

**Facilitated Discussion Notes  
Juvenile Justice & Mental Health  
February 18, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by: CT Juvenile Justice Alliance
- Location: Graustein Foundation Offices, Hamden, CT
- Approximately 18 people participating in person and via teleconference

Question 1: Strengths

- Growing base of EBTs in the JJ system; trauma informed system development, MST, MDFT, other EBTs
- Implementation of EMPS, good responses, has been a helpful service
- MOAs between school districts and police
- Increasing understanding of the complexity of MH needs of children in JJ system
- Assessment procedures like the JJIE; ability to match youth to the right treatment
- Emphasis on family-oriented intervention, not treating kids separately. The use of in-home and center-based treatment settings
- Cooperation between schools and probation officers to find appropriate longer-term placements for youth
- School based Health Centers have substance abuse and mental health counselors that have been a helpful first line of defense, especially for poor youth
- Strong interest in improvement of the system; not resting on where they currently stand
- In juvenile court system and probation, access to services, including EBTs, exists for youth, especially programs operated by DCF for "cross-over youth."
- Access to respite has been beneficial to clients.
- EMPS has been helpful for clients in crisis in schools; used often in the court system.
- CT Behavioral Health Partnership has been a great way to access services for clients; has helped access services quickly
- CSSD and DCF joint strategic plan has really helped
- Advocacy of CTJJA and other partnerships is critical
- CONNECT grant to integrate systems and in response to new legislative mandates
- Groups coming together more collaboratively; sharing resources, working as system
- Family-driven and youth-informed approaches have resulted in families feeling more a part of the system.
- DCF Parole department has been a good experience (comment from parent)

- DCF, DMHAS, and OPM, federal funding sources all need to be linked funding streams
- Problems with criminalizing MH and JJ issues of girls
  - Within context of DCF opening a secure facility for youth
- Dually committed youth (child welfare and juvenile justice); where was the treatment while they were in CW to prevent JJ involvement later in youth?
- Need well-trained providers, with experience, to meet complex needs of youth in JJ and MH
  - Providers noted the extensive requirements of RFPs for providing services but not being able to pay clinicians very well. And if they are good, they are hired by the state (b/c of better pay)
- Insufficient numbers of evaluations and assessment of JJ Youth
  - Someone commented that there was less than 200 evaluations of JJ involved youth in a whole year (possibly only in one assessment program) compared to thousands of assessments in Mass.
  - Rebuttal comment that CSSD added Clinical Coordinators to ensure that assessments are being conducted when appropriate, which led to fewer assessments in certain programs, but that doesn't mean they are not getting assessed
  - Evaluations could be more focused on earlier detection, earlier intervention
- DCF's inability to use data, lacking a proper information management system
  - Judicial Branch doing a much better job and are more willing to share data and learn from it. DCF needs to "catch up" to these best practices.
- Contract management at DCF also problematic. There have been facilities that closed almost overnight, with little indication that problems in facilities were known earlier and addressed
- Inability to track youth across more than one system to look at outcomes over time
- DCF not producing data in a timely manner, mostly because they are severely understaffed. That is problematic at an \$850M budget state agency, at a time where RBA is so important
  - There are solutions out there that have not gone anywhere
  - There are/have been committees/groups (JJPOC) making progress on this issue
  - Not clear consensus as to what the problem is: DCF does not have the data? DCF has the data and can't analyze it? DCF has the data and doesn't prioritize it? When legally mandated to do so, they find a way to get good data together
- Improvement in prevention services within the JJ system, to keep kids out of JJ, and to expand prevention programs that have evidence of effectiveness
- We need to support families
  - Parents feel desperate and feel alone in supporting their children
  - Address multigenerational issues
- More emphasis on diversion; SBDI mentioned as example of ensuring access to MH services
  - One participant noted, "We're OK with having kids get arrested because we know CSSD offers really good services. That is not OK."
  - There was not total agreement that CSSD services are "really good."
- Wait lists of services, quality of the services, responsiveness of providers.
- Some health insurance plans will not pay for needed services

- Reality is that some providers are hesitant to provide SA services
- Housing, vocational services for JJ involved youth
- Case management needs to be reimbursed, in addition to treatment
- More opportunities for Positive Youth Development and other S/E development opportunities; discovering strengths and competencies; identity development
- Data Infrastructure
  - DCF needs to develop a better information management system
  - State Legislature needs to ensure that funding is available for this, even if it is not direct services, which tends to be de-emphasized during difficult economic times
  - Keep in mind that there are confidentiality concerns with data; however, there can be systems in place that allow systems to “talk” to each other w/o violating privacy
  - All state agencies involved in serving JJ youth need a better ability to report data, within and across systems, to track outcomes over time. Don’t forget about SDE as an important “data sharer”
  - Consider single entity that has access to all that data
- When it comes to addressing insurance coverage barriers; make sure there are connections between Office of Healthcare Management and Child Advocate to ensure that commercial plans are paying for needed MH/SA services
  - There is good work out there in this area that needs to go from Recommendation to Actions



**Facilitated Discussion Notes**  
**Infant and Early Childhood Mental Health**  
**March 17, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are made in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by the CT Association for Infant Mental Health
- Location: United Way, Rocky Hill, CT
- 23 people in attendance

Question 1: Strengths

- Workforce
  - "The people sitting around this table"
  - The commitment, energy, experience and skills of the people working on this issue
  - Philanthropic/foundation support
  - Governor's support for the Office of Early Childhood
  - Workforce: the staff doing this work are tremendous
  - Early childhood community of professionals is committed to system building
  - Growing interest in and commitment to Competencies and Endorsement in Infant Mental Health through CT-Association for Infant Mental Health.
- ECCP model: Funding through DCF
  - A recent RBA review revealed the effectiveness of ECCP
- Child FIRST
  - 15 sites across state, infrastructure developed across all DCF Area Offices
    - DCF providing financial and infrastructure support
  - Fidelity monitoring and outcomes monitoring—strong data from RCT and from replication sites
  - HRSA accreditation
  - \$10M from philanthropy, public-private partnerships
  - Very strong collaborations in CT that support the model
  - Evidence-based model with strong individualized treatment approach
  - Data collection and fidelity to models are key components
- EPIC program
  - Early identification in pediatric practices; connection to resources
- CT has the Early Child Comprehensive Systems (ECCS) grant, Help Me Grow, Birth to 3, Child Development InfoLine
- Advocacy is strong here. More public awareness of the issue is leading to growing political will
- Collaboration is strong, and getting stronger
  - Lots of synergy across initiatives in the early childhood arena
  - Several constituents coming together to push forward the issue of early childhood
  - Collaboration within community-based agencies: building more early childhood infrastructure right into their agencies

- Need capacity to serve more families prenatally
  - Families say they cannot get into CGCs regardless of insurance or system involvement
  - Rare to find clinicians prepared to engage very young children and their families in CGCs.
  - Access barriers: transportation, cost, hours, quality
- Lack of consistency of service access across geographic regions of the state
  - Some areas of state do not have comprehensive continuum of care; what there is may be spread out across multiple agencies
  - Some programs and services are only available in certain areas
  - Some families won't leave a city with good services, others have to move to get services that are not available where they live. Services shouldn't be based on the city you live in
  - Working in geographic areas smaller than the state level, larger than the city level—problematic
- Need more capacity, especially for Child FIRST
  - More capacity, especially in high-need urban settings
  - One site consistently has 25 to 30 families on their wait list; this is a long time in the early childhood world. All sites have waiting lists.
  - If MIECHV fed funds do not get re-authorized, 8 CF sites will go away (without additional state support)
  - 130 families on Child FIRST waitlist, not including families triaged to other services, and not including families in cities that do not have Child FIRST.
- Funding/Reimbursement Issues
  - EC services often closed to privately insured and those who are not "system-involved"
  - Problematic to have to diagnose a child under 5 to get reimbursement for services
  - The funding streams currently are authorized at the individual, rather than the family level. Services for young children require family-level funding streams
- Voluntary Services is problematic
  - Can take 3 months to start; laborious paperwork; many parents do not want to sign up to get involved with an agency that has such stigma
  - Turning custody over to DCF in order to get help is a problem for families
  - The amount of paperwork that needs to be completed to access services is daunting
    - Example from a parent: Voluntary Services was involved for 3 weeks until they linked to services, then they closed the case, then she got 6 months of services, and to get follow up services would have required doing the paperwork all over
- There is a gap between early childhood and school-aged systems of MH care
  - Insufficient linkage/transition between early childhood community and SDE
- Lack of consistency in treatment approaches across early childhood programs
  - Depending on program, you may get very different kinds of service w/different theoretical approaches (attachment-relational vs. CBT-based in other services)
  - When families have participated in other services (IICAPS provided as example which is not designed for children under 6 years), Child FIRST and other attachment-based providers often have to re-train families to "unlearn" what a previous program has done—that can take months
- Data is Insufficient
  - Documentation and tracking does not follow children and families across treatment programs or across the child and family's continuum
- Need for a paradigm shift
  - Behavioral health uses a model that suggests problems can be fixed in 8 to 10 sessions

- More focus on health promotion and promotion of social-emotional development among all children, particularly very young children and not just ameliorating problems of children who are already demonstrating problems
  - Need broad endorsement of social emotional promotion
  - Use public health model to structure the continuum of services
  - Would help providers link families to the right services
- Developing an ECCP type model for home-based providers
- Early Head Start-DCF Partnership expansion
- Create an expectation that services often will be lifelong, not one episode at one point in life
- Teach families the basics of child development
  - See wall calendar example from Birth to 3
  - Infant, toddler, and preschool
- Put the ASQ-SE assessment back in the Help me Grow program
- Need to provide schools with information about what to do with students at risk
  - Build capacity of whole schools to work on this issue
- Be more savvy about how we are reaching parents and whether those approaches are effective
- Workforce development and cultural competence: Need a workforce that is more reflective of the communities served
- Pick up on the "Plain Language" movement; many parents can't understand the materials
- The prevention mandate of DCF never happens—consider moving that out of DCF mandate?

#### Participant Comments on this Facilitated Discussion

- A lot of input opportunities
- Process worked well
- Need to encourage participants to avoid acronyms, facilitators request definition when used
- Continue to get family input integrated in each FD, not just "all family" meetings
- Need to open doors to those who have not been part of this process, so that we aren't "preaching to the choir"



**Facilitated Discussion Notes**  
**Crisis Response and Mental Health**  
**March 21, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Location: Connecticut Valley Hospital, Middletown, CT
- Approximately 24 people in attendance

Strengths

- EMPS
  - a valued service: a good partner; a critical component in the community
  - involved in school system
  - regularly used as an intervention with hospitals
  - effective collaboration
  - integral in preventing escalation and ED utilization
  - timely response
  - training for all EMPS clinicians, early in their involvement, standardization of workforce development
  - EMPS does very well addressing needs for kids with high acuity who do not have other services available to them
  - Strong collaboration between EMPS and EDs
- With respect to EMPS, it has been helpful to have a broader definition of "crisis" that includes psychiatric mental health, exposure to trauma, behavioral problems, poor family functioning
  - has expanded services to more youth
- Seems that the state rallied around Newtown and Sandy Hook to enhance availability of services
- Inpatient system: a network of C/A psychiatric inpatient hospitals
  - kids getting in fairly promptly
  - for the most part, that system is working
- Layers of care seem to be robust; inpatient, sub-acute, residential, outpatient, care coordination
- SBHCs have been important in providing services
- For 90-95% of Connecticut youngsters, the system works well (see below for other 5-10%)
- CSSD detention centers make good services available to those youth
- EDs that are open 24/7 for youth in crisis, and the talented individuals staffing EDs
- Referral volume for outpatient services is through the roof
- Wonderful 211 system

Concerns

- EMPS is not available 24/7, kids have needs at all hours of the day
- Lack of inpatient hospitals in all parts of the state
- The volume of children in crisis, and the volume of youth who need psychiatric hospitalization
- The full service continuum is not available uniformly across the state

- Little continuity of care beyond the setting
  - No contract with providers to ensure those services are available
- Reimbursement model for evidence base practices (EBPs) does not encourage keeping youth in EBPs for longer periods of time; makes it difficult for families to move between EBPs with some continuity
- Inpatient hospitals will not take children currently in detention
  - VO does not authorize for children in detention; this makes no sense
- One hospital indicated that they cannot contact a community-based provider and get good information from them about treatment planning
- State insurance much better for BH than private insurance
  - Self-insured plans are not governed by state insurance commission; those plans do not provide parity
  - Commercial insurance does not reimburse for IICAPS
  - Cost shifting of commercial insurance to public system
- Deterioration of mental health expertise within DCF
- ECCs have secret wait lists to get around the access metrics
- Voluntary Services funded out of discretionary funds without contracts/accounts, entirely based on what the case managers are able to advocate for each month
- There has been a shift away from funding non-traditional services and supports
- There is no funding for collaboration but it is increasingly expected and takes up a lot of time

#### Recommendations

- Increase availability of EMPS
  - However, next phase of EMPS development should consider 24/7, 7 days/week, longer days, more availability
- Embed providers within Primary Care offices. That would help obtain a range of services
- Need to work with schools so they are not overwhelmed; need to educate them about mental health symptoms and services
  - Consider education programs in schools such as MHFA, Parents and Teachers as Allies
- Medical Home Model required to integrate behavioral health in pediatric practices
- Educate police and first responders about behavioral health problems; reduce referral of youth with MH concerns to JJ system
- Need an "elite team" to work with the kids who are highly acute and chronic; high-utilizers
- Need Wraparound services for children with complex needs
- Public Service Announcements to inform families where they can get crisis services: television, internet, grocery stores, wherever families are.
- State could use an 800 Number for bed tracking
  - VO has this for Medicaid involved children, can this be centralized for all children?
- Accountability through transparency
  - VO keeps data on the inpatient hospitals
  - Need that for all elements of the service system, all programs need basic data on their service delivery, access, quality, and outcomes
  - Hold state agencies accountable through data on quality, RBA
- Expand in-home services for children
  - Specifically for 6-11 year old youth
- Need IOP in community-based clinics that will see children more frequently, run groups, arrange for medication management



**DCF Senior Administrators Meeting**  
**5/28/14**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

Increasing Access to Care and Coordination of Care

- Currently what works well requires DCF involvement which often equates to extreme need. Families shouldn't need to become system involved.
- Increase opportunity and access earlier on for children and families.
- Adequate network, single point of access and quality control.
- Single point of access: Call one place - one location - ASO - not working the way it should.
- Single point of access - who to call - has to be managed well.
- Incentives need to be aligned
- We need an adequate network that matches the population seeking services
- Communication, coordination and access
- We need to increase care coordination
- Need behavioral health service that meet all populations needs.

Structuring and Financing Mental Health Care

- We need to reshape how we operate. Promote multi-state agency collaboration including CSSD and SDE, financially and administratively contributing to one entity
- Structural point of view needed to delineate between public and private operation - we have a balance and not enough discipline between the two. Create fiscal discipline regarding "Pay for Success". People rewarded for good outcomes.
- Structurally delineate roles - (public & private) operational/government, not enough delineation/clarity between the two.
- Wraparound idea = CPSSA. Kansas at 1/2 of case rate per member. 5% of kids in congregate care. Structures inside state government made it difficult for government to move in right direction. 2.) Structural case management model is not correct model for behavioral health issues that are longer term. Our model works well in short term. Case management model is not our model
- Structurally - case management model to address alleged child abuse and neglect is not designed to meet the long term and chronic needs of children and families. Very different model from a care coordination model
- Involvement of commercial insurers - what is their philosophy.
- Commercial insurance - lack of access to care.

- **Child Welfare.** Mandated report - lack of knowledge about legislative requirements. Public policy issue - what we should be delineating as roles and responsibilities doesn't mean that Child Welfare shouldn't be the "lead organization".

#### The Role of Schools and SDE

- Improve the role of schools interacting with behavioral health system.
- Role of schools - reflect on their approaches -too much emphasis now on children and "fixing" them vs. teachers roles, contributions and approach. Should obtain surveys from young people
- Schools should be involved. PBIS, what we think children should do, not staff. School climate is important. Gather more information on school climate from students/young people/children on how they see the school. More information and framing on human behavior, behavioral health, kids well being
- Concerns regarding schools. 2000 kids under age of six were suspended. That's a failure. Suspect that behavioral health issues and disproportionate number of kids of color or minority. We are failing. External meetings need SDE at the table. DCF is not the only system who touch children, more school based health clinics needed. Be the norm. We can't go looking for behavior health issues either.
- Need to see SDE as active participant at many tables
- Further support and utilization of School health clinics to help make behavioral health a more normative part of understanding and helping children.
- Region 2 has an opportunity based on new federal award - school based wrap. All too often see pilots but it's unclear how well these pilots are sustained and scaled up.
- SDE is doing their thing, and DCF is too - we need to work together.

#### Data and Outcomes

- Not enough recognition of what works well.
- Identify and determine which service delivery outcomes are better if delivered through the public vs. the private sectors.
- Develop services by real measureable data.
- Providers need to be held accountable. Nurses, physicians, social workers need to share their information about the kids and families.
- Data on quality are needed, and importance can't be understated - better connections

#### Public Awareness

- We need to consider a public and social marketing campaign. Describes roles and responsibilities, who does what, and that it's everyone's job. Informing people regarding where to go. Legislature - who had their own struggles with where to go and how to navigate. Need a campaign for money and social marketing plan.
- Separate plan/funds to support message.

#### Clinical Services

- More diagnostic clarity with release of DSM-V.



**Facilitated Discussion Notes**  
**The Education System and Mental Health**  
**May 7, 2014**

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General Notes

- Location: Value Options, 3<sup>rd</sup> Floor Hartford Room
- Approximately 17 people in attendance

Question 1: Strengths

- Complementary roles of school social workers and school based mental health clinic staff – the latter can provide more clinical services if in the school systems.
- We have been able to show the positive impact of providing MH services onsite right away without barriers to access.
- Campaign for a Stronger CT- grant that is focused on working with the education community to raise the voice of the education community to raise the awareness of the need for MH services in education. Participant shared those materials.
- EMPS and how widespread it has become. It is an amazing tool. I wish the response time window was less than 45 minutes. But it's an amazing first step.
- School districts are increasing the number of consulting behavioral health professionals in the schools. It's a more recent thing. To create programs to try and assist kids who can't access education in a traditional way—creating opportunities in a regular school setting.
- SRBI (Scientifically Researched Based Interventions) system has potential to have impact—Idea was to shift toward earlier intervention. Provides universal support.
- Positive behavioral supports (PBIS) and interventions that look at a continuum of services and preventative services.
- Inter-agency discussions are helpful
- State grants that provide early MH intervention- One in particular: after responding to a screener, they get services. It has initial screening and outcome data. It is only \$500,000/yr across all districts and reaches 1000 kids. Pre-K to grade 3. It focuses on mild-moderate behavioral concerns. It is play-based intervention, helpful for kids that are shy, withdrawn, dealing with family transition. The RFP is sent out annually to district leaders. Apply for grant—approx. 23-26 districts receive the money. Each district gets \$25K or so each. They receive in-kind support from providers.
- SAMSHA grants—Safe Schools Healthy Students grants- provides districts with money to provide Positive Behavioral Support interventions, access to resources; focus is that district is working closely with other agencies.
- Having a conversation like this Facilitated Discussion that shows the link between Education and MH. We are beginning to understand each other.
- School-based Health Centers—highly regarded nationally and make a big difference in the schools they are working in.



- We need more pediatric mental health professionals.
- We need more providers that are culturally versed to avoid misdiagnosis or over diagnosis.
- Early intervention – need more.
- School social workers are not allowed to ask about children's psychiatric medication. She can ask them about other physical health meds but not MH problems. She can't recommend therapy because the school may have to pay for it. It's considered an unwritten rule to keep your mouth shut about the needs of kids so that the school doesn't have to pay for it.
- School staff members think about identifying problems and making a referral. What they don't do is think about what the impact is of school (grading, teacher style, etc.) on children.
- There are many missed opportunities where kids are truant, suspended, etc. Schools are not going through the process of identifying MH problems. The schools are reluctant to have to financially support any extra MH efforts.
- There is a lack of knowledge regarding cost—schools think they will have to pay a lot but they may not have to.
- By law you can discuss medication and the facilitation but not recommend the use of the medication.
- Schools are scared because law suits get thrown at them so they have to be so careful.
- We, as school staff, get the direction to be careful on what on what we say. We can't recommend medication or indicate a diagnosis. Can't ask questions or recommend counseling. We can only recommend special education but that may not be the issue.
- The system is at conflict between budget and the needs. They have a limited budget so can't really open their eyes and see what the problem is. There is a disincentive to do something. Can the State help with the financials for schools.
- There are major policy implications for supporting and not supporting kids mental health issues—systems issues.
- Need for confidentiality and need for communication in state of emergency—these two are at odds. You have to be able to override existing confidentiality policies based on emergency needs but it's a tricky situation. Schools need to know what they can do and not do regarding confidentiality.
- One parent indicated she has a child that takes multiple medications every day for physical and mental health problems. She doesn't understand why someone can't ask about her child's use of the medication (did they take the medication?—either physical or mental). This should be allowed.
- One parent indicated that we need the SW to get involved and tell us what referrals we need.
- One parent indicated that the IQ test that the psychologist administered was considered not accurate due to youth's anxiety but can't adjust the IQ test in any way. How do we address the real problem if don't make a connection between the anxiety and the IQ test taking.
- Staffing is an important issue. We have highly trained professionals who can work in MH and work in the school setting. We need to put more staff out there.
- The pressure for the schools to be more rigorous, we need more MH providers. The ratio is 1-1300 (nationally). Should be 1-500 (social workers) or 1-250 (counselors). School psychologist are understaffed in CT. We need more MH staff in schools.
- Access to students is a problem. When do you see the kids and still give them enough time to do the curriculum. How to provide MH services and still progress in education. Increasing staffing will help this.

- Understand the social, cultural, and linguist aspects of our students. Understand their background, needs. Understand their identity issues and how they may impact MH and social and emotional functioning. We need training in this area for all school professionals.
- Recommend that school districts maintain the national recommendations around MH staffing levels, including school nurse, SW, psychologist, and counselor. These professionals should be funded by all the state agencies. The money should come from DSS, DPH, and DCF. These should help fund these positions because, ultimately, they will be impacted by good child MH. Eg: in MA, dept. of public health hires all the school nurses. Because kids health is a public health issue. The MA dept. of public health gathers data and then makes data-driven decisions.
- Need State level funding. We need more services at the middle level—kids who are at risk. For high need kids- provide them with a serious level of intervention. Consider re-adjusting the funding so that other agencies can help.
- Kids in shelter need extra educational help. (The McKinney–Vento Homeless Assistance Act of 1987)
- Need to better balance the education with MH issues. Which is more important? For some focusing on MH may be more critical.
- Autism waiver program—there needs to be faster response to families.
- Teachers need good training on what MH and trauma looks like in the classroom—what are the symptoms and behaviors.
- Collaboration between MH agencies and the schools.
- We need to allow schools to tell families what we think is really wrong. When we know there is trauma—we should be allowed to tell the parent that they can benefit from a certain intervention.
- Transportation support for an extended school day based in the schools for after school hours.
- Resource mapping for professionals. Some agency need to be able to link professionals.
- Mindfulness – it has a lot of potential for students and adults. It's easy and effective if delivered in a trained way. Both kids and adults in schools. Adults get drained so they need to also get services to serve students better. Students need to learn to tap into themselves. Mindfulness would help.

#### General Feedback on the Discussion

- Very effective, well structured.
- I hope there is follow-up that involves the people that were here.
- Use technology to keep the ball going.
- Excited to able to have a voice. Also this was wonderful to see all these professionals out there addressing the same things I am interested in.
- Some people use these types of discussions as a formality but I'm hoping this is not the case and that this conversation will truly inform the process moving forward.



**Facilitated Discussion Notes**  
**Autism and Mental Health**  
**May 12, 2014**

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General Notes

- Location: Value Options, 3<sup>rd</sup> Floor, Hartford Room
- Approximately 19 people in attendance

Question 1: Strengths

- We have seen lots of improvements over time. We see improvements in outcomes because we are getting kids into treatment earlier and providing structured education.
- The first sets of outcome studies show that about 5% of those with Autism were independent and self-sufficient and now it's closer to 30-35%. This is a major shift. For instance, we now have kids going to college.
- If you have the means, you can access really good resources.
- We have great resources for families compared to other states.
- We have strengths in teaching schools and programs how to work with kids with Autism.
- For the public schools, there are guidelines in place that help ensure school districts are prepared (but the guidelines do need to be updated).
- We have a lot of dedicated people who have worked hard and we are moving in the right direction. An example includes the development of the CT clinical guidelines for the clinical diagnosis of Autism, based on collaborative work. CT is one of three States in the country to have such guidelines (the other two are CA and WI).
- Some of the professional groups have practice guidelines on working with children with Autism, which can also be helpful.
- We have good infrastructure in CT. For example, the DDS autism plan is one. We also have parental supports and the medical home model.
- We have a lot of cooperation between state agencies. Much better than other states.
- The involvement of the parents and their coordinated efforts of advocacy are great and much better than on the adult side.
- We have good legislative champions and this is essential because of their influence.
- CAAC (CT Autism Action Coalition) is bringing agencies together to communicate & collaborate.
- We have a Medicaid waiver that expands the pool of those able to get services and expands the type of services they can receive.
- DDS has done a great job to build momentum around improving services for children w/ Autism.
- The most important thing is that we have so many wonderful people on the spectrum who are self-advocates and who have sought out their own education.
- Providers are listening to the self-advocates and using that information to guide their work.
- The general public has more of an awareness and understanding of Autism. The awareness is creating more acceptance and respect for a person with Autism. It used to be people with



- They need full day pre-K. Because then you have the same amount of time for intervention with the pre-school children as you do with the school aged children.
- You need a skilled person who is facilitating the child's activities in a classroom.
- Lack of training is a huge problem across disciplines. More training is needed.
- Our funding is locally based which is a problem and there are school to school differences. We need parity across districts and schools.
- Stress on families. Some families fight for more services for their children but some don't even know what to ask for. We have a system that is so individually focused (on the child with Autism) but not meeting the needs of families and siblings.
- We have seen families falling apart because our approach is "one-size fits all." The interventions sometimes don't match needs. We are not doing needs assessments. We are telling them what we have and that's all they can choose from. Because of this, families do not trust the system.
- Transition to adulthood
  - Adults with Autism spectrum disorders are "falling off the face of the earth" after 18. They "are graduating into nothing." They are not able to get the help they need because providers are not taking private insurance or Medicaid. It is the most frustrating thing about my job. Nowhere to send the adults in need. It is a real crisis.
  - You've got some of these kids who go to school and families work hard to keep them included with their peers. Then it comes time for graduation. While in high school, the child may have had a job and they were able to access nice community organizations through school, and then they graduate. School is no longer there for them as a support.
  - You have to look at how adults with Autism are under-employed or unemployed. Most are unemployed. Schools are not doing appropriate transition plans when the child with Autism graduates. Kids who are at the mid to high end of spectrum suffer the most from this transition problem. They are not being trained to develop skills for competitive employment. We need to look at how we are preparing them. They need to be prepared differently than other special populations.
  - Individuals with Autism don't transition from school with social skills, life skills, driving, and housing. Need transition services focused on those areas
- Autism and Behavioral Crisis
  - We really don't have a capacity for individuals with Autism who are in a behavioral crisis. There are limitations with crisis programs (ED or 211) including limited ability to respond and lack of informed care. They do not have trained staff to work with Autism. They are psychiatrically trained with some trauma training only.
  - We know EMPS has been used by families but the staff are not trained in Autism and there is not an alternate system. Not sure it should be the same service for Autism. Maybe something different? If EMPS approaches them wrong, it can exacerbate the situation and lead to medicating the child, which can be more harmful. This experience may make them not come back to that resource and try to deal with it themselves.
- Screening is critical and needs to be implemented universally. Developmental screening and Autism screening should match other screening rates such as collecting vitals, which is close to 100%. A pediatrician and family care doctor should start that journey together with the family. In CT we are at about 38% for screening for Autism in the primary care setting.
- With Birth To Three, it's helpful but at three it stops and then school and Department of Children and Families supports the family. Those schools have challenges providing adequate support. Families don't have a natural support and the services they are being provided don't

the work feel like they have buy-in from the state agencies. Business and churches may sponsor these groups too.

- There are models in other states (e.g., SC, NC, Maine) to help communities put together a family/local program to help families navigate the system in a culturally, appropriate way. We have people who could do this but there are no resources/funds to support it.
- The transition from Birth To Three to DCF (Age 4-7) to DDS (8-18) is not good. Families can apply for autism waivers but it takes too long. We need to consolidate services under one agency. Families have to go from culture to culture to culture and this is very hard for them.
- We need to look at how to develop successful transition programs in the high school. Southern CT has the CT Center for Excellence and they could develop this transition program.
- Need to diagnose early. We have children being diagnosed late and this overwhelms families.
- Things can be therapeutic without being therapy. Boy Scouts for example. A little teaching about Autism to these local community organizations could make a big difference.
- Commercial Insurance Specific Recommendations:
  - Self-funded insurance plans that don't have to follow a mandate—these are federally regulated. People on these plans have trouble getting services covered for Autism. Self-funded employers don't want to fund these services. You can advocate for services at your place of employment but you might worry about losing your job and it takes a lot of time.
  - Sometimes services are only covered for 16 weeks or some limited time. It shouldn't be time limited.
  - Questions about who is on the insurance companies Provider Panel. There needs to be a mandate to have appropriate providers on the panel. Some companies won't put certain people on the panel if they are not licensed and that is limiting.
- Need appropriate funding for DDS as an agency so they can do more. There is a waitlist and we can't serve everyone. Need more money for DDS.
- Design one system that covers everyone--- Medicaid, non-Medicaid, private, non-private, no insurance, etc.
- Assist the family who is usually the constant. What about having a parent do the screenings in a primary care setting—get creative.
- Need funding for training. The training should be for the whole team (e.g., teachers, speech professionals, counselors) and it needs to be funded by the State.
- Every teacher has been trained but they get one class on disabilities and then one lecture on Autism which is not enough (unless they specialize in it).
- Please remember adults on the spectrum. We are graduating our youth from high schools and they are not prepared for adulthood.
- Training—developing some online didactic material and then adding on the coaching and modeling components. There could be cost sharing between State and district.
- Transition should start when you are starting a system. Even when they are in kindergarten, start thinking about when they are adults. It starts at the beginning.
- One-size does not fit all. Each disability needs different types of services.

#### General Feedback on the Discussion

- Have people from the State Department of Education & Office of Early Childhood provide input.
- This was enough time to share. Two hours was good.



**Facilitated Discussion Notes**  
**Coordination of Care and Integration of Care**  
**April 23, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by Coordination of Care and Consumer Access Subcommittees of the Behavioral Health Partnership Oversight Council
- Location: CT Legislative Office Building Room 1E
- 19 people in attendance

Question 1: Strengths

- Engagement of families and consumers is a strength in CT
  - Lot of programs and resources for families
  - Strong family participation across state
  - Information about programs and services are shared between families
  - Subcommittees (such as Consumer Access and Coordination of Care) allow consumers to share what's working
  - Training at grassroots level to include family participation across systems tables
  - State sees value of incorporating input from youth into the plan
- Existing services and programs in the state
  - Increasing numbers of services/ intervention programs recognize the complexity of needs faced by youth and families and do have identified roles for care coordinators, patient navigators, and/or peer and family peer specialists and provide access to care coordination to reduce barriers
  - Increase of Patient Centered Medical Homes bodes well for expanding coordination of care
  - Department of Public Health (DPH) programs provide care coordination at state, regional, local levels to share information around shared cases
    - Medical home initiative care coordinators are very successful in helping families navigate the complexities of the system
    - DPH School-based health centers
    - Community health centers also help to meet the needs
  - Home visitation and accompaniment to specialty clinics and PPT meetings is a strength
  - Some programs monitor to ensure that families receive the offered/referred resources
  - Wide array of children's behavioral health services available in the state, including acute care, home-based, and ambulatory with ongoing communication across service providers and ValueOptions (state Administrative Service Organization):
    - Pediatric acute services: spend considerable time in discharge/transition planning when child is leaving the hospital through Value Options (ASO) to increase likelihood that child is connected to next level of care. Positive, stable relationship and clear communication between hospitals and ValueOptions, rare denial of services.



- Barriers to communication across systems by state regulations on privacy and confidentiality; "State laws impose greater constraints than does HIPAA"
- Need to go beyond medical needs to assess broader stress and challenges faced by children/families; where there is recognition, there is not enough programming or resources
- Multiple demands are placed on families served by the Department of Children and Families to do so much within a short period of time without making sure basic needs are first met for families
- In-home services need to be adapted on an individual basis for families who need different services or providers (e.g., a family may need more than 6 sessions for an evidence-based treatment)
- Reduced Department of Public Health budget (due to legislative cuts) will have impact statewide on care coordination for children with special health care needs next year to result in reduced staff and reduced care coordination services for families
- State database outdated, doesn't allow for sharing outcomes or information beyond demographics
- Lack of access to care for children with commercial insurance compared to those on HUSKY, particularly for in-home services. Coordination of care is predicated on health insurance coverage, so goals for coordination of care will not be realized without enrollment. Explore parity legislatively.
- Lack of non-English speaking providers is a growing concern.
- Family voice not taken into consideration or acknowledged as it should be, although families are increasingly engaged across systems
- Lack of mental health providers

### Question 3: Recommendations

- Need alignment across systems to facilitate service access
  - Align ages for transitions across state agencies to avoid gaps, frustration, and lack of payment (e.g., child may be receiving DCF services, but have a need for another agency's services and be rendered ineligible due to age restrictions even if they otherwise qualify)
  - Allow multiple family members to receive same services as needed
- Workforce needs training to be knowledgeable about all care coordination services for all mental health and medical providers that work with children, perhaps through DCF Training Academy
- Data/medical records/information sharing:
  - Coordination of electronic medical records across all child-serving settings, needs to be compatible, encrypted; The Health Information Technology Exchange Connecticut (HITEC) may serve as a resource
  - Patient registry to be implemented on universal basis across all pediatric and family primary care practices to ensure tracking of patient information for children with behavioral health needs—CT Chapter of American Academy of Pediatrics and the CT Academy of Family Physicians, together with the Health Information Technology Exchange may be able to assist
  - All agencies need to have policies requiring information sharing across virtual treatment / interagency teams
  - Statewide policy is needed regarding confidentiality laws and information sharing--CT Psychological Association may be resource in this process
  - Need database for outcomes with funding for staff to manage database; stop re-creating the wheel and use existing data to drive decision-making
- Time for care coordination must be reimbursed under current fee-for-service system; "these activities should be considered as a necessary component of care in a bundled fee arrangement"
- Care coordination to be provided to all children who need it across all ages and all areas of need
- More cross-collaboration across existing care coordination programs and cross-training across systems, with full funding, in a manner that incorporates grass-roots and faith-based providers

**Facilitated Discussion Notes**  
**Commercial Insurance**  
**June 5, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by: Connecticut Department of Insurance
- Location: Department of Insurance Central Office, Hartford
- Approximately 20 people in attendance

Agencies Represented

- Anthem; Cigna; Aetna; United Health Care; Optum; Connecticare; DCF; Healthy CT; Connecticut Department of Insurance, CHDI

Strengths

- Having a paradigm to oversee the delivery of the services: what is delivered; what network delivers contracted services; overseeing quality and standards of care
- Some advances in offering in-home service delivery
  - e.g., one carrier noted their collaboration with Wheeler Clinic on the design and delivery of home-based services
- Quality control processes available: when there are concerns about providers they receive follow-up, requests for records, and actions by the carrier may then be taken
- The flexibility to add providers, remove providers, and reconfigure the network without the red tape that exists in the public sector system
- Integration with other medical care: commercial carriers are able to use their data to more easily see "the whole picture" across general health and mental health
- Most carriers are substantially moving away from simple utilization management toward helping the family handle a condition and providing support for the parents:
  - case management, coaching about handling BH issues;
  - come a long way from simply approving or denying care
- The capacity within their data systems for predictive modeling and trend identification
  - Able to identify trends at population level; care that will be needed; ability to identify high-risk situations early
  - There are consultants out there that compare data across carriers re: use of services
  - Developing educational programs based on what they are seeing in the data: at individual and population levels
  - Data sharing comparing across their providers has been a powerful tool for change
- Customer service: Helping inform parents about the care that they need and linking them to providers and making appointments on their behalf
- They have a good sense of the needs of "the ACA cohort:" 18-26 year olds and their substance use and abuse trends



- They have clinicians on staff who are trained in crisis stabilization but they do not get the calls to stabilize and recommend care
- Concern about the large portion of the mental health utilizers that one might characterize as “the “worried well.”
  - A problematic group for carriers.
  - It’s not clear that their services are medically necessary, but they are willing to use services week after week
- The challenge of shifting providers from volume to value (data-driven)
  - Lack of clinical outcome data in outpatient care
  - A belief among service providers that their services are valuable in the absence of outcomes data demonstrating effectiveness
  - They have offered to pay providers to use standardized measures like symptom checklists and rating scales, and providers still don’t use them
  - They are going to get more assertive about requiring providers to demonstrate value; can’t afford the volume-based system any more
  - Example was shared about data that was shown to psychiatrists about their clients’ medication adherence: when they pointed out to the psychiatrist that they were below average, they saw an almost immediate 6% increase in medication compliance among those “worst” providers
  - Providers need to connect with the carriers that have the data, use the tools and the data, and demonstrate value and outcomes
- Opportunities to train private practice clinicians in their network on the use of EBPs
  - A potential public and commercial sector collaboration was suggested to build provider capacity to delivery EBPs
  - The only way they can get MDs to attend training is to make it part of CEUs; however, they can get CEU credits in 5 minutes in online AMA courses, so the incentive to attend substantive CME is limited.
  - Another option would be to require EBP training through maintenance of certification
- One participant said it’s simply an excuse when providers say they don’t have the time to participate in training in EBPs
  - The majority of providers believe they are providing best quality care
  - There is going to be “provider shock” when carriers begin to coalesce around high-quality providers only
  - They may require use of screening and assessment and the use of an online protocol for treatment rather than “routine therapy”
  - Enhanced reimbursement at premium level is possible for providers who agree to use these treatment support tools
- Better data sharing among providers in the management of patients is needed
  - Fragmentation of care as patients move along continuum and data are not shared.
- Crossover from medical home or accountable care organizations medical care, to mental health care, is challenging. Lack of integration there.

- One provider does not authorize 40 hours of care unless the provider can demonstrate why they need that much service
- One indicated that the research demonstrates that ABA is effective at 25 hours/week
- Some have worked with certified and non-certified ABA providers
- There is a true problem with the lack of credentialing among ABA therapists
  - There are a lot of people treating Autism out there and some are not qualified
- Need to have a certification and/or licensing process for Autism therapists providing ABA and other Autism services
- The state did not agree when the insurance providers asked the state to license Autism ABA providers
- Autism Speaks reportedly supports this move as well; a lot of support for this; the health plans supported this move
- Concerns about Substance Abuse treatment:
  - A lot of variability between quality of providers and level integration with medical care in integrating substance abuse treatment
  - Shortage of providers for child and adolescent substance abuse
  - One participant stated that CT has a lot more adolescent substance abuse providers than a lot of other states; they have not seen a major access problems in this state
- Public sector, to deal with workforce issues and manage costs, has used non-licensed clinicians:
  - Commercial insurers believe that requiring appropriate credentials is important.
  - Regulations, accrediting standards, NCQA regulations restrict the types of clinicians they can bring into the network
  - Some concerns about quality of care among providers
  - They insist on supervision by a licensed provider of a non-licensed provider
  - Some said they have recently loosened those restrictions a bit
- People tend to assume that the highest level of care is the best treatment; problem with public perception of which level of care is best to meet the need
  - Need to look at functional strengths, treatment needs to occur at the least restrictive setting appropriate to their needs
  - Their data demonstrate no correlation between LOS and recidivism (in substance abuse)
- "A flaw in the system is that we have a provider-centric network"
  - Providers say that they have to treat for long LOS to get outcomes, which may or may not be supported by the data
  - Patient-centered care would dictate that providers work with families to determine appropriate level of care that is regularly reviewed
- The public in CT has established an expectation that the most restrictive settings are the best care options (EDs, inpatient, residential)—a history of high utilization of these levels of care
- Providers have an obligation to ensure that treatment being provided is medically necessary
- Need to clarify what is perceived to be a social service and what is considered a medically necessary mental health treatment service

#### Other Specific Recommendations

- Health Information Exchanges:
  - Need to loosen restrictions on sharing information about behavioral health care;
  - Need to educate public about why doctors need to be able to access records; both at the individual and at the aggregate level
  - State needs to establish entity that identifies trends and promotes information sharing



**Facilitated Discussion Notes**  
**Evidence-Based Practices**  
**April 24, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by Advanced Behavioral Health
- Location: Middlesex Corporate Center, Middletown, CT
- Approximately 24 people in attendance

Question 1: Strengths

*Access to EBPs*

- In the public sector, CT is fortunate to have a variety of models available; a lot of access to EBPs for certain populations of youth and families
- Access to EBPs is helpful to families
- CT has some of the largest implementations of EBPs in the country, and even the world
- In the case of MDFT, all children, it's not just those who are DCF-involved can access
- More options for community-based care

*Funding for EBPs*

- A good degree of Medicaid reimbursement for EBPs;
- Most other states do not have as many resources available for EBPs as Connecticut
- DCF has been the champion of many EBPs, but good collaboration across state agencies, especially CSSD, in funding and sustaining EBPs; partnership between all parties involved has been very helpful for sustainability
  - Co-contracting between and among state agencies has helped ensure consistent implementation of EBPs and has created some important efficiencies
- DCF and other state agencies have funded studies of whether EBPs are working, led by agencies like CHDI and ABH
- Blending state agency, philanthropic, and other dollars to fund EBPs

*The Importance of Various EBP Supports*

- DCF has been able to support non-profit providers with ongoing costs of sustaining EBPs (training, consultation, QA)
  - Without the financial support from DCF, many agencies would not be able to implement EBPs with fidelity

- Most, but not all, EBPs involve the whole family (parent comment). Family-orientation EBPs have had a potential impact on siblings as well.

## Question 2: Concerns

### *Limited Access to EBPs among Commercially Insured*

- There are still huge gaps in who can access EBPs
- Almost everything mentioned in this discussion of EBPs is only available in the public sector.
- There is a growing amount of care being provided by private practitioners that mostly is not evidence-based
- A lack of clinicians in the private sector who specifically work with children and families
- Children do not have access to the best treatments unless they get involved with state agency systems, or Voluntary Services, or unless they have Medicaid

### *Limited Access to EBPs Related to Other Factors*

- Most EBPs are in-home; we have fewer EBPs available in routine outpatient care settings where most kids receive MH treatment
- Capacity problem; there are huge wait lists in early childhood programs;
- DCF funding may only cover town-specific regions leaving some towns without access
- Early childhood EBPs have a developmental context that needs to be addressed
- Wait Lists for Some EBPs in Community Settings
  - Getting into a CGC can be difficult due to wait list for EBPs
- Lack of child/adolescent psychiatrists in CT
- Lack of EBPs for specific populations: young children, autism, transition-aged youth, truants
- A need to educate referral sources around the range of EBPs and their differences and similarities and what would be the best match
- Kids in child welfare do not have access to EBPs

### *Follow-up and Continuity for Families, Within and Across EBPs*

- A parent said that after the EBP was delivered, there was little evaluation or after-care that asked how the service worked for them and if they had other needs
  - Need sustained contact with families during and after the EBP is delivered
- Many families have to use multiple EBPs sequentially, and there is not great linkage across programs; information is not always shared across programs
- We need more parent and family input to share their experiences about what is working and not working with all services, including EBPs
- We need a continuum of care within an agency; providers trying to make seamless transitions but they may not have a broad range of services.
- Families transitioning from one service to another can be confused as they try to engage with multiple service providers



#### *Ensure Continuity of Care Within and Across EBPs*

- Develop a centralized system for intake, treatment course, and discharge information so that providers can access information about families without having to ask them to repeat their story and complete the intake process over and over

#### *Increase Awareness in Community of Availability of EBPs*

- Develop systems that increase awareness among families as to which EBPs are available to them and which EBPs best match their profile and needs
- Education and public awareness to potential consumers

#### *Address Ongoing Need for Workforce Development in EBPs*

- Expand workforce through graduate education programs in EBPs
- Address the need for better cultural and linguistic competence in the workforce
  - Continue to prioritize hiring that represents the population served; especially racially and ethnically diverse and Spanish-speaking clinicians
- Explore the possibility of making BA level staff (with supervision and fidelity to treatment) eligible for reimbursement for services
  - The evidence on relation of degree to outcomes is far from clear
  - For example, BA level care coordinators or family partners who “apprentice” with EBP clinicians get great training and may go on to pursue advanced degrees
- Engage young, diverse teens in High School and recruit them to work in the MH field

#### *Funding*

- Ensure Medicaid and commercial insurance reimbursement rates that fund actual cost of care
- Shift funds away from agencies that are not living up to standards and re-invest those funds to agencies who are implementing with fidelity and achieving outcomes
- Seek Medicaid match funding (50%) that is available from the federal government for research on services that are delivered to the Medicaid population
- Use braided state agency funding to support models that combine treatment for children with treatment for parents and siblings
  - E.g., there are some services that treat parents along with children, but DMHAS does not currently contribute funding for those services
- Schools are an important setting for service delivery and they are responsible for social and emotional development; engage SDE in funding and delivering services

#### *Data Needs*

- Collect data to support the understanding that using EBPs will save money in the long run
- A more robust data system across service and programs that demonstrates the long-term cost savings to the state and the private insurance companies

**Facilitated Discussion Notes  
Substance Abuse and Recovery  
May 13, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Location: Value Options, 3<sup>rd</sup> Floor Hartford Room

Question 1: Strengths

- CT does well developing a recovery oriented system of care (ROSC) for the adult population.
- Juvenile probation officers are doing an effective job identifying youth who need intervention. They tend to be a primary referral source for treatment.
- CT has a strong community and family based intervention system for adolescents. We provide more Multi-systemic Family Therapy (MSFT), per capita, than anywhere else in the US. Other great evidence based interventions that CT has include: Multi-Dimensional Family Therapy, Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC)
- We have strong quality assurance and monitoring systems in place.
- We have a strong system in terms of transitioning older adolescents into the Young Adult Services of the Department of Mental Health and Addiction Services (DMHAS). We are a leader nationally in our treatment efforts for this population.
- CT is a small state and has a lot of community based resources that we can build on to better serve our youth. There are opportunities to make community based resources more effective.
- DMHAS has combined services. We use the "Dartmouth-based model", which is an evidence based practice. There is a family component to it and it is associated with the Stages of Change Theory (Trans-theoretical Model of Change).
- DCF and DMHAS have been encouraging outpatient programs to assess substance abuse even if they refer on to other services versus being able to provide treatment services directly. They can't always do both (assessment and treatment) and see them as separate services.
- Mental health and substance abuse issues for adolescents cut across all three areas of responsibility for DCF focuses. There has been a level of collaboration between the three areas: (1) child welfare, (2) juvenile justice, and (3) behavioral health. Having all of these services under one department also helps with coordination.
  - There is a unique organization and structure here that doesn't exist in other states.
  - There is a clear focus on the children and their needs regardless of which of the three areas they are under. DCF looks at children and families first.
- State insurance covers substance abuse treatment. It's easier to get coverage through Husky than through private insurance.
- Court Support Services Division (CSSD) has a program for females and males dealing with substance abuse and they have a follow up component using MDFT. That seems very well utilized with the perception of good outcomes from that program.



- Most private insurance companies don't think rehabilitation is necessary and that only detox is necessary. At the end of detox, the detox team usually has to say that your insurance wouldn't pay for rehabilitation so you need to come pick them up.
- It is a weakness that youth have to transition from DCF to DMHAS. Kids fall through this gap. Who covers this kid? The substance abuse issues require a broader look.
- The court system is a huge problem. If you are a white kid with a lawyer, you will get your case dismissed. These kids think getting arrested for drugs is a joke. They get community service, etc. and not real consequences. Also, kids learn to work the court system—they stop using marijuana because it stays in systems longer—so they use harder drugs which get out of system quicker. Now they went from having a marijuana problem to a worse problem.
- There are grant federal dollars that are not pursued by CT because DCF says it's not their domain and DMHAS says it's not their domain--missed opportunities.
- There is not an excellent system of recovery (ROSC) for kids. We have the ability to do it but it's not happening.
- CT gives 16 year olds too much power. If you are 16, you can't be involuntarily placed and sometimes it is in your best interest. 16 year olds have rights that they probably don't deserve at such a young age.
- With private insurance, there are barriers to getting on their provider panels.
- With the new legalization of marijuana in some states, the kids are not getting the message about the dangers of marijuana.
- The private insurance doesn't support vocation or other options. State services give you a "package of treatment" which helps fit the right treatment for each person. We need to tell the private insurance companies that we need an array of services not a single service.
- There is misinformation about how many people are using drugs. We should record numbers and share them with the public. It's the #1 health problem in the state.
- They should make it mandatory for emergency departments to make referrals to treatment if they have a youth with a substance abuse problem.
- Sometimes parents approach treatment for substance abuse as something the kids need to be sent away for. In CT, that would mean being sent out of state because we don't have residential SA care in the state. Parents want to send their kids away to get "fixed" but that may not be the best approach.
- Some people have seen discharge plans for youth presenting at an emergency departments for substance abuse, that don't even include a recommendation for substance abuse treatment.
- Seeing very young kids using very high-end drugs. Heroin is a big problem. No one is screaming about this. They are not creating more services to address this problem.
- Services do not sufficiently take family-based care into account. Providers often require the youth to self-identify as the "patient" and deny a family who is seeking care for their child.

### Question 3: Recommendations

- DCF needs to develop a global way to market to families about the SA services we have.
- Extended day treatment program are good for substance abuse but we can't have kids in that program if substance abuse is the primary presenting problem. We would like to be able to change those contracts to serve more youth with substance abuse problems.
- We need to build the ROSC for youth. It has to be local. There already is a certification for recovery support services.
- We need to get peer support as part of what the treatment offers.

**Facilitated Discussion Notes**  
**Law Enforcement & Children's Behavioral Health**  
**June 2, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

General Notes

- Hosted by: Yale Child Study Center
- Location: Yale Child Study Center, New Haven
- Four people in attendance

Question 1: Strengths

- CDCP (Child Development – Community Policing Program) essential elements
  1. Intensive cross-training and riding with LE (Law Enforcement) for many hours
  2. On-call 24/7
  3. Weekly case conference to build and sustain relationships
  4. Protocols for how LE and clinicians respond
  5. Immediate intervention and longer-term interventions
- Two interfaces exist:
  - LE interfacing with acutely and/or chronically psychiatrically ill individuals; e.g. CIT training out of Nashville. Many communities have trained their LE workforce.
  - LE serve as first responders in which children are exposed to traumatic events; e.g., domestic violence, sexual abuse. Requires identification and early intervention, which improves outcomes.
- The collaboration in New Haven is viewed as very strong by New Haven PD and YCSC.
- Yale Child Study Center's CDCP model has been funded through grants and private money, bringing these services to the region at no cost to the state.
- Child Advocacy Centers exist to support children and adolescents.
- LE members are most often the first responders to children exposed to traumatic events. Their role involves an immediate response and there is also the potential for follow-up intervention from LE as well.
- The YCSC model has been adopted elsewhere, e.g., Charlotte (\$700,000 in annual state funding) and Cleveland.
- The model in New Haven works in part because relationships have been developed between LE and mental health over 20 years. Many of the individuals involved meet weekly and consult each other frequently. Confidence in the model grows out of experience with the model.
- LE and clinicians learn to recognize each other's roles.
- There are two CIT-Youth (CIT-Y) Programs in the state: trains LE to deal directly with youth (traditional CIT is focused on adults). The program is linking LE to EMPS through 211. Clinicians then respond by phone or are deployed to the community. Exists, for example, in Manchester.
- Commissioner of DMHAS supports CIT and that support flows down through the regions. There are 9 CIT clinicians in the state. CIT clinicians get 40 hours of training to better understand LE and the interface with LE.



- Need a good sales pitch for the work, ideally from another police officer. For example, "We care about these kids, we want to help them." Use real world examples.
- Be clear about roles and responsibilities and don't blur the roles.
- The models have to make the work of the professionals involved easier and more effective; better clinical outcomes and greater public safety.
- Go slow. If you try and do this everywhere in the state it will fall apart. There has to be buy-in.
- Need the right people to serve as trainers. CABLE using co-trainers: mental health and LE.
- Don't use the word "mandate" in any legislation. It will scare LE away.
- Make sure all EMPS clinicians have the right kind of training and that there are enough of them.
- Distinguish between interventions related to acute psychiatric conditions vs. trauma exposure.
- Legislature should support a public awareness campaign about children's behavioral health and the evidence supporting mental health and LE collaboration.

#### Other Comments

- Overwhelming events are overwhelming for everyone, especially if not appropriately trained. The last time to build partnerships is in the middle of a crisis.
- Largest lesson not learned is that the majority of violence is not committed by psychiatrically ill individuals. The opposite idea has proliferated (more violence comes from the psychiatrically ill).

**Children's Behavioral Health Plan  
Facilitated Discussion Notes  
Keep the Promise Coalition  
March 20, 2014**

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are made in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: [info@plan4children.org](mailto:info@plan4children.org).

**General Notes**

- Hosted by the Keep the Promise Coalition, Children's Committee
- Location: CCPA Office, Rocky Hill
- 20 people in attendance

**Question 1: Strengths**

- Effective School-Based Health Centers
  - There are 88 School-Based Health Centers that are funded by the Department of Public Health
  - Each has a licensed mental health clinician right in the school.
  - Families have easy access and are also connected with community providers for other services if needed.
- Behavioral Health Partnership is working well.
  - Authorization goes well when working with the schools
- School- Based Diversion Initiative
  - Great Initiative-Reducing School-Based Arrests
- Systems of Care
  - Infrastructure that can be built upon
  - CONNECT is a big part of consolidating the SOC framework
- The establishment of the Office of Early Childhood
- Medicaid payments have increased somewhat, which improved access
- DCF
  - Has the Differential Response in place
  - DCF Voluntary services is helpful, but there are still some barriers
  - DCF has made some more improvements in working with families that have members with mental health diagnoses. In the past they had made some inappropriate decisions in working with such families
  - DCF decided to hire new staff that have Social Worker degrees in order to improve the quality of service
  - Bringing the family voice to the table by having Family System Managers (at FAVOR)
- Emergency Mobile Psychiatric Services
  - Utilization of EMPS instead of 911 in the school systems
- TFCBT- CHDI
  - CT is very good with evidence based models such as TFCBT
- CCSD
  - Is doing great work in identifying kids with mental health needs and using diversion initiatives.

**Question 2: Concerns**

- DCF Voluntary Services barriers
  - It is problematic that kids in the Juvenile Justice System can't access these services unless there is a waiver from the Commissioner.
- School-Based Health Centers
  - Are having a great deal of difficulty with students who are hospitalized and then are transitioning back to school due to no notification to the schools about the discharge date or plan
  - More early identification and early intervention is needed; Universal screening in the school setting by utilizing the school-based health centers
  - Programs like this increase partnerships with families



- Provide funding on the existing grant programs available rather than starting (and paying for) new programs
- Have participation from Commercial Insurance to address the insurance issues many families are facing
- Track recidivism for juvenile offenders
- Improve the transition from youth services to adult services (only 17% of youth transitioning from DCF to DMHAS had a transition plan)

#### Additional Ideas:

- Take a look at research done on family skills-development
- Create a system that provides family supports and provides more assistance to parents
- Create a system that supports evidence based services AND non -traditional services
- A system that recognizes that evidence based services sometimes do not work for all families and children
- Concern about the quality of care provided by trainees and the lack of continuity of care as they constantly turn over at agencies
- None of these ideas are new – simply more funding is needed to provide adequate services and supports
- Look at all the costs being created by not spending adequately on prevention and treatment
- Every new service funded in the state has been met with cuts elsewhere
- “Connecticut is a ‘Kingdom of Pilot Programs’ with no sustainability plan.”

#### Participant Comments on this Facilitated Discussion

- Positive comments about the Facilitated Discussion process and content
- Making public the trends and themes found in these discussions
- Sharing some notes prior to the report being finalized. Would like to see what are other people are thinking
- Posting some of the summary comments on the website from the facilitated discussions