

Connecticut Children's Behavioral Health Plan

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And Submitted to Connecticut General Assembly

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I. Introduction

A. Legislative Charge: PA 13-178

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act (PA)13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012.¹ The legislation called for development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." Although developed under the guidance of DCF, this Plan is the product of extensive public input and discussion over the past eight months and aspires to be owned by the diverse set of organizations and individuals who had a part in its design and hopefully will be invested in making it a reality.

Every child deserves the opportunity to grow up in a nurturing and supportive home and in a community and school that promotes optimal social and emotional development. To achieve their best possible health and well-being, children require, at a minimum: safety and security, positive relationships with peers and caring adults; a sense of meaning and purpose; connections to community; physical activity and nutrition; and opportunities for play and learning.^{2,3} Existing frameworks for well-being differ but all underscore the basic principle that the absence of illness is not the same as the presence of health. The well-being framework adopted by the Administration on Children, Youth and Families (ACYF) specifies measurable domains of well-being in the areas of cognitive functioning, physical health, behavioral/emotional health, and social functioning.^{4,5} Domains of health and well-being can be threatened throughout the lifespan by trauma, maltreatment, and other adverse childhood experiences that result in toxic stress and can lead to emotional or mental illness.⁶ The scope of PA 13-178 envisions a statewide children's behavioral health system in which the well-being of all children is actively promoted, the damaging consequences of toxic stress are prevented, and children with identified needs and their families have access to timely, appropriate and effective supports and interventions that will restore them to a path toward sustained well-being.

There are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment.^{7,8} Researchers have found that between 37 and 39 percent of youth in the three studies had received one or more behavioral health diagnoses between ages 9 and 16.⁹ Half of all lifetime diagnosable mental illness begins by age 14.¹⁰ Despite the prevalence of behavioral health conditions, an estimated 75-80% of children in Connecticut with behavioral health needs do not receive treatment.¹¹

Exposure to trauma or Adverse Childhood Experiences (ACE) is a growing concern, with a recent study suggesting that two-thirds of children have at least one ACE and 10% have five or more.¹² Eighty percent of the youth admitted to detention in Connecticut report a history of trauma.¹³ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports the prevalence rates for substance abuse by age 17 (nationwide) as more than 30% for marijuana and more than 60% for alcohol.¹⁴ Additionally, according to DCF data, more than 60% of boys in the CT Juvenile Training School (CJTS) over the past three years had a substance use diagnosis. Additionally, youth who are involved in the juvenile justice system have high rates of diagnosable behavioral health conditions, as high as 70% for youth in juvenile detention.¹⁵

A recent Institute of Medicine report on prevention concludes that "there is consistent evidence from multiple recent studies that early [behavioral health] disorders should be considered as commonplace as a

fractured limb: not inevitable but not at all unusual. The prevalence of these disorders is the same in young people as it is in adults. An implication for prevention is that universal programs will not be wasted on large numbers of risk-free children.”¹⁶

Despite the prevalence of behavioral health and substance abuse concerns and that an estimated 96% of children are covered by health insurance, practitioners and policy makers still have extensive work to do to ensure compliance with federal and state mandates regarding promotion, prevention, and early identification, access to care, parity between behavioral health care and medical care, and access to treatment in the least restrictive environment.

The State of Connecticut has made tremendous strides in building a more responsive, publicly funded behavioral health service system in recent years that includes an array of school, center- and home-based services (See Section III.B.). Twenty-four Child Guidance Clinic (representing upwards of 90 sites) have been designated as Enhanced Care Clinics with increased reimbursement for providers committed to achieving a set of pre-defined service improvements. Forty-seven of these locations offer specialty evidence-based trauma focused clinical treatment for children suffering from adverse child experiences. Twenty-six System of Care (SOC) community collaboratives across the state are supported by a workforce of care coordinators who coordinate cross-sector child and family teams to individualize treatment planning for children with serious emotional disturbance (SED). State-supported School-Based Health Centers (SBHC) have expanded in number to 96, many more schools receive behavioral health supports through other means, including hospital and community-clinic partnerships and the co-location of pediatric and family behavioral health providers. There is increasing attention to the behavioral health needs of very young children through such interventions as Early Head Start/Head Start, Birth to Three, the Early Childhood Consultation Partnership, Child First and the Infant Mental Health Endorsement. Statewide and community-level family advocacy organizations have resulted in a stronger presence of family advocacy and family and youth participation in governance and service delivery. Through the Connecticut Behavioral Health Partnership (CT BHP), resources and services for children enrolled in Medicaid are much more efficiently and effectively managed through an Administrative Services Organization.

Notwithstanding these significant improvements and reforms for children served through the public sector, too many families with children in need of immediate behavioral health services struggle to understand and navigate a difficult and fragmented system that lacks basic capacity across the array of services. Identified roadblocks for accessing care include a diffuse network of payers, differing categorical and financial eligibility criteria, restrictions on covered services, and inconsistent standards for clinical practices. Access issues are compounded by inadequate training for specific behavioral health conditions as well as lack of trained personnel. Policymakers have faced a barrage of constituent complaints about the lack of access to services, lack of complete and clear data on the current system and a conflicting array of prescriptive actions for remedying the situation. The many families who told their stories in the course of gathering information for this Plan attest to the fact that, despite significant improvements, the system remains broken.

Table I.1 Coverage Status of Connecticut Children Under Age 18

Coverage Category	Percent	Number of Children
Covered by private commercial plans subject to State coverage mandates	28.0%	219,240
Covered by private plans of self-insured employers (not subject to State mandates)	28.0%	219,240
Covered by public plans (HUSKY A, HUSKY B, other)	40.0%	313,099
Uninsured	4.0%	31,000
Total	100.0%	783,000

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

This Plan provides Connecticut with a timely opportunity to institute substantive changes that will align policy, practice and systems development, building on the strengths in the current system while rectifying the weaknesses that exist. The goal of the Plan is to ensure that all children and their families have access to effective behavioral health prevention, treatment and support. DCF, as the State's children's behavioral health authority, was designated as the lead agency to develop and submit this Plan in consultation with: families and youth; representatives of the children and families served by the Department; providers of mental, emotional or behavioral health services for children and families; advocates; and others invested in the well-being of children.¹⁷

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

At a minimum, Public Act 13-178 calls for the Plan to include the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

- A. Employing prevention-focused techniques, with an emphasis on early identification and intervention;
- B. Ensuring access to developmentally-appropriate services;
- C. Offering comprehensive care through an array of services;
- D. Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;
- E. Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;
- F. Establishing results-based accountability measures to track progress towards the goals and objectives outlined in this section and sections 2 to 7, inclusive, of this act;
- G. Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;
- H. Improving the integration of school- and community-based behavioral health services; and
- I. Enhancing early interventions, consumer input and public information and accountability by:
 - (i) increasing family and youth engagement in medical homes in collaboration with the Department of Public Health,;
 - (ii) increasing awareness of the 2-1-1 Infoline program in collaboration with the Department of Social Services,; and
 - (iii) increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options, in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state.

Although the State has made important strides in reforming the publicly funded components of the system through the CT BHP,¹⁸ this Plan recognizes that only about 40% of children in the State are covered by that system (Table 1.1). Furthermore, of the estimated 56% of children covered by private plans, only half are in plans that are subject to state-level public mandates related to coverage. Larger companies that are self-insured cover the remaining children. Companies who self-insure their employees

are covered by federal law (ERISA) but are subject to limited state oversight.¹⁹ A shrinking but still significant segment of children, ranging from 2-6% depending on location,²⁰ remain completely uninsured due to immigration status or other factors. Families in all three covered categories as well as the uninsured use many of the same providers and systems, with variation in access and services offered.

This Plan will address these challenges directly, reflecting a growing determination across sectors to create a behavioral health service system that not only provides the best possible treatment but promotes social, emotional, and behavioral well-being and provides all Connecticut's children the opportunity to live happy, healthy and richly rewarding lives.

B. Plan Structure

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

C. Methods

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

The Steering Team gathered input from nearly 1,000 people including families, youth, advocates, providers, and recognized experts over the course of three months, from March-June, using the following strategies:

- **Website Input.** The Steering Team asked individuals and groups with an interest in the children's behavioral health system for input through a structured feedback questionnaire that could be entered through the website, completed and emailed, or mailed to CHDI. Forty-five individuals and nineteen groups submitted comments on a range of topics.²¹

After the draft Plan was posted to the website, 115 people submitted a total of 73 pages of detailed comments and suggested changes.

- **Open Forums.** Six forums open to the public were held across the state and attended by a total of 232 individuals. The Forums were publicized on the Plan website, in the media, and through email blast communications to numerous listservs operated by a variety of stakeholders. Each Open Forum was facilitated by experts from Yale University and from the African Caribbean American Parents of Children with Disabilities (AFCAMP). Each Open Forum included Spanish

and American Sign Language translation as needed by attendees. One or more Advisory Committee members attended each Open Forum.

- **Network of Care Community Conversations.** FAVOR, Connecticut's non-profit Statewide Family Advocacy Organization, convened a total of 26 family and community meetings regarding the Plan. These Community Conversations, co-facilitated by FAVOR Family System Managers and family members, were held in large and small cities and towns across the state, in English and Spanish, and involved a total of 339 adults and 94 youth. The Community Conversations were initially developed as part of the SAMHSA-funded CONNECT System of Care Expansion Planning Grant that was being implemented simultaneously to this Plan's input-gathering activities, creating opportunities for synergy.
- **Facilitated Discussions.** A series of Facilitated Discussions were held across the state on various topic areas. Facilitated Discussions were facilitated by experts from Yale University and from AFCAMP. A total of 220 individuals participated in these opportunities including invited stakeholders, experts, and family members with specific expertise in the topic. Facilitated Discussion topics included the following:
 - The Juvenile Justice System and Behavioral Health
 - Infant and Early Childhood Behavioral Health
 - Crisis Response and Management
 - The Education System and Behavioral Health
 - Autism Services and Supports
 - Coordination of Care
 - The Role of Commercial Insurance
 - Evidence-Based Practices
 - Substance Use and Recovery
 - Law Enforcement and Behavioral Health
 - Keep the Promise Children's Coalition
 - DCF Senior Team Discussion on Child Welfare and Behavioral Health

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

- **Review of Background Documents and Data.** The Planning Team reviewed documents from a number of intensive planning processes and ongoing initiatives, which are listed in Appendix B and referenced in Section II.B. The team also reviewed national reports and systems building efforts in other states.
- **National Literature Review.** At the national level, a series of plans and reports from the Institute of Medicine, the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Surgeon General, the Robert Wood Johnson Foundation, university-based centers (at Georgetown, UCLA and elsewhere), specialized think tanks (e.g., Zero To Three and ChildTrends), and others have informed Connecticut's work.

In addition to the input-gathering activities above, the Advisory Committee held five meetings to review progress and provide guidance and feedback on the process, the emerging themes, and the Connecticut context that would further inform the Plan (see inside cover for list of Advisory Committee members).

Although it would have been useful, there was not sufficient time or resources in the planning process to conduct a detailed secondary analyses of Medicaid or other quantitative data sources. Such sources of information are of great value and should be called upon in the future to guide system development and implementation efforts.

II. The Current System

A. Quantitative Description of System

U.S. Census data indicate that Connecticut has 783,945 residents under the age of 18. Recent data from the CT BHP indicates enrollment of 313,099 youth under age 18, or approximately 40% of the statewide youth population. State employees are Connecticut's largest group of individuals covered by self-insured/employer-sponsored plans.

Data received from the Connecticut Insurance Department, gathered from four of the largest commercial insurance providers in Connecticut, indicate that a total of 136,007 children age 18 and younger were insured in Calendar Year 2013, 100% of whom had some form of behavioral health coverage. Across all four carriers, 9% of covered youth used behavioral health services during the year, primarily for outpatient care (see Table II.A.1 below).

According to the Office of the State Comptroller, in Calendar Year 2013, there were 38,728 children under age 18 covered by the state's health insurance plan. All of these children had behavioral health coverage, and 6,654 (17.2%) used behavioral health services during the year.

Quantitative indicators of behavioral health service utilization can help inform an understanding of the current children's behavioral health system and the issues in that system. Utilization of crisis services (e.g., emergency departments), for example, is one way to assess the overall functioning of the children's behavioral health system. High rates of Emergency Department (ED) utilization for behavioral health concerns suggest a behavioral health system that is not sufficiently meeting the needs of children and their families. National data suggests an alarming increase in the number of youth presenting to EDs for behavioral health treatment, with one study indicating an increase of 26% from 2001 to 2010.²² A review of Connecticut data indicates a similar trend. One study reported that Connecticut has experienced a 30% increase in behavioral health ED utilization between 2011 and 2012. The study found that DCF-involved youth, even though they make up only 2.6% of the state population, accounted for 22% of all behavioral health ED visits.²³

ED utilization is likely influenced by a number of additional factors, including, but not limited to: increased recognition and awareness among families and schools of behavioral health symptoms; zero tolerance policies, overreliance on 911, demand for services that exceeds the supply of services; historical patterns of service utilization; lack of information about or access to appropriate community-based services; and fragmentation associated with multiple payers and systems that provide behavioral health care.

Looking at data from Emergency Mobile Psychiatric Services (EMPS), we can glean insight into overall patterns of the use of crisis behavioral health services and the systems issues facing Connecticut's children's behavioral health system. For example, EMPS is one of the few behavioral health services in Connecticut that is accessible to all children in the state, regardless of system involvement, insurance status, or geographic location. In Fiscal Year 2011, there were 9,455 EMPS episodes of care and 12,367 episodes of care in Fiscal Year 2014, a 31% increase. Most referrals to EMPS during that timeframe came from families (43.0%) and schools (34.6%).²⁴ In Fiscal Year 2014, 62% of youth served by EMPS were enrolled in Medicaid, 32% were privately insured and more than 80% had no DCF involvement. Hospital EDs and community-based EMPS providers report significant difficulties meeting the elevated

demand for their services, and a lack of appropriate follow-up care options for youth and their families that might divert the youth from future ED utilization and ensure that all youth are able to receive effective treatment while remaining in their homes, schools, and communities.

Table II.A.1 Information on Commercial Insurance Coverage for Behavioral Health Services (Youth under 18 years): Calendar Year 2013					
Served	Anthem	United Healthcare/Oxford Health	CIGNA and Affiliates	ConnectiCare Inc. & Affiliates	Aetna
Total Members Covered	46,118	23,297	22,948	43,644	23,816
Children who Received Behavioral Health Care	5,788 (12.6%)	1,970 (8.5%)	1,915 (8.3%)	2,565 (5.9%)	2,699 (11.3%)
Children who Received Behavioral Health Care, by Level of Care*					
<i>Inpatient Hospitalization</i>	130 (2%)	88 (4%)	97 (5%)	103 (4%)	106 (4%)
<i>Outpatient Treatment</i>	5,777 (99%)	1,955 (99%)	1,384 (72%)	2,554 (99%)	2,657 (98%)
<i>Emergency Services</i>	235 (4%)	6 (<1%)	56 (3%)	78 (3%)	181 (7%)
<i>Residential Treatment</i>	20 (<1%)	12 (<1%)	378 (20%)	20 (<1%)	18 (<1%)

* Data were supplied by commercial insurance providers to the Connecticut Insurance Department. These data exclude self-insured private and public employers. Utilization at various levels of care represents unduplicated counts within each service category, although youth could use services at more than one level of care in the calendar year.

The children's behavioral health system also struggles with significant racial/ethnic disparities in access to and outcomes of treatment. A recent review found that the Black, Hispanic and Asian youth in the Medicaid population in Connecticut used behavioral health services at low rates relative to their proportion of the population. White children, by contrast, make up only 39% of the Connecticut youth Medicaid population, yet account for 45-46% of the use of behavioral health services.²⁵ System reforms must address racial and ethnic disparities in behavioral health care to ensure that all children have equal access to the full array of behavioral health services and supports.

This data supports the contention that Connecticut is in need of significant reforms that emphasize promotion of social and emotional skills and well-being, the ongoing development of a comprehensive service array at all levels of care, and a number of other supports that reduce the burden of behavioral health concerns that currently impact children and families across the state. Furthermore, the lack of easily accessible data is a barrier to statewide planning and implementation efforts. Systematic data collection and reporting on a common set of system-level indicators will help statewide stakeholders monitor implementation of the children's behavioral health system and allow for timely responses to issues that negatively affect service delivery for children and families. Ideally, this data should be integrated across insurance types and child-serving systems.

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

This Plan builds on a series of efforts over the last four decades to develop a more responsive and effective children's behavioral health system nationally and in Connecticut. This section recounts, in a timeline, the highlights of these efforts in Connecticut, as reflected in published plans and reports.

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

- 1980:** The Department of Children and Youth Services (precursor to DCF) adopts recommendations of a broad-based public-private working committee that children's behavioral health services be described and developed according to a Continuum of Care model.²⁶
- 1989:** Publication of the Department's first ever children's mental health plan,²⁷ including a new mission statement and operating principles.
- 1997:** The Legislature mandates the development of a "system of care" in Connecticut and articulates the guiding principles (P.A. 97-272); these became the genesis of the 26 local System of Care groups in operation covering all 169 towns in the state.
- 1999:** Young Adult Service Program Launched, a partnership among DCF, DMHAS, DDS, and OPM to assist with transitions from adolescence to young adulthood
- 2000:** Creation of FAVOR, a statewide family advocacy organization.
- 2001:** The Department of Social Services (DSS) leads a planning effort in 1999-2000 that results in Connecticut Community KidCare and the formation of the Connecticut Behavioral Health Partnership (BHP).²⁸ The resulting report identifies all public funding sources supporting children's behavioral health and recommends a new structure for improving services through an Administrative Services Organization (ASO).
- 2006:** DSS and DCF launch the BHP, carving out behavioral health services from the HUSKY managed care contracts and blending it with DCF funding through an ASO (ValueOptions, Inc.) selected through an RFP process to manage development of and access to an integrated continuum of services.
- 2008:** Passage of the Mental Health Parity and Addiction Equity Act of 2008
- 2010:** A Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issues Mental Health Care 'Blueprint' for Children in Connecticut in June.
- 2011:** DMHAS joins the BHP, adding management of services for eligible adults.
- 2011:** Implementation of Rehabilitation Option in Medicaid allowing for reimbursement for in-home services and expansion of IICAPS (Sec 17a-22q-1)
- 2011:** DCF leadership emphasizes greater engagement with families and communities to assure children's health, safety, learning, and success²⁹ with enhanced focus on supporting birth families and relative foster family care when a child must be placed out of home.
- 2013:** OHA publishes January 2013 report, "Findings and Recommendations: Access to Mental Health and Substance Use Services"
- 2013:** PRI Reports on Access to Substance Use Services for Privately Insured Youth
- 2013:** DCF receives a planning grant to develop a "Network of Care," which provides the foundation for this Plan and is described in Section III. DCF leads a collaborative that applied for federal implementation funds for the **Connecticut Network of Care Transformation (CONNECT)**.
- 2013:** The Office of the Health Care Advocate leads a team developing the Connecticut Healthcare Innovation Plan under the State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation (CMMI; Implementation funding application submitted in July 2014).
- 2013:** Passage of Public Act 13-3 – sections 64-79, provisions on Behavioral Health Taskforce, reforms to behavioral health and substance use utilization review for insurance plans, Access Mental Health and assertive community teams under DMHAS, DMHAS care coordination teams, and mental health first aid training.
- 2014:** Connecticut Department of Public Health issues Healthy Connecticut 2020 State Health Assessment and Health Improvement Plan (Focus Area 6 is Mental Health, Alcohol, and Substance Abuse).

- 2014:** Task Force to Study the Provision of Behavioral Health Services for Young Adults, Established Pursuant to Public Act 13-3 (Section 66), issues its report on April 20.
- 2014:** Passage of P.A. 14-115 requires OHA to establish, by January 1, 2015, a behavioral health care provider information and referral service to help residents and providers with resources, timely referrals, and access. OHA is required to report annually on “...gaps in services and the resources needed to improve behavioral healthcare options...” PA 14-115 mandates collaboration with stakeholders, a public awareness and educational campaign and a data-reporting mechanism for measuring effectiveness.

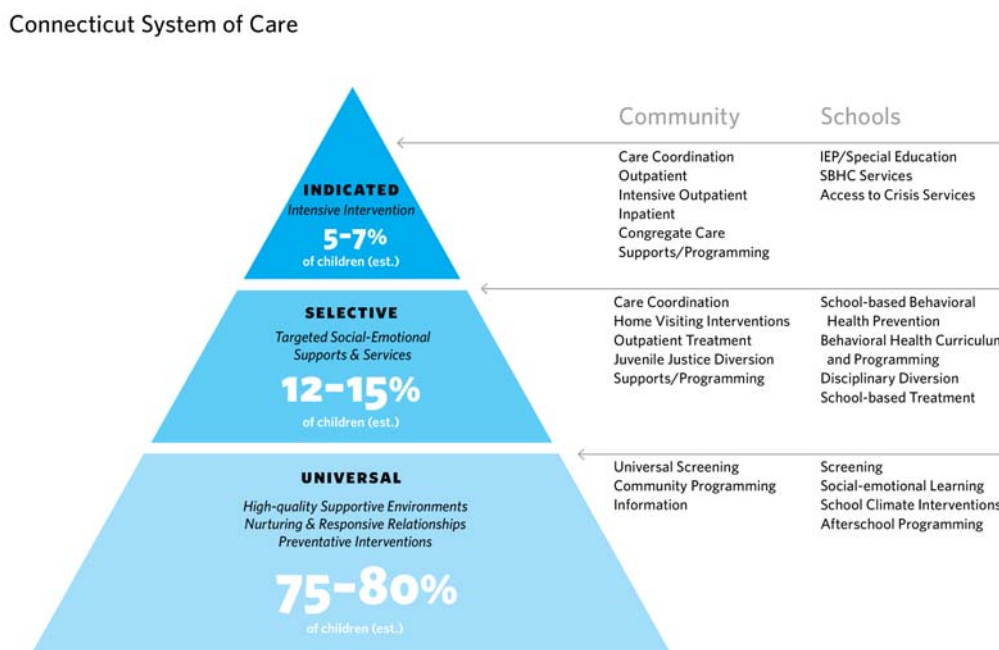
Notwithstanding all these efforts and some measureable improvements, the goal of an efficient, accessible system that meets families’ needs eludes our state. Building on a series of in-depth analyses and the work of a number of committees, this Plan identifies the critical system development tasks that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

III. Conceptual Framework for the Plan

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a “system of care” for youth and families facing behavioral health challenges and by the Institute of Medicine’s (IOM) framework for addressing the full array of services and supports that comprise a comprehensive system (see Figures III.1 and III.2). A system of care is defined as:

“A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.”³⁰

Figure III.1



The system of care offers states and communities a conceptual and practical framework on which to base system and service development that benefits the behavioral health and wellness of children and their families. Such a system also ensures access to services regardless of geographic location, race, ethnicity, agency affiliation (or not), or insurance status. Connecticut to date has undertaken efforts to incorporate some, but not all, elements of the system of care concept.

The IOM's framework aligns services and resources along an axis that includes universal services for all children to promote optimal social and emotional development and well-being, selective services (e.g., early identification, early intervention) for children at high risk of developing a behavioral health condition, and indicated services for treating those with serious and complex disorders.³¹ According to this framework, preventive interventions aim to reduce risk factors and promote protective factors (at the child and family level), and prevent or reduce the impact of behavioral health conditions. This array of services and supports is used to organize the planning and implementation of a system that will meet the needs of all youth and their families.

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

- **Family-driven and youth-guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally- and linguistically-competent**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.
- **Trauma informed**, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

*Thirteen guiding principles are listed in Table III.1.

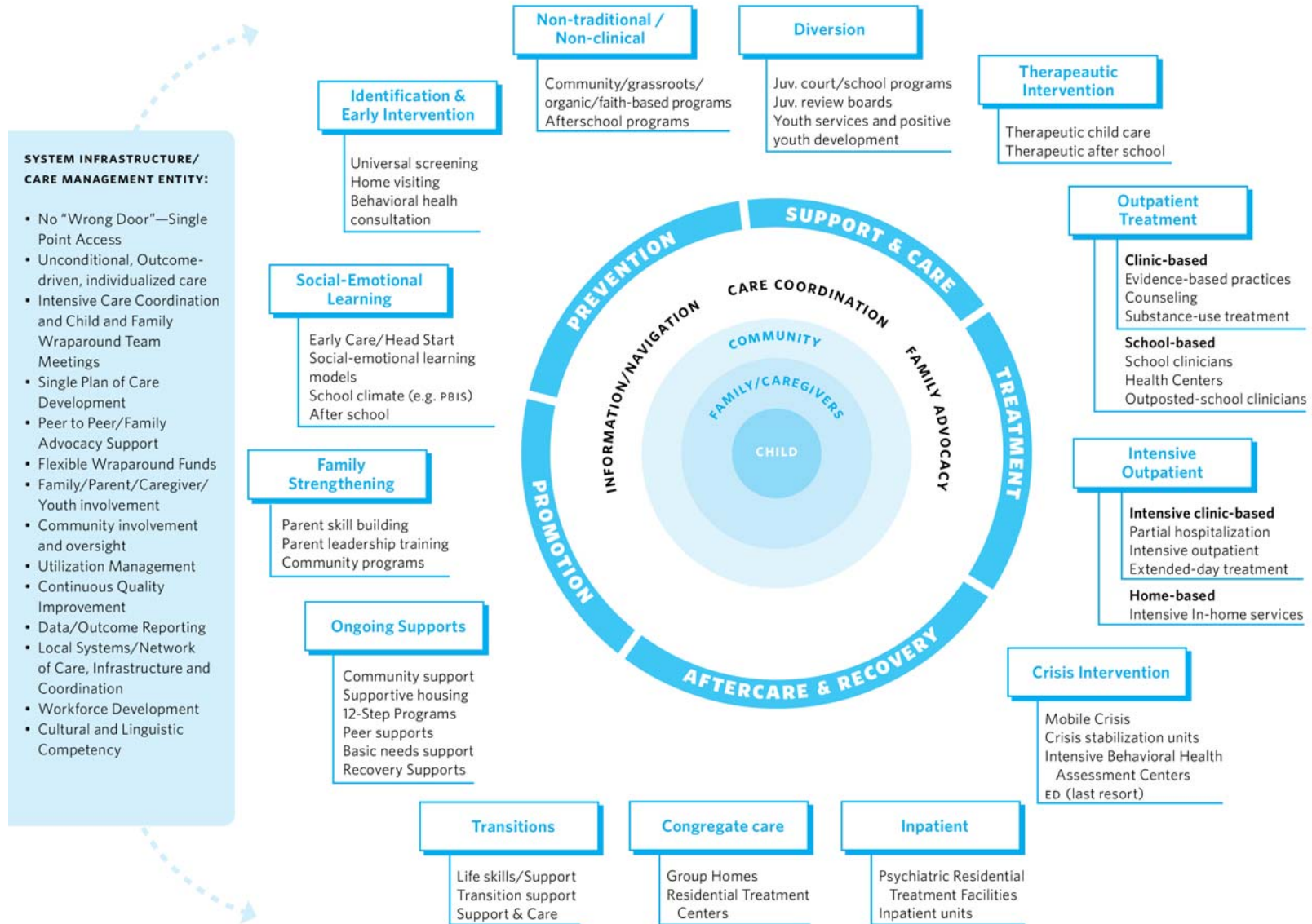
*Figure 3.2 illustrates an improved service array and highlighting primary system infrastructure functions

Table III.1 Guiding Principles of the Connecticut System of Care

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

Figure III.2. Array of Services and Supports in the Connecticut Behavioral Health System of Care

CT Children’s Behavioral Health System of Care



IV. Implementation Plan by Thematic Area

The Plan is organized into six major thematic categories. For each area, the Plan sets from one to three major goals and associated strategies, for a total of 14 goals and 38 strategies. In each area, we provide a brief overview of the findings that form the basis for the goals and strategies; we also provide explanations of the strategies. The six thematic areas, and associated goals, are summarized in Table IV.1

Table IV.1 Plan Thematic Areas and Goals

A. System Organization, Financing and Accountability

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

Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children’s behavioral health needs.

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

B. Health Promotion, Prevention and Early Identification

Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Goal B.3. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

Goal B.4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation

C. Access to a Comprehensive Array of Services and Supports

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

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

Goal C.3 Strengthen the role of schools in addressing the behavioral health needs of students.

Goal C.4. Integrate and coordinate suicide prevention activities across the behavioral health service array and multiple sectors and settings.

D. Pediatric Primary Care and Behavioral Health Care Integration

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

E. Disparities in Access to Culturally Appropriate Care

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

Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

F. Family and Youth Engagement

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

G. Workforce

Workforce strategies are distributed across the other thematic sections.

A. System Organization, Financing and Accountability

Among the most consistent themes from the input gathering process is the “fragmentation” of the children’s behavioral health system reported in different ways by family members, providers, and advocates and repeatedly identified in past reports on Connecticut’s and the national children’s behavioral health systems.³²

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

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

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

In addition to the problems cited above, families indicate that they are not aware of available services. Even the best designed and implemented service system will not address the behavioral health needs of families if they are unaware of or unable to access those services. For example, families report that, especially in the early stages of behavioral health difficulties, they may not identify the problems their child is experiencing as behavioral health symptoms. This failure to identify may be due to lack of awareness and lack of education about behavioral health issues as well as the persistent stigma associated with mental illness. Even once families were clear that their child was in need of behavioral health services, they weren’t always sure where to find the right services. For example, 2-1-1 and Child Development Infoline systems are widely thought of as helpful resources; however, many parents report that 2-1-1 is not sufficiently tailored to families seeking behavioral health services and supports, and that the Child Development Infoline is only available for young children. The expansion of the Child Development Infoline and coordination with the efforts of OHA to implement PA 14-115, as described later in this Plan, will help address concerns such as these. In addition, DCF and DSS will continue to improve promotional opportunities to build awareness of the 2-1-1 and EMPS system.

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

1. Coverage for selected services (e.g., intensive, in-home/community evidence-based practices; emergency mobile psychiatric services; other home and school-based services);
2. Adequacy of coverage/services for selected conditions (e.g., autism, substance abuse);
3. Medical necessity criteria and utilization management and review procedures (e.g., authorized access to care; time limits);
4. Adequacy of provider networks;
5. Perceived cost shifting to individuals and to the State.

The Connecticut Insurance Department convened a productive meeting between the CHDI Planning Team and representatives of DCF and major insurance carriers in the state. The representatives of the carriers and DCF acknowledged shared interests in potential collaboration on issues such as utilization of high intensity and crisis services, monitoring and improving service quality, and examining service utilization data. A few carriers acknowledged selected challenges, such as difficulty finding a sufficient number of child psychiatrists to participate in their networks. By and large, however, the carriers questioned what they viewed as inaccuracies about commercial insurance, stating that their networks, covered services, policies on covered conditions, and procedures were of high quality.

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

Some participants suggest that Connecticut has failed to adopt and embed important characteristics of the system of care, which has contributed to less-than-desired outcomes over time. Fully adopting those characteristics would require significant restructuring with respect to: public financing, organizational structure, integration of commercial payers, and data reporting infrastructure. Each of these areas is addressed below.

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

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

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

Funding additional administrative infrastructure should be undertaken in addition to, not in place of, ensuring sufficient funding for a significant expansion of children's behavioral health services (see Section C).

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

The Children's Behavioral Health Implementation Team (see Section V) should be charged with driving this system redesign process and with implementing the resulting design based on the principles and recommendations in this Plan. This Team will include representatives from all state agencies that fund children's behavioral health, other relevant state agency representatives (including the Department of Insurance), behavioral health providers, advocates, family members, and youth.

This work will include the following:

- **Identify existing spending on children's behavioral health services and supports across all state agencies.** Connecticut should identify the total spending on children's behavioral health and related interventions to generate a baseline understanding of the funding that is available, the services those funds are purchasing, gaps in services, areas of redundancy, and opportunities for creating efficiencies.
- **Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.** If, as expected, existing funding is not sufficient to implement the full service array including the expansions described in this report, stakeholders will need to implement all relevant strategies to identify sufficient funding (e.g., direct appropriations, pooled state agency funds, re-directed cost savings, federal grant funding, social entrepreneurship).
- **Explore mechanisms for pooling funding across all state agencies.** The task force will explore specific strategies for pooling funding and organizing it under a single entity that will finance and deliver children's behavioral health care. It is recommended that the state examine the Connecticut Behavioral Health Partnership as an effective model.
- **Identify a full array of services and supports that will constitute the children's behavioral health system of care (See Strategy C.1.1).** The full array will include a range of services across all age groups that includes promotion, prevention, screening and early identification, early intervention, all levels of treatment, and aftercare, with a focus on services that are evidence-based as well as innovative and promising services that meet the needs of specific populations (those interventions are described more fully in Section C). The pooled funding structure will create a single point of entry into the system of care that will reduce fragmentation for Connecticut's youth and families. The pooled funding system should be sufficiently flexible to allow for the funding of family-based services that treat children, caregivers, and siblings together as a family unit.
- **Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.** Contract with a health economist or another qualified professional to conduct a comprehensive cost analysis. It is presumed that there will be significant, long-term cost savings associated with preventing serious behavioral health problems, avoiding costly and restrictive treatment and placement settings when clinically appropriate (e.g., congregate care, emergency departments, inpatient hospitalization, juvenile detention), and expanding access to effective home-, school-, and community-based services. Those savings can be re-invested into developing and sustaining the full system of care. The findings also can be used to justify ongoing participation among state agencies and to attract the participation of other payers and funders, including federal agencies, philanthropy, commercial insurance providers, employee-sponsored plans and social entrepreneurship entities.
- **Identify and address workforce development needs in the children's behavioral health system of care.** The Plan identifies a number of goals and strategies with direct implications for

workforce development (see Section IV.G for a review). The Plan necessitates workforce development activities that will take place across sectors (e.g., behavioral health, primary care, education, child welfare, law enforcement) involving various system stakeholders (e.g., providers, caregivers, parents, youth, school personnel), across age groups (e.g., early childhood, adolescent, transition-age youth), and for various behavioral health conditions (e.g., mental health, autism, traumatic stress disorders, substance abuse). In addition, there is a significant need to identify and recruit professionals into the workforce to enhance its representativeness relative to the population served, with respect to race, ethnicity, culture, and language. It is recommended that the Children's Behavioral Health Implementation Team establish a committee within its governance structure to identify and address a number of workforce development challenges. This committee should have funding available to systematically address various workforce challenges.

Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Stakeholders expressed the following concerns (among others) in the planning process regarding the current quality of care coordination:

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

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" will improve outcomes for children and will lower costs of behavioral health services.³³

A care management entity (CME) is "an organizational entity that serves as a centralized accountable hub to coordinate all care for youth with complex behavioral health challenges and their families."³⁴ There are several models with respect to the organization implementing the CME, as well as their financing, structure, and function. CMEs have been implemented within state agencies, non-profit agencies with no service delivery role, and non-profit service providers that take on additional administrative roles and functions. Some models include a single statewide CME whereas other models use a network of CMEs. Funding for CMEs varies, but generally comes from State agency grant funds, a blending of child serving cross sector funds or at times with Medicaid options or waivers.

Regardless of the model utilized, a CME is intended to put into effect system of care values and principles and work toward the primary goals of reducing fragmentation, improving efficiencies, improving clinical and functional outcomes and resilience, and reducing costs.³⁵ Some CME models espouse goals similar to those of health homes for children with behavioral health needs. A CME can take on key administrative and service delivery functions of the system of care. Service delivery activities may include screening and assessment, care coordination using high-quality wraparound implementation, and ensuring access to a full array of behavioral health services and supports (including youth and caregiver peer supports and family advocacy). Administrative functions can include information management, utilization management, purchasing services, quality improvement, outcomes measurement, training, and care monitoring/review.³⁶ CMEs can be used to implement a value-based purchasing approach that emphasizes reimbursement for service quality and outcomes. CMEs can play a role in

disseminating information on behavioral health services and affirmatively connecting families to services. A CME can connect locally to Connecticut's 26 Community Collaboratives to localize family and youth engagement efforts and ensure the implementation of services that are culturally and linguistically appropriate. The CME approach can help ensure the family's experience of a system as having "no wrong door" by centralizing and coordinating administrative and service functions and by improving a family's access to information and care.

Although the system of care and CME approach would be created initially for families and children in the public systems, information on the outcomes and cost savings associated with this approach would be made freely available and commercial payers would be able to participate in the system of care based on demonstrated effectiveness (a development that has occurred in New Jersey's system of care).

In order for a CME approach to be effective, each of the strategies below must be carried out with focused attention to cultural and linguistic appropriateness to ensure access for all children and families. Parent and youth peer-to-peer networks within the CME must promote full engagement of youth and families in services and supports (see Section IV.F for detail on Family and Youth Engagement).

Strategy A.2.1 Design and implement a Care Management Entity (CME) to create an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.

Effective care coordination is a foundation of Connecticut's efforts to build a System of Care for children with behavioral health needs (as reflected in a recent federal grant submitted by the State).³⁷ Care coordination will be expanded and coordinated across sectors and providers based on evidence-based models of Wraparound services and child and family teaming. The service is delivered by a number of providers at the regional and local levels. A CME, operating within statewide standards and protocols, can be made responsible for purchasing or delivering care coordination services. The 75 care coordinators currently supporting the 26 system of care community collaboratives would be incorporated into this model, with the specific details of that design to be determined. The CMEs would also need to interface seamlessly with the work proposed for "Advanced Medical Homes" under the State Implementation Model (SIM) and other efforts to move pediatric care to a Medical Home model of integrated care. Pediatric providers could contract with the CME for care coordination for behavioral health services.

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

Another model for integrating pediatric and behavioral health services through care coordination is New Haven Wraparound, in development by Clifford Beers Child Guidance Clinic under a recent \$9 million federal Center for Medicaid and Medicare Services system innovation grant. These initiatives, and others, should be closely examined for integration and possible statewide replication.

The system of care model can be extended to function across behavioral health, health, education, juvenile justice, and community support services to ensure better cross-sector coordination of care for children in the behavioral health system as well as for children in other systems who need connection to behavioral health services. The care coordination collaborative model can bring together behavioral

health service coordinators in a variety of treatment settings (e.g. DCF, Enhanced Care Clinics, residential treatment services) and connect them with others who are coordinating other services that children with behavioral health challenges use, such as schools and health care.

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

Findings strongly indicate a need for families to have access to information and resources that are specific to mental health and substance use services. Public Act 14-115 charged the Office of the Healthcare Advocate (OHA) with establishing “an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers,” and in doing so, required OHA to work with state agencies, the Behavioral Health Partnership, 2-1-1, community collaboratives, and providers. Given the overlap of this OHA-led initiative with this plan and the proposed functions of the CME, integration of the PA 14-115 initiative within the CME array of information and services should be strongly considered.

A family support clearinghouse can serve as a central hub for information that is specific to behavioral health services and supports, including substance use, and will be accessible to any family member, youth, professional, or community member who is concerned about a child and is seeking information, resources, supports and services, regardless of level of risk, system involvement, or insurance status.

Preliminary plans for the OHA-led effort under PA 14-115 include an on-the-ground referral service that also conducts assessments and warm handoffs. The proposed service would coordinate with 2-1-1 and Child Development Infoline (for children with developmental concerns), OHA, service providers and agencies and would also collect data on access and waiting lists. Collaborative and technological linkage to 2-1-1 is required in order to quickly access EMPS services for those families who call in the midst of an active behavioral health crisis situation.

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

Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

The role of the commercial insurance industry is complex and requires additional analysis and planning. Public Act 13-178 calls for an implementation plan that addresses the behavioral health needs of all children in the state. Given the number of children covered by commercial plans and self-employed plans (Table I.1), the full participation of the commercial insurance industry in the ongoing funding, design, and delivery of behavioral health services is critical to achieving that goal. A number of state entities have processes in place to systematically identify and address concerns with the role of commercial insurance providers in the behavioral health system. Connecticut should continue to build on those processes, including those that have led to the development of the Children's Behavioral Health Plan. Those processes can be organized around the systematic investigation of the five areas of concern identified in the findings above.

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

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

Steps in this process, involving the Connecticut Insurance Department, the Office of the Healthcare Advocate, state agencies (e.g., DCF, DMHAS), advocacy groups, youth and families, and other stakeholders, should include the following: (1) **assemble and summarize all available relevant data and input**, starting with the sources listed in Table A.3.1; (2) **produce a report for the legislature** that will:

1. Clarify the issues that are under the purview of the commercial insurance industry, employee-sponsored plans, and Medicaid;
2. Identify the issues for which carriers may not be fully meeting their responsibilities under law, regulation, or contract; and
3. Formulate specific recommendations for action to address substantive concerns.

The report to the legislature will summarize the general findings and implications of the process, and will be used to guide and inform system of care planning and implementation efforts, as described in this plan.

Table A.3.1 Sources of Information Related to Commercial Insurance
* Connecticut Insurance Department
* Office of the Healthcare Advocate
* The Connecticut Legislature
* Office of the Child Advocate
* Other state agencies, offices, or commissions
* Insurance carriers
* Professional associations
* Trade associations
* Advocacy organizations
* Families and youth

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

The Federal Department of Labor, OHA and other entities review and monitor self-funded/employer-sponsored plans. OHA and other entities should come together in a process similar to the one described above, to generate information that could inform efforts to examine or address concerns regarding self-funded/employer-sponsored plans in subsequent phases of the effort to improve children’s behavioral health services.

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

Section 1 of PA 13-178 calls for “establishing results-based accountability measures to track progress towards the goals and objectives” as well as “increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability, and access to treatment options.” Furthermore, ongoing reviews of system implementation following plan development include the use of “data-driven recommendations to alter or augment the implementation in

accordance with section 11-4a of the general statute.” Data collection, analysis, and reporting will support the delivery of effective services across the service array. Systematic reporting on indicators of access, service quality, and outcomes will contribute to a culture of data-informed decision-making. This work should be objective and transparent, and promote public accountability using the Results Based Accountability (RBA) framework, as well as quality improvement, program evaluation, and research methodologies.

There are pockets of excellence in data collection, analysis, and reporting in Connecticut including a small number of behavioral health services where support for data collection, analysis, and reporting are completed in collaboration between DCF, the providers and a Performance Improvement Center. In addition, Value Options, on behalf of the CTBHP, has a robust data collection approach for individual service categories that allows a nuanced examination of access, quality, and outcomes. These data, however, are only for youth enrolled in the state Medicaid program.

Our findings indicate a need for data infrastructure at the systems level to support a fully integrated system, as well as the need for data that allows stakeholders to engage in program-specific evaluation and quality improvement. Data infrastructure development at the systems level should parallel the proposed reorganization of the behavioral health system to integrate across disparate child-serving systems. Issues of confidentiality and data security are of paramount importance in these efforts.

The challenges in this work are many:

- Data sources tend to be in siloes within state agencies without a common identifier that would allow more efficient tracking of outcomes across systems;
- Programmatic data that are housed within a single state agency often are not linked in order to track and monitor service utilization and outcomes over time;
- DCF, for example, does not have sufficient numbers of personnel to analyze and report data that are collected from their funded services, as noted by some stakeholders;
- Data are not shared across systems to promote accountability and transparency; and
- It is crucial to guard the security of protected health information, as families and providers strongly cautioned.
- Data and data reports are not routinely made available to all stakeholders including members of the public for the purposes of accountability and transparency.

The system of care should include outcome measurement that captures meaningful changes in child and family functioning, improves the effectiveness of the interventions we are offering, and determines which interventions work best for which populations. This type of data management system can be transformational in ensuring accountability for quality behavioral health services that are provided to all youth.

Strategy A.4.1 Convene a statewide Data-Driven Accountability (DDA) committee grounded in new legislative authority to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.

This Data Driven Accountability Committee, working under the Children's Behavioral Health Implementation Team, should ensure that mechanisms and resources are in place to implement the data-related activities outlined in the following strategies. The committee should consist of representatives from all agencies participating in providing behavioral health services for families and youth, and data analysts and evaluation experts in the field. The committee should ensure that the data systems are independent (i.e., not collected and managed by the people providing the services being evaluated), objective, and transparent. This is aligned with

Executive Order 39, the establishment of the CT Open Data Portal, supporting the timely and consistent publication of public information and data as an essential component of an open and effective government.

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

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

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

Strategy A.4.3 Improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.

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

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

Analytic staff supporting the Implementation Team and within the CME should work together to: (1) standardize key data collection process and outcome measures across agencies and programs as appropriate; (2) monitor and manage the data collection process; and (3) analyze and report results. The Implementation Team support staff, the CME, and the funding agencies must have the capacity to conduct data analyses and develop reports that help state, regional, and local directors and program managers to make data-driven program management and supervision decisions. Data-informed management must be part of the service array, not separate from it.

B. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan called for by PA 13-178. The law requires the inclusion of strategies that employ prevention-

focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services.

In the information gathering process, parents, providers and advocates repeatedly highlighted the importance of both promotion and prevention in the system of care. Many suggested a significant shift of focus from treatment to prevention of mental, emotional, and behavioral disorders by investing in the following: promoting nurturing environments and addressing basic material needs; promoting social and emotional skill development across the age span such as through evidence-based school curriculum; and engaging in screening and early identification among pre-school and school-aged children. Participants presented the following concerns and associated recommendations:

1. Include in all parent strengthening programs for caregivers of young children the importance of early relationships and social-emotional development;
2. Include social and emotional skill development in school health curriculum;
3. Increase prevention efforts and early interventions, especially for children under three years of age but also across all ages.
4. Identify children at risk for difficulties in social-emotional development and behavioral health problems at the earliest possible point through a combination of screening with standardized tools and surveillance by child health providers and school personnel, recognizing that many issues emerge as children enter teenage years.
5. Screen for maternal depression, trauma and other behavioral health risk factors in the family, and ensure that appropriate interventions are available and accessible.
6. Train child health providers on infant mental health and screening for behavioral and neurodevelopmental concerns such as autism among very young children, to ensure referrals for further assessment and intervention including through the Birth-to-Three system when appropriate.
7. Provide more statewide cross-system training in early childhood mental health for staff across all early childhood systems as well as for foster parents.
8. Recruit, train, and hire more bilingual providers to ensure that prevention, early identification and early intervention services are accessible and culturally relevant for children and families.
9. Expand existing evidence-based programs for young children to meet the mental and behavioral health concerns of children birth to five years old.

Participants identified the important role of promoting nurturing environments and relationships among children, acknowledging that Connecticut has an opportunity to strengthen this aspect of the system to ensure well-being among all children and prevent the onset of behavioral health concerns. Furthermore, the process revealed a strong desire among participants to address the significant gap in the service array in the area of universal prevention. This speaks to a public-health approach to prevention as outlined in the 2009 Institute of Medicine Report on the Prevention of Mental, Emotional, and Behavioral Disorders Among Young People.³⁸ The IOM report documents the science and practical knowledge that can guide efforts to prevent, reduce or avert mental illnesses in our children cost-effectively, with a return on investment as high as 80-to-1 for simple universal strategies.³⁹ Such a public-health prevention model has been elaborated in multiple publications subsequently.⁴⁰ Connecticut has the opportunity to be the first state to systematically implement preventive strategies across our communities and schools and reduce the number of youth who develop behavioral health concerns.

Significant expansion of promotion and prevention activities has been proven to reduce the number of youth who will develop behavioral health concerns; nevertheless, some children are at high risk for developing problems and must be identified early. The value of providing services and supports to children with signs of early delay and their families pays off many times over in school success and life

outcomes. Although the number of children in Connecticut screened for behavioral health concerns has increased a great deal over the past five years, screening is nowhere near universal. Connecticut does not have the data needed to precisely measure penetration rates but we estimate about half of all recommended early childhood developmental screening are taking place.⁴¹ Screening also needs to occur for older youth to aid in early identification of behavioral health concerns that may surface at later stages of development. Many participants, however, cautioned that increasing the understanding of behavioral health issues across all child-serving systems and moving to universal behavioral health screening will generate an increase in referrals for services that are already overburdened. Screening needs to go hand-in-hand with an expansion of services for those identified as in need to avoid longer waiting lists, delayed treatment and increased frustration for parents, caregivers, and providers.

The goals and strategies in this Plan address the need to strengthen early identification and screening activities, so that children with emerging behavioral health concerns receive the earliest interventions possible resulting in the best possible outcomes. The approach also seeks to change the environments and experiences of children in their homes, at school and in the community through proven strategies that are effective at promoting well-being and preventing poor outcomes beginning in the earliest years through the transition to adulthood.

Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the need statewide.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders.

Strategy B.1.1 Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the need statewide.

CT has a wealth of expertise and programmatic efforts to train early care and education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. Examples include: the use of the Pyramid Model in settings for young children birth to five, developed by the Center on the Social and Emotional Foundations for Early Learning, used by a collaboration of early childhood systems in CT;⁴² Yale's Center for Emotional Intelligence RULER program;⁴³ UCONN Neag School of Education and the State Education Resource Center's Positive Behavioral Interventions and Supports;⁴⁴ Mental Health First Aid being taught in schools and communities throughout CT;⁴⁵ and the Campaign for Grade-Level Reading – Social Emotional Peer Learning Pilot through a partnership with the Office of Early Childhood and several foundations.⁴⁶

Although there are myriad initiatives to address promotion and prevention, they reach different audiences with different approaches and are nowhere near taken to scale to reach all children and providers statewide. Therefore, we recommend developing steps to ensure coordination across sectors and accessibility statewide. (See also Strategy C.3.3. regarding professional development for school personnel in behavioral health).

Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Enhancing the identification of early-onset behavioral health disorders for children and adolescents was one of the seven goals of the Task Force on Behavioral Health Services for Young Adults with a specific recommendation to mandate screening for behavioral health problems by primary care providers in the health care setting and reimbursing providers for the time and effort required. Our approach in this Plan shares a similar goal but deviates slightly in approach. We believe this goal can be achieved without a mandate but through providing sufficient financial incentives and services and supports. There are already many such supports in CT but they will need to be reviewed for effectiveness, and then the most effective approaches expanded and sustained to reach a higher number of children. We also are recommending screening needs to take place in both health care settings and other settings (e.g. early care and education, home visits, and public and private schools), as after the age of three, children are seen less frequently for well-child visits.

Specific actions to increase the rate of screenings and assuring children have access to further assessments and services involves a coordinated approach across systems not only for children birth to three but throughout the school years as well. There are already significant efforts underway in Connecticut, in cooperation with key state agencies that could serve as a locus to oversee the implementation of the recommended strategies, notably the Connecticut Health Innovation Plan (the "SIM" Plan) and the Early Childhood Comprehensive Systems grant-funded initiative. The work must ensure that all of the thousands of high-risk infants and toddlers who come into contact with any state department or their provider network, have access to screening, evaluation and appropriate referral to evidence-based, developmentally appropriate, trauma-informed supports.

The barriers to universal screening most often cited are inadequate reimbursement, cost, lack of time, inadequate behavioral health training for health providers and lack of resources for referral. Children covered by Medicaid in Connecticut already have several avenues through which to access Medicaid-reimbursable developmental or behavioral health screenings including in primary care offices, free-standing clinics, and school-based health centers, and most commercial insurers cover screening as well. Primary care providers can obtain reimbursement separately for behavioral health screenings conducted as part of a well-child visit by both Medicaid and commercial insurers. Reimbursement, however, should be contingent on adding the results to the child's medical record to support continuity of services. This plan addresses the barriers related to training and expansion of resources for referral.

Strategy B.2.1 Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life.

Behavioral health screening using validated tools is an effective and evidence-based approach to providing early detection of children in need of assessment, leading to early intervention services across all age groups. Screening criteria and processes for young children should be aligned with the Office of Early Childhood's Early Learning and Development Standards⁴⁷ and screening for youth of all ages should identify risk conditions in the environment, which lead to significant behavioral health problems, specifically maternal depression, child trauma, domestic violence, substance abuse, or homelessness. The research on the effect of toxic stress (Harvard Center on the Developing Child) and adversity (ACE Study) clearly indicates that these conditions damage the developing brain and lead to serious behavioral health, cognitive, and health problems. We need to identify these high-risk conditions in which children are developing in order to intervene early and prevent later developmental problems.

There are a number of validated screening measures that can assist parents and other caregivers to identify children and youth across all ages who may be exhibiting behavioral health concerns. The Office of Early Childhood seeks to expand the number of parents engaged in assessing their children's

development using a standardized tool in seven communities through a campaign to expand use of Help Me Grow. Help Me Grow at CDI administers the Ages and Stages Monitoring System, one of many tools available. The ASQ:SE is an add-on to the standard ASQ-3 and could be included in the standard set of tools provided to parents. ASQ-3 reaches several thousand parents. Pediatric practices, early care and education providers and schools use a range of other tools to screen youth for developmental concerns. These are models that can be the basis for a statewide strategy.

Strategy B.2.2 Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

This strategy assures that screening does not happen in isolation of appropriate follow-up and treatment when needed, which requires a broader systemic approach. Many stakeholders noted that periodic screening will only be of value if there is an adequate network to refer children and families who screen positive for further prompt, adequate, and efficient assessments and early intervention. An important resource in CT is the Child Development Infoline Program that provides services to parents and providers to link children to needed services (a model being replicated in 18 other states); currently it only serves children birth to five. We are recommending not only providing the resources to assure this service has the capacity to meet an increased demand as more children are screened but also that it be enhanced, or that a similar service be developed to meet the needs of school age children. This should be coordinated with the work underway at the Office of the Health Care Advocate to support information and referral as authorized in PA 14-115 (see Strategy A.2.2). Any system enhancement needs to ensure that high-risk families use it and are actually connected to services as a result, and that the system is accessible across languages and cultures.

Goal B.3 Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

A workforce competent in behavioral health across all settings is key to promoting healthy social and emotional development, recognizing the early signs of problems and connecting children to services as early as possible. Those who work with young children need very specific training.

Strategy B.3.1. Conduct statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

The CT Association for Infant Mental Health (CT-AIMH) has been a leader in this regard, having developed specific early childhood mental health training, a set of competencies that can lead to an Endorsement in Infant Mental Health, and provided reflective supervision opportunities. To date, 23 people in CT have earned an IMH Endorsement and 25 more are progressing toward Endorsement. Several efforts already underway serve as models upon which to build including CT-AIMH's partnership with DCF to cross-train child welfare and Head Start staff and CT-AIMH's partnership with OEC to develop and deliver training on infant mental health for pediatricians and child care providers. These efforts, however, are limited in scale and scope. Training opportunities need to be expanded, with increased opportunities for all those who work with young children including but not limited to DCF personnel, early care and education providers, early interventionists through Birth to Three, home visitors, and health and behavioral health providers.

Goal B.4 Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Suicide prevention programming and training have been a central focus of the Connecticut Suicide Advisory Board with member agencies having greatly expanded. The following suicide prevention programs, among others, have been offered in the state during the last year: Question, Persuade and Refer (QPR) accompanied by Training of Trainers; Applied Suicide Intervention Skills Training (ASIST); Assessing and Managing Suicidal Risk (AMSR); Assessing Suicidal & Self-Injurious Youth (ASSIY); TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment; Connect Prevention and Training of Trainers; Connect Prevention and Training of Trainers; Mental Health First Aid; Recognizing and Responding to Suicide Risk – Primary Care; and SafeTalk.

Strategy B.4.1 Continue cross agency collaboration and coordination with planned evaluation activities of the Connecticut Suicide Advisory Board.

The evaluation of existing and emerging suicide prevention programming is essential to ensuring the provision of effective suicide prevention activities.

C. Access to a Comprehensive Array of Services and Supports

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

- Ensuring access to developmentally-appropriate services;
- Offering a comprehensive array of services;
- Improving the integration of school- and community-based behavioral health services;
- Enhancing consumer input and public information and accountability and in partnership between DCF and DSS increasing awareness of the 2-1-1- Infoline program.

Numerous stakeholders identified the need for a comprehensive array of services and supports that includes promotion, prevention, early identification, early intervention, treatment, and transition services (see Figure III.2 above). Full access to that service array must be in place for all children regardless of insurance status, system involvement and geographic location. For example, a number of participants note that many elements of the current array of services and supports are not covered by commercial insurance plans. Furthermore, services may only be available to youth involved in certain public systems, and many services are not equally distributed and accessible in all parts of the state. Although Connecticut is considered a national leader in the provision of many elements of the service array (e.g., in-home evidence-based practices), significant expansion is required to establish Connecticut as a national leader in the full service array and ensuring that all youth and families have access to those services.

Providers and family members repeatedly indicate lack of capacity and not enough services across the service array, and report long wait lists for some service categories. There are significant service gaps in some parts of the state, particularly in the Northeast, Northwest, and Southwest regions of Connecticut. One result of the dearth of services is an increase in emergency department visits. Providers suggest the level of acuity of youth presenting at all levels of care is much higher than it was even a few years ago, noting various contributing factors such as greater awareness of behavioral health needs and zero tolerance policies at schools that result in more referrals to EDs and other services. Utilization data indicates large increases in emergency department utilization for youth presenting with primary behavioral health diagnoses and reductions in inpatient hospital lengths of stay and capacity issues during

period of high volume. Schools and families refer the majority of children that are seen in EDs. Providers strongly indicate that the statewide network of outpatient psychiatric clinics for children and child guidance clinics is consistently underfunded and has difficulty attracting and retaining a stable, highly trained workforce. This situation has contributed to problems ensuring a full service array and continuity of care in all parts of the state. Utilization of EMPS has increased 31% since Fiscal Year 2011 and further increases should be anticipated given the requirements of PA 13-178 for schools to establish MOAs with EMPS to avoid referrals to an ED whenever children can be safely and effectively treated in home and community settings.

Stakeholders also noted a decrease in the number of congregate facilities, stressing the importance of service availability for those with higher acuity needs. According to CTBHP data, since October 2009 six residential treatment centers have closed, in-state bed capacity has reduced by 54%, and the utilization of out-of-state providers has decreased by 85% in the past five years.⁴⁸ Occupancy data from the CTBHP illustrates consistent vacancies across a range of congregate treatment settings, including Therapeutic Group Homes and Residential Treatment Centers. In 2012, Connecticut's overreliance of congregate care settings for children in DCF custody was among the highest in the country and above the national average of approximately 14%.⁴⁹ At the time of this report, although Connecticut has seen a decrease in congregate care utilization and a simultaneous increase in children remaining at home with one or more biological parents, Connecticut remains above the national average in congregate care placement rates. Many states have demonstrated that congregate care reductions have resulted in better outcomes and reduced costs, and these efforts are effective when accompanied with significant increases in funding for community-based service and data-driven monitoring of needs and service utilization. Yet it is clear that residential treatment and other congregate care settings are needed for some youth. Efficient use of this level of care for youth who require this level of treatment should be fully supported as an important part of the full service array.

The primary recommended action with respect to treatment services was to ensure sufficient capacity across the array of behavioral health services, care and support, delivered in various settings (community-based clinics, schools, home-based) that will assist in maintaining children in their homes, schools, and communities, consistent with national research. Many service categories were identified as needing sufficient expansion (Goal C.1).

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

Our findings indicate a need for significant expansion in many sectors of the service array and ongoing monitoring of the adequacy of the service array. Unless services are enhanced, screening for behavioral problems is likely to lead to an increase in demand for services from an already overburdened system, resulting in children being referred to longer wait lists rather than effective services. Although service expansion across the full array will be complex and costly, and will require further specification and planning to ensure that the most effective services are targeted for expansion, a growing body of literature and community experience documents strategic service expansion as an investment that will ultimately have a positive impact on outcomes for Connecticut's children and prove to be cost effective. In many cases, service expansion is in fact mandated in the Medicaid system by requirements like EPSDT.

Significant service expansion should take place quickly, simultaneous to the system infrastructure enhancements described in Section IV.A. This work will draw on extensive recent efforts to document the service array and gaps in that array, and to recommend solutions (see Section I-III and Appendix B). This work would become a core responsibility of the governance entity established to oversee plan

implementation (see Section V). Service expansion should be informed by the emerging field of implementation science, which examines approaches to disseminating and implementing treatment models.⁵⁰

The service array would emphasize prevention activities and non-traditional/informal supports while also providing sufficient evidence-based and evidence-informed behavioral health services. New, innovative services to meet the needs of specific populations should also be fully promoted in the service array, with adequate supports to ensure effectiveness (e.g., access and knowledge of services, training, data collection, quality assurance/improvement). Services should continue to be delivered across settings (e.g., home-based, early care and education, schools, outpatient clinics) to increase access and prevent and treat social/emotional disorders as early as possible.

The following goals and strategies provide guidance as to where the state can begin to make significant improvements to enhance the service array.

Strategy C.1.1 Establish a process for initial planning of the array of services and supports and ongoing needs assessment, across local, regional, and statewide levels.

Within the context of the system structure and governance articulated in Section IV.A, DCF and its partners will lead the process, with strong family and provider input, to: consistently assess the array of services and supports involved in the System of Care; quantify the gaps identified through an ongoing needs assessment process; and implement a plan for service enhancements. A transparent, web-based process to document each component of the service array, its requirements, its funding, and its place in the overall system will aid in identifying the specific steps to enhance each component and then enable tracking of progress.

Needs assessment is critical for identifying and responding to gaps in the service array, and should be conducted at the local and regional level, employing a broad definition of the array of services. Information on known service gaps can be gleaned from existing reports including regular Value Options reports, the Juan F. Court Monitor process, and recent reports from Office of the Health Care Advocate, the Legislature's Program Review and Investigations Committee, and from the Early Childhood Comprehensive Systems grant. A process and online data collection tools for conducting these local/regional needs assessments and rolling them up to the statewide level should commence immediately and be pursued with some urgency based on public and providers concerns about capacity issues. The strategy for financing this expansion of services is articulated in Goal A.2 above.

Strategy C.1.2 Finance the expansion of the services and supports within the array that have demonstrated gaps.

The planning process has identified a number of components of the service array that require increased investment to meet current and projected needs. As noted throughout this report, the current high utilization of EDs is related to an insufficient supply of community-based alternatives across the service array; consequently, expansion across the service array is strongly recommended. The section below describes a number of service categories that were identified as lacking capacity. Expansion in each area is strongly recommended.

In addition to meeting existing demand, expansion is recommended to plan for the anticipated growth in demand for services resulting from increased efforts in the area of screening for behavioral health concerns, as described in Section IV.B.

While this Section IV.C covers the comprehensive view of developing the entire system of care, much of which will be enhanced through the existing network of child guidance clinics and outpatient psychiatric clinics for children, two areas targeted for development intersect with many components of this array of services and were pulled out in separate goals below:

- **Crisis response services (Goal C.2).** Many stakeholders noted significant increases in the number of youth presenting in behavioral health crisis to services such as Emergency Mobile Psychiatric Services (EMPS), EDs, and inpatient hospitals. Further expansion of this level of care is an immediate need and an important part of the overall system of care; accordingly, it is described in further detail in Goal C.2 below.
- **School-based behavioral health (Goal C.3).** Many planning participants cited schools as ideal settings for screening, early identification of behavioral health needs, and delivery of and linkage to treatment services. Further expansion of school-based behavioral health care, in close cooperation with existing community-based clinics, is an important part of the overall system of care and is described in further detail in Goal C.3 below.

The services in this array will continue to be delivered by providers with extensive experience and deep roots in the community. Services and supports in need of expansion are described below, including: early childhood interventions; non-traditional/non-clinical interventions; care coordination; and behavioral health treatment options.

a. Early Childhood Interventions

Section B includes description and strategies for increasing the incorporation of universal prevention approaches as an important element of the service array; this section describes preventive interventions primarily at the selective and indicated levels for youth who are found to be at-risk for social, emotional, and behavioral problems. The early childhood behavioral health system must include an array of evidence-based interventions from low to high intensity, delivered in a variety of settings. Early childhood behavioral health intervention/treatment can dramatically decrease the need for deep end services later delivered by schools and community-based agencies. Intervening early is documented to be effective, both in terms of cost and morbidity, with a convincing body of evidence that home visitation programs improve developmental outcomes,⁵¹ increase caregiver capacity, reduce incidents of abuse and neglect, and address the implications of Adverse Childhood Experiences on health and well-being.⁵² By considering these programs as Community Health Providers within the SIM framework, an opportunity may be created to further develop and bring to scale critical and cost-efficient early interventions.⁵³

Infant mental health advocates point out that intervention and treatment for infants and young children is very different than for older youth. Services for the very young are not simply a downward extension of intervention used for older children. Infancy is the time of the most rapid brain development and trauma and other adversity that occurs at that developmental stage has profound effects on behavioral health, cognition, and physical health. A two-generation, trauma-informed, developmentally appropriate approach that focuses on the relationship between caregiver and child is fundamental to protecting the developing brain from the devastating effects of stress and trauma and is the foundation for interventions for this population.

In every case, the level of intensity of service and the setting must be matched with the unique needs of the young child and family. For example, children meeting typical developmental benchmarks might be served with a consultation in a pediatric office; challenging behaviors in preschool might benefit from a behavioral health consultation model; and some parents might need skill building as a third possibility. Young children who have experienced trauma, who have parents with significant challenges (e.g., depression, domestic violence, substance use), or who have experienced abuse and neglect need more intensive, home-based, trauma-informed, two-generation services.

The state's service capacity to offer preventive interventions is inadequate, with long waitlists for some evidence-based interventions. Consequently, the state should ensure a sufficient capacity of early childhood interventions to meet the needs of all families, including home visiting services featuring trauma-informed models, early care-based interventions, and clinic or community-based interventions to ensure that such services are scaled up.

b. Non-Traditional/Non-Clinical Services

Families point to the need for an expansion of non-traditional, non-clinical services that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, behavioral health symptoms. Such interventions should be supported as important element of the service array in the area of promotion, prevention or early intervention (depending on the nature of the program and its target population). Families identify such interventions as being highly responsive to community needs, family-friendly, accessible, and effective. Furthermore, families report that such interventions often are delivered by individuals who know their community, which contributes to the acceptability of those services. Included in this category are community-based services that provide a bridge between families, schools, and pediatric health care providers.

Considerable work is underway to ensure that children with behavioral health and substance use issues are not ensnared in a juvenile justice process that could contribute to negative longer-term outcomes and not address their underlying issues. Programs have been piloted across the state to work with schools, Juvenile Review Boards, or Youth Service Boards, to identify at-risk children, facilitate assessment of their needs, and connect them with services or pro-social community activities. These prevention and early intervention programs often are small and grant-funded. As Connecticut re-imagines its health care delivery and payment system, these services should be considered, potentially with a plan for certification or licensing, support for fidelity and outcomes measurement, and a path for insurance reimbursement.

c. Care Coordination

Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches is highly recommended, and as described in Section IV.A.2, such services are an essential component of the proposed re-organization and the roles and functions of the system of care. Youth and family members who are involved in multiple systems indicate difficulties meeting the varying recommendations, protocols, and requirements for treatment across those systems. Families report that they constantly feel the need to “start over” when circumstances change, and that information about their behavioral health and treatment history “does not follow” them, suggesting that treatment information is not shared efficiently with the next clinician or agency. This often results in frustration and lack of continuity of care. Effective care coordination can address this issue and streamline access to the most appropriate services and address issues of continuity of care.

Care Coordination should also connect families to the array of services that will reduce family stress, which can be “toxic” to the development of the child. Examples include services to address treatment for maternal depression, parental substance use, or behavioral health disorders; domestic violence; homelessness; food insecurity; and more. As per the Guiding Principles of a System of Care, care coordination is not just about coordination of behavioral health services but about coordination and access to the services and resources across systems that a family needs to promote health and well-being.

d. Behavioral Health Treatment Options

The findings strongly support the need to expand and/or enhance several areas of the treatment service array. Treatment options should be available at varying levels of intensity to meet individual needs. Services should be accessible regardless of insurance type, system involvement, and geographic location. Described below are areas of the service array that are in need of expansion.

Outpatient care. Some providers from the state's Child Guidance Clinics report high numbers of referrals to outpatient services but a lack of sufficient funding to meet the need. Routine outpatient care is often a first referral for a young person with behavioral health needs, a follow-up service referral for youth discharged from other services, and a “step-down” referral from more intensive levels of care. This results in high demand at the outpatient level of care and youth presenting with various presenting concerns and levels of acuity. Increasingly families, providers, and funders understand the high rate of

trauma experienced by youth in our behavioral health and juvenile services system and the associated lifelong medical and societal costs of unaddressed trauma exposure.⁵⁴ In recent years, Connecticut has increased its adoption of evidence-based practice models and in partnership with providers has implemented several of these models in an effort to enhance the quality and outcomes of outpatient care.

Connecticut should continue to support the outpatient level of care and scale-up its nationally recognized trauma support and evidence-based services - including TARGET, TF-CBT, MATCH-ADTC, and other models - to prevent system involvement and reduce escalation of need. Implementation of evidence-based practices at the outpatient level of care may require new reimbursement strategies to participating clinics to cover the additional costs associated with implementing evidence-based practices. Associated costs often are related to reduced productivity related to training and support (e.g., learning collaboratives, consultation calls, supervision), smaller caseloads, and increased requirements for data collection and quality improvement activities.

Intensive treatment models. Many note the need for sufficiently intensive treatment options to meet the needs presented by many youth and their families. This level of care is critical to maintain youth with behavioral health needs in their homes, schools, and communities. Access to intensive treatment models, delivered primarily in community-based settings, is needed, including Extended Day Treatment, Intensive Outpatient Programs, and Partial Hospitalization Programs.

Child and adolescent psychiatry. Many stakeholders identify a significant shortage of qualified child and adolescent psychiatrists to conduct psychiatric evaluations and provide medication management to children who require this level of care.

Substance use services. Participants identify substance use issues as a growing concern among youth. Opiate and prescription drug use are identified as increasingly prevalent among the adolescent population. Participants noted that some excellent, evidence-based services exist for treating adolescent substance use; however, they do not have the capacity necessary to meet the need. Furthermore, Connecticut lacks a recovery-oriented system of care for youth, although such a system does exist for adults through DMHAS. Many of the substance use services in the state are available through the justice system, but children should not need to be arrested to access those services. Reimbursement strategies, particularly among private insurers, do not sufficiently fund a long-term recovery model. A more effective approach would be to enhance access to substance use treatment for all youth who need it, thereby preventing juvenile justice and other system involvement. Consultation between DMHAS and the youth-serving system of care is recommended in order to apply relevant lessons learned to the youth population in further developing recovery-oriented services and supports. Better coordination between substance use treatment providers and behavioral health providers, who are often from different agencies, is also needed.

Services and supports for children with autism. Participants feel that the system of care for individuals with autism is overly complicated and insufficient to meet the need. The responsibility for treating youth with autism continues to be shared by too many programs and agencies, and the waitlist to see an expert on autism can be as long as six months. A trained workforce that can provide specialty care for youth with autism is highly recommended. Furthermore, there is a pressing need for all youth, including those with autism, to have access to transition services as they age out of the child-serving system and need supports for independent living, employment, and housing.

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

It is generally acknowledged that EDs are an inappropriate setting for treating youth with behavioral health needs and their families. High utilization of EDs can be addressed through expansion of crisis-oriented services like EMPS, short-term (e.g., 23 hour) behavioral health assessment centers, and longer-term (e.g., 14 day) crisis stabilization units.

EMPS is a proven service that helps divert youth from the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission. EMPS also provides linkages to community-based care for families who are in the ED. The ongoing growth in EMPS utilization suggests that EMPS requires further expansion to meet the demand; in addition, it underscores the important finding that EMPS is necessary but not sufficient to address the high utilization of EDs. A sufficient service array at varying levels of intensity, as described in this section, is required so that EMPS can ensure ongoing treatment at an appropriate level of care. In addition to expanding EMPS, expansion of crisis behavioral health assessment centers and crisis stabilization units are highly recommended as they provide critically important alternatives to EDs.

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

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

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

Along with the expansion of EMPS clinicians generally, enhancements in partnerships between EMPS clinicians with the EDs can further support the diversion of youth from inpatient hospitalization when children can be safely and effectively treated in their homes, schools, and communities. It will also assist EDs by providing direct access to experts in establishing linkages to community-based care. EMPS also works closely with police to divert youth with behavioral health needs from ED utilization as well as arrest.

Strategy C.2.3. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

For youth who are experiencing a behavioral health crisis and are in need of acute care, EDs are not an appropriate setting; however, alternative treatment settings do not exist or are in short supply across the state. Families and providers identified the importance within the service array of behavioral health assessment services (e.g., 23 hour beds) and crisis stabilization units that provide assessment and treatment for longer periods of time (e.g., up to 14 days). An enhanced crisis service system should ensure that EMPS can provide direct access to these treatment settings, which will help alleviate the current crisis in EDs and provide families and youth with a safe treatment environment at a less intensive level of care than inpatient hospitalization. In-state and out-of-state models for crisis respite and crisis stabilization units should be considered as models for expansion. With the proposed expansion of crisis services as alternatives to EDs, some stakeholders have concerns about current federal and state regulations as they relate to accessing these services. For example, the federal Emergency Medical Treatment and Labor Act (EMTALA) describes hospitals' obligations when an individual presents for treatment to an emergency department, and contains other stipulations relating to ambulance transport to a hospital. We recommend that the state closely examine the federal EMTALA law and relevant state law and make appropriate changes to state law as needed to ensure that youth have access to crisis treatment options designed to serve as alternatives to the ED.

Goal C.3 Strengthen the role of schools in addressing the behavioral needs of students.

A significant expansion of school-based behavioral health services is recommended, built on an “expanded school mental health” framework that includes significant collaboration between community-based behavioral health providers and schools.⁵⁵

There is growing evidence that students with behavioral health needs have higher rates of academic failure and also are subject to high rates of “exclusionary discipline” (e.g., arrest, expulsion, suspension). While appreciating that the schools’ primary role is to educate children, schools are also ideal settings for screening and early identification of behavioral health needs and linkages to services. Research suggests that behavioral health services are effective and more accessible to youth when delivered in schools.⁵⁶ School-based behavioral health services are provided by clinicians employed by school districts, school-based health center staff, and/or community-based providers who are either co-located in the schools or located in the community but linked to the school.

Schools have the potential to be the best places for identifying youth in need of intervention and reducing access barriers to provide effective care. Many schools, however, require assistance in building their capacity for these services in order to realize that potential. Over time, school districts have reduced the number of guidance counselors, school social workers and school psychologists due to budget cuts, reducing the schools’ ability to meet the behavioral health needs of students and provide guidance to teachers about how to do the same. School-employed clinicians were reported to have extensive responsibilities related to developing and reviewing Individualized Education Programs/Plans (IEPs) but less available time to provide prevention and intervention services. Additionally, there are difficulties meeting the behavioral health needs of youth with autism in schools, responding to behavioral health crises in schools, and facilitating transitions from inpatient hospitalization back to the school. Parental engagement in care can be more difficult during the school day, and feedback to the primary care provider is inadequate, even with fairly straightforward medical problems. Communication and coordination between schools and community-based behavioral health providers is a significant challenge. School-based health centers, though helpful and effective, are not sufficiently taken to scale across the state and may not have the full capacity needed to ensure coordination of care between the school and the community, particularly when school ends in the summer but children and families require ongoing services. It is clear that if schools are to play a broader role in the delivery of behavioral health services, support will be required to address these various concerns.

It is critical that efforts to enhance the delivery of school-based behavioral health services provide financial support to schools and also to the network of child guidance clinics in Connecticut that will be involved in this effort. Coordination with community-based providers, perhaps through co-location of clinicians in schools, will ensure that youth who are identified or treated in schools have access to the full service array available in the community and experience continuity of care during the after-school hours and over the summer.

School-based services will also need to be coordinated with the overall development of the system of care and the role of the Care Management Entities proposed in Goal A.2, with school-based services part of a broader evaluation and care plan for children served. This will also allow for enhanced data collection and accountability for the delivery of school-based behavioral health services. Data collection practices at the system level should incorporate results of school-based behavioral health screening, referrals and linkages to treatment, and outcomes including school attendance and academic achievement. Annual student health surveys that include questions about physical health, behavioral health, social life, and school engagement and link to health and educational outcomes can help identify needed services (individual, group, school-wide).

Specific strategies in this area are outlined and explained below.

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

This plan should include the following elements:

- **Increase the number of community-based clinicians who are co-located in schools.** It is critically important to integrate delivery of school-based behavioral health services with the state's network of community-based clinics (e.g., child guidance clinics, outpatient psychiatric clinics for children) and the overall system of care described in this report. This is the best way to ensure that students who are identified or treated in schools have access to the full service array and that they experience continuity of care when schools are not in session. All goals and strategies described in this section should be pursued in close coordination with the network of community-based clinics.
- **Address licensing, funding or other regulatory issues** to enable community providers to deliver services on school grounds and receive reimbursement from insurers and/or Medicaid. This alleviates transportation and "no show" issues because the child is already at school, and also helps to address stigma because the youth is going to the school for services, not to a "clinic."
- **Increase the number of school-based behavioral health clinicians.** Connecticut must ensure that all schools have a sufficient number of social workers and school psychologists to meet or exceed recommended standards and to meet the demand for treatment.
- **Adopt and implement standardized screening instruments.** Standardized screening instruments will help school personnel identify behavioral health and support needs, including trauma exposure. Schools need to identify key points of contact among school staff who can administer the universal screening (e.g. school nurse, SBHC clinicians, guidance counselors, school social workers, community-based clinicians), provide training, and create a centralized data system for sharing of results and to avoid duplication of screenings. Section IV.B provides additional details on behavioral health screening in the system of care.
- **Expand the number of school based health centers (SBHCs).** School-based health centers, staffed by either school employees or contracted staff from local providers, are an effective model for addressing the health and behavioral health needs of students and integrating care. Medical clinicians are now required (for sites funded by DPH) to conduct behavioral health screenings at all visits, which increases the likelihood of early detection and referral. Connecticut should ensure that all school-based health centers achieve the "gold standard" of optimal comprehensive SBHC care that involves having both a health and behavioral health clinician with administrative support. Expansion of SBHCs should follow the establishment of quality standards and the development of effective programmatic oversight at DPH.⁵⁷ DPH will need an increase in funds for administrative staff support to implement and monitor this expansion.
- **Implement evidence-based treatments tailored to schools.** Require that all school-based behavioral health providers are trained in the use of trauma-informed evidence based treatments that are designed for delivery in a school setting and utilize group and individual treatment modalities.
- **Identify model plans across the state that accomplish the goals and strategies outlined in this section, and systematically support replication of those models across the state.** There are a number of potential models for enhancing school-based behavioral health in collaboration with community-based providers. Existing or emerging evidence-based models, such as the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), should be identified and replicated.
- **Integrate measurement of outcomes with statewide data collection and reporting efforts.** Data collection and reporting of outcomes across SBHCs and other school-based services

throughout the state should connect to the statewide model of quality assurance, continuous quality improvement and monitoring of outcomes (see Section IV.A).

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

Municipal funds will be insufficient to support an expansion of school-based behavioral health services. A combination of federal, state, local, and private and public philanthropic funds can be pooled together to fund school-based behavioral health services, reduce fragmentation and cost shifting, and improve the coordination of school- and community-based behavioral health services.

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

In-service professional development will help build the capacity of school personnel to recognize, refer, and/or treat behavioral health concerns. School administrators, teachers, clinical personnel, School Resource Officers, and other school personnel all require different behavioral health competencies and the curriculum should be tailored to their needs and to the developmental level of the students they serve. Initial training for teachers and administrators in behavioral health and developmental issues should be incorporated in teacher and administrator training curriculums in higher education. SDE, school behavioral health trade associations, and school personnel should guide curriculum development for continuing education. All School Resource Officers should be required to undergo training in recognizing and responding to youth with behavioral health needs, increasing rates of diversion from exclusionary discipline including arrests, expulsions, and suspensions, and implementing restorative practices. Training modules should include, at a minimum, the following:

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

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

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

Goal C.4 Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Behavioral health providers should work within their respective agencies and communities to raise the profile of suicide prevention initiatives and activities that promote health and wellness. There is strong institutional and leadership support for suicide prevention through DMHAS, DPH, DOC, DCF and other state agencies.

Strategy C.4.1 Continue to identify and foster attitudes and behaviors within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention.

Central to this effort is the institutionalization of embedded language, policy and activity in agencies for which suicide prevention may not traditionally be part of the central mission.

D. Pediatric Primary Care and Behavioral Health Care Integration

Section 1.I of PA 13-178 calls for offering comprehensive, coordinated care within a continuum of services. The legislation also calls for DPH to work with DCF to increase family involvement in the medical home and integrated care models. Among the challenges in an integrated care delivery system identified by experts in the field through facilitated discussions, community conversations, and a review of the literature, two were most salient and are identified as key goals for addressing continuity, coordination, and integration of care: (1) the integration of pediatric primary care and behavioral health services within Patient Centered Medical Homes (PCMHs); and (2) enhancements to the care coordination systems in the State. Integration of pediatric care and behavioral health is addressed in this section, complementing the recommendation in Section A regarding care coordination and the creation of Care Management Entities as the major system enhancement to ensure coordination and continuity of care across all involved sectors.

Challenges regarding the integration of pediatric primary care and behavioral health services include:

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

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

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

Pediatric primary care services provide a unique opportunity to address children's behavioral health needs. They are universally used across age groups, racial and ethnic groups and geographic locations. For example, children cannot attend childcare, school, camp or play organized sports without first having a physical exam by a licensed child health provider. Engaging at the primary care level also facilitates a family-based approach. Providers can engage families in behavioral health services for their children and

for adults in the family. Integration into primary care more easily allows providers to work with children and their families over time, observing changes in concerns and circumstances. Lastly, primary care services are connected to a wide array of community services that children use, including preschools, schools, and specialty services. Several individuals commented that these connections are not strong enough in Connecticut, and this concern is addressed in this recommendation as well as in the system integration recommendations.

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

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

Coordination between pediatric care and behavioral health care needs to be implemented within the overall approach to coordinating and financing behavioral health care to ensure that developing models work smoothly together.

Strategy D.1.1 Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.

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

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

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

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

Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.

The opportunity to provide education on behavioral health topics—from screening to brief intervention—can be supported through CME requirements for professional licensure. This effort would be similar to requirements for child health providers to obtain CME credits in child abuse. Connecticut statute currently requires that child health providers also receive CME in the following topics annually: Infectious diseases, risk management, sexual assault, domestic violence and cultural competency. Required hours for behavioral health education can be added to this list.

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

To explore care coordination reimbursement for Medicaid enrolled children with behavioral health needs. Such reimbursement will allow practices to connect children and families to helpful community-based services at the earliest stage of behavioral health concerns.

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

Unlike other states, Connecticut’s confidentiality laws do not allow health and behavioral health providers to share patient behavioral health information. This prohibition hampers communication and coordination of care between the two providers. Although families express concern about confidentiality, they also express frustrations with uncoordinated care between their children’s many providers. Allowing health and behavioral health providers to share information would be a positive step toward improved coordination, though we recognize this may be somewhat controversial in relation to rights of privacy.

E. Disparities in Access to Culturally Appropriate Care

Section 1 of PA13-178 identifies a primary strategy for plan development in the area of “being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability.” The planning process identifies the following needs of families, providers, and other stakeholders regarding disparities in access to culturally and linguistically appropriate services:

- A need for additional staff who are from the same community and speak the same language as the families seeking services;

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

Although this section presents recommendations specific to building a system of behavioral health care that addresses disparities in access to culturally appropriate services, additional recommendations that address culturally and linguistically appropriate services are integrated into other sections of the report as these were noted areas of concern heard across the input gathering process.

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

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

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

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

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

(3) ongoing self-assessments to assess and monitor competencies and resources available to promote governance and oversight related to eliminating disparities in access to culturally appropriate services.

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

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

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

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

Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

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

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

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

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

Communication materials should be developed and/or interpreted into the preferred language and cultural perspectives of families served. Competent and professional language assistance services must be

included at all points of contact to allow all youth and families to fully participate in services, and selected and endorsed treatments must be deemed effective with the target populations to be served.

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

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

F. Family and Youth Engagement

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

Youth and family members' concerns and recommendations are integrated throughout all sections of the report along with those of advocates, providers, and other stakeholders in the children's behavioral health system. There also is a need, however, to specifically identify the topic of family and youth engagement as a core area in the development and implementation of the system of care, and to outline goals and strategies that ensure the **ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services**. Families and youth strongly requested this throughout the input gathering process, but it is important to note the strong consensus among providers, advocates, state agency representatives, and other stakeholders. Family and youth engagement in the children's behavioral health system of care will help ensure that their input is fully incorporated in the children's behavioral health service delivery system and that Connecticut continues to move toward the goal of a family-driven and youth-guided system of care.⁵⁸ Many families indicate that Connecticut has made progress in this regard but more needs to be done.

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

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

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

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

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

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

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

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

Strategy F.1.3 Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.

Parents consistently note their desire for opportunities to gain additional skills in fulfilling their role in the system governance structure. A number of parent leadership training curricula is offered in Connecticut including Agents of Transformation, Parent Leadership Training Institute (PLTI), Parent Seeking Educational Excellence (Parent SEE), and People Empowering People (PEP). Funding should be available to provide expanded opportunities for families to develop those skills. Trainings should be offered in face-to-face and webinar formats to ensure multiple opportunities for participation.

Strategy F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums, and continue to sustain the infrastructure of the Plan4children website input mechanism to ensure ongoing feedback into system development.

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

activities during meetings; and transportation. Findings from these input sessions should be used for planning, delivery, and evaluation of services at the statewide and regional level, and summarized for inclusion in the centralized governance structures of the system of care.

G. Workforce

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

It is clear from the input received during the planning process that the concept of “workforce” is used broadly in Connecticut with respect to children’s behavioral health. It includes, but is not limited to: licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support.

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

Table IV.G.1: Strategies Involving Workforce Development

A.2.1	Design and implement a Care Management Entity with attention to integration across initiatives and training.
A.4.4	Increase staff capacity to analyze data and report results
B.1.3	Expand the use of validated screening tools
B.3.1	Conduct statewide trainings on infant mental health
C.1.2	Child mental health workers, clinicians, and psychiatrists across all settings
C.2.1	Increase EMPS clinicians
C.3.1	Increase school-based services
C.3.3	Mental Health professional development for school personnel
D.1.2	Education for clinicians seeking to co-locate with primary care providers
D.1.3	Require CME credits in mental health
E.2.1	Enhance training and supervision in CLAS
E.2.3	Cultural competencies are integrated into professional credentialing
F.1.1	Participation of family members in governance
F.1.2	Expand capacity of family advocacy organizations
F.1.3	Parents trained in parent leadership curricula

V. Implementation Plan

In order to turn this Plan into reality, legislative action is highly recommended to fully authorize DCF and other key agencies and systems to ensure that the most urgent plan components are implemented in the short term and a detailed workplan, financing strategy and timeline are in place to implement the longer term strategies. We recommend the creation of a Children's Behavioral Health Implementation Team to guarantee integrated, coordinated efforts as well as full transparency and meaningful engagement of all stakeholders, including families and youth. This team should draw on lessons from implementation science that can be applied to complex systems reforms.⁵⁹ Each core initiative could be documented on a searchable web site with clear goals, progress benchmarks, and reporting of all actions and results. These individual component reports could then be "rolled up" into a Children's Behavioral Health Dashboard that will clearly report progress on a range of system and outcome measures.

State level implementation will include connection to DCF regional offices and to the 26 regional System of Care collaboratives for guidance on implementation. In the substance use area, implementation will connect to the 13 Regional Action Councils established by DMHAS under their federal prevention grant that are crafting regional strategies to prevent substance use. In the early childhood area, implementation will connect to the 46 community collaboratives that are crafting or implementing early childhood plans within their communities with support from the Graustein Memorial Fund's Discovery Initiative and the Office of Early Childhood.

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

The proposed timeline for implementation (Table V.1) focuses on the development of the infrastructure and the planning of the array of services that will comprise the System of Care. In keeping with the statutory mandate, DCF would convene the Children's Behavioral Health Implementation Team in the Second Quarter of SFY 2014-15 to begin the implementation process. An early step would be to create the detailed work plan and timeline to carry out the remaining strategies in the Plan related to: services, integration of pediatric and behavioral health care, addressing disparities, and Family and Youth Engagement. As implementation proceeds, the Team also would identify needs for legislative statutory and budgetary actions required for implementation.

Table V.1 Timeline for Implementation of the Connecticut Behavioral Health Plan

□=Initiate a process ♦=ongoing operation / work ❖ = plan/report ⊙= legislation

I. Tasks by Goal (with Strategies in parentheses)	SFY 2014-15			SFY 2015-16				SFY 16-17	SFY 17-18	SFY 18-19
	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Goal A.1 System Redesign										
Convene Implementation Team (A.1.1) (with regular reports)	□	♦	❖	♦	❖		❖	❖	❖	❖
Develop overall work plan and timeline for all goals/strategies	❖									
Develop web-based tools for presenting plans and data in dashboards	□	❖	♦	♦	♦	♦	♦	♦	♦	♦
Launch system redesign process (A.1.1)		□	♦	♦						
Complete initial report on system redesign				❖						
Implement system redesign				□	♦	♦	♦	♦	♦	♦
Form Workforce Committee of Implementation Team (A.1.1)		□	♦	♦						
Complete initial report on workforce				❖						
Implement workforce recommendations				□	♦	♦	♦	♦	♦	♦
Secure Legislation necessary to Implementation			⊙				⊙		⊙	
Issue “State of Implementation” Report			❖		❖		❖	❖	❖❖	❖
Goal A.2 Care Management Entity										
Complete design of proposed Care Management Entity (CME) (A.2.1)		□	♦	♦	❖					
Implement CME (A.2.1)						□	♦	♦	♦	♦
Integration of family support clearinghouse function (A.2.2)		□	♦	♦	♦	♦	♦	♦	♦	♦
Goal A.3 Address Concerns about Commercial Insurance										
Initiate process to address concerns re commercial insurance A.3.1	□	♦	♦	❖						
Apply findings from A.3.1 to self-insured				□	♦	♦	❖			
Goal A.4 Data System and Capacity Development										
Convene a statewide Data-Driven Accountability (DDA) committee (A.4.1)			□	♦	♦					
Complete initial assessment and plan for data system integration and reporting and capacity development (A.4.1)						❖				
Implement data system recommendations						□	♦	♦	♦	♦
Goal B.1										
Develop plans to expand preventive social-emotional learning and support interventions (B.1.1)		□	♦	❖	♦	♦	❖	❖	❖	❖
Goal B.2 Universal Screening with Validated Tools										
Implement plan for universal screening (B.2.1)		□	♦	❖	♦	♦	❖	❖	❖	❖
Develop and implement mechanisms to link children with positive screens to services (B.2.2)			□	♦	❖	♦	❖	❖	❖	❖
Goal C.1 Build and resource array of services										
Create plan for expansion of services and ongoing needs assessment (C.1.1)		□	♦	♦	❖					
Monitor needs and adjust plan annually (C.1.1)					♦	♦	❖	❖	❖	❖
Create short term plan to address highest priority gaps in SFY 2015-17 biennial budget (C1.2)	□	❖	⊙							
Create longer term financing plan			□	♦	❖	⊙				
Goal C.2 Expand Crisis Services										
Expand EMPS (C.2.1)	□	❖	⊙							
Enhance linkages between EMPS and EDs (C.2.2)		□	♦	❖	♦	♦	❖	❖	❖	❖
Expand crisis stabilization resources (C.2.3)	□	❖	⊙							

I. Tasks by Goal (with Strategies in parentheses)	SFY 2014-15			SFY 2015-16				SFY 16-17	SFY 17-18	SFY 18-19
	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Goal C.3 Strengthen the Role of Schools										
Develop and implement plan for school-based services (C.3.1)		□	◆	❖	◆	◆	❖	❖	❖	❖
Create a blended funding strategy to support expansion of school-based behavioral health services (C.3.2)		□	◆	❖	◆	◆	❖	❖	❖	❖
Goal C.4 Integrate and Coordinate Suicide Prevention Activities										
Implement 2014 Statewide Suicide Prevention Plan (C.4.1)		❖	□	◆	◆	◆	◆	◆	◆	◆

VI. Conclusion

Children and families in Connecticut currently experience significant barriers to accessing quality behavioral health care. Throughout every element of the information gathering process, it was clear that Connecticut can, and should, do better to meet those needs. The process for developing the Plan yielded a comprehensive set of goals and strategies that will require a significant commitment of time and resources with the full participation of all key partners in the public and private sector and a deep commitment from state government, communities, families and youth to reach full implementation over the next five years. It is our hope that this Children’s Behavioral Health Plan provides the foundation for fulfilling the vision of PA 13-178, that together we can meet the mental, emotional and behavioral health needs of all children in the state, and prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children.

Appendix A. Summary Table of Goals and Strategies

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

Goals and Strategies	Cost	Measures
A. System Organization, Financing, and Accountability		
Goal A.1 Redesign the publicly financed system of mental health care for children to direct the allocation of existing and new resources.		
Strategy A.1.1 Establish a process to guide the redesign of the publicly financed system.	\$	<ul style="list-style-type: none"> • Redesign plan developed • Public financing pooled
Goal A.2 Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.		
Strategy A.2.1 Design and implement a Care Management Entity (CME) to create an effective care coordination model based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.	\$\$\$	<ul style="list-style-type: none"> • CME created and operational • # of families engaged with CME for care coordination
Strategy A.2.2 Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.	\$	<ul style="list-style-type: none"> • Clearinghouse operational on web and in person • Materials developed and disseminated • Coverage of clearinghouse • # of families using clearinghouse to navigate systems
Goal A.3 Develop a plan to address the major areas of concern regarding how commercial insurers meet children’s behavioral health needs		
Strategy A.3.1 Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions	\$	<ul style="list-style-type: none"> • Commercial insurance plan issues defined and quantified • Plan to address issues is completed
Strategy A.3.2 Apply findings from the commercial insurance report to self-funded/employee-sponsored insurance plans.	\$	<ul style="list-style-type: none"> • Self-insured employer plan issues defined and quantified • Plan to address issues is completed
Goal A.4 Develop an agency- and program-wide integrated behavioral health data collection, management, analysis and reporting infrastructure across an integrated public mental health system of care.		
Strategy A.4.1 Convene a statewide Data-Driven Accountability (DDA) committee grounded in new legislative authority to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.	\$\$	<ul style="list-style-type: none"> • Integrated data capability developed • Regular system reports available
Strategy A.4.2 Utilize reliable standards to guide the new data collection, management and reporting system.	\$	<ul style="list-style-type: none"> • Standards developed • Standards adopted across systems • Adherence to standards across systems
Strategy A.4.3 Improve current data collection systems to serve in an integrated system across all agencies involved in providing child mental health services.	\$\$	<ul style="list-style-type: none"> • Integrated data available for system planning (see Appendix C re Measures)

Goals and Strategies	Cost	Measures
Strategy A.4.4 Increase State capacity to analyze data and report results.	\$\$	<ul style="list-style-type: none"> • Increase in funding dedicated to building capacity to analyze data and report results at systems and practice levels • Production of usable reports for the purposes of system and program monitoring and quality improvement
B. Health Promotion, Prevention, and Early Identification		
Goal B.1 Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the need statewide.		
Strategy B.1.1 Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the need statewide.	\$\$	<ul style="list-style-type: none"> • Number and percent of children receiving effective social-emotional learning in schools and community by model used •
Goal B.2 All children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.		
Strategy B.2.1 Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child’s life.	\$	<ul style="list-style-type: none"> • Number of entities actively promoting and using validated screening tools and reporting data • Number of children with completed validated screening • Number of children identified as requiring follow up and getting services
Strategy B.2.2 Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.	\$	<ul style="list-style-type: none"> • Percent of children referred who are connected to services
Goal B.3 Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.		
Strategy B.3.1 Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.	\$	<ul style="list-style-type: none"> • # of people trained • # of people earning CT-AIMH Endorsement (IMH-E®)
Goal B.4 Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.		
Strategy B.4.1 Continue cross agency collaboration and coordination with planned evaluation activities of the Connecticut Suicide Advisory Board.	\$	<ul style="list-style-type: none"> • Evaluation of suicide prevention activities completed • Number of suicide prevention efforts active
C. Access to a Comprehensive Array of Services and Supports		

Goals and Strategies	Cost	Measures
Goal C.1 Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.		
Strategy C.1.1 Establish a process for initial planning of the array of services and supports and ongoing needs assessment, across local, regional, and statewide levels.	\$	<ul style="list-style-type: none"> • Completion of initial assessment of array of services and supports • Completion of web-based presentation of array of services for information and analysis • Completion of at least annual needs assessment (local and regional).
Strategy C.1.2 Finance the expansion of the services and supports within the array that have demonstrated gaps	\$\$\$\$	<ul style="list-style-type: none"> • Increase in funding • Increase in capacity across critical component so Continuum of Services, e.g. • More child and adolescent psychiatrists working in Connecticut • Additional in-patient and intensive outpatient treatment slots as needed • Reduction in average time from referral to treatment initiation • Reductions in emergency department utilization and inpatient hospitalization • Demonstration of positive outcomes
Goal C.2 Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments		
Strategy C.2.1 Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services	\$\$	<ul style="list-style-type: none"> • # of clinicians in EMPS • # of cases handled
Strategy C.2.2 Enhance partnerships between EMPS clinicians in EDs to facilitate effective diversions and linkages from EDs to community-based services		<ul style="list-style-type: none"> • # of EMPS clinicians co-located in EDs • Develop additional measures re: EMPS
Strategy C.2.3 Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.		<ul style="list-style-type: none"> • # of crisis assessment centers • # of crisis stabilization beds • Utilization of crisis assessment centers and stabilization beds
Goal C.3 Strengthen the role of schools in addressing the behavioral needs of students.		
Strategy C.3.1 Develop and implement a plan to expand school-based behavioral health services.	\$\$\$\$	<ul style="list-style-type: none"> • # of clinics, # students served, # with clinicians % screened, # of positive referred • # of schools with personnel trained in EBPs
Strategy C.3.2 Create a blended funding strategy to support expansion of school-based behavioral health services		<ul style="list-style-type: none"> • Funding for school-based services, by source
Strategy C.3.3 Develop and implement a mental health professional development curriculum for school personnel	\$	<ul style="list-style-type: none"> • Curriculum developed • # /% of staff trained
Strategy C.3.3 Require formal collaborations between schools and the community.	\$	<ul style="list-style-type: none"> • # of MOUs executed between schools and providers

Goals and Strategies	Cost	Measures
Goal C.4 Integrate and coordinate suicide prevention activities across the behavioral health service array and multiple sectors and settings.		
Strategy C.4.1 Continue to identify and foster attitudes and behaviors within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention.	\$	<ul style="list-style-type: none"> • # of initiatives for suicide prevention • # of suicides
D. Pediatric Primary Care and Mental Health Care Integration		
Goal D.1 Strengthen connections between pediatric primary care and behavioral health services.		
Strategy D.1.1 Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.	\$	<ul style="list-style-type: none"> • Number of pediatric primary care practices with mental health practitioners on site or written memoranda of understanding between health/ behav health. health providers
Strategy D.1.2 Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices	\$	<ul style="list-style-type: none"> • Delivery of education programs at graduate and postgraduate levels; Number of mental health clinicians trained to work in pediatric practices
Strategy D.1.3 Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic..	\$	<ul style="list-style-type: none"> • Documentation of CME obtained in mental health topic for all child health providers licensed by DPH
Strategy D.1.4 Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health or staff from sites working on behalf of medical homes.	\$\$	<ul style="list-style-type: none"> • Payment approved and used for care coordination in, or on behalf of, primary care efforts to connect children to services
Strategy D.1.5 Reform state confidentiality laws to allow for sharing of behavioral health information between health and mental health providers.	\$	<ul style="list-style-type: none"> • Legislation allowing health and mental health providers to share mental health information
E. Disparities in Access to Culturally Appropriate Care		
Goal E.1 Develop, implement, and sustain standards of culturally and linguistically appropriate care.		<ul style="list-style-type: none"> • Reduction in disparities in access and outcomes • Increase in patient satisfaction across racial/economic groups
Strategy E.1.1 Conduct a needs assessment at statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.	\$	<ul style="list-style-type: none"> • Completion of needs assessment every other yr (state, regional, and local); completion of annual self-assessments (state, regional, and local);
Strategy E.1.2 Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate	\$\$	<ul style="list-style-type: none"> • Data systems are adjusted to facilitate analysis of equity issues
Strategy E.1.3 Require all service delivery contracts to reflect principles of culturally and linguistically appropriate services	\$	<ul style="list-style-type: none"> • # and % of contracts incorporating CLAS principles
Goal E.2 Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.		
Strategy E.2.1 Enhance training and supervision in cultural competency.	\$	<ul style="list-style-type: none"> • Development and execution of new or adapted training programs • All credentialing contains requirements for cultural competencies

Goals and Strategies	Cost	Measures
Strategy E.2.2 Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.	\$	<ul style="list-style-type: none"> • All material meet this requirement
Strategy E.2.3 Provide financial resources dedicated to recruitment and retention to diversify the workforce.	\$\$	<ul style="list-style-type: none"> • Additional funds are provided for this strategy
F. Family and Youth Engagement		
Goal F.1 Include family members of children with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.		
Strategy F.1.1 Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children’s behavioral health system.	\$	<ul style="list-style-type: none"> • # of family members and advocates on governance bodies
Strategy F.1.2 Expand the capacity of organizations providing family advocacy services at the systems and practice levels.	\$\$	<ul style="list-style-type: none"> • # of FTEs working in advocacy organizations
Strategy F.1.3 Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.	\$	<ul style="list-style-type: none"> • # of parents trained
Strategy F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.	\$	<ul style="list-style-type: none"> • # of community conversations / forums • # of attendees • # of unique website visitors • Evaluation results from forums
G. Workforce		
Workforce strategies are included across other thematic areas as noted in Plan		<ul style="list-style-type: none"> • See measures for strategies listed in Table IV.G.1

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

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<http://www.ct.gov/cid/lib/cid/2013CIDMentalHealthParityReport.pdf>
- Task Force to Study the Provision of Behavioral Health Services for Young Adults (April 2014). Report prepared pursuant to Public Act 13-3 (Section 66).
<http://www.cga.ct.gov/ph/BHTF/docs/Final%20Report%20for%20the%20Task%20Force%20to%20Study%20the%20Provision%20of%20Behavioral%20Health%20Services%20for%20Young%20Adults.pdf>

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Recommendations: http://www.ct.gov/oca/lib/oca/Final_OCA_Infant_Toddler_Fatality_Report.pdf

Appendix C Connecticut Behavioral Health Utilization and Quality Measures

Below is an initial draft set of sample utilization and quality measures for Connecticut’s children’s behavioral health system as discussed with ValueOptions and members of the CT Behavioral Health Partnership. The governance body overseeing plan implementation will develop and promulgate, with extensive input, the measures that will guide system development.

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

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

Utilization Measures

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

For consideration:

A measure related to the juvenile justice system, e.g. Number of children discharged from a behavioral health program, service, placement who are arrested or referred to court within 6 months or number of kids in detention

Quality Measures

Measure	Reference*
Behavioral health hospital re-admission 7 and 30 days during measurement period	NCQA- 1937
Follow up after behavioral health hospitalization during measurement period	NCQA-0576
Initiation and engagement of alcohol and other drug dependence treatment during measurement period	NCQA-0004
Use of Multiple Concurrent Antipsychotics in Children and Adolescents during measurement period	HEDIS-0552

Measure	Reference*
Children's and Adolescents' Access to Primary Care Practitioners during measurement period	HEDIS-0724
Asthma Admission Rate during measurement period	NQF/AHRQ- 0283
Development screening in the first three years of life during measurement period	NCQA-1399
Metabolic Monitoring for Children and Adolescents on Antipsychotics during measurement period	HEDIS-0552
Child and adolescent major depressive disorder- Diagnostic Evaluation during measurement period	NQF-1364
Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected behavioral health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a behavioral health practitioner during measurement period	NCQA/HEDIS-0576
Discharge Follow-Up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit during measurement period	NCQA-0576
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen during measurement period	NQF/CMS-0418
Follow-Up after Hospitalization for Mental Illness during measurement period	NCQA-0576

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

Endnotes

¹ Connecticut PA 13-178 State Mental Health Planning Initiative. See www.plan4children.org.

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¹⁷ For explanation of DCF role, see www.ct.gov/dcf

¹⁸ For information on the Connecticut Behavioral Health Partnership (CT BHP) see <http://www.ctbhp.com/>

¹⁹ State insurance laws only apply to insured plans and not to self-insured (employer-sponsored) plans. However, self-insured plans are subject to the federal requirements. The U.S Department of Labor has jurisdiction over private sector self-insured plans, and the Center for Medicare and Medicaid Services has jurisdiction over self-insured government (state and municipal) plans. See <http://www.ct.gov/cid/cwp/view.asp?a=4092&Q=479346>.

²⁰ CT Voices for Children, data from the 2014 U.S. Census American Community Survey.

²¹ Comments by topic included general input (19); prevention/early childhood (13); juvenile justice system and MH (6); child welfare system and MH (5); autism services and supports (4); educational system and MH (4); integrated

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³⁷ Information drawn from CONNECT grant application, available from Department of Children and Families.

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