

# Connecticut Children's Behavioral Health Plan: Progress Report

## Executive Summary

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

October 1, 2017

Submitted by

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

The Department of Children and Families and the Children's Behavioral Health Plan Implementation Advisory Board are submitting this report in fulfillment of the requirements of Public Acts 13-178 and 15-27. On or before October 1, 2015, and biennially thereafter through and including 2019, the department shall submit and present progress reports on the status of implementation, and any data-driven recommendations to alter or augment the implementation in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children and appropriations. 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.

## **Letter from Commissioner of the Department of Children and Families**

Connecticut's children and families have benefitted from the passage of PA 13-178 and PA 15-27 in developing a framework and a set of expectations specific to coordination, integration and collaboration across systems and across payers. The input gathering process that provided valuable feedback about what was working well and which areas needed improvement was repeated in 2016-17 in a continued effort to benefit from consumer and stakeholder feedback. The 2014 Behavioral Health Plan called for increased attention in several areas including: system organization and financing, health promotion, prevention and early identification, a comprehensive service array, greater integration between primary care and behavioral health, disparities in service delivery and outcomes, increased family and youth engagement and greater investment in workforce development. Connecticut has the benefit of a robust service array delivered through various agencies and organizations in recognition that different agencies have different yet equally important mandates which when taken as a whole, offer a range of supports across disciplines and across the lifespan. This report represents the work done by so many. To that end there, much progress has been made though there remains more to do.

Over the last 3 years there has been a number of outcomes that have supported key elements outlined in the thematic areas. A fiscal map template has been developed and applied to two state agencies with the hopes that the remaining agencies named in legislation will also participate. This effort highlighted deficiencies that needed development, for example the lack of adolescent substance use screening and recovery supports. With the advent of the Governor's Open Data Portal, data is becoming increasingly more available and accessible. This is critical as it allows an examination of services, supports and outcomes at both the statewide level and the community level and further informs and empowers consumers. Early identification and access to care were central during the plan's development. Since its submission, there has been increased access to behavioral health screening, specifically related to trauma and substance use, and the use of those screening tools has been widely adopted across behavioral health, education, pediatric and juvenile justice settings. A number of partners joined together to create and implement the Connecticut Trauma Screen, and since 2014 more than 20,000 children and youth have been screened. There has been increased access to mobile crisis and the expansion from 14 to 82 crisis stabilization/respite beds across the state. Connecticut has seen an expansion of evidence based treatment models to respond to the needs identified through screening with a particular emphasis on trauma informed care and increased access to services that support schools. Moreover, with recognition of the lack of psychiatric support in CT and nationally and the benefits to integrated care, ACCESS MH has proven to be a supportive and accessible tool to practitioners across the state further enabling them to support the children and youth they serve. With an expanded evidence based service array comes the need for workforce development. Implementation and investment in these services has required an investment in training, coaching and evaluation. Another identified theme was addressing disparities in service provision. In response, public and private agencies have engaged in self assessments and the development of health equity plans to improve access and service delivery. While these system changes represent progress in improving access and outcomes, there are still improvements to be made.

When reviewing efforts to advance the system level components, as noted above, the framework is in place for continued fiscal mapping across the serving system. As the state continues to examine its investments, fiscal mapping across all service systems will continue to inform program development to best meet needs across the state. Efforts to scale up and build upon those models that demonstrate success continue, though funding challenges are a part of the state's reality. In addition, children and families experiences are often

intertwined among multiple agencies. The absence of a single unique identifier makes it challenging to fully assess and understand a family's experience across systems.

From the direct service perspective, though gains have been made – screening is not consistently applied or accessible in all corners of the state; nor are some of the evidence based treatment models that are yielding improved outcomes for children and families.

Progress should be acknowledged while recognizing that it is that progress that motivates us to learn from what's working, to pay attention to what isn't and to continue to build on the sound recommendations offered to the State in the development of the 2014 plan. Key opportunities would include continued collective commitment to fiscal mapping that further informs investments in the service array, increased data submissions to the Governor's Open Data Portal and continued attention on unique identifiers to both better understand a child and family's experience and to create efficiencies in the service delivery system that will further support families.

Respectfully Submitted by Commissioner Joette Katz, DCF

## Executive Summary prepared by the Tri-Chairs of the Connecticut Children’s Behavioral Health Plan Implementation Advisory Board

The Children’s Behavioral Health<sup>1</sup> Plan Implementation Advisory Board (“Board”) submits the following report summarizing initiatives and activities underway to advance the recommendations outlined in the Plan, which was originally submitted to the general assembly on October 1, 2014.<sup>[2]</sup> Collaboration among community providers, family members and other advocates for children and families, and the multiple state departments and agencies that either offer services, regulate providers and payers, or represent children and families was a hallmark of the process that resulted in the development of the Plan. The need for ongoing collaboration among all key stakeholders has never been more critical given the state’s dire fiscal situation, growing limitations on available resources to address increasing demand for services, and uncertainty in federal healthcare policy. These challenges confirm the wisdom of establishing a mechanism through the Plan and Board to seek input and coordinate data from all of the legislatively-identified departments and specifically-identified stakeholders that are included on the Board. We know from the research that population health and well-being is promoted by early prevention, detection and intervention. Attending to the behavioral health of our children and adolescents is not only critical for improving their life outcomes, it is also fiscally prudent. Research consistently demonstrates the long-term adverse impact on individuals and communities when children’s behavioral health needs are not addressed. If Connecticut continues to enhance access, scope and quality in our children’s behavioral health system, we will have significant cost savings to healthcare across the lifespan.

### *Summary of Progress to Date*

Key stakeholders in the Connecticut children’s behavioral health system continue to invest energy and commitment toward achieving the goals of the Children’s Behavioral Health Plan. This is evident from the **new and ongoing activities related to detection, prevention and promotion of children’s behavioral health** in all seven thematic areas outlined by the Plan and reported by each contributing partner in the attached Update Report. This energy and commitment is also seen in the thoughtful contributions from appointed members of the Connecticut Children’s Behavioral Health Plan Implementation Advisory Board, and by expressed interest to promote the work of the Plan from other organizations that play important roles in advocacy and the promotion of child and family wellbeing. While the submissions to the Update Report continue to be received and reported under separate department headings, review of the activities included reflect **increasing collaboration and strengthened partnerships** in numerous behavioral health prevention and promotion activities, systems advocacy and successful federal grant applications that help to bring resources to our system. In reviewing the reports from multiple state departments and agencies, there is

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[1] Behavioral health is defined by the Substance Abuse and Mental Health Administration (SAMHSA) as: *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.* The Advisory Board respectfully adds that to ensure the behavioral health of children and adolescents it is critical to consider the behavioral health of caregivers and the interactional impact of child and caregiver wellbeing.

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

evidence of significant progress in the **inclusion of consumer and family voice and meaningful participation in shaping the children's behavioral health system.**

The work of the Advisory Board has been advanced in significant part by the resources DCF has dedicated through certain federal demonstration grants that have aligned well with Plan goals. The CONNECT grant, for example, has provided some of the infrastructure and resources to support the development of templates for fiscal mapping and for system evaluation that are foundational to implementation of the Plan. These templates have begun to be populated with information from DCF and Medicaid claims and preliminary results suggest great promise for moving the system evaluation work of the Plan forward. Further advancement of these aspects of the Board's work will require that other departments and funders contribute service and fiscal information to the templates. Members of the advisory board have suggested that consideration of other funding models may be a way to achieve many of the goals of the plan; such consideration would be facilitated by expanded and integrated fiscal and service system mapping.

Other challenges to achieving the goals of the plan and to assessing full progress were highlighted through the process of preparing the Update Report. While the partnering state departments and agencies included in PA 15-27 reported on a number of important activities and initiatives underway over the past year, the Board had hoped the reports would have a greater focus on data about impact, scope of coverage and access to services across demographics and geographical locations. More precise assessment of the progress of the implementation of the Plan requires more data from all stakeholders about who is being served through the many reported services and initiatives, where services are available or missing, and objective data about whether the reported activities have positive impact in promoting behavioral health for those served. Consideration and identification of more global metrics to assess the effectiveness of the children's behavioral system was also recommended. These indicators could be selected to represent different critical points in the system where improvement would be anticipated as the implementation of the Plan moves ahead.

The plan itself is expansive and broad sweeping with many areas for attention and monitoring. This has been challenging to manage, evaluate, summarize and report back on without dedicated staffing. Attention to multiple areas of the children's behavioral health system may diffuse the focus and slow down progress in any one area of the Plan. As the advisory board reviewed the submissions for the current Update Report, it was suggested that a more targeted focus by the board on one or two goals of the Plan would be more strategic for promoting system improvement. The area of screening for behavioral health concerns was identified as one potential area for more in-depth focus over the upcoming year, with recognition that this focus and resulting enhancements to the system will have an impact across multiple domains of the Plan.

Another critical area for further attention identified by the advisory board, is the challenge of different client identifiers used by each child serving system. Even as each stakeholder's data becomes more available and coordinated, such as through fiscal and network mapping, cross-system analysis of impact will remain difficult as long as each system is required and able to report on services delivered to its own clients without being able to cross reference whether those same clients received services elsewhere. Establishment of a common client identifier across systems would allow for calculation of cumulative costs and client-specific outcomes across providers and programs, thus allowing for a more informative service system evaluation. A common client identification system would also promote better assessment of how many children (i.e. un-duplicated counts of children in need) are actually being identified and connected to services and supports.

### *Moving Forward with Plan Implementation*

PA 13-178 established a 5 year timeline providing the guidance that fuels the Advisory Board's sense of urgency to effectively advance the goals of the Plan. While such urgency is critical, it is important to note that PA 15-27 recognizes that the children's behavioral health field evolves and the needs of various populations change over time. As such, it is incumbent upon the Board to engage in an ongoing critical examination of the service system from System Infrastructure, Health Promotion, Treatment and Aftercare, in order to make informed recommendations to the legislature for continued enhancements, adjustments and investments.

The overarching goal of the Plan is to construct a strong and sustainable behavioral health system that prevents, identifies, and addresses the behavioral health needs of all children in Connecticut. Now more than ever it is critical to underscore the elements that are essential to achieving this goal:

- I. Timely contribution of data from every key agency and department, delivered in a manner that will allow for meaningful network analysis and fiscal analysis by the Board;
- II. Improved communications, integration, and coordination between the Board and every public and private entity that interfaces with behavioral health in order to ensure the most effective and efficient allocation of resources;
- III. Ongoing assessment of Plan priorities to determine which goals may be reasonably accomplished in the short term, to develop strategies to achieve long-term goals, and to adjust Plan timelines as may be appropriate; and
- IV. Dedicated staff to ensure the advancement of Plan goals and to meet statutory obligations and legislative expectations.

### *Summary and Recommendations*

The behavioral health service system for children in Connecticut continues to have many strengths, not the least of which is a commitment across multiple state departments and the provider and advocacy networks to improve the wellbeing of children and families, and to enhance access to and coordination of services that is evident throughout the submissions that were received for the report. There is much work ahead, however, to achieve the goals set forth in the plan. In order to promote the work ahead, the following recommendations are offered to maximize progress on plan implementation going forward:

1. Amend the enabling statute to require state agencies and departments to provide data on or before an annual deadline that will enable the Board to generate a complete report to the general assembly. Submitted data must include information about access, financing and scope of impact so that the mapping of resources and areas of need can be better identified
2. For the Board to choose one to two targeted goal(s) from the plan and remain focused on achieving and monitoring progress and barriers to achieving that/those goal(s).
3. To establish a workgroup with representation from departments with a critical role for each target area identified, that will meet with more regularity than the full advisory Board to examine implementation strategies, barriers and impact.
4. Obtain modest yet sufficient funding to staff the coordinating work of the Board in order to advance the achievement of Plan goals. The Board will explore public and private funding sources and/or

engagements with partners who could support the collection, coordination, and compilation of information and data.

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

Enactment of these recommendations will provide sufficient mandate, incentive, focus and dedicated resources to enable the Board to fulfill its obligation and better inform and shape the work being done to achieve full implementation.

We thank the departments and agencies that contributed information for inclusion in this Report. We underscore that it will remain critical that adequate data, network, and fiscal analysis continue and that information is provided to the Board in a timely manner. We implore every stakeholder who works with children or their caregivers, or who funds, provides, or evaluates behavioral health services, to work in a coordinated and collaborative way with the Board to maximize the impact and effectiveness of existing detection, intervention and prevention resources, identify and help fill resource gaps in the system, and ensure the well-being of Connecticut's children. We are grateful for the opportunity with our fellow Board members to shepherd the implementation of the Children's Behavioral Health Plan. We look forward to working with the General Assembly to realize the vision set forth in the Plan. Respectfully submitted,

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

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The development of the Children's Behavioral Health Plan (CBHP) and the subsequent progress reports have been submitted by the Department of Children and Families (DCF) in collaboration with key stakeholders and the agencies named in PA 15-27:

1. *Department of Developmental Services (DDS)*
2. *Department of Social Services (DSS)*
3. *Department of Public Health (DPH)*
4. *Department of Mental Health and Addiction Services (DMHAS)*
5. *Connecticut State Department of Education (CSDE)*
6. *The Connecticut Insurance Department (CID)*
7. *The Office of Early Childhood (OEC)*
8. *The Office of the Child Advocate (OCA)*
9. *The Office of the Healthcare Advocate (OHA)*
10. *The Judicial Branch -Court Support Services Division (CSSD)*
11. *The Commission on Women Children and Seniors (formally Commission on Children) (CWCS)*

This report offers an update 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 and demonstrates the achievement of key outcomes. It also highlights the investment of multiple state agencies to advance the goals of the Children's Behavioral Health Plan while also identifying areas in need of improvement to remain consistent with the core mandates of the 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; Office of Policy and Management's CT Data Portal). We are optimistic that data and additional information necessary to further advance the Children's Behavioral Health Plan will be available through these activities to better inform and shape the work that lies ahead to achieve full implementation while developing an infrastructure to support this work well into the future.

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 best 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.

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

Of the twelve partner agencies, eight agencies provided a response under section A.

Central to the 2014 plan was needed attention on System Organization, Financing and Accountability. Identified by many through the input gathering process was a sense of fragmentation as a result of multiple payers, different eligibility criteria, lack of coordination, access to data at the local level and geographic challenges relative to service provision. This section will outline progress while noting continued areas of attention. Over the last three years there are multiple examples of increased coordination.

A major advancement was the completion of a process and template for fiscal mapping. DCF and DSS began and there is continued interest in completing this across agencies. The opportunity for more careful analysis of system expenditures created by this financial mapping is noted in a couple of the bulleted sections below, including tracking proportional expenditures across the continuum of care, and using the information provided further inform specific efforts to fill identified gaps. In order to effectively understand how the system supports health promotion through treatment and recovery, continued financial mapping across systems and their respective mandates will crystalize what the system in full has and what it needs.

### **DCF Response**

- A key recommendation of the Plan was the creation of a Care Management Entity designed to streamline access to and management of services in a fully integrated system of behavioral health care for children. The first phase of development occurred in 2015 using the national wraparound model of practice and the Child and Family Teaming model. To date the CME has served mostly DCF involved youth or non-DCF children being discharged from Psychiatric Residential Treatment Facilities (PRTFs). Capacity is limited at this time, serving approximately 120-160 youth annually.
- DCF has continued to enhance the fiscal map of the total behavioral health contracted expenditures for state fiscal year 2015. DCF substance use and mental health service fiscal mapping is complete. Additionally, Beacon Health has completed a fiscal map inclusive of the substance use mapping and mental health use of Medicaid claims data for the same fiscal year. It is the Board's hope that other state departments will participate in the fiscal mapping of their behavioral health expenditures. Preliminary results show that DCF spends most of its Behavioral Health dollars in the treatment setting, with much less spent in health promotion, prevention, and aftercare and recovery.
- Fiscal mapping specific to the substance use service array was completed and identified gaps in screening and recovery supports for adolescents. As such DCF upon award of a federal grant focused its efforts to address those gaps. The timeframe for the grant is from 9/30/2017 – 9/29/2021 with a funding amount of \$800,000 annually.
- DCF is the lead in an application for the State School Mental Health Technical Assistance Opportunity. The primary goal of this project is to increase the number of school districts that complete the National School Mental Health Census and Performance Measures using the

School Health Assessment and Performance Evaluation (SHAPE) electronic self-assessment system.

In the next two years, DCF, CSDE, Child Health and Development Institute (CHDI) and Connecticut Children’s Medical Center-Injury Prevention Center – Injury Prevention Center (CCMC-IPC) will recruit up to 20 school districts to participate in this self-assessment process.

- Activities with the CONNECT federal system of care SAMHSA grant continue. Given that the central intent of the SAMHSA system of care grant is behavioral health system development, DCF has placed a high priority of on - ***System Organization, Financing and Accountability.***

These priorities align with the Connecticut Children’s Behavioral Health Plan and with .the three workgroups of the Children’s Behavioral Health Implementation Advisory Board (appendix A). The advisory group continues to meet quarterly on: September 12, 2016, February 27, 2017, May 1, 2017 and August 28, 2017. Work continues with the three work groups:

1. Fiscal Analysis and Mapping
2. Network of Care Analysis
3. Data Integration

Additionally, the work groups of the CONNECT federal System of Care grant are also aligned to behavior health system development and infrastructure support. These additional work groups include:

4. Workforce Development
5. Implementation of the national CLAS standards and racial justice activities.
6. Communication
7. Family and Youth Engagement
8. Early Childhood

Below is a brief description of all eight workgroups. Each of these workgroups and the activities associated with them are guided by:

- Vision
- Goal
- Key Strategies
- Work Plan
- Outcomes and Results
- Quarterly and annual updates

**i. Fiscal Analysis and Mapping:**

**Vision:** to identify current public spending and utilization patterns; monitor spending across time and possibly individuals served; support financing of appropriate services and supports; inform the development of a comprehensive financial plan that would allow children’s behavioral health spending to be most effective and efficient.

**Goal:** To create a fiscal map of all state and federal behavioral health expenditures that serve children and their families.

**Key Strategies:** Develop a template using current fiscal software to create a fiscal map that can be utilized across multiple child and family-sector mandates and the state departments' responsible for those mandates.

**Outcomes and Results:**

A fiscal Map template was developed using *Figure III.2 Array of Services and Support in the Connecticut Behavioral Health System of Care*. The five broadest categories with more detailed sub-categories include:

1. Health Promotion
2. Prevention
  - a. Identification and Early Intervention
  - b. Therapeutic Intervention
3. Support and Care
  - a. On-going supports
  - b. Family Strengthening
  - c. Transitions
  - d. Diversion
4. Treatment
  - a. Outpatient Care
  - b. Intensive Outpatient Care
  - c. Inpatient Care
  - d. Crisis Intervention
  - e. Congregate Care
5. Aftercare and Recovery
  - a. Withdrawal Management
  - b.
6. System Infrastructure Support
  - a. evaluation, quality management, performance improvement
  - b. racial cultural and linguistically competent care.

DSS Medicaid and DCF contractual behavioral health fiscal expenditures from state fiscal year 2015 have been completed. The advisory board is currently pursuing the addition of the expenditures of all the state departments and agencies that are named partners in this report.

**ii. Network of Care Analysis:**

**Vision:** To integrate all child serving systems into a seamless Network of Care to equally and effectively serve children and families in need and to reduce fragmentation of the behavioral health system in Connecticut.

**Goal:** Conduct an analysis of the Network of Care to examine the level of integration and collaboration between service sectors, providers and family members.

**Key strategies:**

1. Conduct a Network of Care analysis to assess the integration and collaboration among behavioral health programs.
2. Conduct a survey and focus group to assess the integration and collaboration among behavioral health and Pediatric primary care provider practices.

3. Conduct an assessment of the integration of behavioral health support within schools themselves and to assess the collaboration among schools and behavioral health services.
4. Conduct an assessment of the integration and collaboration among caregivers/parents and youth and behavioral health services.

### **Outcomes and Results:**

1. **Behavioral Health Collaboration** reports were finalized and these findings were presented in each of the six geographical regions. Regional work plans are currently being developed by using the data to inform local integration efforts.
2. **The Primary Care survey results were completed and final reports** were shared. In addition, six focus groups were held throughout the state. These focus groups utilize system support mapping that brought together primary care and behavioral health providers to discuss system needs. Formal recommendations were made that will be shared with primary care and behavioral health providers, as well as schools, caregivers/parents and youth. Additional strategies are currently under development for further integration of primary care and behavioral health.
3. **The school survey used a web-based system support mapping process.** The survey began in May and was completed in June. The survey was disseminated to school staff such as social workers, nurses, teachers, guidance, and administrators.
4. **The parent, caregiver, youth and other family member survey used a community-based participatory research process.** Thirty community conversations were held throughout the state between October 2016 and February 2017 receiving input from 484 people (333 adults and 151 youth) about what is working well, what is not working well, and gathering suggestions for change. This invaluable feedback was compiled and a report finalized.

Thirty community conversations were facilitated by FAVOR staff and Family Champions. The notes from each of the community conversations have been coded by two FAVOR staff and a member of the Yale Evaluation team. After the initial coding, the evaluation team reviewed the codes to insure that the inter-rater reliability was within acceptable levels. Overall, five categories emerged:

- **Service Characteristics** (access to services; agency policies; communication with families; individualized; strength-based; quality of service; quality of staff; professional development and respect);
- **Schools** (in-school resources; school climate; professional development; access to services/supports; respect);
- **Community Characteristics** (community resources);
- **Family Support** (caregiver support; youth support; recreational; basic needs; caregiver training); and
- **System Characteristics** (family voice; family choice; insurance; information; transitions; communications; professional development; policies; system gaps; respect).

The FAVOR team in collaboration with the evaluation team have analyzed half of the data. The data analysis should be complete by mid-July. A data summary will be developed and shared with the groups that provided input during the community conversations starting in early August. It is anticipated that a final summary of the findings will be available in October.

iii. **Data Integration:**

**Vision:** Improve statewide data sharing through a user-driven process across child serving sectors to drive planning, policy, budgeting and decision making to transform local, regional and statewide networks of care.

**Goal:** Provide an opportunity for families, providers and state agency partners to share and identify data needs, measure strength, gaps and opportunities to build an integrated statewide system.

**Key strategies:**

1. To collaborate with Office of Policy and Management (OPM) to support the Governor's Open Data Policy Executive Order and the development of the Open Data Portal website.
2. To collaborate with OPM to develop a Connecticut Data Work Plan.
3. To collaborate with OPM to support the CT Data Collaborative and the development of a user-friendly statewide behavioral health data platform.
4. To create an open, accessible, transparent and publically available data system that is useful, understandable and user friendly.

**Outcome and Results:**

- The Statewide Data Integration team is co-chaired by the OPM Lead Data Officer and a parent, and has eight state department Lead Data Analysts as well as eight family members
- A CT Data Work plan was developed with thirty-seven data sets identified and targeted for posting on the Open Data Portal website. Thirty of the thirty-seven data sets have been posted either to the Open Data Portal or to a publicly assessable website.
- The Statewide Data Integration team successfully transitioned to bimonthly meetings. Meetings are currently held on the odd months and on even months, the co-chairs and representatives from the CT Data Collaborative have been hosting local geographical data listening sessions, to continue to identify data sets to inform the CT Data Work Plan and post on the Open Data Portal. February and April meetings were held in Bridgeport and Waterbury respectively.
- OPM provides routine updates on the CT Data Work Plan, as state agencies continue efforts to post data to the public.
- Regional meetings were held across the state to share workgroup updates and hear from families, providers, and communities about data needs. Ongoing regional data trainings were also offered to increase understanding and use of data.
- Two Data Basics trainings were completed in April and May 2017 through CT Data Collaborative. CT Data Collaborative has also developed a data scraping tool to better access and make available educational data

**iv. Workforce Development**

See workforce section on page 51.

**v. Cultural and Linguistic Competency Development Workgroup**

See Disparities in Access to Culturally Appropriate Care section on page 43.

**vi. Communication**

**Vision:** The “CONNECTing Children and Families to Care” communications strategy increases awareness of the Network of Care and its principles as well as increasing awareness of behavioral health needs and services.

**Goal:** Implement “CONNECTing Children and Families to Care” social marketing strategies to create awareness of a statewide Network of Care’s ability to improve quality of services, reduce gaps in the service array and when able to increase access to needed services.

**Key strategies:**

1. Develop a “CONNECTing Children and Families to Care” communication plan that reflects the values and intent of the Connecticut Children’s Behavioral Health Plan.
2. Develop “CONNECTing Children and Families to Care” brand identification and unified messaging throughout the integrated local, regional, and statewide Network of Care
3. Develop and disseminate culturally responsive and linguistically competent materials that promote the Network of Care development and System of Care values and principles
4. Expand the WRAPCT.org website into a fully integrated statewide communication and distribution web portal
5. Collaborate with United Way-211 and state agencies on creating Healthy Lives CT website.
6. Support the workgroups through social media strategies and assisting them with the creation of communication and marketing materials with a particular focus on racial, cultural and linguistic competency and the implementation of the national CLAS standards.

**Outcomes and Results:**

- The “CONNECTing Children and Families to Care” communication plan was written in 2014 was updated in 2017 and is consistent with the values and principles of the Connecticut Children’s Behavioral Health Plan. Communication and marketing materials were developed for: “No Wrong Door” or single point of access; Cultural and Linguistic Competency Development; Data Integration; Network of Care Analysis; Workforce Development; the Wraparound Process; and Connecticut Network of Care Transformation.
- The CONNECTing Children and Families to Care communication plan includes participation in multiple events during May is Mental Health Awareness Month.

**vii. Family and Youth Engagement**

See Family and Youth Engagement section on page 47.

**viii. Early Childhood Workgroup**

The early Childhood Workgroup has recently been formed from members of the Help Me Grow advisory group with additional interested representative from the Early Childhood Alliance. They are currently developing their Vision and Goals, and prioritizing Key Strategies to consider.

**Department of Developmental Services (DDS) Response:**

DDS is committed to working as a collaborative partner to help construct a strong and sustainable behavioral health system that prevents, identifies, and addresses the behavioral health needs of all children in Connecticut. However, limited resources make it difficult for DDS to focus on children's issues, while continuing to fulfill the agency's statutory commitment to adults with intellectual disability. The cuts in DDS funding and personnel have resulted in an expansion of waitlists for many services that the department provides to people age 21 and older. Additionally, it has become more challenging to address emergency issues in a timely manner. Although we recognize that attending to the behavioral health of our children and adolescents is critical for improving their life outcomes, and is also fiscally wise; the growing demands presented by aging parents who can no longer support their adult child at home is a real and pressing challenge for DDS. Children with behavioral support needs, by virtue of education and other laws, get some mandated support. There is no law or regulation that requires support for adults. The reality is that when hard choices need to be made, non-entitlement services are the first to be reduced.

DDS has a long history of collaboration with DCF, DMHAS and DSS on complex case reviews. DDS is pleased that the collaboration supported by the DDS Director of Psychological Services is viewed as beneficial by the Administrative Services Organization (Beacon) staff and by other groups. This partnership occurs despite a significant reduction in DDS management, clinical and health related staff. DDS has seen a significant reduction in clinical-behavioral staff positions and is currently working to manage critical shortages in these areas across all three regions.

Finally, while we applaud the success in creating new diversion strategies in schools and in the justice system, these tactics have not reduced the number of people with IDD in the judicial system, nor has it reduced the use of costly forensic support services that the department is often required to provide when adults with IDD are involved in the criminal justice system.

***The DDS Reality: The wait time for the provision of supports to people in emergency situations has increased. There are waiting lists for many services provided by DDS, on which both adults and children continue have been placed. At the end of FY 2017 there were 20 children categorized as Emergencies on the Emergency Residential Waiting List, and 29 Children on the BSP Waiting List representing those up to the age of 21.***

DDS is actively working to reduce emergency wait times and to address the needs of those waiting for services. The department has created a Positive Behavior Support Strategies goal in its Five Year Plan: This goal states, "DDS will continue to build on the strong partnerships that have been developed with DCF, DMHAS, DPH and others to help better support the complex behavioral needs of individuals supported by the agency. This project will focus on providing

information to families on implementation of effective positive behavior support strategies across the lifespan, beginning at an early age.”

DDS has traditionally faced challenges in accessing treatment data from outside sources for individuals we support. Recently, DDS executed an MOA with DSS allowing access to Medicaid Management Information System (MMIS) claims data. DDS staff have received MMIS data warehouse training, and are now working to develop analytical reports that will allow the department to extract meaningful and useful metrics. In a continuing effort to improve accountability and transparency, DDS has engaged with the state’s Chief Data Officer, Tyler Kleykamp, to explore expanding our data sets on the CT Open Data Portal. We have also recently rejoined the CT Data Collaborative where we can explore the use and generation of data with public and private partners and stakeholders to help develop system-level views across supported populations. Finally, DDS has been developing a BI Analytics program using Tableau software and SSRS reporting tools to develop data and analytic reports and visualizations. Although DDS lacks a dedicated reporting resource, it is our hope that we can increase our maturity in the use of available data by making it accessible to more individuals.

**Department of Social Services (DSS) Response:**

DSS and DCF have convened exploratory meetings to discuss potential improvements and modifications to the Medicaid state plan services for individuals under the age of 21.

Exploratory ideas include, but are not limited to:

- Transition clinic services to rehabilitation services under the Medicaid state plan to allow providers more flexibility on where they deliver the services to individuals
- Based on the experience and model of the Certified Community Behavioral Health Clinic (CCBHC) Planning grant, continue to explore value based payment methodologies that reward positive outcomes
- Continue to refine policies, regulations, rates for the Autism Spectrum Disorder (ASD) state plan services that went into effect on January 1, 2015. As of September 2017, approximately 1,000 individuals have been served by the ASD state plan services under Medicaid. There are approximately 150 enrolled practitioners and/or providers

**CSDE Activities:**

The CSDE provides direct funding for student support services through a number of grant opportunities available to school districts and youth serving community-based partners. These grant opportunities include:

- ***Primary Mental Health Program*** with an annual allocation of approximately \$400,000, is a nationally recognized evidence-based program developed to assist students in Pre-K to 3 with improved social competencies and learning.
- ***School Climate Transformation Grant***, with annual allocations of \$750,000, is a five-year federal award (currently in its fourth year) that has been established to assist state agencies in developing, enhancing and expanding their statewide systems of support to local education agencies (LEAs) and schools implementing an evidence-based, multi-tiered systems of support (MTSS) for improving behavioral outcomes and learning conditions for all students.

- **Family Resources Center** grants (approximately \$7.8 million annually) have been established based on the "Schools of the 21st Century" concept developed by Dr. Edward Zigler of Yale University. Family Resource Centers provide access, within a community, to a broad continuum of early childhood and family support services which foster the optimal development of children and families.
- **Youth Service Bureau** grants (approximately \$3 million annually including primary funding and enhancement funding) are intended to provide community, youth development and support activities for youth and families.
- **The School-based Diversion Initiative**, with allocations for schools and community agencies provide more than \$900,000 to support schools with high arrest rates in reducing student arrests and developing alternatives to punitive sanctions.
- The CSDE **21st Century Community Learning Centers** (approximately \$8-million annually) after-school funding provides programs focused on supporting students in high-need schools in preschool through grade 12 to succeed academically and to decrease the risk of students dropping out.
- Funding to districts under **Every Student Succeeds Act** Title IV, Part A will be \$3.25 million. These targeted funds are intended to improve the educational experience of students and provide schools with capacity to address priority needs for their student population.

For more information on these programs, see CSDE Activities under Section C: Access to a Comprehensive Array of Services and Supports.

**Connecticut Insurance Department Response:**

CID is accountable for regulation of the commercial insurance market. Since the start of the CT Children's Behavioral Health Plan there have been significant changes to Insurance Statutes to address concerns. Specifically there were changes to the requirements for Utilization review. Connecticut insurance statutes 38a-591 through 38a591n require that insurers utilize clinical peers when issuing a denial of services based on a medical necessity determination. Connecticut now has very specific requirements for behavioral health reviewers in terms of credentials. Further child reviews must be conducted by a reviewer with expertise and credentials specifically in child and adolescent fields.

Connecticut General Statute 38a-591c defines the Clinical Criteria that an insurer must use when evaluating requests for behavioral health services. These are subdivided by adult vs, child for mental health disorders. (4) For any utilization review for the treatment of a child or adolescent mental disorder, the clinical review criteria used shall be: (A) The most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument,

One of the most important aspects of CID's regulatory activities is administration of the External review program. This allows for independent third party determinations regarding medical necessity claim denials by insurance companies. Based on increased focus for Children's Behavioral Health issues, CID has been coding all behavioral health external review cases so that reporting can be broken out by adult vs. child.

External Review coding also allows reporting by where the behavioral health services are delivered such as inpatient services, outpatient services, pharmacy services and Emergency Room. External Review coding also gives reporting by condition: Behavioral Health, Substance Abuse, Behavioral Health Comorbidity and Eating Disorder. Children's behavioral health levels of treatment are also identified for reporting purposes including: Psychiatric, Acute Care, Substance Abuse Detox, Partial Hospitalization, Intensive Outpatient, and Residential Treatment Center.

This coding allows the department to quickly determine any Children's Behavioral Health trends that are occurring in the commercial health insurance marketplace overall or by a specific insurance company.

**Office of the Child Advocate Response:**

- With regard to the Plan's goal of re-designing the publicly-financed system of behavioral health for children and ensuring adequate allocation of existing or new resources, OCA's ongoing advocacy on behalf of children with disabilities and their families has included examination of the state's continuum of services for children with complex developmental disabilities, including how such a continuum is funded and made accessible to families who are covered by different health care payers. OCA is a lead participant on the Developmental Disabilities work group established through P.A. 16-142, *An Act Concerning Recommendations For Services Provided To Children And Young Adults With Developmental Disabilities*. OCA has found that families who have children with developmental disabilities often struggle to access services that they need to support their child's learning, development and mental health, and that families have disparate access depending on their insurance coverage for health care services. The lack of access to necessary and high quality care can have devastating impact for children and their families, up to and including the repeated or prolonged hospitalization or institutionalization of children with complex needs. The working group issued its first report July 2017 to the legislative Medical Assistance Program Oversight Council (MAPOC) with the initial findings and several recommendations focused on improving service delivery, ensuring provision of high-skilled care coordination to families, and ensuring access to state-funded voluntary services through an effective and collaborative state-agency approach. The report of the P.A. 16-142 work group can be found at: [https://www.cga.ct.gov/med/council/qtr/2017QTR\\_Report%20of%20the%20Developmental%20Disabilities%20Work%20Group;%20July%202017%20-%20Final.pdf](https://www.cga.ct.gov/med/council/qtr/2017QTR_Report%20of%20the%20Developmental%20Disabilities%20Work%20Group;%20July%202017%20-%20Final.pdf)

**Office of the Health Care Advocate Response:**

- Per P.A. 15-146, the Health Care Cabinet was tasked with studying efforts in other states to identify and implement health care cost containment strategies for Connecticut. Under statute, OHA provides administrative support for the Cabinet, in addition to being a sitting member, and worked with the Lt. Governor to design the study parameters, identifying funding for the project, develop an RFP and select a vendor/consultant. After several months of comprehensive study,

analysis and discussion, a final report was generated recommending legislative and policy changes to promote improved cost controls and health quality.

- Under P.A. 14-115, OHA was tasked with the creation and implementation of a comprehensive, online database of behavioral health providers, searchable by carrier, network status, availability, discipline and more. A robust and sustainable model has been developed, but funding remains elusive.
- For both fully and self-insured plans, OHA actively collects and tracks information about each consumer case, with routine analysis of this data to identify potential trends in access or quality, including mental health parity. Past data is available in the CT Open Data Portal, and analysis of key trends is reported in OHA's annual reports. OHA continues to develop and enhance its data collection and reporting capabilities, seeking greater granularity in the types of issues we see.

**Judicial Branch-Court Support Services Division (JB-CSSD) Response:**

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 are longer detained for risk of self-harm, running away, family conflict, or inaccessibility of behavioral health treatment. The result of this law change is about a 30% reduction in detention admissions since January 1<sup>st</sup>.

- The Judicial Branch's Court Support Services Division (CSSD), in conjunction with the Department of Children and Families, developed the *Detention Diversion and Release Plan*, in response to Public Act 16-147, Section 5. The Plan, as required by Public Act 16-147, is informed by the Children's Behavioral Health Plan and addresses the provision of community-based services to children who are diverted or released from detention. Per Section 5, the plan is informed by the comprehensive behavioral health implementation plan and addresses 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. The plan was submitted in February 2017 and must be implemented not later than July 1, 2017. As a result, there has been an increase in court-involved children accessing the S-FIT programs in lieu of or as a discharge placement from detention. CSSD is working with Beacon Health Options to produce a quarterly report describing the court-involved youth referred to the S-FIT programs. In addition, CSSD issued a request for proposal for a short-term stabilization, clinical assessment, and family intervention program (The HAMILTON Program) for delinquent children in violation of court orders. The program award should occur once the state budget passes. The program will serve approximately 150 boys and their families annually.
- Judicial continues to fund, in collaboration with DCF, CSDE and DMHAS, the School-based Diversion Initiative (SBDI) which is coordinated by the Child Health and Development Institute (CHDI) to reduce school-based arrests. SBDI has been implemented in 37 schools across 13 Connecticut school districts. On average, first 18 participating schools reduced court referrals by

45% in their first year of participation and have increased mobile crisis intervention service (EMPS) referrals by 94%.

- 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 CSDE, DCF, DMHAS, and the Judicial Branch, including cost options, should be completed by the end of 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 CSDE 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. The JJPOC has adopted the recommendation that the Community-based Diversion System Plan be coordinated with the efforts of the Children’s Behavioral Health Plan. The Community-based Diversion System Plan is to be implemented in two (2) phases beginning July 1, 2017 and July 1, 2018.
- 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.

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

Of the twelve partner agencies, nine agencies provided a response under section B.

The World Health Organization noted “Mental health promotion aims to impact on determinants of mental health so as to increase positive mental health, to reduce inequalities, to build social capital, to create health gains and to narrow the gap in health expectancy between countries and groups (Jakarta Declaration for Health Promotion, WHO, 1997). Prevention of Mental Disorders, Summary Report 2004)

It is not surprising that Health Promotion, Prevention and Early Identification were highlighted throughout the input gathering process, recognizing the importance of both promotion and prevention and the need to further invest in the promotion of nurturing environments, social and emotional skill development, the creation of trauma informed environments and addressing basic needs. Multiple cross system, cross discipline efforts are outlined in this section to advance this critical part of the service system. These examples provide a snapshot of the ways in which the systems are aligning around essential areas impacting the overall well-being of children. Although there has been significant movement and complimentary efforts, access is not yet universal.

### **DCF Response:**

- Since spring of 2013, DCF has supported nine Infant Mental Health Training Series, one in each of the six DCF regions and 3 statewide trainings with one more scheduled in the fall of 2017.

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.

- Beginning in 2016, DCF began investing in training staff and supervisors in Circle of Security Parenting (COS P). Priority was given to training staff in DCF-funded programs that served parents who had open cases with DCF, including staff from Parenting Support Services (formerly Triple P), Therapeutic Child Care, Caregiver Support Teams, Therapeutic Foster Care, and Intimate Partner Violence programs.

The second priority was to build capacity in CT cities and towns to offer COS P. This has resulted in training of staff working with the DMHAS-Early Head Start initiative, staff from community agencies wanting to build capacity to offer COS P, Nurturing Families Network staff, and staff from DMHAS.

There continues to be an increasing number of disciplines and settings requesting training in COS P and a growing interest from groups that want to build capacity in their communities to offer COS P. Currently, a total of 360 staff have completed the four-day training, 86 of whom have also received the COS P DVD in Spanish to bring the COS P intervention to Spanish-speaking families in their primary language, and 3 have received the French version to use with Haitian families. The 27 Parenting Support Services providers in CT have begun to offer COS P groups to parents and foster parents. This allows them to serve more parents and to reach parents who prefer a group intervention rather than an in-home intervention.

- The Early Childhood Consultation Partnership (ECCP) provides early intervention and prevention mental health strategies and supports the implementation of such strategies to prevent the disruption of children from their early care and education settings. To date ECCP has served approximately 88% of all of Connecticut's eligible early care and education centers. In SFY 17, at a 6 month follow-up, an average of 100% of children in Q4 and; 99.9% (across 4 Quarters- 7.1.16 to 6.30.17) were not suspended or expelled.
- The Connecticut Suicide Advisory Board (CTSAB) continues to be co-chaired by DCF and DMHAS. Currently DMHAS is the lead state department for a Garret Lee Smith Suicide Prevention award with DCF and DPH serving as system partners. The Connecticut Suicide Prevention Plan 2020 and the CTSAB continue to provide Connecticut's blueprint for suicide prevention activities throughout the state
- DCF participates in the CHA Neonatal Abstinence Syndrome-Comprehensive Education and Needs Training (NASCENT) initiative to develop standardized approaches to NAS across hospitals and to improve early recognition of substance use disorders in pregnant and parenting women.

### **DDS Response:**

Through its national Supporting Families Community of Practice (COP) system change grant, DDS has introduced the Charting the LifeCourse Planning principles and practices to stakeholders as a way to assist families to better understand their loved one's needs and to help expand and enhance the manner in which they respond to these needs. Use of the Charting the

LifeCourse practices helps families to build a stronger and broader foundation of support. Charting the LifeCourse principles and practices have been incorporated into DDS eligibility, Helpline, Individual and Family Supports (IFS), and Case Management services. Charting the LifeCourse planning has also been incorporated into teacher training provided by the State Education Resource Center of CT (SERC) and into the training provided by the Department of Rehabilitation Services to their staff who work with transition age youth. All of these activities impact the promotion, prevention and identification of supports and services for both children and adults with IDD. Charting the LifeCourse is a universal, person-centered planning tool that was developed for families by families. This common sense, easy-to-use tool assists families to navigate, use and coordinate services across multiples agencies and funding sources.

***The DDS Reality: DDS had 18 transition/education advisors who worked in school districts on activities related to prevention, promotion, and early identification activities. Today, DDS has only three of these positions filled to continue to provide support and consultation to over 1500 youth age 16-21, in each of the 169+ school districts. In addition, many critical case manager positions remain unfilled due to ongoing budget issues.***

#### **DPH Response:**

- DPH promotes the (*Learn the Signs. Act Early*) developmental monitoring that can be utilized by providers and families. Learn the Signs. Act Early materials are available on-line and in hard copy from Child Development Infoline.
- DPH SBHCs are required to conduct a mental/behavioral health screening using a DPH approved tool at the time of a physical and at a medical visit as warranted. A variety of screening tools are utilized including but not limited to: GAPS, RAAPS, PHQ 9 and PSC. Screenings are conducted at all 93 DPH SBHC sites. Connecticut School Based Health Centers participating in and reporting data to the School Based Health Alliance National Quality Initiative (piloting national quality measures for SBHCs) have achieved greater than 70% risk assessment screening at the time of medical visits.
- DPH and CT Medical Home Initiative contractors provide support to families and pediatric and family care providers in the utilization of age-appropriate, standardized developmental screening as required by the American Academy of Pediatrics, screening are to take place at 9, 12, 18, 24 and 30 months visits. Medicaid billing claims indicate 33% of children under three years of age have received a developmental screening in the last year.
- Students that screen positive are referred to the SBHC mental health clinician for further assessment and services or to community based providers if the student's needs are beyond the scope of what the SBHC provides. SBHC mental health clinicians utilize EMPH when warranted. DPH co-chairs the SS/HS Data Innovation Committee with the goal of increase consistency, integration and tracking of student data sets by establishing standards and practices for collecting, reporting and sharing social-emotional, developmental and (student support, behavioral health?) data. DPH and the CT Medical Home Initiative support linking children who screen positive to Child Development Infoline for access to supports through the Birth to Three System, Help Me Grow, Preschool Special Education and the Children and Youth with Special Health Care Needs Program.

**DMHAS Response:**

- DMHAS Young Adult Services (YAS) program continues to provide, through funding from the Department of Public Health (DPH), a perinatal support program to young parents engaged in the young adult services program.
- Recently, DPH awarded YAS additional funding to support our ongoing prevention efforts. With these funds, YAS has begun a two-year initiative offering training to young adults using the evidenced based curriculum, Be Proud Be Responsible (BPBR). BPBR was developed to give young people the knowledge and skills that they need to reduce their risk of HIV/STDs, increase condom use, and affect their knowledge and beliefs as they relate to sexual behaviors such as frequency of intercourse, multiple partners and contraceptive use.
- DMHAS' Young Adult Services program continues to participate in the TANF program. Our focus is to prevent and reduce the incidence of out of wedlock pregnancies by identifying the risk of pregnancy and providing interventions to lessen the risk.
- DMHAS with DCF co-leads a statewide initiative for early detection, prevention, screening and assessment of Substance-Exposed Infants. In order to provide prenatal care and services to any child exposed to substances in-utero. DMHAS actively participates in the Early Intervention and Screening Training workgroup to develop statewide standards.
- DMHAS participates in the CHA Neonatal Abstinence Syndrome-Comprehensive Education and Needs Training (NASCENT) initiative to initiate standardized approaches to recognition and treatment of NAS across hospitals and improve early recognition of substance use disorders in pregnant and parenting women.
- DMHAS is working collaboratively with DCF on the development and implementation of the Child Abuse Protection and Treatment Act (CAPTA). This federal mandate requiring healthcare providers to notify DCF when an infant is exposed to in-utero substances.
- 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 continues to collaborate with DCF, CSSD and CSDE in supporting the School Based Diversion Initiative in an effort to reduce school based arrests and identify and provide alternatives and appropriate interventions to youth.

- DMHAS also participates on the Children’s Behavioral Health Advisory Committee (CBHAC) and the Joint Planning Council that combines the CBHAC with the Adult Mental Health Planning Council.
- DMHAS has been providing Mental Health First Aid trainings to youth and to adults to increase awareness and the ability to intervene. Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. In 2016, 83 Youth Mental Health First Aid training sessions were conducted in Connecticut and over 1,221 persons were trained.
- 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, 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.

- DMHAS continues to administer the federally funded Connecticut Safe Schools/Healthy Students, Diffusion Project (Project) with the CSDE and CSSD. The three local education agencies funded under this initiative are implementing evidence - based programs and strategies designed to improve school climate, improve access to behavioral health and other supports and decrease substance use and violence. This project has developed release of information forms that facilitate student level data sharing between schools and community partners and has created a decision tree to assist school –based personnel in identifying and assessing mitigating factors for consideration prior to disciplinary action.
- DMHAS, in collaboration with DCF, continues to administer the federally funded Now is the Time, Healthy Transitions-CT Strong grant. This grant provides wraparound services utilizing a

“whatever it takes” approach to engage youth and young adults ages 16-25 who reside in the cities of New London, Middletown and Milford and who have, or are at risk of developing behavioral health disorders.

**CSDE Response:**

- The CSDE provided an extensive, day-long workshop on Trauma-informed Practices for the state’s Alliance Districts, which represent the 30 lowest performing school districts in Connecticut. Alliance District teams included over 85 educators and administrators.
- The CSDE and the Office of Early Childhood (OEC) have completed the Social-emotional Learning (SEL) Standards for K-3 and are scheduled to go before the State Board of Education.
- The CSDE Health Promotion Services/School Nurse Program provides training and consultation to school nurses, school nurse leaders, school administrators and the community regarding the health and safety of students. This consultation and technical assistance includes addressing the provisions of health services during the school day and the promotion of health and wellness activities that support student achievement. Professional development programs are routinely provided to further assist and support school nurses.

**Connecticut Insurance Department Response:**

Consumer complaints to the CID serve as an important first indicator of troubling trends or problems in the marketplace. Insurance examiners are trained in insurance statutes and regulations and are vigilant in ensuring that the insurance companies comply with these requirements when reviewing consumer complaints. The examiners can quickly spot any trends or areas of concern and escalate them rapidly to the Insurance Department’s Market Conduct division. The Market Conduct division will work the issues through to a regulatory conclusion.

**Office of the Child Advocate Response:**

- With regard to the Plan’s goal of improving screening, assessment and service delivery for young children with emerging behavioral health and developmental service needs, in October of 2016, the OCA published an investigative report detailing educational service delivery for preschool age children with disabilities transitioning into a mid-sized Connecticut school district from the state’s Birth to Three system. In its investigation, the OCA identified a number of children with significant developmental delays or impairments who received services from the district that were inconsistent with best practices, state guidelines, or children’s needs. The report contained a number of strategies and recommendations to ensure that the District improve IDEA Compliance and educational services delivery for children entering from birth to three. Following the investigation but prior to issuance of the OCA’s report, the District took steps to address the issues identified by the OCA, including but not limited to, improved assessment and evaluation procedures for young children entering the school district, attention to workforce development and training for staff working with young children, and increased access to full-day programming for young children with significant service needs. OCA found inconsistencies throughout the state in how early educational interventions are delivered to young children with developmental support needs, and further attention to this issue is urgently recommended. OCA’s full findings and recommendations based on its data-review can be found here:

[http://www.ct.gov/oca/lib/oca/OCA\\_INVESTIGATIVE\\_REPORT\\_EDUCATIONAL\\_SERVICE\\_DELIVERY\\_10\\_27\\_16.pdf](http://www.ct.gov/oca/lib/oca/OCA_INVESTIGATIVE_REPORT_EDUCATIONAL_SERVICE_DELIVERY_10_27_16.pdf).

- With regard to the Plan's goal of developing, implementing and monitoring effective programs that promote wellness and prevent suicide, through OCA's child fatality review and prevention work the OCA participates in the state's suicide prevention work and sits on the CT Suicide Advisory Board. The OCA shares its child fatality review data with state and local partners with the goal of reducing and eliminating youth suicide. Data shows that child fatality trends related to youth suicide have not significantly changed (statistically) in the past 5 years compared to the previous 5 year period. The OCA's most recent 5 year fatality report, published in 2016, can be found here:

[http://www.ct.gov/oca/lib/oca/Final\\_Five\\_Year\\_Fatality\\_Report\\_2011-2015.pdf](http://www.ct.gov/oca/lib/oca/Final_Five_Year_Fatality_Report_2011-2015.pdf)

**Office of the Health Care Advocate Response:**

- P.A. 16-142 created the Developmental Disability Workgroup, developed and championed in collaboration with the Office of the Child Advocate to: identify age-appropriate services and resources available for children and young adults with developmental disabilities; better understand the coordination of the various state efforts to serve this population; identify areas of overlapping services/resources, gaps in services/resources; make policy recommendations as appropriate to facilitate appropriate, cost effective delivery of services. Throughout 2017, the Workgroup invited staff from several state entities to present information about the services they provide, the populations served, and the efforts at inter-agency coordination they undertake. The Workgroup continues to meet on a regular basis, monthly when possible, and to craft a comprehensive map of how these services intersect, overlap and complement each other. The goal is to better understand the service gaps and opportunities to streamline the provision of services to this complex population, while complying with a myriad of state and federal law and regulations, ensuring that those served received the most efficacious care in the most timely, appropriate and efficient manner.
- OHA supports the expansion of the highly successful DCF-OHA collaboration, the primary purpose of which is to maximize the utilization of all available payers for services provided by state agencies to consumer. The DCF-OHA project has facilitated a greater understanding of the importance of insurance coordination of benefits rules, as well as applicable state and federal law concerning the use of government funds, through the efficient identification of consumers receiving services from a state agency with alternate payer sources. This initiative has promoted the timely and effective utilization of these sources to minimize state expenditures. As a result, OHA leadership has initiated discussions with DMHAS, DDS, CSSD and OPM, as well as conversations with the legislature, to expand this effort to identify all opportunities where the state currently pays for services that might otherwise be payable by another party. These discussions have resulted in draft legislative language to promote this expansion to all agencies delivering or paying for clinical services and, while it did not progress through the legislative process during the 2017 session, is expected to be a topic of discussion during the 2018 session.

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

- The Judicial Branch and its CSSD continue to operate 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 court intervention. Hundreds of referrals are returned annually.
- All children admitted to a CSSD residential program (including a detention center) are provided access to a range of healthcare services, including medical, mental health, nursing, dental and pharmacy care. Children are screened for health issues, including various infections, and treated accordingly. In addition, they receive education in a variety of health and hygiene topics.
- 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 provides 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 continues to participate 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, Safe Schools/Healthy Students, Improving Access to Continuing Care and Treatment (IMPACCT) and CT Strong.
- CSSD has representation on the Connecticut Youth Suicide Advisory Board and participates in the Zero Suicide initiative. CSSD has switched to using the Columbia Suicide Severity Risk Scale (C-SSRS) and is revamping its related policy in the detention centers.

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

Of the twelve partner agencies, eight agencies reported activities under section C.

It is well acknowledged that the needs of children, families and communities are diverse. The input gathering process cautioned that systems should not overly prescribe as each community will have its own needs. So while over-prescription is not the answer, equitable access remains essential. It is important that the system continues to build and scale up examples of what works well and to identify the gaps based on need, geography or coverage to name a few. There are multiple examples of where the system has moved from treatment as usual to a strong investment in evidence based practice models.

Though there has been demonstrable progress, it is important to note that we have not fully realized equity in access. There are many districts without particular services. Additionally, loss of funding has begun to impede some access based on their level of system involvement and as such continued examination of who has access to what services and under what circumstances is needed. Improvements have been made, but inequities based on insurance coverage, geography and school districts remain.

**DCF Response:**

- DCF continues to provide 82 beds for crisis stabilization and emergency respite services for up to 14 days through Short Term Family Integrated Treatment (S-FIT) providers. Effective access to these 82 statewide beds occurs through EMPS-Mobile Crisis and Beacon Health Options.
- DCF continues to work closely with CSDE, the EMPS Providers, 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 areas. To date, 169 MOA's have been executed or 82% of the school districts in CT. (An increase in 56 MOUs since last year.)
- There were 581 calls and 385 episodes of care during the expanded hours of operation of 6:00 AM to 8:00 AM Monday through Friday. There were a total of 18,021 calls or a 7.3% increase from the previous year. There were 13,488 episodes of care or an 8.6% increase over last year.
- 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 516 children received a MATCH intervention. An additional 5 agencies were trained in MATCH this past year, bringing the total to 15 agencies statewide. An additional 27 clinicians were trained this year, bringing the total number of clinicians trained to 141.
- 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. Seventeen school districts and over 46 schools are offering CBITS across the state. To date, 806 students have received treatment in school and 90% have successfully completed the intervention with an additional 10% partially completing the treatment course. One percent were referred on to other treatment options. There was a 41% reduction in PTSD symptoms, a 19% reduction in behavior problems from pre to post assessment, indicating significant improvements.
- DCF continued its collaboration with DMHAS to disseminate Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT) throughout the state after the federal funds that launched this effort expired. DCF has supported A-SBIRT in the past year in several ways:
  - a. The purchase of 7,000 Kognito licenses to offer free online SBIRT training

- b. The development of a central training request system at DCF to link communities in need of training with trainers in their area
  - c. Embedding A-SBIRT into DCF Workforce Academy training cycle quarterly and directly providing training in communities without access to an area trainer
  - d. Developing and disseminating electronic and print materials for use by A-SBIRT trainers, and for trainees to do actual screenings
  - e. Adding A-SBIRT into the DCF Provider Information Exchange data collection system
  - f. Training over 100 “Train the Trainers” in the A-SBIRT toolkit
- DCF is nearing the end of the second and final year of a SAMHSA/CSAT grant to develop a comprehensive plan for adolescent substance use treatment known in CT as IMPACCT (Improving Access to Continuing Care and Treatment). DCF has continued collaborating with DMHAS, CSSD, CSDE, Beacon Health Options, youth and families, other SAMHSA grantees in CT, the CT Alcohol and Drug Policy Council (ADPC), and technical experts to develop this plan. This collaborative effort identified important gaps in Connecticut’s systems related to identification of substance use problems among youth, and their access to care. Participation on ADPC’s Treatment and Recovery Support Subcommittee ensures that this grant’s work is aligned with other statewide planning efforts. Major accomplishments of this project over the past year include:
    - a. Development of an innovative treatment model for opioid use problems for adolescents and young adults age 16-21 years, the ASSERT Treatment Model (ATM). ATM combines three evidence-based practices: Multidimensional Family Therapy (MDFT), Medication Assisted Treatment (MAT), and Recovery Management Checkups (RMC) to address the complex and long-term problems that often accompany opioid use. Multiple perspectives informed the development of this approach. DCF partnered with model developers to obtain input from local providers to ensure the model was rooted in sustainable practice, and from youth, and their families to identify the essential and non-essential components of treatment. Training in the ATM approach is expected to begin in January 2018, with services available in February 2018.
    - b. Completion of a Statewide Provider Workforce Development Survey. The workforce development survey will inform the plan to increase the skills and competencies of the substance use treatment workforce to address the multiple problems common among youth who are using substances. The survey, administered by UConn Health, had an over 80% response rates from provider staff. UConn is in the process of analyzing the results that will be used to inform the final workforce training plan.
    - c. Development of a statewide financial map of adolescent substance use services. DCF partnered with Judicial Branch-CSSD, DSS and Beacon Health to identify and “map” these expenditures, and revenue from third-party-billing to better understand what services are purchased/paid for, at what level, and for whom. This map has been completed for SFY16 expenditures, and is ongoing for SFY17. DCF aims to use this information to better understand who is accessing services, at what level, and for what condition(s). This map can allow the state to think strategically about the overall adolescent substance use treatment system and roles each agency and other payers play in service provision. It can identify services gaps and inefficiencies in the system, increase coordination among agencies, identify opportunities for new finance approaches and funding sources.

- d. Social Marketing Training Curriculum. DCF has partnered with DMHAS to align the efforts of several federal grants requiring social marketing activities. Through this partnership DCF's social marketing expert consultant will train DMHAS' community-based sub-recipient grantees to develop and launch social marketing efforts aimed at reducing the stigma associated with substance use, particularly opioid use. The social marketing training plan is drafted and under review by DMHAS.
- DCF was awarded the ASSERT grant, the companion implementation grant to the IMPACCT planning grant. The ASSERT grant will provide funding for CT to implement the IMPACCT comprehensive statewide strategic plan for substance use. This program will fund improvements in treatment for adolescents and transitional aged youth (age 12-21 years) with substance use disorders (SUD) and/or co-occurring substance use and mental health disorders by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. This funding combines infrastructure improvement and direct treatment service delivery and brings together stakeholders across systems to strengthen an existing coordinated network that will enhance/expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices (EBPs), and implement financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment, and recovery support system.

**DDS Response:**

DDS continues to oversee the Behavioral Services Program (BSP). As of 8/11/17, DDS supports 366 individuals age 9-21 in BSP.

BSP policies and procedures were recently updated to help ensure clarity and more effective and efficient use of agency resources. The current DDS/DCF MOA is being updated to formalize the departments' mutual commitment to work together to ensure that each child receives appropriate services. DDS has also identified a Central Office liaison to DCF so that there is cooperation and consistency across departments and regions.

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

- Weekly complex case rounds with Beacon Health for children and adolescents
- Quarterly meetings with DMHAS
- Restraint/Seclusion Prevention Workgroup
- Quarterly oversight meetings with Adelbrook, Inc.
- Quarterly meetings with DCF on age-outs
- Task force to study Voluntary Admissions to DCF
- The IFS Assistant Regional Directors and managers meet on a monthly basis (sometimes bimonthly) to deal with IFS issues, BSP, family grants and helpline services.
- Children's Services Committee to discuss clinical feedback and suggestions on appropriate services that may be available for the most complex children's cases

- Early Childhood Cabinet
- Multiple autism services-related committees, which often take on topics overlapping with behavioral health issues discussed in other forums
- Connecticut's Children's Behavioral Health Plan Advisory group
- Various Birth to 3 groups, DSS committees, family advocacy groups, and various other overlapping committees that address services for children.

Information from these committees is used to enhance the behavioral support services provided to people who receive supports from DDS. The sheer number of these various committees stretches the ability of DDS staff to attend and participate in a meaningful way. It is the agency's hope that the Connecticut Children's Behavioral Health Plan progress report will make recommendations about where overlapping committees and/or work could be reduced or reorganized to more efficiently address the pressing needs of children and families in CT.

***The DDS Reality: DDS provides a variety of individual and family support services to families in need. In FY 17, DDS provided family support to 91 Children (Under 18). Respite Support was provided in DDS Respite Centers to 127 Children, and Respite Grants were provided to 272 Children. More than 2000 people under 18 years of age received assistance from the DDS Helpline. Eight people under age 21 were served through Money Follows the Person (MFP) funding. The demand for these services continues to outweigh available resources.***

In FY17, DDS also implemented a respite project focused on increasing the availability of respite services for individuals who have high behavioral or medical needs. As a result of this project, DDS respite centers have increased utilization; rates have changed for private provider respite providers, and families are now offered increased opportunities to access Community Companion Homes for respite services.

A technology project was also implemented to help families to better understand how assistive technology can be used to enhance communication, learning and behavior and to help ensure safety and supervision.

Additional projects to enhance access to services for people in need of emergency behavioral health supports, consider mobile crisis services, and expand access to additional respite services have been proposed. However, funding and staff resources are not available to implement these projects.

The number of families who seek assistance in providing support to a loved one who experiences challenging behaviors continues to grow. DDS will continue its efforts to collaborate effectively with other stakeholders to address this growing need.

#### **DPH Response:**

- DPH's School Based Health Centers (SBHCs) operate in 28 communities statewide. The all provide mental/behavior health services including: crisis intervention and advocacy, individual, family and group counseling, mental health promotion/education activities, outreach to families and at-risk students, case management referral and follow-up. SBHC. They frequently partner with community based entities to increase their capacity to meet student need while also

exposing students to services available in their community. Examples include: collaborating with the local rape crisis center to provide programming focused on healthy relationships, partnering with the **Porco Foundation** to pilot their *4 What's Next* program in a rural high school, sponsoring health fairs featuring community providers, inviting interactive theater groups to perform).

The demand for SBHC mental health services is often greater than available mental/behavioral health hours. Rather than being able to offer more mental/behavioral services hours to meet the growing need, budget cuts have made it increasingly more difficult for SBHCs to maintain their current staffing levels and some have had to reduce their service hours.

- DPH SBHCs are frequently utilized as training venues for graduate students studying nursing, social work, marriage and family therapy, etc. Several SBHC have served as sites for the National Health Service Corps Federal Loan Repayment Program.

The DPH SBHCs are contractually required to have in place: Access Agreements, School Nurse Communication Agreements, written commitment from SBHC contractor selected community-based service providers to provide back-up care when the SBHC is not in operation and letter of assurance from the school district that school health and psychosocial services will not be diminished because of the presence of the SBHC.

**DMHAS Response:**

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

Since the program began in 2015, 441 Young Adults have been screened for behavioral health related disorders; Outreach has been provided to over 3, 047 young adults and 1092 behavioral health referrals have been made for young adults. Evaluation of the Connecticut project is conducted by the University of Connecticut, School of Social Work and has a National evaluation component. As the project evolves in its implementation, and evaluation data is produced, lessons learned and recommendations will be shared.

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

2016, 83 Youth Mental Health First Aid training sessions were conducted in Connecticut and over 1,221 persons were trained.

- DMHAS is collaborating with DCF in developing a comprehensive plan for adolescent substance use treatment over the next two years.
- DMHAS has established four ACCESS centers throughout CT that offer services to youth who would not necessarily be identified as needing the intensive level of care provided by Young Adult Services. One of the goals of this service is to connect youth with appropriate treatment and community support services. All of the access centers have exceeded goals for number of youth served and for outreach and community educational initiatives. The ever increasing requests/need for support and referrals to other services is stretching the resources of these centers and is indicative of the need for not only the expansion of some of the existing sites/locations but also the development of other centers in different areas of the state.
- DMHAS YAS staff participates on the State Personal Responsibility Education Program (PREP) Advisory Board with DCF, DPH, Department of Education and other stakeholders, which focuses on how to deliver education to young people on preventing pregnancies and how to establish healthy relationships. Since 2010, PREP has had a successful history of reducing teen pregnancy and risk taking behaviors in at risk youth in foster care and other high-risk populations.
- Connecticut's *Safe Schools Healthy Students* Diffusion Initiative uses a school and community partnership model. These partnerships create safe, drug-free and productive environments across all settings for social and emotional learning and promote healthy physical development and academic success. The *SSHS* partnership model connects state policy development and implementation of *SSHS* programs at the school district and community level.
- The *State Management Team (SMT)* assembles diverse stakeholders including parents and representatives from education, mental health and substance use, public health, juvenile justice, social services, child and family protective services, family advocacy and youth development. The *SMT* process supports the wide spread adoption and operation of *SSHS* programs to extend the benefit beyond Connecticut's three initial *SSHS* school districts. In support of developing a process for planning services, the *SSHS* project has developed a template for social workers, psychologists, school psychologists and other professional staff to collect student level behavioral health data within the school setting. *SSHS* has also developed a template for a MOU between schools and community partners to facilitate individual level data sharing about behavioral and mental health services for children.

**CSDE Response:**

- *Youth Service Bureaus (YSB)* provide screening, referrals and direct services that support the social, emotional and behavioral needs of youth. *YSB* programs and services also provide positive youth development and develop leadership qualities in the youth they serve. All youth are welcome, however, *YSBs* have a particular focus on special populations, such as justice involved youth, youth with mental health needs, other youth at risk, and youth needing services

to enhance their education and career advancement. In 2014, **YSBs** served 243,100 students through 2,366 programs (includes duplicates).

- **Family Resource Centers (FRC)** are comprehensive, integrated, school/community-based systems of family support that provide child and family development services located in public school buildings. There are 74 sites in 41 communities serving 7,482 families (9,025 children and 7,239 adults) and 174 early care and education providers. **FRCs** provide access, within a community, to a broad continuum of early childhood and family support services that foster the optimal development of children and families.
- **School Climate Transformation Grant:** This initiative provides training and technical assistance supporting schools' ability and capacity to address students' behavioral health, growth and development, learning capacity, and learning environments. This program also includes a "Tiered Fidelity Inventory," in which schools receive a detailed analysis of the implementation and success of the schools' **Positive Behavioral Intervention and Supports (PBIS)** program and recommendations for improvement. Approximately 142 schools have been served in the two-year period 2015-2017, including 1,420 student interviews and 740 staff participants.
- The **Supports for Pregnant and Parenting Teens** program (**SPPT**) helps pregnant and parenting students in districts with the highest teen pregnancy and school dropout rates. **SPPT** has been in place for 8 years and provides for a nurse as well as a social worker in order to provide physical and emotional supportive services to high school students aged 14-21 in six school districts across the state (Bridgeport, Hartford, New Britain, New Haven, Waterbury, and Windham). Outcomes for participating pregnant and parenting teens included: school attendance improved from 69 percent to 76 percent; 82 percent of seniors in the program graduated; 98 percent of children were up-to-date on well-child visits; and 100 percent of children were meeting developmental milestones or receiving developmental support services. **Supports for Pregnant and Parenting Teens** served 204 pregnant women and 70 expectant fathers in school year 2016-17.
- **Safe Schools/Healthy Students (SSHS) Program served 36,894 students attending 38 schools located in 3 districts.** **SSHS** is a DMHAS partnership program supporting services to improve student mental health and academic performance. Currently piloted in Middletown, New Britain, and Bridgeport and funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the **SSHS** project is entering its final year of its four-year grant and is developing sustainability plans for this project. During the period of implementation, the three districts identified at-risk students and designed interventions most likely to meet their needs. Evidence-based practices include Well-Managed Schools and Classrooms; staff having been trained by the International Institute of Restorative Practices; roll out of new Social-Emotional Learning curriculum and data driven decision making for identifying future needs, resources and improvement plans.
- **The School-Based Diversion Initiative (SBDI)** is a multiagency collaboration directed toward reducing youth contact with police and the juvenile justice system and increasing LEA understanding and capacity to address psychological, emotional, developmental, and behavioral needs among students in collaborating schools. It is currently supporting 18 schools in 6

districts, potentially impacting 14,798 students and producing a 33% decrease in court referrals (statewide decrease is 6%). Outcomes for school year 2016-17 in schools with program Leaders-in-Residence include an overall 33 percent decrease in court referrals and a 42 percent increase in referrals to Emergency Mobile Psychiatric Services (EMPS)

- **Primary Mental Health Program (PMHP)** is an evidence-based program that helps children in Pre-K through third grade adjust to school, gain confidence, social skills, and focus on learning. It does this through the availability of an early intervention mental health program for the detection and prevention of emotional, behavioral and learning problems. **PMHP** currently serves 22 schools in 18 districts, providing services to approximately 1000 pre-K to Kindergarten students.
- **CSDE Consolidated State Plan: “Every Student Succeeds Act”**  
The CSDE has received federal approval for the CSDE Consolidated State Plan in response to the **Every Student Succeeds Act (ESSA)**. Title IV, Part A funds will be used to provide statewide activities supporting strategies for schools to improve school conditions for student learning, including activities that create safe, healthy, and affirming school environments. The CSDE will support Title I schools in examining evidenced based practices in:
  - Developing positive school climate;
  - Addressing bullying and harassment;
  - Skill development in trauma-informed practice;
  - Reducing chronic absenteeism;
  - Building social-emotional learning systems; and
  - Reducing exclusionary discipline through restorative justice practices.
- ESSA Part B funds the **21st Century Community Learning Centers (21CCLC)** after-school programs that are focused on supporting students in high-need schools in preschool through grade 12 to succeed academically and to decrease the risk of students dropping out. The **21CCLC** funding supports a variety of evidence-based strategies to provide well-rounded educational opportunities and enrichment, promote safe and healthy students and schools, and foster digital learning in schools where at least 40 percent of students are eligible for free and reduced-price meal subsidies. Specifically, **21CCLCs** provide opportunities for academic enrichment to students to meet student performance standards in core academic subjects, such as reading, mathematics, and science. Programs also offer extended learning time, project-based learning as well as art and music opportunities. In the area of safe and healthy schools, students are provided with youth development activities including drug, violence, and pregnancy prevention programs; counseling; service learning opportunities; and character education and recreation programs that are designed to reinforce and complement the regular academic program of participating students. The program also offers families of students served by community learning centers opportunities for literacy and related educational development, such as adult development activities, family activities, opportunities for governance and leadership involvement, and participation in school and program events.

- In April 2017, the CSDE released a new guidance document, ***Reducing Chronic Absence in Connecticut Schools: A Prevention and Intervention Guide for Schools and Districts***. The Prevention and Intervention Guide was developed in collaboration with the Interagency Council for Ending the Achievement Gap. Its purpose is to support the work in districts, schools, and communities to identify barriers to consistent school attendance including overly restrictive school policies; poorly managed physical health needs; and unmet social-emotional, behavioral and mental health needs, and design and implement effective strategies to reduce chronic absence. As a result of this work, the number of chronically absent students dropped to 9.6 percent in 2015-16, down from 10.6 percent the year before and down from a high of 11.5 percent in 2012-13. The decline in Connecticut's chronic absence rate means that over 10,000 more students are attending school on a daily basis than four years ago.
- U.S. Department of Education's ***Dual Capacity-Building Framework*** expands school-family-community partnerships and improves schools' ability to support students and families for improved academic success and social-emotional health. To ensure effective cradle-to-career educational partnerships between home and school engagement initiatives include a concerted focus on developing adult capacity, whether through pre- and in-service professional development for educators; academies, workshops, seminars, and workplace trainings for families; or as an integrated part of parent-teacher partnership activities. Such opportunities build and enhance the skills, knowledge, and dispositions of stakeholders to engage in effective partnerships that support student achievement and development and the improvement of schools.
- ***Mental Health First Aid for Youth*** training, a nationally recognized program providing basic information about mental health needs and assistance for non-professionals and is an option available through DMHAS to teachers and other school personnel for professional development.
- ***EMPS Mobile Crisis Service***- 191 out of 206 (92%) districts have in place MOUs with their mobile crisis provider. These MOUs formalize the relationship between districts and their local mobile crisis provider, thus facilitating improved services, better resources to address student behavioral and mental health needs. This partnership helps to divert students from contact with the juvenile justice system by addressing behavioral disruptions as an indication of inadequate coping skills and immaturity rather than a criminal act.
- Schools with school resource officers (SROs) are required to have a MOU with their local law enforcement department that help to clarify and define the duties, scheduling and responsibilities of all partners, including who within the school makes the determination of responses to student behavioral incidents.

**Connecticut Insurance Department Response:**

Network availability for child behavioral health treatment in the commercial insurance market continues to be a concern due to the shortage of health care providers in this field. Further, provider reluctance to become part of networks in Connecticut and throughout the country is well documented. CID will be looking further at this issue in its network adequacy review. Recent legislation has given the Department the responsibility to review the adequacy of commercial insurance networks.

In an effort to better understand the issues that mental health providers face, the Department is also working with many mental health provider groups including Connecticut Psychiatric Society and the Connecticut Council of Child & Adolescent Psychiatry to collect data from their membership.

**Office of the Child Advocate Response:**

- With regard to the Plan’s goal of building an adequate continuum of behavioral health care services that has the capacity to meet child and family needs, the OCA’s individual and systems work on behalf of children with complex developmental disability and their families has emphasized the need to improve the available service array. The OCA has underscored the need for families to have access to high-skilled care coordination. The OCA is also working with stakeholders to discuss the need for a more effective crisis-response and care coordination model for families whose children are experiencing their first behavioral-health related crisis and may be presenting to the local emergency department. Currently available crisis-intervention and acute-care in-home models such as EMPS and IICAPS are not yet tailored for children with developmental disabilities, and families in crisis may struggle to access community-based interventions and supports in a timely fashion. The state is making progress but many service gaps remain throughout the state for children with developmental disability and co-occurring behavioral health treatment needs. Workforce development remains an urgent area in need of ongoing attention.
- With regard to strengthening the role of schools in addressing the behavioral needs of students, the OCA has successfully advocated with at least one large school district to utilize outside experts to increase the district’s capacity to serve children with neurodevelopmental disabilities, which children often have co-occurring behavioral health needs. This district has now engaged in a comprehensive contract with outside-experts to improve its ability to serve children with developmental disability. Many districts struggle to meet the needs of this population of students and may over-rely on out-of-district placements.
- With regard to the Plan’s goal of strengthening the role of schools in addressing the behavioral needs of students, in September 2016, the OCA investigated the continued use of exclusionary discipline for very young children, and in partnership with the Center for Children’s Advocacy (CCA), the OCA published an issue brief sharing information regarding the results of its investigation, and provided recommendations that will better support children and their teachers. The OCA remains in regular contact with leaders at the State Department of Education to support the state’s efforts to reduce reliance on suspension and improve social-emotional outcomes for young children. The state’s data shows that suspension continues to trend downward over the last three years for many children, but that suspension of young children continues despite a new state law that largely prohibits such discipline for children Pre-K through Second Grade. The OCA is co-chairing a new working-group dedicated to improving social-emotional outcomes for young children in school. The state has many promising innovations in a variety of geographic locations and school districts throughout the state, including Project Launch and the New Haven Trauma Coalition, the Ana Grace Project/Klingberg partnership with New Britain Public Schools, all projects dedicated improving the capacity of school districts to capably serve children exposed to trauma and other adversity and improve their social-emotional and academic outcomes. Next steps will include scaling-up effective innovations and ensuring that school districts state-wide are empowered and supported to bring appropriate attention and focus to supporting

children's social-emotional development. The OCA will also continue to advocate for legislation that will eliminate the use of exclusionary discipline for young children in school. The OCA/CCA issue brief, inclusive of data regarding suspension of young children, can be found:

[http://www.ct.gov/oca/lib/oca/SuspensionYoungChildren\\_OCA\\_CCA\\_2016.pdf](http://www.ct.gov/oca/lib/oca/SuspensionYoungChildren_OCA_CCA_2016.pdf).

- The OCA has also advocated for improved service delivery for minors served by the state's juvenile justice and adult criminal justice systems. This past year, the OCA provided the state's Juvenile Justice Policy and Oversight Committee (JJPOC) with data regarding the lack of access to developmentally-appropriate educational, rehabilitative and mental health services for minors incarcerated in the adult criminal justice system. The OCA reviewed demographic data regarding incarcerated youth, their charges, educational status, mental health diagnoses, involvement with DCF, access to programming, and access to family visits. The OCA found significant restrictions on the availability of developmentally-appropriate services, almost entirely due to the challenges of confining juveniles in the adult correctional system. The JJPOC recently recommended that the legislature take steps to remove minors from the adult criminal justice system, acknowledging these youth's need for intensive rehabilitative and therapeutic intervention. Findings and recommendations of the JJPOC Incarceration sub-group, which recommendations reference the information from the OCA, can be found here: [https://www.cga.ct.gov/app/tfs/20141215\\_Juvenile%20Justice%20Policy%20and%20Oversight%20Committee/20170120/2017%20JJPOC%20Recommendations%20final%20%201-17-17.pdf](https://www.cga.ct.gov/app/tfs/20141215_Juvenile%20Justice%20Policy%20and%20Oversight%20Committee/20170120/2017%20JJPOC%20Recommendations%20final%20%201-17-17.pdf), pages 10-13.

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

The Judicial Branch and CSSD suffered significant budget cuts in FY 16. As a result, the following services and programs were cut or reduced:

- Loss of funding for IICAPS for privately insured families whose carrier does not cover the service (approximately 100-110 families annually);
- Loss of access to 12 substance use treatment beds at New Choices/Children's Center of Hamden (approximately 48 families annually);
- Significant reduction of funding for the TF-CBT Learning Collaborative;
- Elimination of 24 slots of MDFT (48 families annually);
- Loss funding for family engagement pilot at Hartford Juvenile Court (36 families annually); and
- All other services took a 6.9% funding cut.

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

Of the twelve partner agencies, four agencies provided a response under section D.

The input gathering process for the plan repeatedly acknowledged the important role primary care plays in the lives of children and youth. This section represents multiple efforts to promote and advance greater integration between primary care and behavioral health and tangible ways in which this is occurring. While there is significant consensus regarding the critical role of pediatric primary care in a truly effective behavioral health system for children, this continues to be an area for system improvement. Pediatric primary care is a critical partner for promoting

children's mental health through educating parents and promoting other prevention strategies, offering universal early and regular screening for behavioral health concerns and facilitating linkage to and coordination with behavioral health services. Exploration across disciplines continues to be examined to maximize these opportunities and to offer recommendations for system improvements to enhance coordination and integration.

**DCF Response:**

See Section A-Network of Care Analysis and the Pediatric Primary Care Analysis.

Implemented in June 2014, ACCESS-MH CT provides telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program allows for face-to-face consultations when a telephone consultation with a child psychiatrist and/or clinician is not sufficient to completely address the PCP's questions. Care coordinators and family peer specialists assist in obtaining identified services. The three "hub" providers contracted to provide the services are Wheeler Clinic, The Institute of Living, and Yale Child Study Center. The program is managed by Beacon Health Options with DCF oversight. Since program inception on June 16, 2014-June 30, 2017:

- 88% of pediatric and family care practices are enrolled representing a 5% increase from last year
- The program has served 3,487 unique youth and their families.
  - Adolescents continue to represent the largest volume by age across both SFY 16 and SFY 17
  - While the program is designed to support youth under the age of 19 years, PCP's continue to request support for young adults. In SFY17, the Hub teams supported 73 young adults (ages 19-25), representing a 43% increase in the volume from SFY16.
- 17,602 consultative activities have been provided statewide since June 2014.
- The benchmark set that 95% of all initial PCP calls requiring a call back would be returned within 30 minutes was exceeded.
- PCP satisfaction rate remains at 4.99 out of 5

**DDS Response:**

In the past, the DDS Program Review Committee (PRC) process required periodic reviews that focused on the quality of the behavioral health supports provided to the individual and the number of medications that the individual was prescribed, as well as a review of any aversives, including restraints. DDS current policy and procedures consolidate three separate documents for PRC, Behavior Modifying Medications, and Behavior Support Planning into two in order to reduce inconsistencies. Under the new PRC system, prescribers and supporting agencies are incentivized to reduce polypharmacy per person (below the statewide average of 2.87). The new positive behavior support policy better outlines expectations for the development of the support plans with an emphasis placed on properly conducting a comprehensive functional behavior assessment (FBA), identifying positive targeted behaviors to replace the behaviors of concern, providing graphed and annotated data, as well as finding ways to enhance the quality of life (e.g., preferred activities) for the individual served. Furthermore, the new behavior support policy

discourages the use of coercive and punitive approaches (e.g., spontaneous and planned ignoring, response cost, delivering consequences, etc.).

**DSS Response:**

- DSS has initiated focus groups with primary care providers in order to understand how the Medicaid program can assist with promoting and supporting integrated care within primary care
  - Primary care practices speak very highly of Access Mental Health
  - For co-location models, MOUs must be in place to facilitate communication
  - DSS and CHN, the medical ASO for the Medicaid Program, have conducted webinars specifically related to behavioral health and primary care integration

**JB-CSSD Response:**

- 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. Over 100 families are referred to HOMECARE annually.

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

Of the twelve partner agencies, seven agencies reported activities under section E.

This section provides an overview of the ways in which the systems individually and collectively examine service delivery and outcomes through a racial justice lens. In various ways, systems are focusing on this critical issue recognizing the ways there has been and continues, to be disparate and disproportionate outcomes for children and families of color. The information noted here reflects an awareness and specific ways in which the system examines critical data and outcomes relative to culturally appropriate care and the service system though it is important to acknowledge that this endeavor is still in its infancy stages. It will be important to examine all of the systems that touch the lives of children and families and better assess the ways in which each system more deeply examines its respective work, environment and data to determine areas needing improvement.

**DCF Response:**

Implementation of CLAS:

**Vision:** To develop, plan and implement a statewide process for incorporating enhanced Culturally Linguistically Appropriate Services (CLAS) standards within the children’s Network of Care in Connecticut.

**Goal:** To partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.

**Key strategies:**

1. To partner with behavioral health organizations in order to incorporate racially just, Cultural and Linguistically Appropriate Services (CLAS) standards into the delivery of services.
2. A five phase strategy will assist agencies with the Assessment and implementation of CLAS standards including the following:
  - a) Phase 1: Commitment to Health Equity assessment by Leadership
  - b) Phase 2: Agency-wide Health Equity Assessment
  - c) Phase 3: Priority Area Planning Development
  - d) Phase 4: Health Equity Plan Implementation and
  - e) Phase 5: Evaluation Outcomes and Services.
3. Improve linguistic accessibility to materials in the preferred language of the youth and families served in each region.

**Outcomes and Results:**

- The *Connecting with CLAS Workgroup* collaborates with Family Systems Managers and Network of Care Managers, to actively recruit child and family serving agencies to participate in the cohorts of *Connecting with CLAS*. Additionally state and agency partners support the recruitment efforts of the *Connecting with CLAS Team*.
- Two Cohorts of twelve agencies each completed their *Health Equity Plans*.
  1. All 12 agencies in Cohort 1 completed their *Health Equity Plans*. Technical Assistance was provided to review their progress, support their efforts, and receive guidance or recommendations for next steps. This included: two site visits per agency, four large group meetings (all cohort agency workgroups coming together), and eight technical assistance conference calls.
  2. All 12 agencies in Cohort 2 went through a similar process as the first cohort.
  3. All 12 Cohort 2 agencies completed their *Health Equity Plans* and presented them on February 27, 2017.
  4. Each Cohort 2 agency received individualized technical assistance to strengthen its *Health Equity Plans*.
  5. Recruitment is occurring for 42 organizations to participate in Cohort 3.
  6. Cohort 3 will transition to a regional technical assistance structure in order to prepare for a sustainable localized approach.
- DCF continues its commitment to address racial inequities in all areas of practice through multiple concurrent strategies. DCF reviews services with a focus on race and ethnicity for those referred, those served and their outcomes associated with their completion of the service. DCF is currently utilizing technical assistance from an individual with experience with the national *Culturally and Linguistically Appropriate Services* standards (CLAS) and is developing its own internal Health Equity plan.

- 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 its own Health Equity Plan. Three cohorts have been established. Cohort I included 12 behavioral health providers from around the state and they completed their Health Equity plans on June 29<sup>th</sup> 2016, and presented them to a statewide group of *CLAS* experts. Cohort II included an additional 12 behavioral health providers who completed their Health Equity plans earlier this year and Cohort III will include over 30 providers and will begin in the fall. Cohorts I and II are currently in the process of implementing their Plans.

**DSS Response:**

- Data Analysis work through the behavioral health Administrative Services Organization has improved since last update. Beacon Health Options continues to become more sophisticated with their reporting capabilities related to children’s behavioral health measures with attention on examining data by race and ethnicity. Measures include, but are not limited to the following:
  - a. ED utilization
  - b. Re-admission to ED (7 and 30 days)
  - c. Hospital inpatient utilization
  - d. Re-admission to hospital (7 and 30 days)
  - e. Hospital inpatient utilization
  - f. Re-admission to hospital (7 and 30 days)

**DPH Response:**

- DPH student/parent satisfaction surveys include questions related to the cultural and linguistic appropriateness of the services received. Student/parent satisfaction surveys are conducted annually. SBHC contractors are required to provide an analysis of the results to DPH. DPH SBHC contracts states: *Contractors have an organized way to collect data on the ethnic and cultural characteristics of the patients served by the program*

Language related to cultural competency is embedded in the contract. There are also SBHC specific contract terms that relate to cultural competency including the following: *The contractor shall provide and implement written strategies to actively recruit and maintain a culturally diverse staff reflective of the Clients served under this Contract and shall ensure that all staff members receive training in the area of cultural competence.*

Current SBHC contract terms state: *The contractor will incorporate cultural competency development in overall staff development/training (through presentations, print, workshops, internet, etc.) and will report on the percentage of providers, staff and volunteers who receive cultural competency and gender specific training.* Additionally, cultural competency training is a continuing education requirement for licensed mental health clinicians including those working in DPH SBHCs.

SBHC contracts have several requirements related to cultural competency including but not limited to: policy and procedures for the provision of interpreter/translation services, non-English client related materials including SBHC forms appropriate for the population served by the program and surveys and other methods of assessing the satisfaction of patients and their families related to cultural diversity.

### **DMHAS Response:**

- DMHAS Young Adult Services has been working on insuring that youth are included in all aspects of programs development. Youth advisory boards have been established at the young adult program sites. Staff has received and continues to receive training on youth culture and issues that impact youth's access to care.
- 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. In support of this goal, *SSHS* is developing operational guidelines/standards for collecting student level behavioral health data.

### **CSDE Activities:**

- The Connecticut State Board of Education's Five-year Comprehensive Plan 2016-21, *Ensuring Equity and Excellence for All Connecticut Students* identifies four promises to Connecticut students. One promise states, "Ensuring their non-academic needs are met so that they are healthy, happy, and ready to learn." It specifically identifies mental health, nutrition and after school as examples of meeting students' non-academic needs.
- Connecticut's *Next Generation Accountability System* greatly enhances the public's access to information and data on schools and districts. It is a broad set of 12 indicators that help tell the story of how well a school is preparing its students for success in college, careers and life. The new system moves beyond test scores and graduation rates and instead provides a more holistic, multifactor perspective of district and school performance and incorporates student growth over time. A key feature of the new accountability system is that it separates data for high-need subgroups of students. That gives us a better idea of how students living in poverty, students who have disabilities and students learning English are performing in school and how we can better support them on the path to success. Data can also be disaggregated by race.
- The CSDE submitted the *Connecticut Plan to Ensure Equitable Access to Excellent Educators* (2015 CT Equity Plan) to the United States Department of Education outlining the steps it will take to ensure that students from low-income families and students of color are not taught at higher rates than other children by inexperienced, unqualified or out-of-field teachers or school leaders.  
The Connecticut plan focuses on six overarching strategies:  
Strategy 1: Strengthen the Preparation, Support, and Development of Principals  
Strategy 2: Strengthen Preparation and Support for Teachers  
Strategy 3: Cultural Consciousness and Competence  
Strategy 4: Working Conditions  
Strategy 5: Examine Effective Use of Per Pupil Expenditures, and  
Strategy 6: Increase Supply of Candidates in Specific Teaching Areas.

### **Office of the Health Care Advocate Response:**

- UConn's Health Disparities Institute has convened a series of meetings with stakeholders across the state to assist with the development of a study to evaluate the impact of medical debt on

distinct populations within Connecticut, with an emphasis on identifying inequities in the system, and any ethnic, racial or other bases for such disparity. One focus of this effort involves the identification of effective data sources to provide meaningful information about medical claims, medical debt, collections and other challenges consumers face, and the development of effective tools to measure this impact. Stakeholders' input has helped the HDI to refine the focus of the study so that the resulting report will have effective and actionable recommendations. While OHA is an active and enthusiastic participant in this process, as the impact of medical debt affects all aspects and the sustainability of Connecticut's healthcare system, the HDI is the primary study author.

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

- 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, inpatient evaluation, CBT, MST, MDFT, and other services by gender and race/ethnicity to identify disparate access to care or outcomes. The availability of Spanish-speaking service providers, in particular, is continuously monitored and new means to attract and retain such personnel remains a priority and challenge for CSSD.
- The Judicial Branch is committed to addressing implicit bias in court personnel's decision making and raising awareness of how unconscious bias impacts interactions with clients, the identification of needs, responses to behavior, access to care, and access to justice. CSSD continues to offer a training series related to cultural competence and responsiveness for all employees and offers additional workshops on understanding and working with specific populations. 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.

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

Of the twelve partner agencies, seven agencies provided a response under section F.

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

## **DCF Response:**

### **Family Engagement**

**Vision:** To increase mental health awareness by partnering with parents, caregivers and youth with the goal of integrating family voice into the statewide Children's Behavioral Health System.

**Goal:** To engage parents, caregivers and youth through-out the state and to train them to be leaders and a positive voice within the communities.

### **Key strategies:**

1. Support existing Family and Youth Engagement Action Teams (FEAT) and create additional teams when needed.
2. Connect with parents, caregivers and youth throughout the state, and educate them on the CT Behavioral Health System and the national CLAS Standards.
3. Actively support the existing workgroups and recruit, educate and support parents, caregivers and youth to participate in the workgroups.

### **Outcomes and Results:**

Family System Managers and the Network of Care managers have attended numerous community collaboratives, LISTs meetings, and other local forums, presenting on the *Connecticut Children's Behavioral Health Plan* goals and principles.

#### **A. Youth Engagement**

**Vision:** To increase mental health awareness by partnering with high school students with the goal of integrating youth voice into the statewide Children's Behavioral Health System

**Goal:** To engage and connect with local high schools and with Future Health Care Professionals (HOSA) groups throughout the state in order to expose high school students to behavioral health occupations.

### **Key strategies:**

1. Connect with high schools throughout the state, particularly using HOSA groups as an instructional tool to introduce high school students to the CT Behavioral Health System and behavioral health occupations
  - a. Offer presentations to 14 afterschool clubs and 4 curriculum based HOSA programs throughout the state
  - b. Provide mental health informational packets for 500 involved HOSA students
  - c. Support student-led HOSA activities and interests related to mental health awareness to a larger student body
2. Develop and present a youth curriculum on the CT Behavioral Health system and the need for Youth to add their voice.

### **Outcomes and Results:**

- A statewide presentation was given to all CT HOSA advisors on *Connecticut Children's Behavioral Health Plan* goals and principles.
- Collaboration and support were provided to the annual CT HOSA conference that focused on increasing mental health awareness among students in CT.

- Multiple outreach activities were offered to the 18 high schools with HOSA clubs.
- Meetings and partnerships were developed with local HOSA advisors and students in five schools including: East Haven, Hamden, Killingworth, Wallingford and Brookfield. Students were introduced to the *Connecticut Children's Behavioral Health Plan* goals and principles. Additionally, Youth Mental Health First Aid has been offered to three sites.

**DDS Response:**

DDS contracts with the CT Family Support Network (CTFSN) to provide outreach to families who do not receive waiver services from the department. CTFSN also assists DDS to support family engagement activities and to encourage families to participate in department training and education activities. CTFSN staff participate in all of the DCF CONNECT regional collaboratives. Information obtained through the CONNECT collaboratives is shared with DDS case managers. Through the Supporting Families COP, a new sibling group has been developed and self-advocacy activities for youth under age 25 have increased. DDS also funds activities implemented by the CT Youth Leadership Project and actively participates in the CT Developmental Disability Council *Partners in Policy Making* educational activities.

The Supporting Families COP family member led the development of a Positive Behavioral Support brochure and helped create training materials for providers to use when training staff to support people with IDD who have challenging behaviors in community environments. These resources are now available for both family members and for our agency qualified providers.

In 2015, DDS received approval from CMS to add a waiver service called “training and counseling services” for individuals who provide unpaid support, training, companionship or supervision to waiver participants (such as parents, siblings, extended family or circle of support). The individual can through the Person Centered Planning process, designate up to \$1200 per year of their waiver funding to use this service. It is expected that this service will help families to better connect with other families in order to learn and benefit from their shared experiences.

**DPH Response:**

- DPH SBHC contracts states: *The contractor shall maintain an independent community based SBHC advisory board... The membership of this advisory board shall include one parent of a student enrolled in the DPH SBHC program.* SBHC make every effort to engage parents/guardians in their child’s care. CT DPH supports the CT Medical Home Advisory Council (MHAC) that provides support to parents and youth to be active members. MHAC addresses a variety of topics including behavioral health needs.
- CT Medical Home Initiative staff which can include family members of children with behavioral health needs to provide direct support to families at the practice level and can provide parent/professional education and support.
- CT DPH supports parents in the development of leadership skills through CT Medical Home Initiative contractors including the CT Family Support Network. CT DPH recommends parents to attend the National Conference of Association of Maternal and Child Health Programs in

order to take part in leadership training and to network with parent leaders throughout the country. In addition CT DPH assist parents to be members of the Healthy CT 2020 Advisory Council which reviews activities related to the CT State Health Improvement Plan (SHIP).

**DMHAS Response:**

- The DMHAS YAS program continues to support the web based project developed through the South West Regional Mental Health Board called *TurningpointCt.org*. *TurningpointCT.org* is a technology based approach to engaging youth and young adults in mental health/recovery services. The web site is youth driven and managed. The result has been a web based resource for adolescents, young adults and families who are looking for answers regarding mental health issues, sharing of stories and resources for help. The number of followers on this site continues to increase.
- The *Now is the Time-Healthy Transitions, CT Strong* grant incorporates a Peer Support and Advocacy component to engage young adults and support family members. Each wraparound team in the grant funded cities of New London, Milford and Middletown has a Peer Advocate and Family Advocate as part of the team. Additionally, the grant funds a Peer Advocacy Coordinator who works with the Project Director and the local teams to bolster and enhance Peer Advocacy efforts throughout the state.

DMHAS supports this model throughout its service system as evidenced by Peer Support Specialists positions located within the LMHA's. Preliminary data indicates that the topics of assistance youth connected with the wraparound teams need most from the teams are: Engagement in treatment planning/case conferencing (65% of youth), Emotional support or counseling (64% of youth), Education support (61% of youth), Vocational Services (57% of youth) and Transportation (49% of youth). Preliminary findings from participant interviews indicates improvements in moving out of homelessness to stable housing (54% increase from baseline to 6 months in number of youth involved who have been able to secure their own housing), and a 35% increase (from baseline to 6 months) sense of belonging to their community. Participant interview findings will continue to be evaluated and shared.

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

### **CSDE Activities:**

- The CSDE initiated the *Commissioner's Roundtable for Family and Community Engagement in Education (Commissioner's Roundtable)* in October 2017. The purpose of the *Commissioner's Roundtable* is to advise the Commissioner of Education regarding policy and programmatic priorities to improve outcomes for all students and advance the State Board of Education's comprehensive plan for equity and excellence in Connecticut schools. Specifically, the group: 1) advises the CSDE on issues and policies related to family and community engagement in education; brings an authentic parent and community voice to CSDE products and initiatives; 2) reviews and makes recommendations on the implementation of Connecticut State Board of Education's Five-year Comprehensive Plan (2016-21), regarding school-family-community partnership initiatives; and 3) reviews and recommends effective practices to increase school and district capacity to develop successful partnerships and families' capacity to support their children's education and determine the feasibility of carrying out those practices in Connecticut.
- Membership in the Commissioner's Roundtable for Family and Community Engagement in Education is intended to reflect a balanced representation of the three major constituencies – school/district staff, parents (or guardians) and community members – as well as students. Appointments to the group are made upon recommendation by the Commissioner of Education and to the extent possible, reflect Connecticut's geographic, economic, ethnic and racial diversity. Meetings are chaired by the Commissioner and take place quarterly.
- *Friday CAFÉ* (Community and Family Engagement) is a monthly gathering for family engagement specialists and provides training, consultation, networking and priority setting for regional activities. Because there is no professional organization or network in Connecticut for peer-to-peer learning and resource sharing, *Friday CAFÉs* are an opportunity to create a professional community.

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

In 2013, the Department collaborated with the industry and leveraged UConn Health Center psychiatry expertise to develop a Behavioral Health Consumer Toolkit. This tool supplies consumers with what they need to know about seeking approval for behavioral health services with their commercial health insurance plan.

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

- CSSD puts much attention on youth and family engagement through its recidivism reduction efforts, particularly through client and family engagement staff training, the use of motivational interviewing, and strengths-based case planning and case management. CSSD is highly successful in engaging families in case review team meetings, home visits, and 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.
- The family engagement pilot established in 2014 at the Hartford Juvenile Probation Office and Detention Center was cut due to a loss of funding.

### **G. Workforce**

Of the twelve partner agencies, seven agencies reported activities under section G.

Workforce development is key to sustaining the improvements that have been made. It is essential to strategically support workforce development. An environment of training as a standalone activity has not yielded the types of desired outcomes in the way that a more comprehensive approach that includes cross-training, coaching, and continuous quality improvement does. There are multiple examples of the systems shift to enhanced workforce development. This acknowledges that the issues faced by children and families can be multifaceted and complex and as such it is critical to arm teams with specialized supports and knowledge.

### **DCF Response:**

#### **Workforce**

**Vision:** To support and mentor youth and family champions by expanding opportunities to share knowledge and expertise in the development of family driven and youth-guided care.

**Goal:** Ensure that families/caregivers, and youth are full partners in all aspects of the planning and delivery of their own care/services and in the policies and procedures that govern care for all children and youth in their community.

#### **Key strategies:**

1. Employ *Youth and Family Engagement Specialists* to identify, recruit, train and support parent, caregiver and youth capacity to be full partners in the planning, delivery, and governance at all levels within their Network of Care.
2. Support parents, caregivers and youth to become actively involved in the decision making process at Network of Care tables.
3. Utilize the curricula to train and prepare parents, caregivers and youth.
4. Expand opportunities at local and state decision-making tables for parents, caregivers and youth to share their knowledge and expertise in the development of a strengths-based, family-driven, youth-guided and culturally/linguistically appropriate care.
5. Ensure the sustainability of family partnership through network development and collaboration with the FAVOR HOPE Learning Collaborative for continued family champion expansion and integration.

### **Outcomes and Results:**

Curriculum has been developed and training of trainers and multiple trainings have occurred for the following:

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

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

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

### **DDS Response:**

DDS continues to partner with DCF, DMHAS, Beacon Health and BRISC to offer trainings to EMPS mobile crisis providers on proactive and reactive strategies to use in work with I/DD children and families. The presentation has been updated to focus more on ASD and will be directed to families, as well.

- DDS continues to assist the community members, providers and family members in expanding skills to support children with complex behavioral needs:
  1. A comprehensive template to support best practices in positive behavior support for families has been developed by DDS psychologists, and multiple materials and trainings have been developed using the template as the foundation.
  2. DDS is one of seven Connecticut state agencies that partnered to form the Connecticut Restraint and Seclusion Prevention Initiative.
  3. DDS partnered with DCF to provide positive behavior support (PBS) training to clinicians who work in Emergency Mobile Psychiatric Services (EMPS) to help them better understand and serve children and adolescents with developmental disabilities.
  4. Beginning in FY16, DDS Staff Development and Psychological Services divisions, in partnership with DMHAS, offered workshops on mental health issues and PBS specific to persons with intellectual disability and autism spectrum disorder.
  5. DDS is in the process of revising its ongoing training programs on abuse and neglect prevention to incorporate the concepts of trauma-informed care, cyber bullying and exploitation, and PBS.
  6. Three DDS psychologists provided the plenary presentation at the Restraint and Seclusion Prevention Annual Conference in October 2016, entitled “*Holistic Approaches to the Prevent the Overuse of Psychiatric Medications for Persons with I/DD.*”

**DSS Response:**

- DSS, with the state agency partners (DCF and DMHAS) and Beacon Health Options has embarked on analysis of health equity within the behavioral health system. We are currently analyzing rates of access to outpatient services by demographics and geography.
- DSS supported the training and webinar related to SBIRT – to ensure primary care practitioners understand that the SBIRT codes are the physician fee schedule and can be billed
- Expanded services under School Based Child Health to include Behavior Modification Services (ABA), Personal Care Assistance Services, Behavior Assessment

**DMHAS Response:**

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

**CSDE Response:**

- The CSDE continues to work with our programs to integrate academic college and career readiness skills with employability skills. These “soft” skills include the ability to think critically, problem solve, communicate effectively, work within a team structure, manage conflict and interact respectfully with people of diverse cultures, races, ages, genders, sexual orientations and religions. Our goal is to provide students with the academic and personal/interpersonal skills necessary for success in post-secondary education, vocational training, apprenticeships or careers.
- The CSDE continues to work with our programs to integrate academic college and career readiness skills with employability skills. Additionally, cross-agency collaboration with the Departments of Labor and Rehabilitation Services is ongoing to implement the requirements of the Federal Workforce Innovation and Opportunities Act (WIOA)

**Office of the Child Advocate Response:**

- The OCA’s work on behalf of families and children with disabilities has led to findings that extensive workforce development needs still exist with regard to the assessment and service delivery for children with complex developmental disabilities, with or without co-occurring behavioral health service needs. Access to experienced board-certified behavior analysts remains limited, for example, and school districts’ as well as children’s mental health providers’ capacity to serve children with complex developmental and intellectual disabilities is still evolving. The OCA has been working with stakeholders on the state’s MAPOC sub-group for children with developmental disabilities, which group has recently issued recommendations to the MAPOC that address the need that school districts have for technical assistance to increase districts’ capacity to serve these students.

- OCA continues its collaboration with the CT Interagency Restraint and Seclusion Prevention Initiative, and in September 2016 was a co-sponsor of the fourth statewide educational forum held at Southern Connecticut State University. The forum, featuring national experts, provided approximately 350 participants with information to assist in the continued work focused on prevention of restraint and seclusion of children and adults across all human service systems.
- In February 2017, the OCA published an investigative report concerning the lack of compliance by one of the state's large school districts with state laws regarding mandated reporting of child abuse and neglect. The report contained a number of strategies and recommendations to support adequate prevention of and response to the abuse/neglect of children in the school setting, along with recommendations regarding how the district can improve its capacity to prevent child-abuse and neglect in the school environment and capably serve children who present with trauma or other disabilities, which may increase their vulnerability to abuse or neglect. Many of OCA's recommendations have begun to be implemented by the district, which has focused on, among other important strategies, increasing its capacity to serve children with complex learning needs and ensuring that all staff are knowledgeable and supported in their ability to detect and respond to suspicions of child abuse and neglect. The OCA continues to work closely with state and local officials to implement strategies and develop legislative solutions that will improve children's safety in the school environment. The full report can be found at: [http://www.ct.gov/oca/lib/oca/OCA\\_Report\\_HPS\\_2017\\_%28002%29.pdf](http://www.ct.gov/oca/lib/oca/OCA_Report_HPS_2017_%28002%29.pdf).

**JB-CSSD Response:**

- CSSD staff receives pre-service and annual refresher trainings on a variety of topics, including but not limited to, adolescent development, behavioral health disorders and effective treatments, the impact of trauma on behavior, and suicide prevention.
- 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 and ASSERT grants 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 (Child, Youth and Family Support Center) 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. Over 3,000 children referred to the Juvenile Probation have been screened since 2014.

### **Summary**

The general inventory of over 150 collective efforts across seven thematic areas by the twelve partner agencies shared above, continues to demonstrate progress in improving the behavioral health system that serves children and families in Connecticut. However, coordination and collaboration efforts between and among the twelve partner agencies needs to continue with more intentional and deliberate efforts given to blending and braiding of resources in the outlined areas of the plan. The core mandates of the partner agencies serves as the cornerstone to build upon in improving the overall system.

Most of the more than 150 efforts reported above, represent some of the strengths of the individual partner agencies or of the system, but more can and should be done including: completion of a behavioral health fiscal map; development of a unique single identifier for children and their families; better data integration efforts across the partner agencies; more early and routine behavioral health screening; and reduction of disparities in access and in outcomes across the behavioral health system are just a few areas of continued focus that needs to be sustained. Additionally, key system outcomes should be identified and a process to track those outcomes to demonstrate success for Connecticut is crucial.

The collective efforts of the partner agencies and providers, should be applauded, while at the same time, the unmet needs of children and their families with behavioral health challenges should continue to motivate all stakeholders, to stay the course and continue working better together.