Connecticut Children's Behavioral Health Plan: Progress Report

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

September 15, 2016
Submitted by
The Children's Behavioral Health Plan Implementation Advisory Board

The Children's Behavioral Health [1] Plan Implementation Advisory Board is submitting this report in fulfillment of the requirements of Public Act 15-27. On or before September 15, 2016, and annually thereafter the board shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to children. During the development of the Children's Behavioral Health Plan (CBHP) and following its submission on October 1, 2014 and the updated progress report submitted on October 1, 2015, the Department of Children and Families (DCF) in collaboration with key stakeholders continues to advance the recommendations that had been outlined in the plan.

This report offers an update on those activities and identifies a number of important initiatives and activities that have been underway over the past year that address and expand resources for children's behavioral health needs in CT. It also highlights the investment of multiple state agencies to advance the goals of the Children's Behavioral Health Plan. Members of the Children's Behavioral Health Plan Implementation Advisory Board also recognize that there remains a long road ahead to achieve all of the goals of the plan over the next couple of years.

There are several other state initiatives mentioned in this report that are well underway that directly intersect with the mandate and vision of the Children's Behavioral Health Plan (e.g. Network Analysis; OPM's CT Data Portal). We are optimistic that data and additional information necessary to further advance the Children's Behavioral Health Plan will begin to be available through these activities to better inform and shape the work that lies ahead to achieve full implementation.

Maximization of the Advisory Board's efforts to support the achievement of the goals of the Children's Behavioral Health Plan will rely heavily on obtaining information from some of these initiatives. We believe it is also important to recognize the impact of the current fiscal environment on the investments that may be needed to achieve all of the goals of the Children's Behavioral Health Plan.

As the work continues, we are optimistic that the information produced by these cross-cutting initiatives will help clarify how to achieve all of the goals of the Children's Behavioral Health Plan, whether that be through reallocation and/or expansion of resources to ensure that the needs of all of Connecticut's children are met. We caution that it will remain critical that adequate data, network and fiscal analysis continues and that information is being fed back to the advisory board.

The following summary table builds on the original grid included in the Plan's October 2014 submission. This modified table is meant to serve as a snapshot reflecting the multiple activities underway by various stakeholders and includes progress updates on the intended measures as well as partners connected to each of the activities. The body of the document provides details relative to those activities noted in the summary table.

---

[1] ***Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but can be overcome. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support. (SAMHSA definition)***

Summary Table of Goals and Strategies

Goals and Strategies	Measures	Updates	Partners
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.	Redesign plan developed Public financing pooled	DCF fiscal analysis underway IMPACCT/CONNECT/13-178 to support Mental Health and Substance Use treatment expenditures including Medicaid CID Behavioral Health Workgroup PA 16-147 development of ***Detention Diversion Release Plan*** and Community based diversion system. School-based diversion plan due 8/15/17. PA 14-45 Home Visitation Consortium Alternative Payor sources work	DCF, BH Advisory Board, SDE, DMHAS, OHA CID, DPH, DSS, DDS, CSSD CSSD, DCF and JJPOC members SDE, DCF, CSSD OEC, DCF, DDS, SDE OHA,DCF, OPM
Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.			
Strategy A.2.1 Design and implement a Care Management Entity (CME) to create an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.	CME created and operational	Program implementation began July 2015. Families engaged with CME for intensive care coordination CT to consider expansion of CME population	DCF, Beacon

Goals and Strategies	Measures	Updates	Partners
Strategy A.2.2 Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.	Clearinghouse operational on web and in person Materials developed and disseminated Coverage of clearinghouse # of families using clearinghouse to navigate systems	In response to PA13-115, since October 2014 the Office of the Health Advocate has been working on the components laid out in legislation including developing the implementation plan, holding focus groups, outlining a timeline with tasks and creating a provider directory. The link with additional details can be found here http://www.ct.gov/oha/cwp/view.asp?a=4363&q=557002	OHA
Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs			
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	Commercial insurance plan issues Defined and quantified Plan to address issues is completed	Public Act 15-5 with convening a working group to develop recommendations for behavioral health utilization and quality measures data	CID, OHA, DCF, DMHAS, DDS, DSS, DPH, Comptrollers, Insurance Carriers, BH Providers, Consumers
Strategy A.3.2 Apply findings from the commercial insurance report to self-funded/employee-sponsored insurance plans.	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.	Integrated data capability developed Regular system reports available	13-178/CONNECT supporting OPM in convening Statewide data integration workgroup with human service state departments OPM requested inventory of data sources from all state departments Implementation of RBA reporting. For DCF 85% Contracts have incorporated RBA framework and complete quarterly reports	

Goals and Strategies	Measures	Updates	Partners
Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.	Standards developed Standards adopted across systems Adherence to standards across systems		
Strategy A.4.3 Improve current data collection systems to serve in an integrated system across all agencies involved in providing child mental health services.	Integrated data available for system planning (see Appendix C re Measures)		
Strategy A.4.4 Increase State capacity to analyze data and report results.	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	State departments to make data more available on state portal and on their websites	
B. Health Promotion, Prevention, and Early Identification			
Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the need statewide.			
Strategy B.1.1 Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the need statewide.	Number and percent of children receiving effective social-emotional learning in schools and community by model used	Investment in range of EBP's statewide including TF CBT (DCF, CSSD), CBITS (DCF), Circle of Security Parenting (DCF, DMHAS), Triple P (DCF, OEC), MST (DCF, CSSD), MDFT (DCF, CSSD), FFT Three sites participating in Safe Schools Healthy Students federal funding (DHMAS). DMHAS-YAS Implementation of ARC DMHAS PREP Grant to provide EBP training CT-STRONG Healthy Transitions Grant. OEC implements DECA	Many of these models have been adopted by multiple agencies to further improve access. DMHAS, DPH, DCF, CSSD DMHAS SDE, CSSD, DCF,DMHAS OEC

Goals and Strategies	Measures	Updates	Partners
		SBDI and SCTG, State Personnel Development Grant	SDE
Goal B.2 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.2.1 Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life.	Number of entities actively promoting and using validated screening tools and reporting data Number of children with completed validated screening Number of children identified as requiring follow up and getting services	DCF incorporated Connecticut Trauma Screen (CTS) into all Multi-disciplinary Evaluations for children entering care. OEC is beginning to use CTS in early childcare settings. CSSD utilizing CTS OEC supports CHDI in EPIC education to Pediatricians	DCF, OEC, CHDI, CSSD, OEC, CHDI, PCPs CSSD
Strategy B.2.2 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.	Percent of children referred who are connected to services	New Haven Trauma Coalition active in 6 NH schools screen most students and refer to CBITS or other appropriate treatment DSS continues to track positive screens to determine whether they result in connection to treatment	DCF DSS
Goal B.3 Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.			
Strategy B.3.1 Expand statewide trainings on infant mental health	# of people trained	7 IMH training series have been sponsored by DCF and an 8th is scheduled for the Fall of 2016. Each training	DCF, CT Association of

Goals and Strategies	Measures	Updates	Partners
competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.	# of people earning CT-AIMH Endorsement (IMH-E®)	has included approximately 60 participants. To date, over 400 people trained.	Infant Mental Health, Early Childcare Providers
Goal B.4 Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.			
Strategy B.4.1 Continue cross agency collaboration and coordination with planned evaluation activities of the Connecticut Suicide Advisory Board.		State Suicide Prevention Plan completed Promotion and delivery of evidence based training including: ASSIST, QPR, AMSR, CONNECTIONS 4 Institutions participating in the Zero Suicide Initiative Suicide Prevention social marketing campaign continues Evaluation of suicide prevention activities continues Garrett Lee Smith Suicide Prevention grant	CTSAB, DCF DMHAS, UCONN, UW211, Clearing- House DMHAS, DCF, DPH, CTSAB
C. Access to a Comprehensive Array of Services and Supports			
Goal C.1 Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.			
Strategy C.1.1 Establish a process for initial planning of the array of services and supports and ongoing needs assessment, across local, regional, and statewide levels.	Completion of initial assessment of array of services and supports Completion of web-based presentation of array of services for information and analysis	Statewide Network of Care analysis underway focus on primary care, schools and behavioral health providers. Local and regional inventory of participants in local collaboratives underway to develop comprehensive list of Network of Care participants	DCF

Goals and Strategies	Measures	Updates	Partners
Strategy C.1.2 Finance the expansion of the services and supports within the array that have demonstrated gaps	Increase in funding Increase in capacity across critical components of Service Continuum, e.g.: • More child and adolescent psychiatrists • Additional in-patient and intensive outpatient treatment • Reduction in average time from referral to treatment initiation • Reductions in emergency department utilization and inpatient hospitalization Demonstration of positive outcomes	In 2016, expansion of intensive in home services including: MST Building Stronger Families (BSF), MST Transitioning Age Youth (TAY), Family Based Recovery (FBR), Emergency Mobile Psychiatric Services (EMPS), Intimate Partner Violence-FAIR (IPV-FAIR). Circle of Security – trained over 200 people since January 2016 from various service types. Introduced Adolescent Screening Brief Intervention and Referral to Treatment (ASBIRT) into service array including training to EMPS, SBHC and Youth Service Bureaus.	DCF DCF DCF, DMHAS
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		Expansion of approximately 18 FTE EMPS-Mobile Crisis clinicians to approximately 100 FTEs with 50 per diem 18,000 calls 15,000 episodes of care	DCF, EMPS Providers
Strategy C.2.2 Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services		EMPS Mobile Crisis clinicians dedicated to responding to EDs EMPS Mobile Crisis added Facility Liaison position for high need children and youth	
Strategy C.2.3 Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.	# of crisis assessment centers # of crisis stabilization beds Utilization of crisis assessment centers and stabilization beds	SFIT increased capacity for crisis respite/crisis stabilization from 14 to 82 bed capacity.	DCF, Beacon
Goal C.3 Strengthen the role of schools in addressing the behavioral needs of students.			

Goals and Strategies	Measures	Updates	Partners
Strategy C.3.1 Develop and implement a plan to expand school-based behavioral health services.	# of clinics, # students served, # with clinicians % screened, # of positive referred, # of schools with personnel trained in EBPs	CBITS expansion to over 90 school-based-clinicians in 13 communities and multiple schools Expansion of SBDI – to 18 school in six districts	DCF, Local Educational Agencies including; New Haven, New London, Bridgeport, Stamford, Norwalk SDE, DCF, CSSD, DMHAS, CHDI
Strategy C.3.2 Create a blended funding strategy to support expansion of school-based behavioral health services	Funding for school-based services, by source		
Strategy C.3.3 Develop and implement a mental health professional development curriculum for school personnel	Curriculum developed • # /% of staff trained	Mental Health First Aid being delivered throughout the state 7/1/14-6/30/15 o # of MHFA courses in CT: 194 o # of YMHFA courses: 91 o # of MHFA participants: 1,640 o # of YMHFA participants: 1,447 • 7/1/15-6/30/16 o # of MHFA courses in CT: 152 o # of YMHFA courses: 74 o # of MHFA participants: 2,327 o # of YMHFA participants: 1,011	DMHAS
Strategy C.3.3 Require formal collaborations between schools and the community.	# of MOUs executed between schools and providers	113 MOA's established between EMPS and LEA's, representing over 50% completion rate.	DCF, SDE, EMPS, LEA's
Goal C.4 Integrate and coordinate suicide prevention activities across the behavioral health service array and multiple sectors and settings.			

Goals and Strategies	Measures	Updates	Partners
Strategy C.4.1 Continue to identify and foster attitudes and behaviors within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and post-vention.	# of initiatives for suicide prevention • # of suicides	State Suicide Prevention Plan completed Promotion and delivery of evidence based training including: ASSIST, QPR, AMSR, CONNECTIONS 4 Institutions participating in the Zero Suicide Initiative Suicide Prevention social marketing campaign continues Evaluation of suicide prevention activities continues	CTSAB, UCONN, DCF, DPH, DMHAS
D. Pediatric Primary Care and Mental Health Care Integration			
Goal D.1 Strengthen connections between pediatric primary care and behavioral health services.		Data from June 2014 through June 2016: Access Mental Health has enrolled 388 (83%) Primary Care Provider (PCPs) 11,081 consultative activities provided to PCPs Consults involving 2,331 unduplicated youth presenting with mental health concerns For consults in SFY 16, 56% involved children with commercial insurance, 37% for children with Husky, 6% for children unidentified insurance, less than 1% for children with no insurance	DCF, Beacon, ACCESS MH Hubs, AAP
Strategy D.1.1 Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.	Number of pediatric primary care practices with mental health practitioners on site or written memoranda of understanding between health/ behavioral health providers	Efforts underway through the Elm City Project Launch SAMHSA Grant specific to New Haven.	DCF, DPH, OEC, Wheeler Clinic, Clifford Beers, ECCP, Mom's Partnership
Strategy D.1.2 Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices	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 behavioral health topic.	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, behavioral health or staff from	Payment approved and used for care coordination in, or on behalf of, primary care efforts to connect children to services		

Goals and Strategies	Measures	Updates	Partners
sites working on behalf of medical homes.			
Strategy D.1.5 Reform state confidentiality laws to allow for sharing of behavioral health information between health and mental health providers.	Legislation allowing health and mental health providers to share mental health information		
E. Disparities in Access to Culturally Appropriate Care			
Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care.	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.	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	Data systems are adjusted to facilitate analysis of equity issues	RBA report cards being developed by state agencies include data by race and ethnicity in terms of who is served and outcomes associated with service delivery.	
Strategy E.1.3 Require all service delivery contracts to reflect principles of culturally and linguistically appropriate services	# and % of contracts incorporating CLAS principles DCF implementing Tier System which requires reporting on staff and board race, ethnicity and linguistic make-up in relation to populations being served.	13-178/CONNECT CLAS project 14 agencies completing cohort 1; cohort 2 to have 14 agencies to complete a Health Equity Plan which includes organizational and individual self-assessments.	DCF, multiple non-profit agencies
Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.			
Strategy E.2.1 Enhance training and supervision in cultural competency.	Development and execution of new or adapted training programs All credentialing contains requirements for cultural competencies		

Goals and Strategies	Measures	Updates	Partners
Strategy E.2.2 Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.	All material meets this requirement		
Strategy E.2.3 Provide financial resources dedicated to recruitment and retention to diversify the workforce.	Additional funds are provided for this strategy		
F. Family and Youth Engagement			
Goal F.1 Include family members of children 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.	# 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.	# of FTEs working in advocacy organizations	Curriculums under development: • Network of Care-Agents of Transformation (completed) • Data 101 • Persuasive Story Telling • Young Adult/Youth versions	
Strategy F.1.3 Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.		55 parent/caregiver/family members of have completed the training of trainers of the Network of Care-Agents of Transformation training 44 have been certified as trainers 23 have trained at least one class 20 trainings have been completed statewide 311 parents/caregivers/ family members have been trained	
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	# of community conversations / forums # of attendees # of unique website visitors Evaluation results from forums	Family Engagement Action Teams will be meeting in fall for additional Community Conversations	

Goals and Strategies	Measures	Updates	Partners
mechanism to ensure ongoing feedback into system development.			
G. Workforce			
Workforce strategies are included across other thematic areas as noted in Plan	See measures for strategies listed in Table IV.G.1 of original submission		

The following is intended to offer a more detailed accounting of activities and progress that have occurred to date. The Children's Behavioral Health Plan and its recommendations are grounded in 7 thematic areas, which are:

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

A. System Organization, Financing and Accountability

DCF activities:

- The Children's Behavioral Health Implementation Advisory Board (appendix A) formed in March 2015, meets quarterly. The advisory group met on: December 7, 2015; March 7, 2016; June 6 2016; and September 12, 2016. Three of the four work groups have been developed and have coordinated with federal grants. Activities related to Fiscal Analysis and Mapping have been joined with the efforts of two federal grants. ***The Connecticut Network of Care Transformation*** or ***CONNECT*** system of care grant as well as the ***IMPACCT*** adolescent substance use planning grant. Additionally, the Network of Care Analysis and the Data Integration workgroups have coordinated their activities to the ***CONNECT*** workgroups. The Logic Model/Theory of Change workgroup updated the Logic Model to assist in guiding the work to be completed. Collaborating with other similar efforts allows resources to go further and coordinates data and information that has been gathered.

- The Care Management Entity (CME) has been implemented and has begun to serve children and families with significant behavioral health needs. Using the national wraparound model of practice and the Child and Family Teaming model, the CME has served mostly DCF involved youth who are exiting congregate care settings or at risk of entering such settings or children being discharged from Psychiatric Residential Treatment Facilities (PRTFs) regardless of DCF involvement. The Children's Behavioral Health Implementation Advisory Board continues to have the important goal of creating a behavioral health system inclusive of all children regardless of insurance status or system involvement. To that end, the CME continues to work with a cohort of frequent visitors to Emergency Departments and PRTFs regardless of the payee. To date the CME has served 67 children and their families.

- DCF has continued to work to complete a fiscal map of the total behavioral health contracted expenditures for state fiscal year 2015. Internally, substance use fiscal mapping is complete and the expenditures for mental health service continues. Additionally, DCF has contracted with Beacon Health to complete a fiscal map inclusive of the substance use mapping and mental health use of Medicaid claims data for the same fiscal year. Finally, DCF is in the process of establishing an MOU with Judicial in order to complete the fiscal map for youth involved in the justice system.

- ***CONNECT*** is an initiative to create a partnership between families, state agencies, and service providers at the local, regional and state levels to support children, youth and families in accessing the services they need in a timely and effective manner through an integrated network of care. ***CONNECT*** builds upon previous efforts to bridge gaps in services and create an integrated system of care. CSSD, DSS, DPH and other state departments have worked with DCF since the original system of care implementation, known as KidCare, beginning in 2000, and then again with WrapCT in 2006.

Other State Department Activities:

Connecticut Insurance Department (CID)

CID is charged in Public Act 15-5 with convening a working group to develop recommendations for behavioral health utilization and quality measures data that should be collected uniformly from state agencies that pay health care claims, group hospitalization and medical and surgical insurance plans established pursuant to section 5-259 of the general statutes, the state medical assistance program and health insurance companies. The purposes of such recommendations include, but are not limited to, protecting behavioral health parity for youths and other populations.

The work group consists of: the Commissioner of CID, the Healthcare Advocate, the Commissioners of Social Services, Public Health, Mental Health and Addiction Services, Children and Families, Developmental Services and the Comptroller, or their designees, and representatives from health insurance companies, behavioral health providers and the consumer community.

CID completed its work from the first Behavioral Health Working Group, which was convened by Commissioner Katharine L. Wade, and issued a report February 23, 2016.
http://www.ct.gov/cid/lib/cid/2016-Behavioral-Health-Working-Group-Report.pdf
The Working Group found that network availability for child behavioral health treatment continues to be a concern due to the shortage of health care providers in this field. Further, provider reluctance to become part of networks in Connecticut and throughout the country is well documented. The Insurance Department will be looking further at this issue in its network adequacy review and has expanded its data calls of behavior health denial and appeal rates to include children. The data sets will include the following information:

- Authorization of Medical Necessity Coverage by Type and Level of Treatment
- Denial of Medical Necessity Coverage by Type and Level of Treatment
- Denials of Medical Necessity Upheld or Overturned by Type and Level of Treatment

Levels and Types of Treatment will include the following:

- Acute Inpatient
- Residential
- Partial hospitalization
- Intensive Outpatient
- Routine Outpatient

- Substance Abuse Detox

This data will be included in the 2016 Consumer Report Card on Health Insurance Carriers in Connecticut, which will be published and available online in October 2016.

Outreach: The Insurance Department participated in a series of statewide public forums on opioid abuse, helping parents with concerns about their policies, coverage and other insurance issues as they related to behavioral health. The forums provided an opportunity for department representatives to distribute the Department's Behavioral Health Consumer ToolKit, which helps families navigate the claims process for behavioral health and substance abuse treatment. Department staff also distributed the Toolkits during meetings with provider groups that included psychiatrists, psychologists and social workers. Additionally, the Department launched a public service campaign – "Let's Be Clear" in April 2016 to help raise public awareness of all the Department's free public resources, including the Toolkit. The Department also has a Web page dedicated to Mental Health Parity and is a repository for numerous resources.

Carrier Guidance: On May 31, 2016, the Department issued Bulletin HC-112 reminding carriers that FDA-approved opioid abuse deterrent drugs must be included on a health plan's drug formulary and that the Department monitors those formularies to ensure compliance. The Bulletin further reminded carriers that they must have an exception policy for any opioid abuse determined drug that is not on the list but deemed medically necessary by a provider. On September 23, 2015, the Department issued Bulletin HC-105, which outlines specific requirements for clinical review criteria to be used for treatment of child and adolescent mental disorders.

Court Support Services Division (CSSD)

The Judicial Branch very much appreciates the value of the Children's Behavioral Health Plan, pursuant to Public Act 13-178, in that it seeks to build an integrated, comprehensive system of care that delivers needed services to all children and youth in the most efficient and effective manner; regardless of system involvement, payment source, race, ethnicity, gender, age, culture, language, or geography. Other states and jurisdictions that have implemented similar plans have realized the access, quality of care, and cost-effective promises of their plans. Full implementation of the Connecticut Children's Behavioral Health Plan will require sufficient funding and capacity to ensure that all children and youth obtain timely, comprehensive, and effective services.

While children and youth of color are in the minority of the under age 18 population in Connecticut, and in the state's behavioral health system, they are in the majority of children and youth represented in the juvenile justice system. Through its framework and effort to expand service access, create an integrated system of care, engage youth and families, deliver culturally responsive services, and develop a culturally responsive workforce, the Children's Behavioral Health Plan holds the promise that all children's and youths' needs will be identified early, appropriate interventions and supports will be provided, and certain adolescent behaviors will no longer lead to arrest, but to care. The Children's Behavioral Health Plan, along with Public Act 16-147, *An Act Concerning the Recommendations of the Juvenile Justice Policy and Oversight*

Committee, provide the infrastructure to limit contact with the juvenile justice system and to appropriately meet the behavioral health needs of all Connecticut's children and youth.

Per Public Act 16-147, Section 1(c), as of January 1, 2017, a child may only be detained by the Court for one of three grounds; (i) probable cause to believe that the child will pose a risk to public safety if released to the community prior to the initial court hearing or disposition; (ii) a need to hold the child in order to ensure the child's appearance before the court, as demonstrated by the child's previous failure to respond to the court process, or (iii) a need to hold the child for another jurisdiction. Children and youth will no longer be detained for risk of self-harm, running away, family conflict, or inaccessibility of behavioral health treatment.

The Judicial Branch's Court Support Services Division (CSSD), in conjunction with the Department of Children and Families, is developing a *Detention Diversion and Release Plan,* due October 1, 2016, in response to Public Act 16-147, Section 5. The Plan, as required by Public Act 16-147, shall be informed by the Children's Behavioral Health Plan and address the provision of community-based services to children who are diverted or released from detention. Per Section 5, the plan must be informed by the comprehensive behavioral health implementation plan and shall address the needs of the child, concerning (1) behavioral health, (2) intervention in the case of family violence, and (3) identification and means of resolution of precipitating behavioral factors that may be exhibited by a child who may run away. Such services may include, but need not be limited to, assessment centers, intensive care coordination and respite beds. The plan must be implemented not later than July 1, 2017.

Section 11 of Public Act 16-147 requires the development of a plan to expand school-based diversion initiatives to divert from the juvenile justice system students with behavioral health issues. The initiative is to be expanded to schools and school districts with high rates of school-based arrests, disproportionate minority contact, and court referrals. The plan to be jointly developed by SDE, DCF, DMHAS, and the Judicial Branch, including cost options, is due by August 15, 2017.

Section 18(k) of Public Act 16-147 requires the Juvenile Justice Policy and Oversight Committee (JJPOC), of which the Judicial Branch, its Court Support Services Division, DCF, DMHAS, and SDE are members, to develop a community-based diversion system plan, including cost options, which must include recommendations to address issues concerning mental health and juvenile justice:

(1) Diversion of children who commit crimes, excluding serious juvenile offenses, from the juvenile justice system;
(2) Identification of services that are evidence-based, trauma- informed and culturally and linguistically appropriate;
(3) Expansion of the capacity of juvenile review boards to accept referrals from municipal police departments and schools and implement restorative practices;
(4) Expansion of the provision of prevention, intervention and treatment services by youth service bureaus;
(5) Expansion of access to in-home and community-based services;

(6) Identification and expansion of services needed to support children who are truant or exhibiting behaviors defiant of school rules and enhance collaboration between school districts and community providers in order to best serve such children;
(7) Expansion of the use of memoranda of understanding pursuant to section 10-233m between local law enforcement agencies and local and regional boards of education;
(8) Expansion of the use of memoranda of understanding between local and regional boards of education and community providers for provision of community-based services;
(9) Recommendations to ensure that children in the juvenile justice system have access to a full range of community-based behavioral health services;
(10) Reinvestment of cost savings associated with reduced incarceration rates for children and increased accessibility to community-based behavioral health services;
(11) Reimbursement policies that incentivize providers to deliver evidence-based practices to children in the juvenile justice system;
(12) Recommendations to promote the use of common behavioral health screening tools in schools and communities;
(13) Recommendations to ensure that secure facilities operated by the Department of Children and Families or the Court Support Services Division of the Judicial Department and private service providers contracting with said department or division to screen children in such facilities for behavioral health issues; and
(14) Expansion of service capacities informed by an examination of grant funds and federal Medicaid reimbursement rates.

The Judicial Branch has been working with the Office of Policy and Management and the Department of Social Services to maximize federal reimbursement for eligible services, as well, as with contracted providers to maximize the use of client's private insurance to reimburse for eligible services. The Judicial Branch Court Support Services Division is also working with DCF and DMHAS to develop pragmatic funding and payment strategies for evidence-based practices for cost effective and high quality care through the CT STRONG and IMPACCT grants.

The Court Support Services Division continues to expand the implementation of its Contracted Data Collection System (CDCS) which allows staff to make automated referrals to network providers and track program utilization and outcomes, including but not limited to, treatment completion and recidivism reduction.

Department of Social Services (DSS)

DSS has put forth a sample quality measure set (see Appendix B) for the children's behavioral health plan that could be used across all payers to see how the state is doing on a set of uniform quality measures for children.

Office of Early Childhood (OEC)

The Home Visitation Program Consortium created by Public Act 15-45 is tasked with advising the Office of Early Childhood, Department of Children and Families, Department of Developmental Services and the Department of Education regarding the implementation of the recommendations from the 2014 report to the CT General Assembly for the coordination of home visitation programs within the early childhood system

(http://www.ct.gov/oec/lib/oec/familysupport/homevisiting/workgroup/home_visiting_plan_2014.pdf). In 2016, the consortium formed three workgroups (Infrastructure, Workforce Development, and Quality Development) that align with the recommendations.

Office of the Health Advocate (OHA)

The Office of the Healthcare Advocate launches its Behavioral Health Clearinghouse informational website at http://www.ct.gov/oha/cwp/view.asp?Q=558178&A=4571

The Office of the Healthcare Advocate actively supports the initiatives promoted by the Children's Behavioral Health Plan, per Public Act 13-178, and continues to work with key stakeholders to increase understanding of the challenges facing Connecticut's children's ability to access quality, consistent and affordable behavioral health services.

One key barrier for many Connecticut families is inconsistent or confusing coverage of mental health and substance use services. OHA, in cooperation with advocates, legislators and partner state agencies, successfully advocated for Public Act 15-226, which codifies a series of behavioral healthcare services that must be included in all commercial plans regulated by the state of Connecticut. In addition, OHA collaborated with the Connecticut Insurance Department (CID) and multiple stakeholders on the Behavioral Health Working Group whose work has been extended with Public Act 16-158.

Another key area of focus for OHA has been the delivery of these much needed services by state agencies, and the significant costs. OHA has been expanding its outreach to other state agencies to identify opportunities for alternate payor sources. The first collaboration of this kind, with DCF, has been very successful, with savings through 12/31/2015 for consumers of $2.2 million, DCF $2.5 million and another $1.7 in cost avoidance. These savings represent the value of services that DCF or the families would have otherwise paid for. OHA is working with the Office of Policy and Management to identify additional opportunities to maximize the use of non-state payors when available, and has initiated planning discussions with DMHAS, Court Support Services Division (CSSD), DDS and DSS. If successful, this effort has the potential to reduce the state's expenditures on needed behavioral health services and treatment by millions of dollars.

In addition to these cost reduction efforts, OHA has been and remains actively engaged in consumer outreach and education. With more than 800 outreach events in the last year, and participation at dozens of forums on behavioral health and the opioid crisis, OHA continues to promote consumer engagement in and education about the processes for coverage of needed treatment, as well as resources for assistance.

Identification of and access to behavioral healthcare and substance use services remains a significant challenge for consumers, especially those with commercial insurance. Public Act 14-115 tasked OHA with the development and implementation of "an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers." OHA staff has developed a robust, sustainable model for this behavioral health clearinghouse (BHC) that will provide a single, comprehensive resource with information about behavioral healthcare, insurance, health literacy and more, as well as a searchable robust, accurate directory of behavioral health providers to

minimize the barriers to initiating and maintaining a course of treatment for consumers. Although no funding was provided to implement the BHC, OHA staff has conducted numerous outreach activities to consumers and providers to incorporate their perspective into the model and to build the collaborations needed to ensure that the BHC is responsive to consumer's needs.

B. Health Promotion, Prevention and Early Identification

DCF activities:

- Since spring of 2013, DCF has supported seven Infant Mental Health Training Series, one in each of the six DCF regions and a statewide training with one more scheduled in the Fall of 2016. Participation has included DCF, Early Headstart and Headstart, Birth to Three and other early childhood partners. To date this investment has resulted in over 400 people trained.

- In addition to supporting community based training of Circle of Security Parenting, DCF, in 2016, expanded the use of Circle of Security Parenting, a relationship based early intervention program designed to enhance attachment security between parents and children. This expansion included the training of over 100 practitioners including those working in Triple P, Therapeutic Child Care and the Nurturing Families Network (NFN). In addition, The Department of Mental Health and Addiction Services (DMHAS) has been training staff in the Young Adult Services programs across the state in the Circle of Security Parenting since 2013.

  Another 175 participants were trained in August 2016. Those participants included practitioners working in; Caregiver Support Teams, Intimate Partner Violence-Family Assessment Intervention Response (IPV-FAIR), Therapeutic Foster Care programs, Elm City Project LAUNCH, Pediatricians and the Dept. of Corrections. One provider is included nine staff who will then train the agencies 191 staff members as a way to integrate Circle of Security Parenting perspective, concepts and language into the treatment provided.

  New Haven and Middletown have been building capacity in their communities to offer Circle of Security Parenting. We are seeing interest in Groton and Manchester about building capacity in their city/town to offer Circle of Security Parenting. All four cities are either currently working with their school district to build the capacity of teachers to view and respond to students' classroom behavior from an attachment perspective or are interested in being able to do that.

- DCF continues to facilitate in partnership with DPH, the Elm City Project Launch (ECPL) grant. ECPL is in the second year of a five year, federally funded grant that uses a public health approach to promote children's health and wellness with efforts that promote prevention, early identification and intervention. DPH staff serve as the Young Child Wellness Partner.

- The Early Childhood Consultation Partnership (ECCP) is a statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings that began in 2002. The program builds the capacity of caregivers at an individual, family, classroom, or center-wide level. It provides support, education, and consultation to caregivers in order to promote enduring and optimal outcomes for young children.

  To support further capacity, DCF worked collaboratively with the CT Office of Early Childhood to expand ECCP services. In 2014 OEC used funding from the federal Preschool Development Expansion Grant to fund an additional five ECCP mental health consultants. The focus of the grant was to expand high-quality preschool for low-income 4-year-olds in our state.

  ECCP has been closely evaluated and continues to achieve impressive outcomes including:
  - At 1 month follow-up, 100% of children who received ECCP services in SFY 2016 were not suspended/expelled from their early care and education setting. At 6 month follow-up, an average of 97% were not suspended or expelled. Given that exclusionary discipline practices occur at high rates nationally in early care and education settings and at even higher rates for young children of color, ECCP's success in preventing suspensions and expulsions from early child care settings is quite impressive.

  - In 2016, 101 of 317 of children had pre-test scores within the clinical-borderline range of the Child Behavior Checklist (CBCL). While ECCP is a prevention program, it is evident that parental pre-test ratings of clinical symptoms indicate a high number of children scored within the clinical –borderline clinical range on the CBCL. In spite of the severity of their scores, a significant number, 60 of 101 children, moved from the clinical range to improved ratings. ECCP has helped to improve ratings on average by 59% over this reporting period.

  - In SFY 2016 243 of 323 (75%) had pre-test scores within the clinical -borderline clinical range of the Child Teacher Report Form (CTR-F). ECCP has helped to improve ratings by 52% (127 of 243), an impressive finding since ECCP is prevention and not a clinical program. Given the severity of behaviors teachers are reporting in these children, and based on the results of the rigorous evaluation by Yale, these percentages indicate ECCP has a significant & meaningful impact upon the children they serve.

  - The Connecticut Suicide Advisory Board (CTSAB) co-chaired by DCF and DMHAS is a diverse, collaborative network of over 310 people and 100 agencies representing advocates, educators, leaders, and survivors concerned with advancing and sustaining efforts to eliminate suicide across the life span. The state of Connecticut Suicide Prevention Plan 2020 was issued in December 2014 and the CTSAB continues to utilize it for Connecticut's blueprint for suicide prevention activities.

Other State Department Activities:

Court Support Services Division (CSSD)

One of the goals of the Judicial Branch and its Court Support Services Division is to divert children and youth whose behaviors and offense(s) do not warrant court involvement. The reasons for doing so are several: 1) there is a recognition that engaging in delinquent behavior is developmentally normative behavior and that most children and youth will grow out of such behavior; 2) national and international research literature on child and adolescent development and delinquency indicate that court involvement for children and youth is not helpful, but harmful, putting such young people at greater risk of further court involvement, dropping out of school, unemployment, and other negative social outcomes; and 3) scarce resources should be used for youth whose behavior presents a risk to public safety.

Since September 1, 2011, the Judicial Branch and it Court Support Services Division has operated under a policy that encourages Juvenile Probation Supervisors to return court referrals to the source (schools and police) if the alleged behavior does not warrant intervention. CSSD, along with DCF, has worked with communities through the Local Interagency Services Teams (LISTs) to encourage and support local community-based interventions to address child and youth disruptive and other minor delinquent-type behaviors through the use of juvenile review boards, school-based interventions, and the implementation of restorative justice practices.

For those children and youth whose referral is accepted by the juvenile court, CSSD staff (both Juvenile Residential Services, also known as Detention, and Juvenile Probation) and contracted provider staff at the Child, Youth and Family Support Centers (CYFSCs) use validated screening instruments, the MAYSI-2 and Connecticut Trauma Screen (CTS) to identify mental health, substance use, suicide risk and trauma issues. Given the nature of detention and the high risk for suicide within the first 24 hours, detention staff provide additional screenings for suicide risk, substance use, and mental health, physical and dental needs. For those children and youth identified with need, they are referred to licensed mental health professionals for further evaluation and recommendation for services.

CSSD also participates in the Children's' Behavioral Health Advisory Committee (CBHAC) and the Joint Planning Council that combines the CBHAC and the Adult Mental Health Planning Council. CSSD works collaboratively with state agencies on the implementation of several federal grants including CONNECT, IMPACCT and CT Strong.

Department of Mental Health and Addiction Services (DMHAS)

- In 2015 DMHAS, Connecticut was awarded a Garrett Lee Smith Memorial Suicide Prevention federal grant. The CT Departments of Children and Families, Mental Health and Addiction Services and Public Health, partnered with: the CT Suicide Advisory Board (CTSAB), Community Health Resources; United Way 211, Manchester Public Schools, Manchester Police Department, Manchester Community College; the Eastern CT Health Network; and the UConn Health Center. Through this partnership and the resources awarded Connecticut will establish a statewide Network of Care for suicide prevention, intervention and response, and implement an intensive community-based effort to reduce non-fatal suicide attempts and suicide deaths among at risk youth age 10-24.

The network of care will be statewide and comprised of five regional, and one community network in the town of Manchester which will be the focus of an intensive community-based effort. It will embed suicide prevention as a core priority in CT and utilize interventions that are data and quality-driven, sustainable, culturally competent, formalized, uniformed, and accountable with the capacity and readiness to provide services in an organized and timely fashion.

- In 2012, DMHAS received a 5 year grant from The Department of Public Health to provide a perinatal support program to young parents engaged in services through the DMHAS Young Adults Services program (YAS).

- The Department of Mental Health and Addiction Services (DMHAS) has continued to train YAS staff, the perinatal support program staff and two parenting peer mentors in ***Circle of Security-P***, an attachment based parenting education program.

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

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

- DMHAS YAS was granted additional funding from the Department of Public Health PREP grant to train YAS staff, the YAS Perinatal Support Team and the Peer Mentors in evidenced based curriculums that reduce teen pregnancy, address HIV and STD risk and reduce repeated pregnancies while promoting birth space planning.

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

- DMHAS has been providing Mental Health First Aid trainings to youth and to adults to increase awareness and the ability to intervene.

- DMHAS/ABH received funding to provide training to police and crisis intervention teams in order to teach them how to identify someone who needs diversion to services verses someone who requires incarceration.

- DMHAS, in collaboration with DCF and CSSD, continues to administer the federally funded ***Now is the Time, Healthy Transitions-CT Strong*** grant. This grant provides wraparound services utilizing a "whatever it takes" approach to engage youth and young adults ages 16-25 who reside in the cities of New London, Middletown and Milford and who have, or are at risk of developing behavioral health disorders. The project coordinates public awareness, outreach and engagement strategies, as well as, works to increase access to appropriate treatment, services and supports. CT STRONG has included intentional outreach to the local Juvenile and Adult Probation Offices in an attempt to reach court-involved youth in need of such services.

Department of Public Health (DPH)

DPH has established new State Performance Measures for the Title V Maternal and Child Health Block Grant to include Adolescent Suicide Prevention and Bullying Prevention. Strategies include working through Connecticut Children's Medical Center, the School Based Health Centers, and community partners to implement Protective Factors Framework training, Suicide Prevention training for primary care providers, and other promotion and prevention activities.

Department of Social Services (DSS)

DSS is strongly committed to continued support of prevention programs and currently covers several evidence based in-home rehabilitation services. DSS also pays for developmental screenings and behavioral health screenings separately from the well-child visit with a primary care provider. DSS continues to track positive screens to determine whether they result in connection to treatment.

DSS has been exploring how to best utilize the Medicaid preventive services authority to implement services that directly address and reduce the likelihood of childhood trauma. DSS will be working collaboratively with other state agencies as part of the planning process relative to adverse childhood experiences within a two- generation model.

Office of Early Childhood (OEC)

The OEC Birth to Three System has identified a licensed mental health clinician in all 36 programs. Each is trained to evaluate and assess children referred for concerns with social emotional development. Additionally, over 100 Birth to Three providers have been trained in using the Devereux Early Childhood Assessment for Infants and Toddlers (DECA). This instrument is specifically developed to identify and evaluate children with social emotional concerns.

Office of Early Childhood (OEC) submitted to the Connecticut General Assembly in December 2014, the Connecticut Home Visiting Plan for Families with Young Children. The purpose of the plan is to support greater collaboration and coordination among the various home visiting programs and services in the state. The plan includes information about the population of families served by home visiting programs, the benefits of the services, and recommendations for enhanced collaboration and systems development. The plan was established by a multidisciplinary workgroup convened by the OEC.

OEC provided funds to the Child Health and Development Institute (CHDI) for the purpose of enhancing and increasing mental health training for pediatricians and health care providers. The funding led to the development of several training modules and on-site training for health care practitioners. In addition, CHDI established a web site that provides information for parents, early care and education providers, and on-line training opportunities for health care practitioners. The web site can be accessed at www.kidsmentalhealthinfo.com

OEC provided funds to Eastern Connecticut State University to develop training materials about children's the mental health for early care and education providers. The training materials include videos and supplemental handouts that can help early care and education providers to better understand the mental health needs of children and respond to challenging situations in their classrooms.

OEC has also been actively involved with the state's Early Childhood Comprehensive Systems grant. The OEC Commissioner has served as co-Chair of the grant advisory committee and has lent agency staff and resources to the development of comprehensive plan to strengthen developmental screening efforts for all children in the state.

OEC is funding the services of the Early Childhood Consultation Program to provide children's mental health support to 53 preschool classrooms under its Preschool Development Grant.

The State Department of Education (SDE)

- ***The Connecticut Safe Schools/Healthy Students*** (***SSHS***) project is an $8.6 million, four-year federal grant awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to create safe and supportive schools and communities statewide. The project utilizes the ***SSHS*** model and framework to enhance improvements in school climate; increase access to behavioral health and other supports; reduce substance use; and reduce and mitigate exposure to violence in students in Pre-K through Grade 12.

  The project is administered by the DMHAS and SDE with collaboration from DCF, the DPH, the Judicial Branch -CSSD, School Based Health Centers and three Local Educational Agencies (LEA): Bridgeport Public Schools, Middletown Public Schools, and the Consolidated School District of New Britain. Several community agencies representing key stakeholders assist in providing leadership and support to the LEAs. Each LEA receives $500,000 annually.

  The project is beginning its fourth year in October 2016, and a sustainability plan is in development. This plan is being designed to complement strategies developed through other, time-limited grant programs and to identify funding to ensure continuation of these essential services.

- ***The School-based Diversion Initiative*** (***SBDI***), is jointly funded by Judicial-CSSD, DCF DMHAS and SDE, and coordinated by the Child Health and Development Institute (CHDI).

SBDI is an effort to reduce school based arrests and identify the behavioral health needs of students. In the 2015 legislative session, as part of the Governor's Second Chance Society, $1,000,000 per year for two years was appropriated to SDE to support the expansion of SBDI in three to four schools in each of six districts for a total of 48 schools over the 2016 and 2017 school years.

SBDI is a school-level initiative that engages teachers, staff, administrators and school resource officers through consultation, expert training and capacity building activities. Although overall rates of juvenile arrests are declining, in-school arrests continue to be an issue of great concern in Connecticut, particularly among youth of color and youth with unmet mental health needs.

SBDI is designed to prevent youth from entering the juvenile justice system by helping schools reduce the use of in-school arrests, out-of-school suspensions and other exclusionary discipline practices, build knowledge and skills among key school professionals to recognize and manage behavioral health crises in the school and access needed community resources and link youth who are at-risk of arrest to appropriate school and community-based services and supports. ***SBDI*** is a collaborative led by SDE in partnership with; DCF, CSSD, DMHAS and the Child Health and Development Institute (CHDI).

It uses proven strategies to increase access to mental health prevention supports and treatment services in schools and local communities for students and their families. In the 2015 legislative session, as part of the Governor's Second Chance Society, $1 million per year for two years was appropriated to the SDE to support the expansion of ***SBDI*** over the 2016 and 2017 school years. ***SBDI*** has now been implemented in 21 schools across 10 Connecticut school districts. Among the 18 schools that have participated in ***SBDI*** since 2010, those schools have reduced court referrals by 45 percent on average in their first year of participation and have increased EMPS-Mobile Crisis referrals by 94 percent. Sustainability plans for the continuation of the project are in development. In the 2015-16 academic year, eleven schools were directly served in three districts, with ancillary supports provided to other schools in their respective districts.

- The ***School Climate Transformation Grant*** (***SCTG***) is a five-year award established by the U.S. Department of Education to assist state education agencies in developing, enhancing and expanding their statewide systems of support for, and technical assistance to LEAs and schools implementing an evidence-based, multi-tiered behavioral framework (MTBF). The goal of the ***SCTG*** is to enhance and deliver high-quality professional development, to expand a cadre of trained professionals to build school capacity and to align statewide improvement efforts focusing on school climate.

  The purpose of this project is to directly address the state's educational agenda to: a) improve the behavioral health of all students; b) support student growth and development by enhancing their ability to learn; and c) create innovative teaching and learning environments for all students. Project facilitators are currently conducting a Tiered Fidelity Inventory (TFI), reviewing and evaluating all Connecticut schools currently implementing the Positive Behavioral Interventions and Supports framework (approximately 400 schools/100 schools annually) and will provide recommendations for supplemental, booster trainings to ensure

framework sustainability and maintained implementation fidelity. Additionally, the ***SCTG*** Training of Trainers (TOT) protocol has been developed and piloted with an initial group of state trainers and is beginning to gain traction as an exemplary national model. This ***SCTG*** TOT has been developed through a strong partnership with researchers from the University of Connecticut Center for Behavioral Education and Research. The collaborative is currently developing a five-year strategic plan.

- The SDE is entering the final year of its ***State Personnel Development Grant*** that fosters the implementation of an integrated model of literacy instruction and behavioral supports. This effort is being provided in 79 schools with specific attention to the achievement of students with disabilities, students of color and students acquiring English.

- The SDE, in collaboration with DCF, CSSD, DMHAS, DPH and others, is developing strategies to ensure sustainability, continuity and expansion of the services that have been initiated through grant funding. Many of these components have provided important lessons learned on critical services for youth to reduce arrest, violence, interruptions of educational progress and the negative consequences of untreated mental and behavioral health conditions.

- The passage of Public Act 15-232 amended Section 10-220a of the Connecticut General Statutes requiring the State Board of Education, within available appropriations and utilizing available materials, to assist and encourage local and regional boards of education to include trauma-informed practices for the school setting to enable teachers, administrators and pupil personnel to more adequately respond to students with mental, emotional or behavioral health needs. The SDE is collaborating with other state agencies and community-based organizations to develop guidance for school districts on the provision of effective trauma-sensitive supports within their schools. Additionally, the SDE will be presenting a conference on Trauma Informed Care in the 2016-17 school year.

- Multiple divisions within the SDE are focusing a number of professional learning efforts in Connecticut's Alliance Districts, which are the 30 lowest performing school districts in the state. This includes training on social-emotional, behavioral and mental health supports and the impact on student academic success and well-being.

C. Access to a Comprehensive Array of Services and Supports

DCF activities:

- DCF continues to provide crisis stabilization and emergency respite services for up to 14 days through Short Term Family Integrated Treatment (S-FIT) providers. Statewide these beds are available for any child or youth who is in need of a short-term emergency placement and a plan to return back to their parents or a caregiver. Effective access to these 82 statewide beds occurs through EMPS-Mobile Crisis and Beacon Health Options.

- DCF has been working closely with the EMPS Providers, SDE, and school districts throughout the state, to fulfill the requirement in PA 13-178 to execute MOA's between EMPS-Mobile Crisis providers and the local school districts in their service area. To date,

113 MOA's have been executed. (An increase in 60 MOUs since last year.) Recently, DCF working with United Way 211 sent out a 3 minute video, to all Superintendents in the state, addressing the need to complete the MOU's under Public Act 13-178. This is intended to facilitate school responses to working with the Mobile Crisis agencies in completing the MOU's. Additionally, UW211 will be sending the video to other school staff including school psychologists, counselors and nurses. The video has also been posted to the EMPS web-site.

- DCF expanded the current capacity of all the EMPS Mobile Crisis providers by no less than two additional full time employees. One of those staff members has been designated as a Facility Liaison position working with high-needs children who are on overstays in hospital Emergency Departments or at risk of this; and children at risk for placement in an Inpatient Unit, Crisis Stabilization Program or Psychiatric Residential Treatment Facility (PRTF) or other behavioral health congregate setting for crisis management.

  The Facility Liaison will work to prevent and divert high-needs children from going to the ED or being placed in these settings for crisis management. This work will include ongoing communication and coordination with other EMPS providers, ED's and other behavioral health congregate and community based programs in support of maintaining high-needs children in their homes and in the community

  Mobile Crisis has also expanded mobile hours of operation for an additional two hours Monday through Friday. Formally, hours of mobile operation during weekdays were 8:00 AM to 10:00 PM. Following the additional hours, mobility is 6:00 AM to 10:00 PM.

- DCF continues to expand access to Modular Approach to Therapy for Children (MATCH), an evidence based outpatient treatment intervention that addresses 70% of the most common presenting problems in children seeking mental health outpatient services. Currently fifteen organizations in over twenty sites are participating in the Learning Collaborative and have an average of five clinicians per agency trained or actively being trained to deliver services.

  Last year 572 children received a MATCH intervention. According to data collected on the Ohio Scales caregiver responses, 70% of children experienced a reliable change of a 10 point reduction in problem severity scores and/or an 8 point improved functioning score; and on children's responses, 65% experienced reliable change of 10 point reduction in problem severity scores and/or an 8 point improved functioning score.

- DCF continues to expand access to Cognitive Behavioral Intervention for Trauma in Schools (CBITS); an evidenced based treatment model for children suffering from post-traumatic stress symptoms as a result of trauma experiences in their lives. Nine school districts and over 20 schools will be offering CBITS across the state this fall. To date, 292 students have received treatment in school and 95% has successfully completed the intervention with an additional 4% partially completing the treatment course. One percent were referred on to other treatment options. There was a 41% reduction in PTSD symptoms, a 23% reduction in behavior problems, and a 5% improvement in functioning from pre to post assessment, indicating significant improvements.

CBITS is delivered through 10 group sessions as well as individual sessions for each student in the group while in the school setting. Many children and youth experience traumatic events including exposure to community violence and family/interpersonal violence. CBITS includes a screening process to identify children with elevated stress reactions and brings an evidenced based treatment to schools for traumatized students.

- DCF is collaborating with DMHAS to implement a statewide adolescent substance use initiative to train professionals at all levels utilizing the Adolescent Screening Brief Intervention, and Referral to Treatment or A-SBIRT approach. The goal is to create a broad, ongoing network for A-SBIRT that will provide early identification and intervention for youth using or at risk of using substances. The statewide initiative has included the training of pediatricians, mental health professionals, EMPS-Mobile Crisis clinicians, DCF staff, community youth services workers, school based health centers, school social work staff, community prevention services workers and other professional and community staff in conducting A-SBIRT screenings. This statewide initiative has involved a number of activities, but particularly a "training of trainers" approach. This will allow CT to continue to develop statewide adolescent substance use screening capacity.

- DCF is nearing the end of the first year of a two-year SAMHSA/CSAT grant to develop a comprehensive plan for adolescent substance use treatment known in CT as the ***IMPACCT*** (***Improving Access to Continuing Care and Treatment***) grant. DCF is collaborating with DMHAS and Judicial-CSSD, SDE, Beacon Health Options, youth and families, other SAMHSA grantees in CT, the CT Alcohol and Drug Policy Council (ADPC), and technical experts to develop this plan. This collaborative effort identifies important gaps in Connecticut's systems and addresses issues of access to care and will lead to improvements that enhance statewide coordination of the multiple treatment and continuing care systems for youth in support of better access to and retention in high quality care.

  DCF is selecting, training and implementing the evidence-based adolescent SBIRT (Screening, Brief Intervention, and Referral to Treatment) initiative statewide. To ensure sustainability of these efforts, implementation plans include consultation and technical support to develop a "train-the-trainer" model, and to enhance current workforce training modules to include SBIRT components. CSSD is also working with The National Center for Mental Health and Juvenile Justice to test the use of SBIRT in juvenile justice settings.

  The plan will be the state's strategy for adolescent substance use treatment. It will include a communications plan aimed at reducing stigma associated with substance use problems, and improving access to services for youth and their families by increasing awareness of available options for care. This effort will also respond to PA 14-7, which tasks DMHAS and DCF with the development of a similar plan.

In the past year this effort has included:

- Outreach to existing statewide youth and family groups to increase awareness of this project, and to build relationships for ongoing collaboration to develop the plan;

- Meetings with providers and provider organizations to identify strategies to expand the capacity and increase the retention of the substance use and mental health disorders treatment and continuing care workforces;
- Initial development of a financial map to identify pragmatic funding and payment strategies for services;
- Developing scale-up plan for the implementation of Adolescent Screening Brief Intervention and Referral to Treatment
- Drafting an MOU with state agency partners to enhance sharing of information to inform the plan
- Participation on the Alcohol and Drug Policy Council's Treatment and Recovery Support Subcommittee to align this work with other statewide planning efforts
- Participation in social marketing efforts underway statewide for other SAMHSA grants
- Gathering statewide and national data related to adolescent substance use and co-occurring mental health problems to inform the plan.

Other State Department Activities:

Court Support Services Division (CSSD)

Despite significant budget reductions, the Judicial-CSSD maintains a continuum of evidence-based services and supports to meet the mental health and substance use treatment needs of children and youth involved with the juvenile justice system, as well as to address the criminogenic risk factors that lead to court involvement. The CSSD continuum of contracted services includes:

- Behavioral health assessments;
- Short-term psychiatric medication management bridging services (HOMECARE);
- Community-based Child, Youth and Family Support Centers (CYFSCs) which offer family counseling, mediation, assessment, cognitive behavioral therapies, such as, TARGET to address trauma and MET/CBT to address substance use, and access to in-home family therapy;
- Outpatient substance use treatment (ACRA-ACC);
- In-home family therapy (Multisystemic Therapy (MST) and Multidimensional Family Therapy (MDFT)); and
- Short-term residential treatment (MDFT Intermediate Residential programs and the TRAC respite and assessment center).

In addition, Juvenile Probation Officers refer families to:

- Emergency mobile psychiatric services (EMPS);
- Community collaboratives for care coordination;
- Child Guidance Clinics for assessment and access to TF-CBT and individual counseling;
- Intensive, in-home child and adolescent psychiatric services (IICAPS);
- Intensive outpatient services and partial hospitalization programs;
- Short-term Family Integrated Treatment (S-FIT);
- Inpatient hospitalization; and

• Residential treatment.

Department of Mental Health and Addiction Services (DMHAS)

- DMHAS had made a concerted effort throughout the years to establish a comprehensive array of clinical and support services including education and employment for young adults throughout the state.

- DMHAS funds a supported education program at CCSU and has developed supported education programs at many of the community colleges in CT.

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

- DMHAS is collaborating with DCF in developing a comprehensive plan for adolescent substance use treatment by encouraging the implementation and use of A-SBIRT. (see note above)

- DMHAS has established three ACCESS centers throughout CT that offer services to youth who would not necessarily be identified as needing the intensive level of care provided by Young Adult Services. One of the goals of this service is to connect youth with appropriate treatment and community support services.

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

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

- Connecticut's ***Safe Schools Healthy Students*** (***SSHS***) Diffusion Initiative uses a school and community partnership model. These partnerships create safe, drug -free and productive environments across all settings for social and emotional learning and promote healthy

physical development and academic success. The ***SSHS*** partnership model connects state policy development and implementation of ***SSHS*** programs at the school district and community level. The State Management Team (SMT) assembles diverse stakeholders including parents and representatives from education, mental health and substance use, public health, juvenile justice, social services, child and family protective services, family advocacy and youth development. The SMT process supports the wide spread adoption and operation of ***SSHS*** programs to extend the benefit beyond Connecticut's three initial SSHS school districts.

Department of Public Health (DPH)

DPH facilitates a Systems Enhancement for Children and Youth with Special Health Care Needs through Systems Integration project with the goal of increasing access to medical homes and related services for children with special health care needs and other children. The project focuses on systems level integration, cross-systems shared care coordination and shared resources. Numerous private and state agencies are partnering including DCF and DSS.

Department of Social Services (DSS)

- On January 1, 2015, DSS, in partnership with DCF and DDS, implemented autism evaluation and treatment services for individuals under the age of 21 under the Medicaid Program. In addition to evaluation and treatment services, Beacon Health Options offers care coordination services to individuals with autism spectrum disorder and/or their families regardless of age. DSS is in the process of updating the existing Medicaid ASD fee schedule as well as expanding the services available to individuals with ASD.
- See Appendix B, a catalogue of Medicaid covered services for the adult and child populations.

State Department of Education (SDE)

The SDE continues to work with school districts on making connections to mental health services. The SDE previously issued a memo to superintendents highlighting the importance of complying with Public Act 13-178 requiring EMPS-Mobile Crisis providers to collaborate with the contracting authority for each local or regional board of education throughout the state. These collaborations include, but are not limited to, memoranda of understanding, policies and protocols regarding referrals and coordination between the respective entities.

D. Pediatric Primary Care and Behavioral Health Care Integration

DCF activities:

- DCF continues to support ACCESS Mental Health to ensure that all youth under 19 years of age, have access to psychiatric and behavioral health services through their primary care providers (PCP), irrespective of insurance coverage. The program is designed to increase PCP's behavioral health knowledge to better identify and treat behavioral health disorders more effectively and expand their awareness of local resources.

  By June, 2016, 476 pediatric and family care practices statewide were identified as being eligible for enrollment by Hub Teams, with approximately 83% of these practices having

enrolled. The three psychiatric hubs provided 11,081 consultative activities for 2,331 unduplicated youth with mental health concern between June 2014 and June 2016. Insurance coverage for these youth was varied, noting that 53% were for youth with commercial insurance, 37% involved youth with Husky, and 6% had unidentified insurance coverage.

Other State Department Activities

Court Support Services Division (CSSD)

CSSD has been funding HOMECARE, a psychiatric medication monitoring bridging service, since 2003. HOMECARE was developed, in conjunction with DCF and the University of Connecticut Health Center, to address the needs of children and youth in detention who were being held until an appropriate community-based treatment service could be accessed. Limited access to community-based child psychiatry led to youth being held in detention until an appointment could be accessed. HOMECARE delivers psychiatric medication monitoring services at the federally qualified health centers (FQHCs) to both court-involved and non-court involved children and youth, filling a gap in the FQHCs service delivery system. Youth can be released from detention with an appointment within two weeks of release for medication monitoring, prescription refill, etc. HOMECARE services are intended to be short term and last two to 12 weeks. Many families decide to continue receiving both primary and psychiatric care at the FQHC after HOMECARE services have ended.

Department of Social Services (DSS)

DSS strongly supports integrating primary care and behavioral health services as evidenced by several Medicaid initiatives to facilitate improved coordination between primary care and behavioral health services, including Health Homes and the State Innovation Model.

E. Disparities in Access to Culturally Appropriate Care

DCF Activities:

- One of DCF's established cross cutting themes is a commitment to is addressing racial inequities in all areas of our practice. As such a statewide Racial Justice Workgroup has been established inclusive of internal and external stakeholders. The agencies review of services includes a focus of race/ethnicity elements in terms of those referred, those served and outcome activities. DCF has benefitted from consultation from a national expert assisting teams in identifying key areas to reduce disparity and disproportionality.

- DCF through the ***CONNECT*** federal SAMHSA grant developed a Cultural and Linguistic Competency work group and hired technical assistants to work with behavioral health providers to develop their own Health Equity Plan. Three cohorts have been established. Cohort A included 12 behavioral health providers from around the state and they completed their Health Equity plans on June 29th 2016, and presented them to a statewide group of CLAS experts. Cohort B will be 14 behavioral health providers and is currently being selected. Cohort C will be over 30 providers and will begin in the fall. Cohort A is currently in the process of implementing their Plans.

Other State Department Activities:

Court Support Services Division (CSSD)

The Judicial Branch is committed to providing equal access to justice and eliminating barriers related to linguistic or cultural differences. The Judicial Branch has an extensive limited English proficiency (LEP) initiative that works to address the communication needs of clients. Access to interpreters, the use of language-line services, and adherence to CLAS standards are embedded in each CSSD service contract, as well as, used by all Judicial Branch staff.

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

The Judicial Branch is committed to addressing implicit bias in court personnel's decision making and raising awareness of how unconscious bias impacts interactions with clients, the identification of needs, responses to behavior, access to care, and access to justice. CSSD has developed a training series related to cultural competence and responsiveness for all employees and offers additional workshops on understanding and working with specific populations. In addition, CSSD utilizes a "brown bag lunch series" to bring one-hour discussions on cultural differences and biases to local offices on a routine basis. One of the most popular discussions features The Color of Justice documentary developed by the state's Juvenile Justice Advisory Committee in response to racial and ethnic disproportionately and disparity in the juvenile justice system.

Department of Mental Health and Addiction Services (DMHAS)

- DMHAS Young Adult Services has been working on insuring that youth are included in all aspects of programs development. Youth advisory boards have been established at the young adult program sites. Staff has received and continues to receive training on youth culture and issues that impact youth's access to care.
- Connecticut's SSHS initiative leverages the efforts of its Office of Multicultural Healthcare Equality (OMHE) to address health and education disparities and assures that cultural competence is an integral quality of all services provided through the initiative.

F. Family and Youth Engagement

DCF Activities:

- DCF has made parents, young adults, youth, other family members and family advocacy groups' key members of the Children's Behavioral Health Plan Implementation Advisory Board. Preparations are underway to complete another round of "Community Conversations" to gather updated information and continued feedback from and partnership with families as Behavioral Health Plan activities continue. We will be doing this using the ***CONNECT*** six Family Engagement and Action Teams (FEAT). The first round of the follow-up Community Conversations will occur in late September. The role of the FEAT

teams is to coalesce and motivate the diversity of family support and advocacy groups throughout the state into an umbrella of unified family voices.

- DCF has made family and youth involvement a priority in both the implementation of the CME and the ***CONNECT*** federal grant. The ***CONNECT*** grant requires that all committees and workgroups are no less than 50% family members. FAVOR and AFCAMP, have played a major role in the implementation of the CME.

Other State Department Activities:

Court Support Services Division (CSSD)

CSSD puts much attention on youth and family engagement through its recidivism reduction efforts, particularly through client and family engagement staff training, the use of motivational interviewing, and strengths-based case planning and case management. CSSD is highly successful in engaging families in case review team meetings, home visits, and comprehensive discharge planning.

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

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

In 2014, CSSD implemented a family engagement pilot at the Hartford Juvenile Probation Office and Detention Center in an effort to work more effectively with families that staff was struggling to engage. CSSD contracted with AFCAMP to provide family engagement services through the uses of a family engagement specialist who worked with referred families to educate them on the juvenile justice system, eliminate barriers to engagement, and develop self-advocacy skills. The program served approximately 40 families over two (2) years and exceeded all expectations. Unfortunately, due to the state fiscal crisis, the program funding was eliminated for FY17.

Department of Mental Health and Addiction Services (DMHAS)

- The CT Adult Mental Health Planning Council provided funds from the Mental Health Block Grant to South-West Regional Mental Health Board to create a technology-based approach to engaging youth and young adults in the mental health/recovery services. The project is youth driven and managed and the result has been a web-based resource called TurningpointCt.org. It is for adolescents who are looking for answers regarding mental health issues, sharing of stories and resources for help. The project is in the process of mapping the behavioral health and wellness services and supports aimed at youth and their families that exist in CT.

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

- The Youth Advocate and Outreach Specialist for the ***CT Strong*** grant has assembled a group of youth leaders from across CT whose vision is to ensure that "Every young person will achieve a healthy transition into adulthood." The group, Youth Leaders Partnership, is driven by young adults who promote culturally appropriate services by building relationships and bridging systems to enhance outcomes for youth in the community.

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

- DMHAS Young Adult Services Family Initiative is comprised of program managers, supervisors, providers and clients from around the state to identify and disseminate knowledge on how clients can engage and involve family members and other supportive connections in their recovery.

State Department of Education (SDE)

The SDE is implementing the U.S. Department of Education's **Dual Capacity- Building Framework** for expanding school-family partnerships, including components that (1) describe capacity challenges that must be addressed so as to cultivate effective home-school partnerships; (2) articulate the conditions necessary to ensure successful family-school partnerships initiatives and interventions; (3) identify intermediate capacity goals that should be the focus of family engagement policies and programs; and (4) describe the capacity-building outcomes for schools and families. The SDE, in collaboration with the State Education Resource Center (SERC), the Commission on Women, Children and Seniors (formerly Connecticut Commission on Children) and other key partners, convened a statewide family engagement conference for school personnel, families, family engagement professionals and community leaders entitled *High-Impact Strategies for Family-School Partnerships:* http://www2.ed.gov/documents/family-community/ct-framework.pdf. A subsequent blog was published on the U.S. Department of Education's Web site related to the conference: http://www.ed.gov/family-and-community-engagement/bulletin-board/promoting-equity-through-family-school-partnerships. A second conference is planned for October 2016, which will further develop capacities for family engagement, specifically targeting those districts participating in complimentary projects and initiatives, such as the ***School Based Diversion Initiative, School Climate Transformation***

Grant and the Safe Schools/Healthy Students project . Additionally, the SDE is creating the Commissioner's Roundtable for Family and Community Engagement in Education to advise the Commissioner of Education regarding policy and programmatic priorities to improve outcomes for all students. The membership of the roundtable will be comprised of a culturally, racially, ethnically and linguistically diverse group of parents and guardians, school and district staff, community representatives and students.

The SDE supports a systematic and comprehensive delivery of services, programs and practices to meet the physical and mental health needs of all students. This approach will help reduce the health and educational disparities facing Connecticut students and ensure that all students have the opportunity to thrive academically and become healthy, productive citizens. The Connecticut State Board of Education (CSBE) has recently approved its Five-year Comprehensive Plan: *Ensuring Equity and Excellence for All Connecticut Students*. The plan addresses the importance of schools ensuring that students' "non-academic needs are met so they are healthy, happy and ready to learn." The CSBE further acknowledges available resources, including the ***SBDI*** and, increase in the utilization of EMPS-Mobile Crisis to reduce chronic absenteeism, punitive disciplinary practices and school-based arrests. The plan recognizes the importance of collaborative relationships and the commitment of critical partners at both the state and local level in improving student outcomes.

The SDE, in collaboration with DCF, CSSD, DMHAS, DPH and others, is developing strategies to ensure sustainability, continuity and expansion of the services that have been initiated through grant funding. Many of these components have provided important lessons learned on critical services for youth to reduce arrest, violence, interruptions of educational progress and the negative consequences of untreated mental and behavioral health conditions. These efforts are directed toward addressing school-community linkages; standardizing school approaches to behavioral health crises; and integrating best practices learned from multiple interventions and initiatives.

G. Workforce

DCF Activities:

- DCF through the ***CONNECT*** workforce development committee has developed three family training curriculums: the ***Network of Care-Agents of Transformation (NOC-AOT)*** training curriculum; ***Persuasive Story Telling, and Data 101***. Each of these one-day curriculums train volunteer parents, caregivers and other family members to be comfortable and competent in the behavioral health system and prepare them to be more informed partners in the behavioral health system. To date over 350 family members have been trained.

Other State Department Activities:

Court Support Services Division (CSSD)

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

CSSD has implemented two significant initiatives during the last three years related to substance use and trauma. CSSD underwent a comprehensive review of its substance use service delivery system with consultation provided by Dr. Lou Ando, former behavioral health and quality improvement bureau chief at DCF, Mr. Peter Panzarella, former substance abuse division director at DCF, and Dr. Yifrah Kaminer, adolescent substance use expert at UCHC. CSSD continues to implement the recommendations from that review. The substance use screening and assessment process has been streamlined. A continuous quality improvement rapid cycle change initiative has been implemented with Juvenile Probation Officers and CSSD contracted providers to streamline access to care and to effectively use available, but limited, resources. CSSD is working with DCF, DMHAS and UCHC through the IMPACCT grant to further define and address workforce training needs.

CSSD has also worked to integrate an understanding of the impact of trauma on child and adolescent behavior in order to make CSSD staff and services trauma-informed. Through the Trauma-focused Cognitive Behavioral Therapy (TF CBT) Learning Collaborative, in partnership with DCF and CHDI, juvenile probation officers, clinical coordinators, and contracted service providers have been trained in trauma, trauma-informed care, trauma screening and working effectively with TF CBT providers. TF CBT providers have been conjointly trained with CSSD staff and contracted providers in order to learn about the juvenile justice system, to increase communication and coordination between systems, and to effectively engage court-involved children, youth and families. Juvenile Probation and CYFSC providers have implemented the Connecticut Brief Trauma Screen statewide to identify children and youth in need of trauma services. CSSD continues to participate in this joint effort with DCF and CHDI to ensure that court-involved youth are screened for trauma, referred for trauma assessments and treatment services as appropriate, and to support youth and family engagement.

Department of Mental Health and Addiction Services (DMHAS)

- DMHAS YAS in collaboration with UCONN has received a grant from HRSA to provide internships for 18 second year or advanced placement master level social worker's in young adult programs for the next 3 years. DMHAS and UCONN will be providing training for these social workers in an effort to establish a skilled workforce for youth with mental health and substance use issues.

The Office of Early Childhood (OEC)

- For the past 3 years the OEC Birth to Three System has used federal dollars through the ***State Personnel Development Grant (SPDG)*** to train providers through learning communities using the Pyramid Model approach and its resources for working with families in challenging situations (poverty and severe socio-economic stress, domestic abuse, substance abuse,

mental health issues, parents with intellectual disabilities, medically fragile, chronically ill and terminally ill children).

- In April 2016 the 23rd annual **Together We Will** Conference focused on Serving all Children and Families in Challenging Situations. Over 400 early childhood and family support staff attended and local and national speakers addressed issues such as homelessness, substance abuse, and early childhood trauma.

- In 2016, OEC will provide four Touchpoints® training and train 90 participants to family support providers within OEC evidence based home visiting programs. The training on the Touchpoints® model by T. Berry Brazelton, MD, promotes the idea that all development for a child takes place within and in interaction with relationships and that development is enhanced when the parent-child relationship is strengthened. The goal of Touchpoints® is to support parents and therefore children in developing the basic trust that is vital to naturally develop healthy interdependence.

- To date, the OEC has provided training in Triple P (Positive Parenting Program®) to more than 160 community providers working with families, including staff in public schools, libraries, family resource centers and organizations offering behavioral health services. Triple P is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers.

In summary, seven state Departments have contributed to multiple activities currently underway to support the seven thematic areas of the Children's Behavioral Health Plan. These activities and the thematic areas are grounded in the belief that Connecticut will achieve a truly integrated behavioral health system that cares equally for all children, youth and their families, (regardless of race, ethnicity, insurance status or income) through a multi-state department and multi-stakeholder partnership with families, children and youth as equal partners in all system transformation efforts. As is outlined in this report and its supporting document, many of these efforts include collaborative efforts among multi-state agencies and other key stakeholders. Such collaborative efforts only serve to enhance the opportunity for success and long term sustainability.

In reviewing the information provided by the state departments for inclusion in this report, along with the summary table, members of the advisory board determined that going forward, incorporating additional information into the table would be helpful for future planning purposes. While the report provides updates about a wide array of very important services, programs and system initiatives that are underway, additional information is needed to determine the scope of impact (e.g. , penetration rates for those in need, are there inclusionary and exclusionary eligibility requirements; geographic reach, etc.).

Summary information about time-limited funding and sustainability plans for various initiatives is also important to evaluating ongoing system scope and capacity. Considering the current and future fiscal climate in Connecticut, this information will be important in helping this Advisory Board to assess the adequacy of resources and make recommendations about resource

development and distribution that will help to support the goals of the Children's Behavioral Health Plan. An Advisory Board workgroup will recommend including additional reporting categories for the departments contributing to the next annual update report to facilitate the collection of information to assist in system assessment and planning.

Appendix A

Children's Behavioral Health Plan Implementation Advisory Board Members

Name	Title	Organization
Patricia Baker	President & CEO	Connecticut Health Foundation
Tanya Barrett	Sr. Vice President	211 United Way of CT
Josephine Bennett	Family Member	
Elisabeth Cannata *	Vice President	Wheeler Clinic
Kendell Coker	Assistant Professor/Advocate	University of New Haven, College of Criminal Justice & Forensic Sciences
Brunilda Ferraj	Senior Public Policy Specialist	Connecticut Community Nonprofit Alliance
Cathy Foley-Geib	Manager	Judicial Branch Court Support Services Division
Hector Glynn, MSW	Vice President- Outpatient & Community Services	The Village for Families & Children
Susan Graham	Family Member	
Grace Grinnell	Family Member	
Phil Guzman	Provider/Retired	
William Halsey	Director, Behavioral Health	Department of Social Services
Jo Hawke	Executive Director	FAVOR
Steven Hernandez	Executive Director	CT Commission on Women, Children and Seniors
Lynn Johnson	Director of Family Services	Office of Early Childhood
Allon Kalisher	Regional Administrator	Department of Children and Families
Mark Keenan	State Title V CYSHCN Director	Department of Public Health
Theresa Kane	Superintendent	East Windsor Public Schools
Steve Korn	Medical Director	Anthem
Sharon Langer	Advocacy Director	Connecticut Voices for Children
Carol Poehnert	Family Member	
Nikki Richer	Director of Operations	DMHAS Young Adult Services
Steve Rogers	Division of Emergency Medicine	CT Children's Medical Center
Knute Rotto	CEO of Operations	Beacon Health Options, Inc.
Charlene Russell-Tucker	Chief Operating Officer	State Department of Education

Carl Schiessl *	Director, Regulatory Advocacy	CT Hospital Association
Ann Smith *	Executive Director	AFCAMP
Karen Snyder	Consultant	Office of the Child Advocate
Jeff Vanderploeg	Vice President for Mental Health	Child Health and Development Institute of Connecticut
Doriana Vicedomini	Family Member	
Valerie Wyzykowski	Nurse Case Manager	Office of the Health Advocate
Jesse White-Frese	Executive Director	School Based Health Centers
Katherine Wade	Commissioner	CT Insurance Department
Beresford Wilson	Family Member/FSM	FAVOR
Robin Wood	Director, Family Support Strategies & Advocacy	Department of Developmental Services
*** - Tri-chairs**		

Appendix B

SERVICES	DESCRIPTION	Husky A Covered	Husky B Covered	Husky C & D Covered
INPATIENT - PSYCHIATRIC				
Psychiatric Hospitalization	Inpatient psychiatric hospitalization	Y	Y	Y
CHILD AND ADOLESCENT RAPID EMERGENCY SERVICE (CARES)				
C.A.R.E.S. Outpatient (Evaluation) - Hartford Hospital	C.A.R.E.S. - Treatment Room - Evaluation	Y if age 5-17	Y if age 5-17	Y if age 5-17
C.A.R.E.S. Inpatient - Hartford Hospital - Crisis Stabilization Unit	C.A.R.E.S. - All Inclusive Room & Board			
OBSERVATION SERVICES				
23 Hour Observation	23 Hour Observation	Y	Y	Y
PSYCHIATRIC RESIDENTIAL TREATMENT SERVICES				
Psychiatric Residential Treatment Facility (PRTF)	Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem	Y if age < 21	Y if age < 21	Y if age < 21
DCF RESIDENTIAL SERVICES (DCF INVOLVED YOUTH)				
DCF Residential Treatment Center	DCF Funded Residential Care	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Group Home - 2.0	Therapeutic Group Home - Intensive Staffing	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Group Home - 1.5	Therapeutic Group Home	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Group Home - 1.0	Group Home - without therapeutic services	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Foster Care-Treatment Foster Care	Treatment Foster Care	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Foster Care-Therapeutic Foster Care	Therapeutic Foster Care	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF Foster Care-Professional Parents	Professional Parents	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
DCF One-to-One Support	One to One Support to Client in DCF Residential or Group Home Setting	DCF Involved Youth	DCF Involved Youth	DCF Involved Youth
EMERGENCY MOBILE PSYCHIATRIC SERVICES				
Emergency Mobile Psychiatric Services (EMPS)	Mobile Crisis Unit Response - initial evaluation	Y age < 21	Y age < 21	Y age < 21
	Mobile Crisis Unit Response -follow-up			
INTERMEDIATE CARE PROGRAMS				
Partial Hospitalization (PHP)	Partial Hospitalization - Mental Health/Substance Use	Y	Y	Y
Intensive Outpatient (IOP)	Intensive Outpatient - Mental Health/Substance Use	Y	Y	Y
Extended Day Treatment (EDT)	Extended Day Treatment	Y	Y	Y
MEDICAL PSYCHIATRIC THERAPY - ELECTROCONVULSIVE TREATMENT THERAPY				
Electroconvulsive Therapy (ECT)	Electroconvulsive Therapy	Y	Y	Y
HOME BASED SERVICES				

Home Based Services (IICAPS)	Intensive In Home Children and Adolescent Psychiatric Services	Y if age < 21	Y if age < 21	Y if age < 21
Home Based Services (MST)	Multi-systemic therapy	Y if age < 21	Y if age < 21	Y if age < 21
Home Based Services (MDFT)	Multi-dimensional family therapy	Y if age < 21	Y if age < 21	Y if age < 21
Home Based Services (FFT)	Functional family therapy	Y if age < 21	Y if age < 21	Y if age < 21
	SCREENING			
Behavioral Screening	Developmental Screen and Score	Y	Y	Y
	Developmental Testing; extended with interpretation and report			
	Brief emotional/behavioral Assessment			
	AUTISM SPECTURM DISORDER SERVICES			
Comprehensive Diagnosis & Evaluation	Behavior identification evaluation, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	Y	N	Y
Assessment/Treatment	Behavior Assessment	Y	N	Y
	Mental health service plan development			
	Skills and Training Development, per 15 minutes			
	PSYCHOLOGICAL-NEUROLOGICAL TESTING			
Psych Testing - Neuropsych Testing	Psychiatric Services Evaluation	Y	Y	Y
	Psychological Testing			
	Neuropsychological Testing			
	NEUROBEHAVIORAL STATUS EXAM			
Neurobehavioral Status Exam	Neurobehavioral Status Exam	Y	Y	Y
	OUTPATIENT SERVICES			
Outpatient Services	Psychiatric Evaluation	Y	Y	Y
	Individual Psychotherapy			
	Family Psychotherapy			
	Group Psychotherapy			
	Medication Management			
	Preventative Counseling Group - Smoking Cessation			
	SMOKING CESSATION			
Smoking Cessation	Smoking and tobacco use cessation counseling visit	Y ***	Y ***	Y ***
	Smoking and tobacco use cessation group counseling; 1 unit per day			

*** Coverage available for all HUSKY A, C and D members, but restricted to only pregnant HUSKY B members.

INDIRECT SERVICES

Case management	Case management, per 15 minutes, coordination of health care services	Y if age < 19	Y if age < 19	Y if age < 19
EARLY AND PERIODIC SCREENING, DIAGNOSITC & TREATMENT				
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Behavioral Health	Special services - These are all single case agreements.	Y	Y	Y

SERVICES	DESCRIPTION	Husky A Covered	Husky B Covered	Husky C & D Covered
INPATIENT - PSYCHIATRIC				
Psychiatric Hospitalization	Inpatient psychiatric hospitalization	Y	Y	Y
INPATIENT DETOXIFICATION				
Inpatient Detox	Detoxification in an inpatient hospital	Y	Y	Y
23 Hour Observation	23 Hour Observation	Y	Y	Y
INTERMEDIATE CARE PROGRAMS				
Partial Hospitalization (PHP)	Partial Hospitalization - Mental Health/Substance Use	Y	Y	Y
Intensive Outpatient (IOP)	Intensive Outpatient - Mental Health/Substance Use	Y	Y	Y
Extended Day Treatment (EDT)	Extended Day Treatment	Y	Y	Y
MEDICAL PSYCHIATRIC THERAPY - ELECTROCONVULSIVE TREATMENT THERAPY				
Electroconvulsive Therapy (ECT)	Electroconvulsive Therapy	Y	Y	Y
ADULT GROUP HOME SERVICES				
Mental Health Rehabilitation in Adult Group Home Setting	Rehab Services in Adult Group Home	Y	N	Y
METHADONE MAINTENANCE				
Methadone Maintenance	Methadone Maintenance (includes methadone detoxification)	Y	Y	Y
PSYCHOLOGICAL-NEUROLOGICAL TESTING				
Psych Testing - Neuropsych Testing	Psychiatric Services Evaluation Psychological Testing Neuropsychological Testing	Y	Y	Y
NEUROBEHAVIORAL STATUS EXAM				
Neurobehavioral Status Exam	Neurobehavioral Status Exam	Y	Y	Y
SCREENING				
Behavioral Screening	Developmental Screen and Score Developmental Testing; extended with interpretation and report Brief emotional/behavioral Assessment	Y	Y	Y
AUTISM SPECTURM DISORDER SERVICES				

Comprehensive Diagnosis & Evaluation	Behavior identification evaluation, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report Y	N	Y	
Assessment/Treatment	Behavior Assessment	Y	N	Y
	Mental health service plan development			
	Skills and Training Development, per 15 minutes			

Outpatient Services	Psychiatric Evaluation	Y	Y	Y
	Individual Psychotherapy			
	Family Psychotherapy			
	Group Psychotherapy			
	Medication Management			
	Preventative Counseling Group - Smoking Cessation			

OUTPATIENT SERVICES SMOKING CESSATION

Smoking Cessation	Smoking and tobacco use cessation counseling visit	Y ***	Y ***	Y ***
	Smoking and tobacco use cessation group counseling; 1 unit per day			

***Coverage available for all HUSKY A, C and D members, but restricted to only pregnant HUSKY B members.

Home Health Agency Services	Nursing assessment / evaluation (1 per year)	Y	Y	Y
	Nursing, in home			
	Services of a qualified nursing aide			
	Physical Therapy Evaluation			
	Physical Therapy			
	Occupational Therapy Evaluation			
	Occupational Therapy			
	Speech Pathology Therapy Evaluation			
	Speech Pathology Therapy			
Medication Administration Tech	Home Health Aide or Certified Nurse Assistant	Y	Y	Y

HOME HEALTH AGENCY SERVICES

Medication Box Monitoring	Medication reminder service, non-face-to-face	Y	Y	Y

HOME HEALTH - MEDICATION BOX MONITORING