Family and Youth Engagement).

Strategy A.2.1 Design and implement a Care Management Entity (CME) 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.

Care management entities will be responsible for purchasing services, with sufficient funding to implement the full continuum of care at the regional and local level using resources from all public payers. The State of New Jersey currently utilizes this approach by contracting with independent non-profit entities, which are independent of the provider system, to manage the children's mental health system of care at the regional level and purchase services across the full continuum of care. Based on the success of its system of care and its evidence of positive outcomes, the New Jersey state government has begun to move the delivery and management of additional services over to the system of care approach.

Effective care coordination is a foundation of Connecticut's efforts to build a System of Care for children with mental health needs. It is delivered through a range of providers at the regional and local levels. As a core of the proposed System of Care model (as reflected in a recent federal grant), care coordination will be expanded and coordinated across sectors and providers based on evidence-based models of Wraparound services and child and family teaming. Care Management Entities, operating within statewide standards and protocols, will expand capacity and make these services delivered by numerous programs and sectors more efficient and effective. The 75 care coordinators currently supporting the 26 system of care groups would be incorporated into this model, with the specific details of that design to be determined. The CMEs would also need to interface seamlessly with the work proposed for "Advanced Medical Homes" under the State Implementation Model and other efforts to move pediatric care to a Medical Home model of integrated care. Pediatric providers could contract with the CME for care coordination for behavioral health services.

The Hartford Care Coordination Collaborative serves as one model on which to build. The Collaborative brings together care coordinators from several agencies and organizations that serve children in the greater Hartford area. Participating partners include: DCF, DSS Person Centered Medical Home (PCMH) program, Community Health Network care management and practice support programs, CT Family Support Network and several private agencies that provide direct services and coordinate care. Care coordinators from the involved organizations, who are all using different models, meet regularly to review family needs and develop better ways of serving families across their individual sectors and with connection to their medical homes. Based on the success of this pilot in Hartford, DPH has included the development of care coordination collaboratives as a requirement in the five regional care coordination center contracts.

Another model for integrating pediatric and mental health services through care coordination is New Haven Wraparound, in development by Clifford Beers Child Guidance Clinic under a recent \$9 million federal Center for Medicaid and Medicare Services system innovation grant.

The system of care model can be extended to function across mental health, health, education and a community support services to ensure better cross-sector coordination of care for children in the mental health system as well as for children in other systems who need connection to mental health services. The care coordination collaborative model can bring together mental health service coordinators in a variety of mental health treatment settings (e.g. DCF, Enhanced Care Clinics, residential treatment services) and connect them with others who are coordinating other services that children with mental health challenges use, such as schools and health care.

Strategy A.2.2 Develop a family support clearinghouse to increase access to information about available mental health services and improve supports for mental health system navigation.

The findings strongly indicated a need for families to have access to information and resources that are specific to mental health and substance abuse services. Public Act 14-115 charged the Office of the Healthcare Advocate (OHA) with establishing “an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers,” and required OHA to work with state agencies, the Behavioral Health Partnership, 2-1-1, community collaboratives, and providers. The efforts described in this goal and strategy should be in conjunction and alignment with OHA efforts. A family support clearinghouse can serve as a central hub for information that is specific to mental health services and supports, including substance abuse services and supports, and will be accessible to any family member, youth, professional, or community member who is concerned about a child and is seeking information, resources, supports, and services, regardless of level of risk, system involvement, or insurance status. Preliminary plans for the OHA-led effort include an on the ground referral service that also conducts assessments, warm handoff, coordination with 2-1-1, OHA, service providers and agencies as well as data collection on access and waiting lists. Collaborative and technological linkages to 2-1-1 is required in order to quickly access EMPS services for those families who call in the midst of an active crisis mental health situation. Similar connections should be established with Child Development Infoline to address developmental issues.

Information dissemination. The clearinghouse will disseminate information using established and emerging technologies, including smart phone apps, as opposed to disseminating information solely through printed resources such as booklets, flyers, and reports. All information should be available in English and Spanish, at minimum. A campaign to reduce the stigma associated with mental health issues would be a central focus of this work. The target audiences for disseminating information include primarily youth and families directly, but also schools, child health providers, probation officers, and early childcare and education providers, and, for the stigma reduction campaign, the general public.

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

The role of the commercial insurance industry is complex and requires additional analysis and planning. Public Act 13-178 calls for an implementation plan that addresses the mental health needs of all children in the state. Given the number of children covered by commercial plans (Table I.1), the full participation of the commercial insurance industry in the ongoing funding, design, and delivery of mental health services is critical to achieving that goal. A number of state entities have processes in place to systematically identify and address concerns with the role of commercial insurance providers in the behavioral health system. Connecticut should continue to build on those processes, including those that

have led to the development of the Children's Behavioral Health Plan. Those processes can be organized around the systematic investigation of the five areas of concern identified in the findings above.

- Lack of coverage for selected services (e.g., intensive, in-home/community evidence-based practices; emergency mobile psychiatric services; other home and school-based services);
- Lack of adequate coverage/services for selected conditions (e.g., autism, substance abuse);
- Overly restrictive medical necessity criteria and utilization management procedures (e.g., authorized access to care; time limits);
- Lack of adequate provider networks;
- Cost shifting to individuals and to the state.

Strategy A.3.1 Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions

A collaborative group of stakeholders led by the Connecticut Insurance Department, and including partners from the Office of the Healthcare Advocate, state agencies (e.g., DCF, DMHAS), advocacy groups, youth and families, and other stakeholders, will organize a process to review data and input from the commercial insurers and generate specific recommendations to address each of the identified issues. Entities such as the Insurance Department and the Office of the Healthcare Advocate will convene additional meetings with insurers to discuss the issues, data, and potential recommendations. Steps in this process should include:

- Assemble and summarize all available relevant data and input. Sources of information will include, but are not limited to:
 - Connecticut Insurance Department
 - The Connecticut Legislature
 - Office of the Child Advocate
 - Office of the Healthcare Advocate
 - Other state agencies, offices, or commissions
 - Insurance Carriers
 - Professional associations
 - Trade associations
 - Advocacy organizations
 - Families and youth
- **Produce a report that** will: 1) clarify the issues that are under the purview of the commercial insurance industry, employee-sponsored plans, and Medicaid; 2) identify the issues for which carriers may not be fully meeting their responsibilities under law, regulation, or contract; and 3) formulate specific recommendations for potential action by the Insurance Department, the Office of the Healthcare Advocate, and others to address substantive concerns.
- **Issue a report to the Legislature.** The report will summarize the general findings and implications of this process. This report will be used to guide system of care planning and implementation efforts, as described in this plan.

Strategy A.3.2 Apply findings from the process described above to self-funded/employee-sponsored plans.

The Office of the Healthcare Advocate, and other entities, share in the obligation to review and monitor self-funded/employer-sponsored plans. OHA and other entities should come together in a

process described above, to generate information that could inform efforts to examine or address concerns regarding self-funded/employer-sponsored plans in subsequent phases of the effort to improve children's behavioral health services.

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

Findings from the Planning Process

Section 1 of PA 13-178 calls for “establishing results-based accountability measures to track progress towards the goals and objectives” as well as “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.” Furthermore, ongoing reviews of system implementation following plan development include the use of “data-driven recommendations to alter or augment the implementation in accordance with section 11-4a of the general statute.” Data collection, analysis, and reporting will support the delivery of effective services across the continuum of care. Data collection and reporting indicators of access, service quality, and outcomes will contribute to a culture of data-informed decision-making. This work should be objective and transparent, and promote public accountability using the Results Based Accountability (RBA) framework, as well as quality improvement, program evaluation, and research methodologies.

The collection, analysis, and reporting of data is a key element in the delivery of most evidence-based treatments or practices. In short, implementation of the legislation and the implementation of a robust system of mental health 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.

Our findings indicated a need for data infrastructure at the systems level to support a fully integrated system, as well as the need for data that allows stakeholders to engage in program-specific evaluation and quality improvement. The challenges in this work are many:

- Data sources tend to be siloed within state agencies without a common identifier that would allow more efficient tracking of outcomes across systems.
- Programmatic data that are housed within a single state agency often are not linked in order to track and monitor service utilization and outcomes over time.
- Some stakeholders noted that DCF, for example, does not have sufficient numbers of personnel to analyze and report data that are collected from their funded services.
- Data are not shared across systems to promote accountability and transparency.

Data infrastructure development at the systems level should parallel the proposed reorganization of the mental health system to integrate across disparate child-serving systems. Issues of confidentiality and data security are of paramount importance in these efforts.

At the practice level, many mental health services do not currently benefit from robust data collection, analysis, and reporting. Providers discussed the requirements placed upon them by multiple funding and accreditation entities to collect and report data, but describe a “black hole” whereby they never benefit from seeing analysis or results from that data in a way that allows them to improve access, quality, and outcomes. There are pockets of excellence in data collection, analysis, and reporting in Connecticut. Often, but not always, these pockets of excellence are connected to the delivery of evidence-based treatments, which generally include rigorous data collection protocols using standardized outcome measures, fidelity measurement, and regular reporting, analysis, and quality improvement activities. These practices are considered integral elements of providing the service. In addition, Connecticut has a robust data collection approach for the BHP implemented by ValueOptions that allows a nuanced

examination of access, quality, and outcomes. These data, however, are only for youth enrolled in the state Medicaid program. A small number of mental health services include support for data collection, analysis, and reporting through a Performance Improvement Center model. Data-driven quality improvement was identified as helpful for monitoring and improving access, quality, and outcomes for mental health services; however, this model has not been taken to scale to support more service categories.

Finally, data are not routinely made available to all stakeholders including members of the public, for the purposes of accountability and transparency.

Across multiple agencies and programs, rich and potentially useful data is being collected but much of the data is not being adequately utilized. There must be adequate capacity either internally or through contractors to manage, analyze and report the data to make critical and necessary data-driven decisions and programming. In addition, employing rigorous quality assurance protocols based on data will ensure programs are responding to the needs of youth and routinely monitoring and improving the quality of care. Monitoring process (i.e. information and characteristics about the services provided) and outcome (i.e. impact of the services provided) data can identify gaps in access and quality of care and provider training needs, including racial or economic disparities in access or outcomes. Ultimately a comprehensive data management system with routine data mining and strategic analyses can be transformational in ensuring that adequate and quality mental health services are provided to all youth.

Strategy A.4.1 Convene a statewide 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.

This committee, working under the guidance of DCF, should be charged by the Legislature with ensuring that mechanisms and resources are in place to implement the data-related activities outlined in the following strategies. The committee should consist of representatives from all agencies participating in providing mental health services for youth, service delivery program staff, and data analytics and evaluation experts in the field. The committee should also collect and utilize feedback from parents and youth and members from the community. The committee should ensure that the data systems are independent (i.e., not collected and managed by the people providing the services being evaluated), objective, and transparent.

There are significant efforts under way across the health care system, both in Connecticut and nationally, to develop Quality Measure Sets to collect, report, and compare health care outcomes. This committee could also be charged with developing the **Children's Behavioral Health Utilization and Quality Measure Set**. This comprehensive measure set should be required for all insurance plans in Connecticut and would allow us to collect, report via a dashboard, and compare utilization trends and outcomes across payers. An example of such a measure set covering both utilization and quality measures are included in Appendix C.

Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.

The new system should utilize guidelines and protocols from the Results Based Accountability framework used by the Connecticut General Assembly to connect all programs to desired population and system level results while answering the three RBA questions: how much did we do, how well did we do it, and is anyone better off as a result and incorporate new Affordable Care Act performance reporting requirement for reporting to HHS and Treasury (e.g., reporting on the verification of eligibility and reporting related to Medicaid).

Strategy A.4.3 Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing child mental health services.

Current systems such as PSDCRS and systems set up for particular programs or evidence-based practices provide a good foundation for a comprehensive integrated system but they need to be expanded and integrated across agencies. The ValueOptions data system, EPIC Electronic Medical records systems, and the All Payer Claims Database can serve as additional resources in this effort. The data systems must easily link to one another across all systems, which will allow for analyses that examine access, quality, and outcomes in a way that addresses the interests of each participating entity in the integrated system described in Section B. Centralized statewide data with capacity for aggregating data at the levels of the region, the site, and programmatic levels will allow for flexible and meaningful data analyses and results. The new system should allow for flexibility for regions to use the data for secondary analysis to respond to regional/community-level needs.

Strategy A.4.4 Increase State agency capacity to analyze data and report the results.

Analytic staff should (1) standardize key data collection process and outcome measures across agencies and program as appropriate, (2) monitor and manage the data collection, and (3) analyze and report results. Capacity is needed to conduct data analyses and develop reports that are useful for State, regional, and local directors and program managers to make data-driven program management and supervision decisions. It is critical that data-informed management is part of the service, not separate from it.

B. Health Promotion, Prevention, and Early Identification

Findings from the Planning Process

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan called for by Public Act 13-178. The law requires the inclusion of strategies that employ prevention-focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services. Specific approaches cited in the law include:

1. Enhancing early interventions through the medical home model of care.
2. Professional development training for pediatricians and child care providers using a competency-based model.
3. Provision of mental health services to children in the Birth-To-Three program.
4. Adherence to the federal Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).
5. A public information and education campaign that includes an emphasis on parenting that fosters healthy social and emotional development.

The importance of this theme was reinforced through the information gathering process, where parents, providers and advocates highlighted it repeatedly. The concerns and associated recommendations most often presented included the following:

1. Increase prevention efforts, especially for children under three but also across all ages.
2. Identify children at risk for difficulties in social-emotional development and mental health problems at the earliest possible point through a combination of screening with standardized tools and surveillance by child health providers and school personnel, recognizing that many issues emerge as children enter teenage years.
3. Screen for maternal depression, a major risk factor for the social-emotional development of young children, and ensure that intervention is accessible.

4. Expand existing evidence-based programs for young children to meet the mental and behavioral health concerns of children birth to five years old.
5. Train doctors on infant mental health competencies and assessing for behavioral concerns among very young children.
6. Hire more bilingual providers to ensure that prevention, early identification and early intervention services are accessible and culturally relevant for children and families.
7. Provide more statewide cross-systems training in early childhood mental health for staff across early childhood systems, as exemplified by the Head Start/DCF partnership, as well as for foster parents.
8. Conduct a media campaign to address the stigma of mental and behavioral health concerns.
9. Include in all parent education programs for caregivers of young children the importance of early relationships and social-emotional development.
10. Include social and emotional skill development in school health curriculum.

These findings and a review of prior reports and the literature led to the priority goals and strategies presented below.

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.

Strategy B.1.1. Provide training and financial incentives for pediatric primary care, education (including early education), and home visiting providers to use standardized screening measures and to document results and communicate findings with relevant caregivers and providers.

Mental health screening using validated tools is an effective and evidence-based approach to providing early detection and early intervention across all age groups. Children covered by Medicaid in Connecticut have several avenues through which to access Medicaid-reimbursable developmental or behavioral health screenings including in primary care offices, free-standing clinics, and school-based health centers. Primary care providers can obtain reimbursement separately for mental health screenings conducted as part of a well-child visit by both Medicaid and commercial insurers. For school-age children, changes in behavior and academic performance should be triggers for mental health screening. Reimbursement should be contingent on adding the results to the child's medical record to support continuity of services.

The number of children screened in Connecticut has increased a great deal over the past five years but the practice is nowhere near universal. Although Connecticut does not have the data needed to precisely measure penetration rates, we estimate about half of all recommended early childhood screening are taking place.²² The barriers to universal screening most often cited are inadequate reimbursement, cost, lack of time, inadequate mental health training for health providers and lack of resources for referral.

Enhancing the identification of early-onset mental health disorders for children and adolescents was one of the seven goals of the Task Force on Behavioral Health Services for Young Adults with a specific recommendation to mandate screening for behavioral health problems by primary care providers in the health care setting and reimbursing providers for the time and effort required. Our approach in this plan shares a similar goal but deviates slightly in approach. We believe this goal can be achieved without a mandate but through providing sufficient financial incentives and services and supports. There are already many such supports in CT but they will need to be expanded and sustained to reach a higher number of children. These include public and private insurance reimbursement policies, Child Development Infoline, Educating Practices in the Community (EPIC) program and ACCESS MH's consultation services for

primary care providers. We also are recommending screening take place not only in health care settings but in other settings as well. After the age of three, children are seen less frequently for well-child visits so other settings, especially early education and schools, become more important.

Strategy B.1.2. Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

This strategy assures that screening does not happen in isolation of appropriate follow-up and treatment when needed, which requires a broader systemic approach. Many stakeholders noted that periodic screening will only be of value if there is an adequate network to refer children and family who screen positive for further prompt, adequate, and efficient evaluations and early intervention. An important resource in CT is the Child Development Infoline Program that provides services to parents and providers to link children to needed services (a model being replicated in 18 states); but it only serves children birth to five. We are recommending not only providing the resources to assure this service has the capacity to meet an increased demand as more children are screened but that it be enhanced, or a similar service be developed to meet the needs of school age children. This should be coordinated with the work underway at the Office of the Health Care Advocate to support information and referral as authorized in PA 14-115. Any system enhancement needs to ensure that high-risk families use it and are actually connected to services as a result.

Strategy B.1.3. Expand the 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.

Help me Grow at CDI administers the [Ages and Stages Monitoring System](#). The ASQ:SE is an add-on to the standard ASQ-3 and should be included in the standard set of tools provided to parents. ASQ-3 reaches several thousand parents. The Office of Early Childhood, through a Help Me Grow campaign, has made recent efforts to expand that number in seven communities and has also made a concerted community-wide effort in Norwalk. These are models that can be the basis for a statewide strategy. If screening shows concerns, Child Development Infoline staff can help obtain evaluations and connect caregivers to community programs.

Strategy B.1.4. Align screening strategies with the emerging strategies of the State Innovation Model (SIM) and the OEC's Early Childhood Comprehensive Systems (ECCS) grant.

Specific actions to increase the rate of screenings and assuring children have access to further assessments and services involves a coordinated approach across systems not only for children birth to three but throughout the school years as well. There are already significant efforts underway in CT, in cooperation with key state agencies that could serve as a locus to oversee the implementation of the recommended strategies, notably the SIM Plan and the ECCS grant initiative. The work must ensure that all of the thousands of high-risk infants and toddlers who come into contact with DCF CPS or FAR system have access to screening, evaluation and appropriate referral to evidence-based, developmentally appropriate, trauma-informed supports.

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.

Strategy B.2.1. 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.

A workforce competent in mental health across all settings is key to promoting healthy social and emotional development, recognizing the early signs of problems and connecting children to services as early as possible. Those who work with young children need very specific training. The CT Association for Infant Mental Health (CT-AIMH) has been a leader in this regard, having developed specific early childhood mental health training, a set of competencies that can lead to an Endorsement in Infant Mental Health, and provided reflective supervision opportunities. To date, 21 people in CT have earned an IMH Endorsement and 25 more are progressing toward Endorsement. Several efforts already underway serve as models upon which to build including CT-AIMH's partnership with DCF to cross-train child welfare and Head Start staff and their partnership with OEC to develop and deliver training on infant mental health for pediatricians and child care providers. These efforts, however, are limited in scale and scope. Training opportunities need to be expanded, with increased opportunities for all those who work with young children including but not limited to DCF personnel, early care and education providers, early interventionists through Birth to Three, home visitors, and health and mental health providers. A Professional Advisory Committee organized by CT-AIMH, with representatives from key state agencies and programs that serve or support young children, has been meeting over the past five years and could serve as a locus to oversee the development of this work.

Strategy B.2.2. Review current education-based efforts to promote 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.

CT has a wealth of expertise and programmatic efforts to train early care and education and school personnel on the promotion of social and emotional development and mental health concerns in school settings. The use of the Pyramid Model in settings for young children birth to 5, developed by the Center for the Social and Emotional Foundations for Learning, is being advanced through a collaboration of the Head Start Collaborative Office at OEC, Birth to Three – Part C program at the Department of Developmental Services (DDS), and Pre-school Special Education at SDE. Other examples are Yale's Center for Emotional Intelligence RULER program, SERC and UCONN's Neag School of Education's Positive Behavioral Interventions and Supports,¹ Mental Health First Aid, the Grade Level Reading Campaign – Social Emotional Peer Learning Pilot through a partnership with OEC and several foundations, and the School Based Diversion Initiative. Models need to address the recognized impact of trauma and adverse childhood experiences on children's mental health.

As children with intervention needs are identified through these models, such as the PBIS and CSEFL Pyramids, clear paths to access services must be in place. We recommend developing a plan that would review the purpose, scope and scale for each of these and any other programs that may come to light, and

¹ *PBIS Frequently Asked Questions*, POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS, <https://www.pbis.org/school/swpbis-for-beginners/pbis-faqs> (last visited July 22, 2014).

develop steps to coordinate and integrate these efforts and make follow-up services available across the state.

C. Access to a Comprehensive Continuum of Care

Findings from the Planning Process

PA 13-178 identifies a number of strategies that can be broadly characterized as promoting access to a comprehensive continuum of mental health services. Central strategies identified in the legislation include:

- Ensuring access to developmentally-appropriate services
- Offering comprehensive array of services
- Improving the integration of school- and community-based mental health services
- Enhancing consumer input and public information and accountability and increasing awareness of the 2-1-1- Infoline program

Numerous stakeholders identified the need for a comprehensive continuum of support and care that includes prevention, early identification, early intervention, treatment, and transition services (see Figure I.1 above). Full access to that service array is required, regardless of insurance status or system involvement, and regardless of geographic location. Although Connecticut is considered a national leader in the provision of in-home evidence-based practices, significant expansion across the service array is required to establish Connecticut as a national leader in the full continuum of care.

Providers and family members repeatedly indicated lack of capacity and not enough services across the continuum of care, and reported long wait lists for some service categories. The service array has significant gaps in some parts of the state, particularly in the Northeast, Northwest, and Southwest regions of Connecticut. Stakeholders across the state indicated large increases in emergency department utilization for youth presenting with primary mental health diagnoses and reductions in inpatient hospital lengths of stay and capacity issues during period of high volume. Providers suggested the level of acuity of youth presenting at all levels of care is much higher than it was even a few years ago, noting various contributing factors such as greater awareness of mental health needs and zero tolerance policies at schools that result in more referrals to EDs for psychiatric evaluation. Schools and families refer the majority of children that present at EDs. In addition, utilization of EMPS has increased 31% since Fiscal Year 2011 and further increases should be anticipated given the requirements of PA 13-178 for schools to establish MOAs with EMPS to avoid referrals to an ED whenever children can be safely and effectively treated in home and community settings.

Stakeholders also noted a decrease in the number of congregate facilities, stressing the importance of service availability for those with higher acuity needs. Occupancy data from the CT-BHP illustrates consistent vacancies across a range of congregate treatment settings including; Therapeutic Group Homes and Residential Treatment Centers. It is important to note, that in 2012, Connecticut's use of congregate care settings for children in DCF custody was among the highest in the country and above the national average of approximately 14%.²³ At the time of this report, although Connecticut has seen a decrease in congregate care utilization and a simultaneous increase in children remaining at home with one or more biological parents, Connecticut remains above the national average in congregate care placement rates.

The primary recommended action was to ensure sufficient capacity across the continuum of mental health services, care and support that will assist in maintaining children in their homes, schools, and communities. Many service categories were identified as needing sufficient expansion (listed under Goal C.1).

Even the best designed and implemented mental health service system will not address the mental health needs of families if they are unaware of or unable to access those services. Families indicated that

they were not aware of available services and considered the mental health system extremely difficult to navigate and highly fragmented. Families reported that, especially in the early stages of mental health difficulties, they may not identify the problems their child is experiencing as mental health symptoms. This may be due to lack of awareness and education about mental health issues as well as the persistent stigma associated with mental illness. 2-1-1 and Child Development Infoline systems were identified as helpful resources; however, many parents reported that 2-1-1 is not sufficiently tailored to families seeking mental health services and supports, and that the Child Development Infoline is only available for young children. The expansion of Child Development Infoline and coordination with the efforts of OHA to implement PA 14-115, as described throughout this plan, will help address these concerns.

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

Our findings indicate a need for expansion of services across the service array. Unless services are enhanced, the screening for behavioral problems is likely to lead to an increase in demand for services from an already overburdened system, resulting in children being referred to longer wait lists rather than effective services. Although service expansion across the full array will be complex and costly, and will require further specification and planning, the importance of this work is grounded in a growing literature and community experience recognizing strategic service expansion as an investment that will ultimately prove to be cost effective and the right thing to do for Connecticut's children. In many cases, service expansion is in fact mandated in the Medicaid system by requirements like EPSDT. As the case for systemic investment is advanced, the stepwise expansion of key service categories will have a positive impact on outcomes. The following goals and strategies provide guidance as to where the state can begin to make significant improvements to enhance the service continuum.

Strategy C.1.1 Conduct ongoing needs assessment at the local and regional level to identify gaps in the service continuum.

Needs assessment, at the local and regional level, is critical for identifying and responding to gaps in the service continuum. Needs assessment should be conducted regularly and proactively, building on available data from regular Value Options reports, the Juan F. Court Monitor process, and recent reports from Office of the Health Care Advocate and the Legislature's Program Review and Investigations Committee. The methods should be designed to ensure robust and direct participation of families and youth to identify their needs. The findings, including considerations of performance, should be used to plan and implement enhancements that address identified gaps in the service continuum. Needs assessment processes should be aligned with other data collection efforts to promote consolidated and integrated approaches, ideally by coordinating such efforts through the care management structures described in Section A. By conducting needs assessment at the local and regional level, and responding with enhancements where needed, the system will be able to ensure that a full continuum exists across all regions of the state and without regard to system involvement or insurance status. Data collected from the needs assessments should be used to "right-size" the mental health service system, including sufficient capacity at all levels of care, including congregate care and inpatient hospitalization.

As the consensus grows that current array and availability of services, even with desired adjustments, is clearly not sufficient to meet either the need or demand for services, the need for a concrete plan and process to expand services and monitor their expansion closely becomes clear. The strategy for financing this expansion of services is articulated in Goal A.2 above.

Strategy C.1.2 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.

DCF and its partners will lead the process, with strong family and provider input, to (1) further define the continuum of services involved in the System of Care, (2) quantify the gaps identified through the recent and ongoing needs assessment process, and (3) develop and implement a plan and timeline for system development. A transparent, web-based process to document each component of the continuum, its requirements, its funding, and its place in the overall system will aid in identifying the specific steps to enhance each component and then enable tracking of progress.

This work will draw on extensive recent efforts to document the continuum and recommend solutions (see Section I-III and Appendix B). This work would become a core responsibility of the governance entity established to oversee plan implementation (Section V).

The continuum would look to provide sufficient evidence-based and evidence-informed mental health services accessible throughout Connecticut to meet the needs of children across age groups and their families across settings (home-based, early care and education, schools, and outpatient clinics) to prevent and treat social/emotional disorders as early as possible. The plan will:

- Take to scale effective early childhood interventions for young children who screen positive for developmental and behavioral difficulties
- Require documentation of quality and outcomes.
- Use federal, state, and philanthropic funding sources to evaluate the effectiveness of early intervention services in preventing severe behavior and mental health problems later in life.

The continuum includes but is not limited to:

- **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
- **Promotion, prevention and early intervention services including social and emotional skill development and promotion of nurturing family and community environments** (see Section IV.B). The lack of focus on prevention and early identification was repeatedly identified as a significant weakness in the state's behavioral health continuum. Stakeholders suggested a significant shift of focus to preventing mental health diagnoses by promoting nurturing environments, focusing on social and emotional skill development across the age span, and engaging in screening, early identification, and early intervention among both the youngest children and school-aged children. However, increasing the rate of behavioral health screening without an expansion of services to meet the needs of those identified as needing services, will only lead to longer waiting lists and increased frustration for parents and primary care and other providers conducting the screenings. An increase in funding is needed over the next five years, based on a clear assessment of need by geographic region
- **Community-based services that provide a bridge between families, schools, and pediatric health care providers.** Considerable work is underway to ensure that children with mental health and substance abuse issues are not ensnared in a juvenile justice process that could contribute to negative longer-term outcomes and not address their underlying issues. Programs to work with schools, Juvenile Review Boards, or Youth Service Boards, to identify at-risk children, facilitate assessment of their needs, and connect them with services or pro-social community activities have been piloted across the state. These prevention and early intervention programs, *often small and grant-funded*, have the ancillary benefit of reducing child abuse or neglect and closing the achievement gap for at-risk youth. As Connecticut re-imagines its health care delivery and payment system, these services should be considered, potentially with a plan for certification or licensing and a path for insurance reimbursement

- **Continuum of home visiting services.** The state should maximize a continuum of home visiting services, including dyadic trauma-informed models, to ensure that such services are scaled up to meet the needs of all eligible families. As a result, we have in place evidence-based programs including the Positive Parenting Program (Triple-P)(evidence-based for school age), Child First, Early Head Start, and the Early Childhood Consultation Partnership, as well as services provided through outpatient clinics. Increasing capacity in these types of programs/strategies is essential given the efficacy of early intervention and the convincing body of evidence that home visitation programs improve developmental outcomes,²⁴ increase caregiver capacity, reduce incidents of abuse and neglect, and address the implications of Adverse Childhood Experiences on health and well-being.²⁵ By considering these programs as Community Health Providers within the SIM framework, an opportunity may be created to further develop and bring to scale critical and cost-efficient early intervention partners.²⁶
- **Outpatient care.** Some providers from the state's Child Guidance Clinics reported high numbers of referrals to outpatient services but a lack of sufficient funding to meet the need. Increasingly we understand the high rate of trauma experienced by youth in our mental health and juvenile services system.²⁷ In recent years, Connecticut has increased its adoption of evidence based practice models and in partnership with providers implemented several to enhance community based services and supports. Connecticut should continue to scale-up its nationally recognized trauma support services, such as TARGET and TFB-CBT, to a broader group to prevent system involvement and reduce escalation of need.
- **Intensive treatment models.** In order to maintain youth with mental health needs in their homes, schools, and communities, access to intensive treatment models are needed, including Extended Day Treatment, Intensive Outpatient Programs, and Partial Hospitalization Programs.
- **Child and adolescent psychiatry** (evaluation and medication management). Many stakeholders identified a significant shortage of qualified child and adolescent psychiatrists to conduct psychiatric evaluations and provide medication management to child who require this level of care.
- **Services and supports for children with autism.** Participants felt that the system of care for people with autism is overly complicated in this state. It is shared by too many programs and agencies, often with a six month wait to see an expert on autism. There is a pressing need for transition services for youth aging out of childhood services and needing supports around
- **Substance use services.** Participants identified substance use issues as a growing concern among youth. Opiate and prescription drug use were identified as growing concerns among the adolescent population. Participants noted that some excellent, evidence-based services exist for treating adolescent substance abuse; however, they do not have the capacity necessary to meet the need. Connecticut lacks a recovery-oriented system of care. Reimbursement strategies, particularly among private insurers, do not fund a long-term recovery model.
- **Crisis response services.** Many stakeholders noted significant increases in the number of youth presenting in mental health crisis to services such as Emergency Mobile Psychiatric Services (EMPS) also to emergency departments and inpatient hospitals. EMPS was often highlighted as an important service in the continuum of care but their capacity to meet the existing demand is diminished by rapidly increasing volume.
- **Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches (see Section IV.A.2)** Youth and family members indicated difficulties managing different providers across sectors with differing protocols and requirements. Effective care coordination can address this issue and streamline access to the most appropriate services and address issues of continuity of care. Families reported that they are constantly feeling the need to “start over” when circumstances change, and that information about their mental health and

treatment history “does not follow” them, suggesting that treatment information is not shared efficiently with the next clinician or agency, resulting in frustration and lack of continuity of care

Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

High utilization of EDs can be addressed through expansion of crisis-oriented services, as well as other elements of the service array. EMPS is a proven service that helps divert youth from 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. Crisis response services include Emergency Mobile Psychiatric Services (EMPS) and crisis stabilization units.

Strategy C.2.1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services.

The ongoing growth in utilization of EMPS services over the last several years, as well as growing utilization of EDs among youth with primary behavioral health concerns, justifies an expansion of EMPS to address the crisis needs of youth and families. EMPS helps to divert youth from EDs by responding directly to families and schools. Continued outreach to families and execution of MOAs with schools (as required under PA 13-178) is likely to significantly expand EMPS volume. Expansion of capacity within EMPS is required to meet the current and projected increases in demand for this service.

Strategy C.2.2. Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services.

Along with the expansion of EMPS clinicians generally, enhancements in partnerships between EMPS clinicians with the EDs can further support the diversion of youth from inpatient hospitalization when children can be safely and effectively treated in their homes, schools, and communities. It will also assist EDs by providing direct access to experts in establishing linkages to community-based care, and will ensure that families are provided with access to an EMPS clinician..

Strategy C.2.3. Connect expansion of EMPS with an expansion of crisis respite beds throughout the state.

Families and providers identified crisis respite services as a key element of the service array. Expanding crisis respite beds, and linking those beds to the EMPS system, will help families and youth stabilize mental health crisis in a safe environment at a less intensive level of care than inpatient hospitalization. The CARES program at the Institute of Living can be considered as a model for statewide expansion of mental health respite services.

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

A significant expansion of school-based mental health services is recommended, built on an expanded school mental health framework.²⁸

There is growing evidence that students with mental health needs have higher rates of academic failure and also are subject to high rates of “exclusionary discipline”(e.g., arrest, expulsion, suspension). While appreciating that the schools’ primary role is to educate children, schools were seen as ideal settings for screening and early identification of mental health needs and linkages to services. Research suggests that mental health services are effective and more accessible to youth when delivered in

schools.²⁹ Behavioral health providers involved in providing school-based mental health services include clinicians employed by school districts, school-based health center staff, and community-based providers who are either co-located in the schools or located in the community but linked to the school. Parents and providers reported that most schools are not sufficiently resourced to meet students' mental health needs. School-employed clinicians were reported to have extensive responsibilities related to developing and reviewing Individualized Education Programs/Plans (IEPs) but less available time to provide prevention and intervention services. Difficulties were noted in meeting the mental health needs of youth with Autism in schools, responding to mental health crises in schools, and facilitating transitions from inpatient hospitalization back to the school. Communication and coordination between schools and mental health providers was identified as a significant challenge. School-based health centers, though helpful and effective, are not sufficiently taken to scale across the state and may not have the full capacity needed to ensure coordination of care between the school and the community, particularly when school ends in the summer, but children and families require ongoing services.

Schools have the potential for identifying youth in need of intervention and reducing access barriers to provide effective care. Many schools, however, require assistance in building their capacity for these services in order to realize that potential. Many school districts have reduced the number of guidance counselors, school social workers and school psychologists due to budget cuts, further reducing the ability to meet the mental health needs of students and provide guidance to teachers about how to do the same

The expansion of school-based alternatives will need to address issues identified, including: programs are often only available when school is in session, after hours contact and follow-up are difficult, and feedback to the primary care provider is inadequate, even with fairly straightforward medical problems. School-based services will also need to be coordinated with the overall development of the system of care and the proposed role of the Care Management Entities proposed in Goal A.2.

Data collection practices at the system level should incorporate results of school-based mental health screening, referrals and linkages to treatment, and outcomes. In addition, data sharing that allows examination of impacts on academic achievement will help monitor the achievement gap that may result from meeting mental health care needs. Annual student health surveys that include questions about physical, mental health, social, and school engagement and link to health and educational outcomes can help identify services (individual, group, school-wide) needed to support students.

Specific strategies in this area are outlined and explained below.

Strategy C.3.1 Develop and implement a plan to expand school-based mental health services.

This plan should include the following coordinated elements:

- **Increase the number of school-based mental health clinicians.** Connecticut must ensure that all schools have a sufficient number of social workers and school psychologists to meet or exceed recommended standards to meet the demand for treatment.
- **Expand the number of school based health centers (SBHCs).** School based health centers, staffed by either school employees or contracted staff from local providers, are an effective model for addressing the health and mental health needs of students. Medical clinicians are now required (for sites funded by DPH) to conduct mental health screenings at all visits, which increases the likelihood of early detection/referral of issues of more students. Connecticut should ensure that all school-based health centers be the “gold standard” of optimal comprehensive SBHC care: have both a medical and mental health clinicians with administrative support. Expansion of SBHCs should follow the establishment of quality standards and the development of effective programmatic oversight at the Department of Public Health.³⁰
- **Address licensing or other regulatory issues to enable community providers to provide services on school grounds and receive reimbursement from insurers and/or Medicaid.** This

alleviates transportation and “no show” issues because the child is already at school, and also helps to address stigma because the youth is going to the school for services, not to a “clinic.”

- **Implement evidence-based treatments tailored to schools.** Require that all school-based mental health providers are trained in the use of trauma-informed evidence based treatments that are designed for delivery in a school setting and utilize group and individual treatment modalities. Consider a statewide dissemination of Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for this purpose, or a similarly effective intervention.
- **Adopt and implement standardized screening instruments.** Standardized screening instruments will help school personnel identify mental health and support needs, including trauma exposure. Schools need to identify key points of contact school staff who can administer the universal screening (e.g. school nurse, SBHC clinicians, guidance counselors, school social workers), provide training, and create centralized data system for sharing of results and to avoid duplication of screenings

Strategy C.3.2 Create a blended funding strategy to support expansion of school-based mental health services.

Municipal funds will be insufficient to fund an expansion of school-based mental health services. A combination of federal, state, local, and private and public philanthropic funds can be pooled together to fund school-based mental health services, reduce fragmentation and cost shifting, and improve the coordination of school- and community-based mental health services. This should be connected to the statewide model of quality assurance, continuous quality improvement and monitoring of outcomes to ensure there are consistently high care standards and outcomes across SBHCs and other school-based services throughout the state.

Strategy C.3.3 Develop and implement a mental health professional development curriculum for school personnel.

In-service professional development will help build the capacity of school personnel to recognize, refer, and treat mental health concerns. School administrators, teachers, clinical personnel, School Resource Officers, and other school personnel all require different mental health competencies and the curriculum should be tailored to their needs and to the developmental level of the students they serve. Initial training in mental health and development issues for teachers and administrators should be incorporated in teacher and administrator training curriculums in higher education. SDE, school mental health trade associations, and school personnel should guide curriculum development for continuing education. All School Resource Officers should be required to undergo training in recognizing and responding to youth with mental health needs, increasing rates of diversion from exclusionary discipline including arrests, expulsions, and suspensions, and implementing restorative practices. Training modules should include, but are not limited to, the following:

- Introduction to Child/Adolescent Development and Recognizing Mental Health Concerns
- Developing Empathy and Reducing Stigma Associated with Mental Health Concerns
- Effective Classroom Behavior Management Strategies
- Violence Risk Assessment
- Diversion from Exclusionary Discipline
- Cultural Competency

Strategy C.3.4 Require formal collaborations between schools and the community.

PA 13-178 calls for establishment of MOUs between schools and EMPS providers and between schools and police. Schools and community-based agencies should develop much broader MOUs that articulate roles and responsibilities in meeting the mental health needs of students, using EMPS as well as other services and supports. MOUs must address the need for improved communication between schools, police, community-based providers, and hospitals in order to promote coordination and continuity of care.

D. Pediatric Primary Care and Mental Health Care Integration

Findings from the Planning Process

Section 1.I of PA 13-178 calls for offering comprehensive, coordinated care within a continuum of services. Parents, family advocates, and other stakeholders consistently identified fragmentation in the mental health service delivery system and lack of continuity of care as significant barriers. Although many state agencies fund family advocacy and peer supports, there is insufficient coordination of these services and they are tied to system involvement. With respect to a lack of continuity of care, youth and family members indicated that mental health needs frequently change, services are terminated when length of stay limits are reached, and new services and supports are always being put into place. When these changes occur, families feel they are constantly “starting over” and that information about their health and treatment history is not shared seamlessly with the next clinician or agency, resulting in frustration and lack of continuity of care.

Among the challenges identified by experts in the field through facilitated discussions, community conversations, and a review of the literature, two were most salient and are identified as key goals for addressing continuity, coordination, and integration of care: (1) the integration of pediatric primary care and mental health services within Patient Centered Medical Homes (PCMHs); and (2) enhancements to the care coordination systems in the State. Integration of pediatric care and mental health is addressed in this section, complementing the recommendation in Section A regarding care coordination and the creation of Care Management Entities as the major system enhancement to ensure coordination and continuity of care across all involved sectors.

Concerns regarding the integration of pediatric primary care and mental health services included:

- Electronic health record systems do not allow for sharing of information across care settings, such as health and mental health;
- State confidentiality laws require parental consent for health and mental health providers to share information;
- Pediatric providers are not comfortable treating their patients’ mental health conditions;
- Mental health providers are not trained to work in pediatric primary care settings;
- Reimbursement for services presents challenges to mental health clinicians delivering care in pediatric primary care settings;
- The lack of 24/7 availability of providers, including mental health clinicians, contributes to overuse of Emergency Departments;
- Parents are left to do the bulk of coordination of care between their children’s health and mental health providers.

Integration of pediatric care and mental health applies in both the public and private sectors for mental health care systems and will need to be coordinated with the role of the Care Management Entities to avoid duplication. An approach will be needed for families with children with a high level of need who are presently looking to the DCF Voluntary Services program for assistance.

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

Pediatric primary care services provide a unique opportunity to address children's mental health needs. They are universally used across age groups, racial and ethnic groups and geographic locations. For example, children cannot attend childcare, school, camp or play sports without first having a physical exam by a licensed child health provider. Engaging at the primary care level also facilitates a family-based approach. Providers can engage families in mental health services for their children and for adults in the family. Integration into primary care more easily allows providers to work with children and their families over time, observing changes in concerns and circumstances. Lastly, primary care services are connected to a wide array of community services that children use, including preschools, schools, and specialty services. Several individuals commented that these connections are not strong enough in Connecticut, and this concern is addressed in this recommendation as well as in the system integration recommendations.

Connecticut has several initiatives in place for improving connections and coordination between health and mental health providers, including co-locating mental health providers on-site in pediatric practices, and these can be integrated and brought to scale to improve access to mental health services. Some examples of such initiatives include:

- The State Innovation Model (SIM) calls for integrated services with strong care coordination across levels of care and systems of care;
- Medicaid's Person Centered Medical Home (PCMH) program requires that practices hire or contract for the services of a care coordinator;
- The National Committee on Quality Assurance (NCQA) 2014 medical home standards, on which Connecticut's PCMH program is based, requires that practices have agreements with mental health providers and inform patients of those agreements;
- The CT BHP Enhanced Care Clinic (ECC) program requires that mental health agencies with ECC status have at least two memoranda of agreement with primary care sites;
- DCF recently launched a telephone consultation program (Access MH CT) through ValueOptions that provides primary care child health providers with direct contact to a child psychiatrist. Three hubs within the state deliver the telephone consultation in their respective geographic areas;
- DPH recently funded the development of five regional care coordination collaboratives that will bring cross sector care coordination services from a variety of providers (DCF, BHP, Community Health Network) to primary care sites;
- The Educating Practices in the Community (EPIC) program provides education to pediatric primary care sites on many behavioral health issues, including integrated care and connecting children to mental health services. More than 200 practices have received EPIC training in one or more mental health topics;
- CHDI has developed algorithms for co-management of pediatric anxiety and depression, two common child mental health conditions. Co-management shifts care from psychiatrists to pediatricians, thereby increasing access and expanding the capacity of the medical home to address mental health issues.

Strategy D.1.1 Support co-location of behavioral 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.

Behavioral health providers who work in primary care sites often are challenged to gather reimbursement for services. This results from requirements that children served have a mental health

diagnosis. Yet, the goal of co-location is to address mental health concerns before they reach the stage of a full diagnosis; for example, brief intervention that often is accomplished with parent support counseling, or identification of children who need full assessments elsewhere in the system. These two services are ideally provided as part of primary care.

Strategy D.1.2 Support the development of educational programs for mental health clinicians interested in co-locating in pediatric practices.

The provision of mental health services in primary care is different from services provided in mental health agencies, where care is generally long term and assessments are comprehensive. In primary care sites, the treatment model is primarily brief intervention with the family with follow-up, and children with higher intensity needs are triaged to community based mental health services. Mental health clinicians are rarely trained in providing the primary care brief intervention model of care. For co-locating to be successful, programs are needed to provide such training at the graduate and continuing education level.

Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a mental health topic (similar to requirement for child abuse).

The opportunity to provide education in mental health topics—from screening to brief intervention—can be supported through Continuing Medical Education requirements for DPH licensure. Connecticut statute currently requires that child health providers receive CME in the following topics annually: Infectious diseases, risk management, sexual assault, domestic violence and cultural competency. Required hours for mental health education can be added to this list.

Strategy D.1.4 Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, mental health or staff from sites working on behalf of medical homes.

The CT BHP reimburses mental health providers for care coordination provided to Medicaid enrolled children receiving mental health services (Code T1016 (case management) in HUSKY fee schedule; payment for non-ECC mental health providers is \$10.50 per 15 minute unit). This payment needs to be extended to include children with mental health concerns--not necessarily diagnoses--served through primary care child health sites. Such reimbursement will allow practices to connect children and families to helpful community based services at the earliest stage of behavioral health concerns.

Strategy D.1.5 Reform state confidentiality laws to allow for sharing of mental health information between health and mental health providers.

Unlike other states, Connecticut's confidentiality laws do not allow health and mental health providers to share patient mental health information. This prohibition hampers communication and coordination of care between the two providers. Although families expressed concern about confidentiality through their input into the planning process, they also expressed frustrations with uncoordinated care between their children's many providers. Allowing health and mental health providers to share information would be a positive step toward improved coordination, which is highly dependent on information sharing.

E. Disparities in Access to Culturally Appropriate Care

Findings from the Planning Process

Section 1 of Public Act 13-178 identifies a primary strategy for plan development in the area of "being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability." The

planning process identified the following needs of families, providers, and other stakeholders regarding disparities in access to culturally and linguistically appropriate services:

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

Although this section presents recommendations specific to building a system of mental health care that addresses disparities in access to culturally appropriate services, additional recommendations that address culturally and linguistically appropriate services are integrated into other sections of the report.

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

Explanation of the Recommendation

Connecticut Public Act 13-217 calls for continuing education training for physicians in cultural competency. The Connecticut Commission on Health Equity, established by the Legislature, has adopted the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (i.e., "CLAS standards") and is working with state agencies to assess their compliance with the standards and develop plans to meet them.

Connecticut's mental health system of care must include formal adoption and monitoring of CLAS standards in order to reduce disparities in access, service quality, and outcomes. Closely connected to disparities in access to culturally appropriate mental health services are the well-documented issues of racial and ethnic disparities in academic achievement and disproportionate minority contact in the juvenile justice system. Two documents, *A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (Office of Minority Health, U.S. Department of Health and Human Services; 2013) and *The Cultural and Linguistic Competence Implementation Guide* (Martinez & Van Buren, 2008) are available electronically to guide implementation.

Strategy E.1.1 Conduct a needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.

This needs assessment should include an assessment of workforce and recruitment and retention of diverse staff into the mental health field to meet the need for services that are appropriate to the cultural and linguistic characteristics of the service area. Implementation should include: (1) a stakeholder analysis to identify formal and informal youth and family leaders, reflective of the population of focus, to consider for leadership roles within the governance structure; (2) a review and incorporation of findings from the Asian Pacific American Community Needs Assessment (State of Connecticut Asian Pacific

American Affairs Commission, 2014), and other relevant needs assessments; (3) ongoing self-assessments to assess and monitor competencies and resources available to promote governance and oversight related to eliminating disparities in access to culturally appropriate services.

Strategy E.1.2 Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.

Data systems and processes should take into consideration examination of access, service quality, and outcomes that are disaggregated by race, language, culture, and other characteristics of diversity with known disparities. When disparities and disproportionality are identified, these disparities must be formally addressed through corrective action plans and monitored for improvements.

Strategy E.1.3 Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

Funded mental health providers should be required to formally review and plan to strengthen culturally and linguistically appropriate services within their organizations. Contracting agencies should ensure that funding and supports are available so that service providers can live up to these standards (e.g., higher salaries for bi-lingual staff, funding/support for staff to become bi-lingual).

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

The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care must be fully incorporated into the service system to improve availability, access, and delivery of services and supports for all children and families regardless of demographic characteristics, place of residence, or insurance status across the continuum of care. A primary overarching strategy for improving direct services is through workforce development that emphasizes recruiting, retaining, and promoting a diverse workforce and leadership structure that reflects the demographics of the service area. Findings indicated that families feel most comfortable seeking services from clinicians and service providers from their own community, and who reflect their racial, ethnic, cultural, and linguistic background. Families should be engaged as full partners in designing and implementing activities related to cultural and linguistic competency. In addition, it is critical to integrate systems enhancements across the continuum of care, including access to services and supports, prevention and education, screening and assessment, early identification and early intervention, services and supports, and discharge planning.

Strategy E.2.1 Enhance training and supervision in cultural competency.

Training and supervision for staff should also include strategies to track accountability among system partners and leadership to sustain enhancements in culturally appropriate care. This can be executed through the implementation of a learning community focused on culturally and linguistically appropriate service standards and competencies including ongoing education, training, support, and self-assessment. In addition, cultural competence should be integrated into professional credentialing processes for providers.

Strategy E.2.2. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.

Communication materials should be developed and/or interpreted into the preferred language and cultural perspectives of families served. Competent and professional language assistance services must be included at all points of contact to allow all families to fully participate in services, and selected and endorsed treatments must be deemed effective with the target populations to be served.

Strategy E.2.3. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

Financial incentives are required to support the recruitment of diverse professionals into the children's mental health field, in order to create a supply of clinicians that can meet the demand that exists, improve quality of care, and reduce disparities. The children's mental health system should establish partnerships with university training programs, who play an important role in recruiting and preparing a diverse and culturally competent workforce.

F. Family and Youth Engagement

Findings from the Planning Process

PA 13-178 identifies that a central strategy for the Plan is “engaging communities, families, and youth in the planning, delivery, and evaluation of mental, emotional, and behavioral health care services” and “in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes.”

Youth and family members concerns and recommendations are integrated throughout all sections of the report along with those of advocates, providers, and other stakeholders in the children's mental health system. There is also a need, however, to specifically identify the topic of family and youth engagement as a core area in the development and implementation of the system of care, and to outline goals and strategies that ensure the **ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services**. Families strongly requested this throughout the input gathering process, but it is important to note the strong consensus among providers, advocates, state agency representatives, and other stakeholders. Family and youth engagement in the children's behavioral health system of care will help ensure that their input is fully incorporated in the children's mental health service delivery system and that Connecticut continues to move toward the goal of a family-driven and youth-guided system of care.³¹ Many families indicated that Connecticut has made progress in this regard, but more needs to be done.

At the systems-level, families and other stakeholders 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. In addition, families, youth, and family advocates identified the need for paid positions within the governance structure of the children's behavioral health system. Families and youth viewed this change in the system as a significant validation of the importance and professionalization of their role within the system. Families, youth, and advocates indicated that their participation in meetings and system governance is frequently desired or expected, but infrequently paid for through line items budgets. The implementation of this Plan and the resulting expansion of the children's behavioral health system of care present an opportunity to fully recognize the important contributions of families and youth in the governance of behavioral health system by offering paid roles in that system. At the service delivery level, family-advocacy, parent-to-parent support groups, and peer-to-peer support groups were highlighted as important elements of the service delivery continuum and workforce. Stigma reduction campaigns and comprehensive efforts to disseminate information about mental health services were highlighted as strategies for ensuring that families have awareness of and access to the service system. Opportunities for regular family and youth input and feedback into service delivery, at the local and regional level, was also highlighted as extremely important.

This section addresses family involvement in system development, while family involvement in the system of care process itself is assumed as a basic principal (Section III) as well as across all thematic areas.

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

The realization of a family-driven and youth-guided system of behavioral health care requires the full participation of families, youth, and advocates in the planning, delivery, and evaluation of mental health services, at the systems and the local/regional levels. This should be coordinated with broader efforts to engage families at the practice and medical home levels for all health services. Many families requested ongoing opportunities to provide feedback into system development and evaluation using some of the strategies from this Plan's development as well as other feedback opportunities.

Strategy F.1.1 Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.

Family and youth should have paid roles at all levels of the governance structure of the children's behavioral health system of care. Families and youth already make significant contributions to system planning and development efforts, and this Plan calls for an expansion of their roles. Given this expansion, the current Plan provides a unique opportunity to recognize and professionalize their role within the system. Consideration should be given to compensation for family members to be full participants at the table given that professionals are compensated for their time spent in these processes.

Strategy F.1.2 Expand the capacity of organizations providing family advocacy services at the systems and practice levels.

Families identified family advocates as an important part of the service array. Family advocates are increasingly called upon to offer guidance in system planning and development and their role within system governance structure must also be sufficiently funded to support that expanding role. Family advocates can also help to recruit youth and parent participants in system governance structures.

Strategy F.1.3 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.

Parents consistently identified their desire for opportunities to gain additional skills in fulfilling their role in the system governance structure. The Agents of Transformation curriculum presents an opportunity for families to develop those skills and funding should be provided to do so. These trainings should be offered in face-to-face and webinar formats to ensure multiple opportunities for participation.

Strategy F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.

Funding should be identified for co-facilitation, ideally by a family member and a family advocate, of community conversation and open forum sessions. Funding should also support an evaluation consultant to assist families in the preparation of findings and recommendations from these input sessions. Funding also should be included to provide the necessary supports to ensure inclusiveness of a diverse community of parents and youth, including: sessions offered in English and Spanish; availability of Spanish and American Sign Language translation services; convenient meeting times; centralized locations for meetings in community locations (e.g., schools, community centers); child care and supervised child activities during meetings; and transportation. Findings from these input sessions should be used for

planning, delivery, and evaluation of services at the statewide and regional level, and summarized for inclusion in the centralized governance structures of the system of care.

G. Workforce

Another area of focus that emerged during the planning process was workforce development, which is reflected in goals and strategies across most of the thematic categories. Public Act 13-178, section (4d) calls for “the Department of Children and Families, in collaboration with agencies that provide training for mental health care providers in urban, suburban and rural areas, shall provide phased-in, ongoing training for mental healthcare providers in evidence-based and trauma-informed interventions and practices.” The topic of the workforce emerged in almost every discussion held as part of the planning process.

It is clear from the input received during the planning process that 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.

Some participants noted Connecticut’s strengths related to its workforce, which included: compassionate and dedicated staff at the direct care, managerial, and leadership levels; a strong group of parent and family advocates; state operated training academies; and the numerous private non-profit organizations and associations that offer training and consultation. Despite these strengths, many specific concerns about the workforce were raised frequently throughout the planning process. These concerns included, for example: shortages of key professionals or skills in the current workforce; lack of training capacity, including required follow-up coaching, monitoring, and reinforcement in order to maintain gains; insufficient knowledge among many parents as to recognizing mental health concerns; and the lack of adequate knowledge among every sector of the workforce about children’s behavioral health conditions and resources to address them. These discussions contributed directly to the development of strategies above (Table IV.G.1) which together seek to improve the recruitment, training, and effective practice of those who provide services and supports to children, adolescents, and families with behavioral health needs.

Table IV.G.1: Strategies Involving Workforce Development

A.4.4	Increase staff capacity to analyze data and report
B.1.1	Conduct statewide provider trainings on screening
B.2.1	Conduct statewide trainings on infant mental health
B.2.2	Review and promote ability of teachers to deliver social-emotional skill building in schools
C.3.1	Increase school-based clinicians
C.3.2	Mental Health professional development for school personnel
D.1.2	Education for clinicians seeking to co-locate with primary care providers
D.1.3	Require CME credits in mental health
E.2.1	Enhance training and supervision in CLAS
E.2.3	Cultural competencies are integrated into professional credentialing
F.1.3	Parent training as Agents of Transformation

V. Implementation Plan

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 workplan, 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.

An early task will be to design the longer-term governance structure charged with building the System of Care. The governance structure needs to have the authority to advance the ambitious agenda laid out in the plan, to develop the RBA templates to hold the initiative accountable, and a commitment to study of the cost-effectiveness of service delivery types within the state should also be completed.

VI. Conclusion

Children and families in Connecticut currently experience significant barriers to 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.

Appendix A. Summary Table of Goals and Strategies

Cost: Symbols are assigned based on Low Cost (\$), Moderate Cost (\$\$), High Cost (\$\$\$ and \$\$\$\$)

Goals and Strategies	Cost	Measures
A. System Organization, Financing, and Accountability		
Goal A.1 Redesign the publicly financed system of mental health care for children to direct the allocation of existing and new resources.		
Strategy A.1.1 Establish a process to guide the redesign of the publicly financed system.	\$	<ul style="list-style-type: none"> • Redesign plan developed • Public financing pooled
Goal A.2 Create a network of regional “care management entities” to streamline access to and management of services in the publicly financed system of mental health care for children.		
Strategy A.2.1 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.	\$\$\$	<ul style="list-style-type: none"> • CME created and operational • # of families engaged with CME for care coordination
Strategy A.2.2 Develop a clearinghouse to develop and increase access to information about available mental health services and improve supports for mental health system navigation.	\$	<ul style="list-style-type: none"> • Clearinghouse operational on web and in person • Materials developed and disseminated • Coverage of clearinghouse • # of families using clearinghouse to navigate systems
Goal A.3 Systematically examine the major areas of concern regarding commercial insurance for children’s behavioral health		
Strategy A.3.1 Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions	\$	<ul style="list-style-type: none"> • Commercial insurance plan issues defined and quantified • Plan to address issues is completed
Strategy A.3.2 Apply findings from the commercial insurance report to self-funded/employee-sponsored insurance plans.	\$	<ul style="list-style-type: none"> • Self-insured employer plan issues defined and quantified • Plan to address issues is completed
Goal A.4 Develop an agency and program wide integrated behavioral health data collection, management, analysis and reporting infrastructure across an integrated public mental health system of care.		
Strategy A.4.1 Convene a statewide 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.	\$\$	<ul style="list-style-type: none"> • Integrated data capability developed • Regular system reports available
Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.	\$	<ul style="list-style-type: none"> • Standards developed • Standards adopted across systems

Goals and Strategies	Cost	Measures
		<ul style="list-style-type: none"> Adherence to standards across systems
Strategy A.4.3 Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing child mental health services.	\$\$	<ul style="list-style-type: none"> Integrated data available for system planning (see Appendix C re Measures)
Strategy A.4.4 Increase State agency capacity to analyze data and report results.	\$\$	<ul style="list-style-type: none"> Increase in funding dedicated to building capacity to analyze data and report results at systems and practice levels Production of usable reports for the purposes of system and program monitoring and quality improvement
B. Health Promotion, Prevention, Early Identification, and Early Intervention		
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.		
Strategy B.1.1 Provide training and financial incentives for pediatric primary care, education (including early education), and home visiting providers to use standardized screening measures and to document results and communicate findings with relevant caregivers and providers.	\$\$	<ul style="list-style-type: none"> Number and percent of children receiving standardized screenings annually by age group
Strategy B.1.2 Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using United Way's Child Development Infoline (CDI) to identify appropriate resources when needed. Explore expanding CDI to serve the needs of school aged children.	\$	<ul style="list-style-type: none"> Percent of children referred who are connected to services
Strategy B.1.3 Expand the 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.	\$	<ul style="list-style-type: none"> Number of entities actively promoting and sing ASQ:SE Number of children with completed ASQ:SE annually Number of children identified as requiring follow up and getting services
Strategy B.1.4 Align early childhood screening strategies described in this report with the emerging strategies of SIM and the CT United Way/Office of Early Childhood's Early Childhood Comprehensive Systems (ECCS) grant.	\$	<ul style="list-style-type: none"> Adoption of recommendations and outcome measures related to screening in SIM and ECCS plans Number and % of children screened at recommended intervals
Goal B.2 Ensure that all providers and caregivers who work with young children 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 children to services appropriate for their stage of development.		
Strategy B.2.1 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.	\$	<ul style="list-style-type: none"> # of people trained # of people earning CT-AIMH Endorsement (IMH-E®)
Strategy B.2.2 Review current education-based efforts to promote the ability of providers/teachers to promote healthy social and emotional development in early	\$\$	<ul style="list-style-type: none"> Completed plan for implementing an integrated approach to promoting healthy social and emotional

Goals and Strategies	Cost	Measures
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 statewide.		<ul style="list-style-type: none"> development for early childhood and for k-12. # and % of early care providers and schools implementing recommended approaches to social-emotional learning and support
C. Access to a Comprehensive Continuum of Care		
Goal C.1 Build and adequately resource a continuum of mental health care services that is right-sized, appropriate to child and family needs, accessible to all, and equally distributed across all areas of the state.		
Strategy C.1.1 Conduct ongoing needs assessment at the local and regional level to identify gaps in the service continuum.	\$	<ul style="list-style-type: none"> Completion of at least annual needs assessment (local and regional) Completion of web-based presentation of Continuum of services for information and analysis Reports submitted to governance body for mental health SOC
Strategy C.1.2 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	\$\$	<ul style="list-style-type: none"> Increase in funding Increase in capacity across critical component so Continuum of Services, e.g. <ul style="list-style-type: none"> More child and adolescent psychiatrists working in Connecticut Additional in-patient and intensive outpatient treatment slots as needed Reduction in average time from referral to treatment initiation Reduction in average time from referral to treatment initiation Reductions in emergency department utilization and inpatient hospitalization Demonstration of positive outcomes
Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments		
Strategy C.2.1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services	\$\$	<ul style="list-style-type: none"> # of clinicians in EMPS # of cases handled
Strategy C.2.2. Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services		<ul style="list-style-type: none"> # of EMPS clinicians co-located in EDs Develop additional measures re: EMPS
Strategy C.2.3. Connect expansion of EMPS with an expansion of crisis respite beds throughout the state.		<ul style="list-style-type: none"> # of crisis respite beds utilization of crisis respite beds
Goal C.3 Strengthen the role of schools within the array of behavioral health services to address the mental health needs of students		

Goals and Strategies	Cost	Measures
Strategy C.3.1 Develop and implement a plan to expand and finance school-based mental health services.	\$\$\$	<ul style="list-style-type: none"> • # of clinics, # students served, # with clinicians % screened, # of positive referred • # of schools with personnel trained in CBITs • Increased funding
Strategy C.3.2 Develop and implement a mental health professional development curriculum for school personnel	\$	<ul style="list-style-type: none"> • Curriculum developed • # /% of staff trained
Strategy C.3.3 Require formal collaborations between schools and the community.	\$	<ul style="list-style-type: none"> • # of MOUs executed between schools and providers
D. Pediatric Primary Care and Mental Health Care Integration		
Goal D.1 Strengthen connections between pediatric primary care and mental health services.		
Strategy D.1.1 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.	\$	<ul style="list-style-type: none"> • Number of pediatric primary care practices with mental health practitioners on site or written memoranda of understanding between health and mental health providers
Strategy D.1.2 Support the development of educational programs for mental health clinicians interested in co-locating in pediatric practices	\$	<ul style="list-style-type: none"> • Delivery of education programs at graduate and postgraduate levels; Number of mental health clinicians trained to work in pediatric practices
Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a mental health topic (similar to requirement for child abuse).	\$	<ul style="list-style-type: none"> • documentation of CME obtained in mental health topic for all child health providers licensed by DPH
Strategy D.1.4 Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, mental health or staff from sites working on behalf of medical homes.	\$\$	<ul style="list-style-type: none"> • Payment approved and used for care coordination in, or on behalf of, primary care efforts to connect children to services
Strategy D.1.5 Reform state confidentiality laws to allow for sharing of mental health information between health and mental health providers.	\$	<ul style="list-style-type: none"> • Legislation allowing health and mental health providers to share mental health information
E. Disparities in Access to Culturally Appropriate		
Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care		<ul style="list-style-type: none"> • Reduction in disparities in access and outcomes • Increase in patient satisfaction across racial/economic groups
Strategy E.1.1 Conduct a needs assessment at statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.	\$	<ul style="list-style-type: none"> • Completion of needs assessment every other yr (state, regional, and local); completion of annual self-assessments (state, regional, and local);
Strategy E.1.2 Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate	\$\$	<ul style="list-style-type: none"> • Data systems are adjusted to facilitate analysis of equity issues
Strategy E.1.3 Require all service delivery contracts to reflect principles of culturally and linguistically appropriate services	\$	<ul style="list-style-type: none"> • # and % of contracts incorporating CLAS principles
Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of the		

Goals and Strategies	Cost	Measures
service population across the service continuum.		
Strategy E.2.1 Enhance training and supervision in cultural competency.	\$	<ul style="list-style-type: none"> • Development and execution of new or adapted training programs • All credentialing contains requirements for cultural competencies
Strategy E.2.2 Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.	\$	<ul style="list-style-type: none"> • All material meet this requirement
Strategy E.2.3. Provide financial resources dedicated to recruitment and retention to diversify the workforce.	\$\$	<ul style="list-style-type: none"> • Additional funds are provided for this strategy
F. Family and Youth Engagement		
Goal F.1 Include family members of youth with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.		
Strategy F.1.1 Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.	\$	<ul style="list-style-type: none"> • # of family members and advocates on governance bodies
Strategy F.1.2 Expand the capacity of organizations providing family advocacy services at the systems and practice levels.	\$\$	<ul style="list-style-type: none"> • # of FTEs working in advocacy organizations
Strategy F.1.3 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.	\$	<ul style="list-style-type: none"> • # of parents trained
Strategy F.1.4 Provide funding to support community conversations, public forums, and the Plan website to ensure ongoing feedback into system development.	\$	<ul style="list-style-type: none"> • # of community conversations / forums • # of attendees • # of unique website visitors • Evaluation results from forums
G. Workforce		<ul style="list-style-type: none"> •
Workforce strategies are included across other thematic areas as noted in Plan		<ul style="list-style-type: none"> • See measures for strategies listed in Table IV.G.1

Appendix B Bibliography: Major Documents in Development of Connecticut's System of Care

- Connecticut Department of Children and Youth Services, "Carlos Rodriguez id Waiting: Connecticut's Plan for a Comprehensive, Community-based Service System for Children and Adolescents who Experience Serious Emotional Disturbance and Their Families, September 1989.
- Connecticut Department of Social Services. "Delivering and Financing Children's Behavioral Health Services in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 99-279, Section 36." 2000
- A Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issues Mental Health Care 'Blueprint' for Children in Connecticut. 2010
- Legislative PRC report of March 2012 regarding Adolescent Health and the SBHCs Legislative Program Review and Investigations Committee, Connecticut General Assembly, "Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011." March 2012
- Office of the Healthcare Advocate, "Findings and Recommendations: Access to Mental Health and Substance Use Services." January 2013
- Program Review and Investigations Committee, Connecticut General Assembly, "Access to Substance Use Services for Privately Insured Youth." 2013
- CT Department of Children and Families, Behavioral Health Services for Children & Families: A Framework for Planning, Management, and Evaluation, 2013
- CT Department of Children and Families, Connecticut Network of Care Transformation (CONNECT). 2013
- Connecticut Department of Public Health, Healthy Connecticut 2020 State Health Assessment and Health Improvement Plan 2013 (Focus Area 6 is Mental Health, Alcohol, and Substance Abuse).
- Task Force to Study the Provision of Behavioral Health Services for Young Adults, Established Pursuant to Public Act 13-3 (Section 66) State of Connecticut, Final Report, April 2014
- Connecticut Healthcare Innovation Plan, prepared under the State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation (CMMI; Implementation funding application submitted in July 2014).

Appendix C Connecticut Behavioral Health Utilization and Quality Measures

Below is an initial draft set of sample utilization and quality measures for Connecticut's children's behavioral health system developed by DCF staff for discussion. The governance body overseeing plan implementation will develop and promulgate, with extensive input, the measures that will guide system development.

Each measure will be available in aggregate from and will be disaggregated by the following factors to aid in assessing equitable outcomes:

- Age cohort 0-6, 7-12, 13-18
- Non-Hispanic Black/African American Caucasian Asian Native American
- Latino or Hispanic
- Other
- By geography (levels to be determined)
- By system (public, private commercial, private self-insured)

Utilization Measures

Number of members, 18 and younger, who were continuously enrolled in the health plan for at least six months during measurement period
Unduplicated Number/Rate of members who received any behavioral health services during measurement period
Unduplicated Number/Rate of Behavioral Health ED Admission during measurement period
Unduplicated Number/Rate of Behavioral Health Hospital Admissions during measurement period
Unduplicated Number/Rate of Development or BH Screenings during measurement period
Unduplicated Number/Rate of members who had at least one primary care visit during measurement period
Unduplicated Number/Rate of members with at least two outpatient BH services during measurement period
Unduplicated Number/Rate of members with at least two home-based therapeutic services during measurement period
Behavioral health general hospital inpatient average length of stay during measurement period
Unduplicated Number/Rate of members with a diagnosis of autism spectrum disorder during measurement period
Unduplicated Number/Rate of members with a diagnosis of autism spectrum disorder who received an assessment specific to ASD service needs during measurement period

Quality Measures

Measure	Reference*
Behavioral health hospital re-admission 7 and 30 days during measurement period	NCQA- 1937
Follow up after mental health hospitalization during measurement period	NCQA-0576
Initiation and engagement of alcohol and other drug dependence treatment during measurement period	NCQA-0004
Use of Multiple Concurrent Antipsychotics in Children and Adolescents during measurement period	HEDIS-0552
Children's and Adolescents' Access to Primary Care Practitioners during measurement period	HEDIS-0724
Asthma Admission Rate during measurement period	NQF/AHRQ- 0283
Development screening in the first three years of life during measurement period	NCQA-1399

Measure	Reference*
Metabolic Monitoring for Children and Adolescents on Antipsychotics during measurement period	HEDIS-0552
Child and adolescent major depressive disorder- Diagnostic Evaluation during measurement period	NQF-1364
Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner during measurement period	NCQA/HEDIS-0576
Discharge Follow-Up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit during measurement period	NCQA-0576
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen during measurement period	NQF/CMS-0418
Follow-Up after Hospitalization for Mental Illness during measurement period	NCQA-0576

* from Center for Medicaid and Medicare Services (CMS), National Center for Quality Assurance (NCQA), National Quality Forum (NQF), and Healthcare Effectiveness Data and Information Set (HEDIS)

Endnotes

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- ¹ Connecticut PA 13-178 State Mental Health Planning Initiative. See www.plan4children.org.
- ² 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
- ³ Ringel, J. S., & Sturm, R. (2001). National estimates of mental health utilization and expenditures for children in 1998. *Journal of Behavioral Health Services and Research*, 28(3), 319-332. The 7% is from CONNECT grant application. Prevalence estimates on children with Serious Emotional Disturbance (SED) vary, but this is our best estimate.
- ⁴ Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study – Adolescent Supplement (NCS-a). *Jour Am Acad Child Adolesc Psychiatry*. 2010 Oct;49(10):980-989
- ⁵ Anda, Robert MD, MS, “The Health and Social Impact of Growing Up With Adverse Childhood Experiences: The Human and Economic Costs of the Status Quo,” *Adverse Childhood Experiences (ACE) Study*, (2009).
- ⁶ J. KROUTIL ET AL., AGE AND COHORT PATTERNS OF SUBSTANCE USE AMONG ADOLESCENTS, OAS DATA REVIEW 1, 4–6 (2010).
- ⁷ Citation for DCF role - from 1980 and others... web link...
- ⁸ Link to update/status of CT BHP...
- ⁹ State insurance laws only apply to insured plans and not to (employer) self-insured plans. However, self-insured plans are subject to the federal requirements. The U.S Department of Labor has jurisdiction over private sector self-insured plans, and the Center for Medicare and Medicaid Services has jurisdiction over self-insured government (state and municipal) plans. See <http://www.ct.gov/cid/cwp/view.asp?a=4092&Q=479346>
- ¹⁰ CT Voices for Children, data from the U.S. Census American Community Survey, 2014.
- ¹¹ Comments by topic included general input (19); prevention/early childhood (13); juvenile justice system and MH (6); child welfare system and MH (5); autism services and supports (4); educational system and MH (4); integrated pediatric health and mental health care (4); crisis response services (3); evidence-based practices (2); substance abuse (2); and access to services (1).
- ¹² Pittsenbarger, Z.E. & Mannix, R. (2014). Trends in pediatric visits to the emergency department for psychiatric illnesses. *Academic Emergency Medicine*, 21, 25-30.
- ¹³ Draft of the Annual Report for Emergency Mobile Psychiatric Services: Fiscal Year 2014. Child Health and Development Institute: Farmington, CT.
- ¹⁴ Connecticut Department of Children and Youth Services, “Carlos Rodriguez id Waiting: Connecticut’s Plan for a Comprehensive, Community-based Service System for Children and Adolescents who Experience Serious Emotional Disturbance and Their Families, September 1989. http://www.ct.gov/dcf/lib/dcf/mental_health/pdf/carol_rodriguez_is_waiting.pdf
- ¹⁵ Ibid
- ¹⁶ “Delivering and Financing Children’s Behavioral Health Services in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 99-279, Section 36.” From the Connecticut Department of Social Services. Presented by Patricia Wilson-Coker, MSW, JD, Commissioner in collaboration with the Department of Children and Families, the State Department of Education, the Department of Mental Health and Addiction Services, the Department of Mental Retardation, and the Office of Policy and Management. Prepared for the Department of Social Services by the Child Health and Development Institute of Connecticut, Inc., February 2000.
- ¹⁷ CT Department of Children and Families. The Albert J. Solnit Children’s Center Final Consolidation Report, A Report in the Fostering the Future Series, March 19, 2012
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²² See the Child Health and Development Institute's report on Developmental Screening, available for download at <http://www.chdi.org/devscreen-IMPACT>, for more information on screening and challenges collecting screening data.

²³ The Annie E. Casey Foundation. (2009). *Rightsizing Congregate Care: A Powerful First Step in Transforming Child Welfare Systems*. Baltimore, MD: Retrieved from <http://www.aecf.org/resources/rightsizing-congregate-care/>

²⁴ Based on CT Office of Child Advocate, Child Fatality Report, 2014

²⁵ See generally J.P. Shonkoff et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS 232 (2012) (discussing the correlation between child fatalities and adverse childhood experiences).

²⁶ See THE PEW CENTER ON THE STATES, MEDICAID FINANCING OF EARLY CHILDHOOD HOME VISITING PROGRAMS: OPTIONS, OPPORTUNITIES, AND CHALLENGES (2012) (describing how to fund home visiting services under state EPSDT or preventative service plans; or through braiding Medicaid and MIECHV and other grant funding).

²⁷ Of 2,200 CT youth admitted to detention in 2011-2012, 80% had a history of trauma. Robert Franks, Conn. Ctr. For Effective Practice, Child Health, and Development Institute, Presentation to Sandy Hook Commission, *Building a Trauma-Informed System of Care for Children in Connecticut* (2012). Analysis of a sample of 1,959 U.S. youth recently admitted to juvenile detention facilities showed that **41%** were poly-victims – they'd experienced multiple *types* of victimization. J.D. Ford et al., *Poly-Victimization Among Juvenile Justice-Involved Youths*, 10 CHILD ABUSE & NEGLECT 788, 788–800 (2013).

²⁸ Bracey, J.R., Arzubi, E.R., Vanderploeg, J.J., & Franks, R.P. (August 2013). *Improving Outcomes for Children in Schools: Expanded School Mental Health*. IMPACT Report: Child Health and Development Institute of Connecticut.

²⁹ School Based Health Center Report

³⁰ Legislative PRC report of March 2012 regarding Adolescent Health and the SBHCs Legislative Program Review and Investigations Committee, Connecticut General Assembly, "Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011." March 2012

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