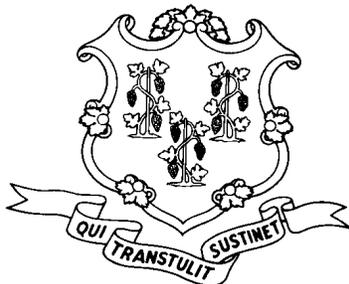


STATE OF CONNECTICUT



Community Mental Health Services Block Grant for FY 2010

In compliance with the requirement of P.L. 102-321

Including

The Community Mental Health Plan For Children & Adults

September 1, 2009

Submitted By

The Department of Children & Families
The Department of Mental Health & Addiction Services

OCTOBER 1, 2009 to SEPTEMBER 30, 2010

PART C SECTION 1: DESCRIPTION OF THE STATE SERVICE SYSTEM - CHILDREN

A. OVERVIEW OF THE STATE'S MENTAL HEALTH SYSTEM

The Department of Children and Families (DCF), established under Section 17a-3 of the Connecticut General Statutes, is one of the nation's few comprehensive, consolidated agencies serving children under age 18 and their families. Connecticut was the first state in the nation to legislate the structure for a consolidated agency for services for children and their families. The move to integrate children's service within a single agency rather than scatter them across separate agencies was based on several premises:

- The mental health needs of children were too often overlooked or given too little attention within the system for adults;
- The developmental needs of children require a specialized set of interventions that are distinct from those that are effective for adults;
- There is considerable overlap in the populations of children and adolescents who have experienced abuse or neglect, those who have significant emotional disabilities and those who have been involved in the juvenile justice system; and
- The wide range of services needed by children and their families can best be met in an agency that works in partnership with families and the community agencies which address the needs of children including schools, advocacy groups, and private providers.

The legislation established in 1974 directs DCF to provide a spectrum of behavioral health services, child protection and family services, juvenile justice services, substance abuse-related services, education services specifically acting in the capacity of a school district for committed children, and prevention services. Further, DCF is mandated to license, monitor and evaluate certain services provided by private and community providers including outpatient psychiatric services, extended day treatment services, foster homes and group homes. The legislative mandate reflects Connecticut's historical belief that the wide range of services necessary to meet the needs of children and their families can best be realized through an integrated approach that draws upon family, community and state resources.

DCF's mission is "to protect children, improve child and family well-being and support and preserve families." Staff works with diverse ethnic and cultural groups and communities in Connecticut, partnering with families, advocacy groups, public and private service providers, local education authorities, other state agencies such as the Department of Mental Health and Addiction Services, Department of Developmental Services, Department of Social Services, Department of Public Health, The Judicial Branch - Court Support Services Division, Department of Corrections, Department of Education, Department of Public Health and federal agencies such as the Department of Health and Human Services.

The work of the department is based on five guiding principles.

- ✚ Overarching Principle Safety/Permanency/Well-Being. DCF is committed to the support and care of all children, including those in need of protection, those who require mental health or substance abuse services, and those who come to the attention of the juvenile services system.
 - Principle One - Families as Allies. The integrity of families and each individual family member is respected, and the importance of the attachments between family members is accepted as critical. All families have strengths and the goal is to build on these strengths. Family involvement and self-determination in the planning and service delivery process is essential.

- Principle Two – Cultural Competence. The diversity of all people is recognized and appreciated. Children and families are to be understood in the context of their own family rules, traditions, history and culture.
- Principle Three – Partnerships. Children and families are best served when they are part of and supported by their community. The Department is part of this community, works in association with community members, and is committed to its services being localized, accessible and individualized to meet the variety of needs.
- Principle Four – Organizational Commitment. A successful organizational structure promotes effective communication, establishes clear directions, defines roles and responsibilities, values the input and professionalism of staff, creates a supportive, respectful and positive environment, and endorses continuous quality improvement and best practice.
- Principle Five – Workforce Development. The work force is highly qualified, well trained and competent, and is provided with the skills necessary to engage, assess, and intervene to assist children and families in achieving safety, permanence and well-being.

Within DCF the Bureau of Behavioral Health and Medicine is vested with the primary responsibility to plan, administer and evaluate a comprehensive, integrated statewide system of behavioral health and substance abuse services and related supports for children, adolescents and their families. Children and families can access state-operated or state/community funded services directly or through referral from various sources. The goal is to foster resiliency to enable the child to function successfully at home, at school and in the community. The family is considered a partner in all aspects of the planning, treatment, and discharge processes. To achieve this goal DCF works with families, other caregivers, and the broader stakeholder community to ensure the availability of an array of clinically effective services for any Connecticut child or adolescent with serious emotional, behavioral and addictive disorders. DCF also provides specialized behavioral health services for those involved with the child protection and/or juvenile justice systems, particularly for those youth with Serious Emotional Disturbance (SED) who are at placement risk, and for those youth with special mental health or developmental needs who are transitioning out of DCF's service system. For the latter population, DCF has Memorandums of Agreement with the CT Department of Mental Health and Addiction Services (DMHAS) and the CT Department of Developmental Services (DDS) that require timely identification of youth with either serious mental illnesses or developmental disabilities, who need to be referred to DMHAS or DDS for ongoing services at the time of transition from DCF. There are established protocols that include standardized Department-wide clinical criteria to determine if referrals are needed, timeliness standards for referral prior to age-out and/or transition, and written discharge plans.

The agency's primary source of revenue for operating expenses and direct services is state general fund appropriations by the General Assembly through the biennial budget process. DCF also receives and/or administers a variety of federal resources. For example, the agency administers the two federal child abuse and neglect formula grants under the Child Abuse Prevention and Treatment Act and the Independent Living Program. It also prepares the children's portion of the federally required state mental health plan for the Community Mental Health Services Block Grant and is responsible for administering and managing the state's cost reimbursement function under federal Title IV-E, Section 474.

DCF adopted the federally endorsed System of Care model as the basis for the state mental health plan for children in 1997 and established 25 local community collaboratives, attached to DCF's 15 local area offices. This statewide integrated system of children's behavioral health services and supports became

known as Connecticut Kid Care in 1999 and continues to operate today. The intent is to promote community-based care planning and local service system development. All services are provided within this framework, per Public Act 97-272, An Act Concerning the Mental Health Mandate of DCF. The legislation asserts that children should receive services in their homes and communities whenever possible; parents and families must be an integral part of the planning, treatment and decision-making process; and services must be culturally and linguistically competent. All treatment, support and care are locally coordinated and provided in a context that meets the child's psychosocial, developmental, educational, treatment and care needs.

A wide range of clinical and non-traditional services are available at the regional or local level to help children with behavioral challenges experience success in their home, school and community environments. DCF, as a direct provider of services operates a children's psychiatric hospital, a residential treatment program, an emergency shelter and diagnostic center, a facility for male adjudicated juvenile offenders, and an experiential wilderness challenge course. Additionally, DCF funds community-based providers to deliver a diverse range of inpatient and outpatient services. Children with complex behavioral health needs may qualify for an enhanced set of services such as emergency mobile psychiatric services, crisis stabilization services, partial hospitalization, individualized support services, respite services, intensive home-based services, extended day treatment services, enhanced care coordination, and therapeutic support. These children are usually involved in two or more service systems and many have received previous treatment in psychiatric inpatient settings or residential treatment facilities.

In addition to these state-operated and state/community-funded services, other service providers include the following:

- Private mental health practitioners that are not DCF funded;
- Private, for-profit service agencies and clinics that are not DCF funded;
- School-based health clinics;
- Judicial Branch – Court Support Services Division (CSSD);
- Health maintenance organizations;
- Primary care physicians; and
- Faith-based community organizations.

Services are organized and integrated at the local level through a network of 25 community collaboratives. Each local collaborative represents a consortium of service providers, advocates, and family members who meet together on a regular basis to identify system of care issues as well as to plan and implement solutions. Although each collaborative works in a slightly different fashion, they all remain committed to helping children with serious emotional disturbance succeed in their homes and communities.

Each collaborative has care coordinators who are specially trained service brokers. Employed by various non-profit agencies, they are trained in the Kid Care philosophy and the system of care model to deliver Level III care coordination services. They serve children, ages 2 to 17 who have a psychiatric diagnosis, are involved with multiple services, and have a need for assistance in identifying and mobilizing personal and community resources.

Care coordinators work in partnership with families to identify and advocate for services appropriate to the child's needs. They support families and are responsible for ensuring that an individual service plan

is developed and implemented. A unique feature is the ability to convene a Child Specific Team meeting at the request of the family to assist the family in forming a service plan to meet the needs of the child in an appropriate and timely manner. The parent, with the assistance of a care coordinator, identifies the members of the Child Specific Team. Family, friends, community service providers, school staff and/or others, at the invitation of the family, collaborate to offer a variety of solutions, services and supports. Also, there are locally assigned family advocates who work at the community level to support and empower families. Families do not need to be DCF involved or Husky eligible (Medicaid Services) to receive assistance, but some services that are recommended may require enrollment in HUSKY Part A or B, or the Limited Benefit Program. Enhanced care coordinators are provided for DCF-involved children and youth, ages 2 to 18 that are transitioning from residential care to the community.

The Managed Service System structure was added in 2004. This represents a consortium of DCF staff and DCF-funded provider agencies convened under the authority of the 15 DCF local area offices to assure that a comprehensive and coordinated array of services are available at the local level to meet the needs of the DCF target population, especially those clients with the most complex behavioral health needs. The goal is to reduce the number of children in residential care and manage access to appropriate levels of community-based care in a timely manner. The bi-monthly meetings focus on coordinating services for all children in DCF facilities, shelters and short term assessment homes, safe homes, inpatient settings, and residential treatment facilities. Key leaders are the DCF behavioral health program directors who have expertise in behavioral health issues, and the DCF area resource group (ARG) specialists from each area office that are comprised of psychiatric social workers, nurses, substance abuse specialists, domestic violence specialists and others to provide consultation and other supportive functions to the DCF social work staff and broader community.

Since January 1, 2006 the CT Behavioral Health Partnership (CTBHP), which is administered by Value Options under contract with DCF and the Department of Social Services (DSS), has managed Medicaid mental health and substance abuse services and many DCF-funded behavioral health services. The goal is to provide enhanced access to, and coordination of, a more complete and effective system of community-based behavioral health services and supports for children and families. The CT BHP offers specific services for children and families who are eligible for the HUSKY Part A or HUSKY Part B programs or the Limited Benefit Program through DCF. For the latter program, children who do not qualify for HUSKY Part A or HUSKY Part B may be eligible to apply for services if they have complex behavioral health needs and are involved with DCF.

The goals established for the CTBHP are codified in state statute, as follows:

- Expand individualized, family-centered, community-based services and reduce unnecessary reliance on institutional and residential services;
- Maximize federal revenue, capture and re-invest funds to increase community-based services;
- Improve administrative oversight and efficiency; and
- Monitor individual outcomes and overall provider performance.

Behavioral health services that are available through the CTBHP include:

- Inpatient psychiatric hospitalization;
- Partial hospitalization;
- Substance abuse/detoxification services;

- Residential treatment services;
- Intensive in-home services;
- Outpatient mental health or substance abuse services;
- Emergency mobile psychiatric services;
- Medication evaluation and management;
- Extended day treatment services; and
- Psychological/neuropsychological testing.

Staff at Value Options works closely with family members, providers and other local social service providers to support the goals of the behavioral health system. There are 6 network managers who, in the past year, have focused on provider-specific targets for increasing access to care by reducing lengths of stay and delayed discharges at local hospital emergency and inpatient departments. During 2007 and 2008 the network managers' role moved to a more focused approach to service capacity/access, quality and outcomes. The network managers may participate in the Managed Service System meetings to review the status of DCF involved children with complex needs and those presented by the local system of care representatives. The network managers provide information and expertise on CTBHP policies, procedures and resources. They provide local and statewide data and reports to guide service system planning, implementation and monitoring. An intensive care manager (ICM) has also been assigned to each area office to assist with clinical treatment planning for complex cases. Among other activities the ICMs track and monitor the status of children seen throughout the state's emergency departments and assist in identifying appropriate resources when diversion is indicated. They attend discharge planning meetings on inpatient units and work with DCF area office staff and family members to effectuate timely discharges. Other Value Options' staff members that work at the local levels include peer support specialists who are adults that have had personal experiences with the mental health and/or substance abuse services system, and family support specialists who are trained parents of children with behavioral health needs. These specialists provide education and outreach to families, help families identify resources including natural support networks, engage in treatment, and navigate the service system. They provide information, identify individual barriers to care, and work closely with the intensive care coordinators and care coordinators to address barriers. Each of the described staff members are organized into "geo teams" that cover a specific area within the state. These teams meet weekly to share information and to develop provider specific or community specific interventions that support the goals of the CTBHP.

All of the resources described above comprise the state's mental health system. Guided by a statewide vision, the diverse array of partners work closely to achieve a comprehensive, integrated system of care.

PART C SECTION 1: DESCRIPTION OF THE STATE SERVICE SYSTEM - CHILDREN

B. ROLE OF THE STATE MENTAL HEALTH AGENCY

DCF plays a key leadership role in coordinating mental health services across the state.

Commissioner Susan I. Hamilton, MSW, JD and designees work closely with the Office of the Governor, the Office of Policy and Management, the Connecticut State Legislature, consumers and family members, advisory groups, advocacy groups, service providers, and state/federal agencies. Commissioner Hamilton has appointments or ex officio memberships to 19 statewide, regional and local boards, councils and committees. Through these venues DCF works collaboratively with a diverse array of stakeholders to solicit multiple perspectives on unmet needs and priorities and to identify short and long term directions for the statewide service delivery system.

DCF staff, particularly from the Bureau of Behavioral Health and Medicine leads and participates in numerous committees and workgroups that are focused on a broad range of issues to better serve Connecticut's mentally ill children, adolescents and families. Examples include: promoting family outreach, engagement and retention throughout the period of care; improving the quality of care through early identification and comprehensive assessment; disseminating and sustaining evidence-based practices; addressing the needs of traumatized children, adolescents and their parents/caregivers; enhancing the knowledge, skills and competencies of the workforce; improving data collection, analysis and reporting systems; integrating plans of care across multiple systems; and enhancing the role of families and other caregivers in all aspects of system design, planning, monitoring and evaluation. Examples of councils and workgroups include the following: local Systems of Care, Regional Advisory Councils, State Advisory Councils, the Children's Behavioral Health Advisory Committee (CBHAC), Oversight Council of the CTBHP, Youth Advisory Council, and regional and statewide family advocacy organizations including Family Advocacy Services (FAVOR), African Caribbean American Parents of Children with Disabilities (AFCAMP), Padres Abiendo Puertas (PAP), Families United for Children's Mental Health (Families United), National Alliance for the Mentally Ill - CT (NAMI-CT), and other grassroots organizations. In addition, DCF maintains relationships with each of the major trade associations including The Children's League, Connecticut Community Provider Association (CCPA), Connecticut Association of Foster and Adoptive Parents (CAFAP), and the Connecticut Association of Non-Profits (CAN).

Of particular significance are several statutorily created advisory bodies that serve as critical partners. These include the following.

- a) State Advisory Council. This seventeen-member council was established through legislation to assist the Department through input into each of the Department's mandated areas of responsibility, including children's behavioral health. The Council recommends, to the Commissioner, programs, legislation or other matters which will improve services for children, youth and their families served by the Department. The State Advisory Council (SAC) assists in the development of, review and comment on the strategic plan for the Department. The SAC reviews quarterly status reports on the plan, independently monitors progress and offers an outside perspective to the Agency.
- b) Children's Behavioral Health Advisory Committee (CBHAC). Established by Public Act 00-188, CBHAC's charge is to promote and enhance the provision of behavioral health services for all children in the state of Connecticut. The committee oversees the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. The committee evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the State Advisory Council on Children and Families. CBHAC members also actively participate

in the CT Joint Mental Health Block Grant Planning Council, which is co-chaired by a Children's Representative.

- c) Youth Advisory Boards. DCF staffs also work in partnership with and solicit input from the Youth Advisory Boards from each of the local area offices and a statewide Youth Advisory Board. Approximately 50 youth in "out-of-home care" participates.
- d) Connecticut Community Providers Association (CCPA). This member-based organization represents providers of services for children with mental illness, substance abuse disorders and other disabilities and special needs. The mission is to achieve service system change, represent the voices of its members at the state and local levels, and support the delivery of high quality, efficient and effective services.
- e) Connecticut Association of Non-Profits. A collaborative of 500 organizations, the association is dedicated to building and sustaining healthy communities. This group also focuses on identifying needs, service priorities, coordination of service systems, and advocacy for effective behavioral health services.

DCF has recently developed a five-year strategic plan to guide agency practice from July 1, 2008 through June 30, 2013. The integrated plan includes goals and activities for each of the Department mandates including child welfare, behavioral health, juvenile justice, substance abuse, and prevention. DCF staff as well as the broader stakeholder community influenced the development of the plan. The strategic planning document includes action steps and time frames for implementation to fulfill the vision, mission, and goals of the agency. Some key behavioral health activities include: establishing a needs assessment methodology to project needs for community-based behavioral health services to guide provider network development and expansion; providing training for targeted providers promoting the utilization of evidence-based practices; and developing and overseeing the implementation of valid, reliable assessment instruments to screen for behavioral health and developmental factors for child welfare cases.

DCF, in partnership with the broader stakeholder community continues to advance the transformation of the statewide mental health system. The transformation initiative aims to further the goals of the President's New Freedom Commission on Mental Health, which are similar to the goals of Kid Care - Connecticut's community-based system of care. Under the aegis of the Mental Health Transformation - State Incentive Grant (MHT – SIG), DCF has partnered with DMHAS, 14 other state agencies, the Judicial Branch and the broader stakeholder community to effectuate meaningful system change. During the past four years of this five-year initiative, there has been a focus on listening and responding to the voices of consumers, youth and families regarding needed system changes, educating all citizens about the importance of mental health and its equivalency to physical health care, using data to evaluate and improve services, and expanding and strengthening the workforce. A summary of activities and initiatives to improve the mental health infrastructure is provided in other sections of this report.

DCF also works in partnership with the University of Connecticut, the University of Connecticut Health Center, Yale University School of Medicine/ Department of Psychiatry, The Consultation Center at Yale University School of Medicine, and the Child Health Development Institute/Connecticut Center for Effective Practice. These academic and research facilities often provide critical support for system-wide planning, policy development, and program development.

PART C SECTION 1: DESCRIPTION OF THE STATE SERVICE SYSTEM - CHILDREN

C. LEGISLATIVE INITIATIVES AND CHANGES - Below is a summary of legislation that impacts behavioral health services for children and families.

PUBLIC ACT 09 - S.B. No. 877 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES

This act implements a number of changes in statutes relating to the Department of Children and Families' planning, programming, and reporting functions. It:

(1) Requires DCF to develop and regularly update a single comprehensive Strategic Plan, following consultation with representatives of the children and families it serves (the plan must define and identify agency goals, timeframes, and indicators of progress);

(2) Expands the authority and oversight of the State Advisory Council on Children and Families (SAC) with respect to DCF programs and services including behavioral health, as follows:

- a. To assist in the development of reviewing and commenting on DCF's Strategic Plan;
- b. To receive quarterly reports from the Commissioner concerning the Department's progress in carrying out the Strategic Plan;
- c. To independently monitor the Department's progress in achieving the Strategic Plan's goals; and
- d. To offer the Department assistance and an outside perspective to help achieve its goals.

By law, SAC makes recommendations to DCF about programs, legislation, and other matters to improve services; annually advises the Commissioner on her proposed budget; explains DCF's policies, duties, and programs to the public; and issues reports to the Governor and Commissioner on an as-needed basis. The bill directs DCF to provide the Council with funding for administrative support and to facilitate participation by council members representing families and youth (10 of its 17 members are parents or relatives of children receiving, or who have received, DCF services). The bill requires the council to hold its meetings at locations that facilitate public participation. DCF must post the council agenda and minutes on its website.

The bill does not change the number of members but changes the membership so that SAC must include:

a) two people aged 18 to 25 served by DCF; and b) one attorney with expertise in children and youth issues. The balance of the membership includes young persons, parents and others interested in the delivery of services to children and youth. The bill specifies that this include child protection, behavioral health, juvenile justice, and prevention services.

(3) Requires, rather than allows, DCF to establish advisory groups for each facility it operates (the Connecticut Children's Place, the Connecticut Juvenile Training School (CJTS), High Meadows, Riverview Hospital, and the Wilderness School) and provide them administrative support;

(4) Requires state agencies cited in an Office of the Child Advocate report to respond to the governor and General Assembly in writing within 90 days; and

(5) Requires DCF to collect and analyze data about child abuse and neglect that involve a parent or guardian with a substance abuse problem.

The act also eliminates several reporting requirements and advisory groups and makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2009

PUBLIC ACT 09 - [S.B. No. 301](#) AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

This act broadens what a group health insurance policy must cover regarding autism spectrum disorders. It requires a policy to cover the diagnosis and treatment of autism spectrum disorders, including behavioral therapy for a child age 15 or younger and certain prescription drugs and psychiatric and psychological services for insured's with autism.

By law, a group health insurance policy must cover physical, speech, and occupational therapy services provided to treat autism to the same extent that it covers them for other diseases and conditions. The act removes that limitation, but specifies different conditions for coverage of the therapy and other services. It permits a policy to set a certain annual dollar maximum for behavioral therapy coverage.

The act authorizes an insurer, HMO, hospital or medical service corporation, or fraternal benefit society to review an autism treatment plan's outpatient services in accordance with its utilization review requirements more often than once every six months, unless the insured's licensed physician, psychologist, or clinical social worker agrees a more frequent review is necessary or changes the insured's treatment plan.

The act specifies that it is not to be interpreted as limiting or affecting (1) other covered benefits under the policy, the state mental and nervous condition insurance law, and the birth-to three coverage law; (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law; or (3) any obligation imposed on a public school by the federal Individual with Disabilities Education Act (20 USC § 1400).

The act also specifies that it must not be interpreted to require a group health insurance policy to provide reimbursement for special education and related services provided to an insured under state law that requires boards of education to provide special education programs and services unless state or federal law requires otherwise.

The act defines "autism spectrum disorders" as the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" including, autistic disorders, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

EFFECTIVE DATE: January 1, 2010

PUBLIC ACT 09 - [S.B. No. 789](#) AN ACT CONCERNING THE SHARING OF INFORMATION BETWEEN THE DEPARTMENT OF CHILDREN AND FAMILIES AND THE DEPARTMENT OF DEVELOPMENTAL SERVICES

This act allows limited disclosure of Department of Children and Families records to the Department of Developmental Services (DDS) without the consent of the person named in the records. In order for DDS to determine a child's eligibility for its Voluntary Services Program (the child must already be a DDS client), assist the child's enrollment in the program, and plan services for the child, the act allows DCF to disclose a written summary of any child abuse or neglect investigation it conducted. DDS must notify parents and guardians when they apply to enroll a child in the program that it may obtain these records from DCF without their consent.

By law, DCF can already disclose records, whether it or someone else created them, without consent, in a variety of other situations. Like these disclosures, before releasing a record under the act, DCF must determine disclosure is in a person's best interest and that the records are not privileged or confidential under state or federal law.

EFFECTIVE DATE: Upon passage

PUBLIC ACT 09-1 - [H.B. No. 5095](#) AN ACT CONCERNING DEFICIT MITIGATION FOR THE FISCAL YEAR ENDING JUNE 30, 2009

This act makes various changes to address the projected FY 09 deficit. Section 27 of the act requires the Department of Children and Families Commissioner, in consultation with the Department of Social Services Commissioner, to create a plan to establish services for children and youth needing residential treatment who would normally be placed in out-of-state facilities. The DCF commissioner must submit the plan to the Human Services and Appropriations committees by March 1, 2009. The plan must (1) use existing state facilities when clinically appropriate and feasible; (2) address available licensed residential treatment capacity; and (3) delineate the cost, savings, and feasibility of implementing the plan by July 1, 2009, or as soon as practicable after that date.

EFFECTIVE DATE: Upon passage, unless otherwise specified.

PUBLIC ACT 09-96 - [H.B. No. 5915](#) AN ACT CONCERNING "STUCK KIDS"

This act requires the Department of Children and Families to review annually the cases of all children and youth in DCF care during the previous calendar year and report the number and age of those:

- (1) living in a psychiatric hospital or out-of-state treatment center, their average length of stay, the number who have overstayed their estimated placement time, and an analysis of the reasons for the out-of-state placements and overstay;
- (2) who have run away or are homeless, the number of days each has been a runaway or homeless, and an analysis of the trends relating to runaways and homelessness;
- (3) who have a permanency plan of another planned permanency living arrangement and an analysis of the trends relating to permanency plans; and
- (4) who have refused DCF services and an analysis of the trends relating to participation in services.

The first report is due by February 1, 2010 and must be sent to Children's and Human Services committees.

EFFECTIVE DATE: July 1, 2009

PUBLIC ACT 09 - [H.B. No. 6678](#) AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH LICENSING STATUTES

House Amendment A (LCO 9326) exempts certain DCF licensed facilities from the Office of Health Care Access's (OHCA) Certificate of Need (CON) process.

The act requires DCF and DPH jointly to investigate reports of abuse and neglect occurring at any day care facility or youth camp. The departments must share all information, records, and reports gathered as part of the investigation.

EFFECTIVE DATE: CON exemption, July 1, 2009

PART C SECTION 1: DESCRIPTION OF THE STATE SERVICE SYSTEM - CHILDREN

D. OTHER NEW DEVELOPMENTS AND ISSUES

Each year the CT BHP, through Value Options (the Administrative Service Organization) works to improve the managed care system of behavioral health services for children and their families. One of the major initiatives is focused on reducing the length of stay in inpatient psychiatric settings. DCF, DSS, Value Options and eight of Connecticut's private general and psychiatric hospitals worked together to support the reduction of unnecessary inpatient days. Efforts included the following:

- Development of a performance incentive program for general and psychiatric hospitals focused on hospital length of stay;
- Establishment of a performance target under the Value Options contract focused on the reduction of discharge delay days within the inpatient system;
- Introduction of hospital-specific quality improvement initiatives and provider analysis and reporting by Value Options; and
- Stepped up efforts in DCF area offices to facilitate timely discharge.

The incentives were aligned across all participants in the system reform.

Under the performance incentive program, participating hospitals are awarded a share of a performance fund based on their demonstrated ability to reduce lengths of stay or maintain efficient lengths of stay. Data collected during a baseline period are used to establish target lengths of stay for each of four categories of children: DCF-Involved Children, ages birth to 12; DCF-Involved Children, ages 13 to 18; Non-DCF involved Children, ages birth to 12; and Non-DCF Involved Children, ages 13 to 18. These target lengths of stay were used to establish a case-mix adjusted predicted length of stay for each participating hospital during the performance period. Each participating hospital is expected to achieve an adjusted average length of stay that is comparable to or better than its predicted length of stay.

The results have been positive. Child psychiatric inpatient hospital days have declined from 43,493 days in calendar 2007 to 38,917 days in 2008, a drop of more than 4, 500 days (10.52%). During this same period, the average monthly enrollment of children in the CT BHP increased 4%, from 231,635 to 241,325. Reduction is not due to a decline in admissions, which have increased over the period in question. The majority of the reduction appears to be due to reduction in the problem of discharge delay - a reduction in both the number of discharges that experience a delay and the average length of stay. A reduction in acute length of stay (about 3%) has also been an important factor contributing to the reduction in authorized days.

A performance initiative was also made available to licensed freestanding clinics and hospitals that are currently active and participating with the CT BHP in the provision of Extended Day Treatment services, a clinical treatment and rehabilitative support program for children/adolescents with significant emotional disturbances. The initiative is intended to promote family engagement, enhance quality of care, and improve child and family outcomes. A total of \$ 120,000 is available each state fiscal year to those programs that meet the specified performance targets that include: established attendance rates by parents/caregivers at initial assessment interviews, treatment plan development meetings, treatment plan review meetings, individual therapy sessions, family therapy sessions, and multiple family group sessions; targeted rates for completion of Risking Connection Basic Training by staff members; and administration of the Ohio Scales as well as targeted increases in overall functioning scores and targeted decreases in problem severity scores.

Another development under the direction of Value Options focuses on fostering change in foster care. The CT BHP conducted a retrospective analysis of data on children and adolescents placed in foster care to identify any relationship between use of behavioral health services and disruption from a first or second foster home placement. This project grew out of clinical discussions with the Departments regarding the children who were brought to local hospital emergency departments by foster families who felt they were

no longer able to care for the children as a result of their behavioral health problems. This led to questions regarding whether a foster child appearing in the emergency department should trigger an urgent behavioral health intervention to prevent a possible disruption from the foster care placement.

Data analysis and focus groups with foster families indicated that a relationship between disruption of foster care placement and authorization of behavioral health care services does exist. One of the findings was that a large number of children who had disrupted from their placements had previously received behavioral health services. Disruptions tended to occur within the first 45 days of placement. In December 2008 DCF and the CT BHP initiated pilot programs in Norwich and Waterbury areas to support foster children with behavioral health needs and their foster families. Targeting children ages 3 to 18 who are experiencing their first removal from home, receive HUSKY benefits, and have already been identified as having behavioral health issues, the programs' goal is to reduce the likelihood of disruption within 45 days of placement. If a child was identified as meeting criteria for participation in the pilot project, both the children and their foster families received outreach calls from the CT BHP's peer specialists (employees of the CT BHP who have either experienced behavioral health issues personally or have family members with behavioral health needs). The peer specialists help the foster parents to understand, predict and plan for the challenges and special behavioral health service needs. CT BHP's intensive care managers also played a role in assuring that every case was authorized for services and linked with providers in a seamless manner. To date no children have disrupted from care. This result would not have occurred without ongoing collaboration between the CT BHP and the DCF area offices. The pilot project is continuing and discussions regarding expansion are underway.

To further address the issue of foster care disruption, the CT BHP is working with DCF to accomplish the following activities:

- Assist DCF in updating the Foster Parent Resource Manual and work towards establishing a section of Value Options website "AchieveSolutions" dedicated to providing information relevant to foster parents; and
- Research practices related to Child-Specific Training and Crisis Prevention Planning for foster parents and their children.

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

A. STRENGTHS AND WEAKNESSES OF THE SERVICE SYSTEM

The Behavioral Health Service system is complex and multi-faceted. Any effort to assess the strengths and weaknesses (challenges) must consider the various components of the system. A review of the issues by DCF and several study committees (Delivering and Financing BH Services in Connecticut/Child Health and Development Institute/2000; Report of the Governor's Blue Ribbon Commission on Mental Health/2000; Achieving the Promise: Transforming Mental Health Care in America/Report of the President's New Freedom Commission on Mental Health/2003; and DCF Strategic Plan/ 2008 - 2013) including but not limited to reveals seven core aspects of behavioral health service delivery and system management including:

1. Access and Service Capacity

Children and families need to easily access the type of service they need at the time they need it. Preferably, services are accessible and provided in the community in the least restrictive setting necessary. The overall capacity of the service system in comparison to need, the variety and type of services within the array (e.g. respite care, behavioral supports, family treatment, medication, etc.) and the allocation of resources across levels of care (e.g. from standard outpatient treatment through extended day treatment to residential and inpatient care) all impact access and the sufficiency of the service system.

2. Service Effectiveness and Quality

Children and families need services that are effective and match their needs and preferences. There are many strategies and approaches to insuring the delivery of quality care. These include the provision of effective screening and assessment, the promotion of evidence based and best practices, development and support of a competent workforce, use of technology to support practice, and the use of data and programs of quality improvement.

3. Child and Family Involvement

The system must be driven and informed by multiple stakeholders, particularly the children and families that receive care. Stakeholder involvement needs to be meaningful and occur at all levels of planning, design, oversight, delivery, and evaluation of behavioral health services.

4. Management of Services and Systems

The coordination of care across providers and service systems is critically important to the overall success of the system. The effectiveness and efficiency of the rules and processes regarding how services are accessed, utilization is managed, and adjustments are made to better meet child and family needs can be as important to the success of the system as the quality of the services themselves. In addition, coordination of services and program development across child welfare, juvenile justice, adult and children's behavioral health, developmental, and healthcare service systems is critical to prevent fragmentation and promote more efficient and integrated service delivery.

5. Cultural Competence

The Behavioral Health Service System must insure effectiveness for all of the children and families that it serves. The system must be knowledgeable of, informed by, and responsive to the variety of ethnic and cultural groups in need of care. Education and training, workforce development, and practice modifications are necessary to effectively engage and care for all cultural groups.

6. Public Awareness

A major barrier to the effectiveness of behavioral health services is the lack of general public awareness that emotional and psychiatric problems are medical conditions, that there is no shame in seeking care, and that they can be effectively treated. Discrimination against individuals or families based on the presence of a psychiatric disorder, or discrimination in policies that govern insurance reimbursement can be more harmful than the condition itself. An effective service system educates the public about behavioral health care and addresses policies that are discriminatory against those with a behavioral health disorder.

7. Funding and Revenue Maximization

The behavioral health service system is funded by a patchwork quilt of state, federal, and local programs, private insurance, philanthropic organizations, school districts, individuals, families, and others. When funding sources are aligned to maximize available resources and ease access to care, children and families are well served. When funding is not well aligned the child and family can be presented with a dizzying array of rules and procedures that create barriers to access and discontinuities in care. A well functioning system maximizes all available sources of revenue and blends or braids funding streams to enhance the service array and improve access to care.

Within each of the seven categories outlined above there are various components and sub-categories. For example, within the section on Access to Services and Service Capacity, resource allocation is an important subcategory. Resource allocation concerns the analysis and adjustment of the relative allocation of resources within the array of services including outpatient and community based services versus residential or institutional care, clinical services versus adjunct or supportive services, or other service parameters. Similarly, within the section on Funding and Revenue Maximization, an effort to structure the State's Medicaid Plan to better fund evidence-based practices is itself multi-faceted and complex.

It should also be noted that the seven categories are somewhat arbitrary and in fact, may overlap in several areas. For example, efforts to expand the service array often involve revenue maximization. Similarly, the cultural competence of the service system can be significantly improved by the inclusion of a diverse group of stakeholders that mirror the population being served on critical factors such as age, gender, race, and ethnicity.

The strengths and weaknesses (challenges) within the seven categories are identified in the chart below.

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
<p>1. Access and Service Capacity</p>	<ul style="list-style-type: none"> ▪ Broad range of clinical/non-traditional services ▪ Tremendous growth in community-based services including Care Coordination, Emergency Mobile Psychiatric Services, Intensive In-Home Services, Therapeutic Group Homes, and Family Advocacy Services ▪ Establishment of community-based Enhanced Care Clinics to expand 	<ul style="list-style-type: none"> ▪ Service capacity remains below estimated need ▪ Uneven distribution of services across communities. (Some communities have limited service types or wait lists for selective services) ▪ Fewer services available in rural areas ▪ Limited transportation resources in certain areas

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>timely access to care</p> <ul style="list-style-type: none"> ▪ DCF/DSS collaboration through the CT BHP to significantly expand Medicaid enrollment and services to children and families ▪ Commitment to deliver prevention activities through state agencies, universities, public and private providers, and DCF Prevention Division (Examples: Suicide prevention training for first responders, DCF staff, community providers, school children/college students, parents, foster parents) ▪ Partnerships between state agencies and the broader stakeholder community to address the needs of young children, birth to five for the purpose of early identification and intervention ▪ Partnerships between state agencies and the broader stakeholder community to address the needs of youth with behavioral health and/or developmental issues who are transitioning to the adult system ▪ A network of 25 community collaboratives with specially trained service brokers to assist families in navigating the service system ▪ Managed Service Systems within the 15 DCF Area Offices to coordinate care for the DCF target population ▪ Strong statewide family advocacy organization, FAVOR to link families with services and organize family support groups ▪ Network of Care for Behavior Health website to assist families in locating services and to educate consumers on behavioral health disorders 	<ul style="list-style-type: none"> ▪ Insufficient specialty services such as traumatized treatments for children/youth ▪ Insufficient treatments services for consumers with co-occurring disorders ▪ Insufficient early access options for young children and families for prevention and/or early intervention ▪ Need for ongoing monitoring and continued reduction of overstays and unnecessary utilization of hospital emergency departments, inpatient, and residential resources ▪ Continued challenges to serve youth with behavioral health and/or developmental issues who are "aging out" of the child welfare system ▪ Need to expand school-based mental health care ▪ Continued coordination & integration of child-serving systems needed to address fragmentation ▪ Shortage of child and adolescent psychiatrists who will serve publically funded consumers ▪ Few behavioral health services designed for child welfare population

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
<p>2. Service Effectiveness & Quality</p>	<ul style="list-style-type: none"> ▪ Extensive array of evidence-based treatments that includes 9 intensive in-home models of care ▪ Expansion of prevention and early intervention initiatives ▪ Implementation of trauma-specific screening and treatment including TF-CBT and DBT ▪ Use of learning collaborative methodology to disseminate and sustain evidence-based practices such as TF-CBT and family engagement protocols ▪ Numerous behavioral health workforce activities to increase knowledge, skills and competencies ▪ Practice standards adopted for most service types ▪ Broad cross-system collaboration and partnering ▪ Collaboration with academic institutions and researchers to identify and support practice improvements ▪ Expanded utilization of quality improvement, data and outcome assessment methodologies ▪ Decreased utilization of high end institutional care including inpatient and residential care due to improved case management and enhanced tracking and monitoring initiatives 	<ul style="list-style-type: none"> ▪ "Right" type of service may not be available at the time of need ▪ Few evidence-based practices available at outpatient psychiatric clinics for children ▪ Services designed for adolescents/young adults are insufficient in quantity and quality ▪ Need to promote mental health of young children ▪ Quality of care varies across providers ▪ Weak Continuous Quality Improvement (CQI) process for the system as a whole and for provider agencies ▪ Continued need to enhance cross-system collaboration to serve "multiple needs" consumers ▪ Too few performance indicators and standardized child/family and system outcome measures for evaluation of the effectiveness of the system of care including all services and programs
<p>3. Child & Family Involvement</p>	<ul style="list-style-type: none"> ▪ CT Kid Care and the wrap-around model of care supports a child-focused, family-centered model ▪ Extensive training within local systems of care, DCF area offices, and the broader community on 	<ul style="list-style-type: none"> ▪ Too often families are not fully involved in their own service planning and treatment ▪ Too few youth and families involved in system design, planning, evaluation and system oversight

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>family-centered practice</p> <ul style="list-style-type: none"> ▪ Expanded use of peer support through CT BHP ▪ Inclusion of family partners as team members in the TF-CBT Learning Collaborative ▪ Implementation of an Engaging Families in Services Learning Collaborative for Extended Day Treatment (EDT) providers, with inclusion of family partners on Quality Improvement Teams ▪ Parent training and leadership initiatives provided to prepare and support family and caregiver involvement at all levels of the system ▪ Funding and other support to sustain the statewide family organization - FAVOR, Inc. ▪ Continued support of youth and family advocacy advisory bodies 	<ul style="list-style-type: none"> ▪ Limited resources dedicated to family outreach and engagement training for DCF staff and providers ▪ Few employment opportunities within the system for family members ▪ Limited use of family as faculty in training agency personnel ▪ Need for longitudinal outcome/impact data on family leadership training
<p>4. Management of Services and Systems</p>	<ul style="list-style-type: none"> ▪ Diverse, dedicated workforce at state/local levels ▪ 1/3 of DCF budget allocated to behavioral health ▪ Creation of positions, policies and programs to improve integration across mandates ▪ Creation of CT BHP and carve-out of behavioral health services within Medicaid ▪ Use of the CT BHP to facilitate improved access to behavioral health services for children and families served in the child welfare system and voluntary services programs 	<ul style="list-style-type: none"> ▪ Insufficient resources dedicated to behavioral health training, fidelity monitoring, and quality assurance ▪ Need to further define and implement performance indicators and outcome measures across service types ▪ Further integration of child welfare/behavioral health needed; i.e. cross training; processes for joint decision-making; and addressing overlapping mandates without overlapping jurisdictions ▪ New PSDCRS includes only community-based services, no inpatient service providers and lacks integration with other databases

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<ul style="list-style-type: none"> ▪ Expansion of clinical case conference methodology to better integrate child welfare ▪ Substantial cross-agency collaboration with DMHAS, DDS, Court Support Services/Juvenile Justice, Education, Public Health and other state agencies ▪ Workforce development initiatives including training and technical assistance for DCF staff through the Training Academy and various training programs for community-based providers ▪ Data systems to support state/federal reporting including URS tables for monitoring purposes ▪ Design & development of a new enhanced behavioral health information system - Programs and Services Data Collection and Reporting System (PSDCRS) in progress 	<ul style="list-style-type: none"> ▪ Lack of resources to support providers' enhancements of their information systems ▪ Lack of sufficient, specially trained staff to aggregate, analyze, and interpret data and to conduct research projects ▪ Inability to make data-informed decisions
<p>5. Cultural Competence</p>	<ul style="list-style-type: none"> ▪ Promotion of cultural competence through personnel practices ▪ DCF Division of Multicultural Affairs develops and sustains initiatives and policies to support diversity needs of clients and staff ▪ DCF staff development and training activities support a culturally informed, culturally competent workforce ▪ Support of culturally specific projects such as True Colors, Quinceanara, and Black History ▪ Improvement of data collection processes to support culturally competent care 	<ul style="list-style-type: none"> ▪ Need for culturally and linguistically competent services exceeds available resources ▪ Tremendous growth of non-English speaking families throughout the state ▪ Rapid shifts in racial, ethnic, linguistic and other areas present complex challenges for the system ▪ Lack of a comprehensive, integrated cultural competency plan to assess, measure and promote cultural competence within the agency and with its contracted providers

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<ul style="list-style-type: none"> ▪ Use of Mental Health Block Grant funds to support culturally competent initiatives 	
<p>6. Public Awareness & Policy</p>	<ul style="list-style-type: none"> ▪ Extensive multi-media public awareness campaign (Opening Doors, Opening Minds) developed and implemented to address mental health myths and facts ▪ Delivery of suicide prevention/education training ▪ Promotion of recovery and resiliency ▪ Education in basic behavioral health needs and services ▪ Support of grassroots advocacy 	<ul style="list-style-type: none"> ▪ Need for comprehensive statewide campaign to address stigma and discrimination ▪ Need to further educate the public about children's' behavioral health disorders and the availability of effective treatments ▪ Need to review and address policies that are discriminatory against those with mental illnesses
<p>7. Funding & Revenue Maximization</p>	<ul style="list-style-type: none"> ▪ Increased enrollment in Medicaid Husky A and B ▪ Shifting of selected services such as Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) from Grants to Fee-for-Service ▪ Blending of DCF Grant Funds and Medicaid through the CT BHP ▪ Shared contracting with Partner Agencies ▪ Aligning Medicaid to support best practice ▪ Revision of clinic option by the CT BHP and DSS to allow reimbursement for school-based clinics ▪ Pending DCF/DSS certification regulation to allow the departments to selectively certify evidence-based programs and promising practices for Medicaid reimbursement 	<ul style="list-style-type: none"> ▪ Need to take further actions to align funding sources such as converting grants to fee-for-service, increasing utilization of joint contracting mechanisms, reducing categorical barriers to access, and removing regulatory barriers to evidence-based and promising practices ▪ Need to consider additional Medicaid waivers to take full advantage of federal funds

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

B. UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM INCLUDING IDENTIFICATION OF DATA SOURCES

Between 2000 and 2003 a trio of seminal reports were generated that in sum, called for an overhaul and reorganization of the children's behavioral health system, both in Connecticut and across the nation. These reports include:

- Delivering and Financing BH Services in Connecticut (Child Health & Development Institute, 2000)
- Report of the Governor's Blue Ribbon Commission on Mental Health (Governor's Blue Ribbon Commission on Mental Health, 2000)
- Achieving the Promise: Transforming Mental Health Care in America (Report of the President's New Freedom Commission on Mental Health, 2003)

These reports identified unmet service needs and gaps as well as critical system issues. The findings are relevant today and are summarized below.

Service Capacity

Despite the significant behavioral health resources that are available in CT, it is important that it is understood in the context of the overall magnitude of the problem. **Between 7% and 9% of children and youth in the United States meet the criteria for serious emotional disturbance (SED)** indicating the presence of a psychiatric disorder that seriously interferes with functioning in the home, school, and/or community. Most recent estimates are that **up to 20% of children and youth have some form of psychiatric disturbance and upwards of 70% do not receive treatment** for their disorder. In Connecticut, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional youth with some form of psychiatric disturbance requiring specialty care. It is also well documented that rates of psychiatric disorder in children and adolescents are even higher within disadvantaged groups including children in poverty and those involved with the child protective or juvenile justice systems. Despite having one of the highest state per capita incomes in the country, Connecticut cities continue to have some of the highest child poverty rates in the nation. Similar to every other state in the nation, Connecticut has far more children with behavioral health needs than the combined public and private systems have the capacity to serve. Correcting this monumental gap between what is available and what is needed will require a significant infusion of new resources as well as improved effectiveness and efficient management of existing services.

Service capacity across geographic areas is not equitably distributed in proportion to need. Many communities have limited or no access to certain services such as intensive in-home services, extended day treatment, care coordination, emergency mobile psychiatric services, and outpatient clinic services. Also, many areas of the state lack a full array of services from most to least restrictive that assures continuity of care.

Service Needs And Gaps

There are multiple challenges to address in order to meet the service needs of Connecticut's children and families. A selection of the most salient needs is listed below.

- Insufficient funding and too few community-based services to meet the needs of the population. Historically, Connecticut's system has been heavily skewed towards inpatient and residential services, with "70% of all behavioral health dollars spent for inpatient psychiatric hospitals and residential care."

- Although there has been some improvement, system gridlock continues to exist. In 2007 two reports were released that described service utilization issues for local hospital emergency departments and residential treatment facilities: Use of Emergency Departments For Mental Health Care For Connecticut's Children A Rising Tide: Statewide Utilization 2001 - 2005 by the Child Health and Development Institute of Connecticut, Inc. and Residential Utilization A Report to the CT BHP Oversight Council by the CT Behavioral Health Partnership. A major finding in both studies was the inability to access the appropriate level of service in a timely manner to meet the level of acuity of the children and youth. There were significant discharge delays for those children and adolescents who were residing in inpatient psychiatric hospitals and residential treatment facilities. The lack of availability of community-based treatment options contributed to prolonged and unnecessary lengths of stay as well as unnecessary utilization of these higher level services.

Despite improved consultation to hospital emergency departments and the development of additional resources for diversion, unnecessary utilization of hospital emergency departments by children in behavioral health crisis continues to increase while utilization of alternative community-based options such as Emergency Mobile Psychiatric Services is flat.

- Lack of an integrated system of comprehensive screening and assessment, an infrastructure for reporting and analysis, and processes to promote the use of data in daily practice.
- Limited availability of evidence-based practices across the continuum of care. Connecticut's first forays into evidence-based practice focused on intensive community-based treatments that could divert youth from residential care. Although this focus was strategic and appropriate, it has resulted in less availability of these practices in less intensive outpatient settings and more intensive residential and hospital level care. There is a need to have evidence-based practices readily available at all levels of care in the continuum of services. Only a small percentage of children are receiving these treatments. There is a need for ongoing funding and infrastructure to fully implement and sustain these practices.
- Lack of statewide dissemination of trauma-specific services to insure that all children requiring care can access effective trauma treatments.
- Limited specialty services for children and families that are involved in the child welfare system.
- Limited specialty services for young adults. Young adults often do not respond well to the services and supports designed for the adult population and the existing services to address their needs are insufficient in both quantity and breadth.
- Shortage of child and adolescent psychiatrists to meet the needs of the population. Many psychiatrists are employed in multiple settings due to the demand.
- Other unmet needs include housing and related support services such as case management, vocational assistance, financial planning and budgeting.
- Transportation resources to access services are not available in all communities, especially the rural areas of the state.
- Lack of capacity to support the diverse needs of staff and clients regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social economic status, or language. At present the Department lacks a

comprehensive and integrated plan to assess measure and promote cultural competence within the agency and with its contracted providers.

- Under-utilization of early intervention services. It has been that early intervention strategies and services positively impact human and economic outcomes, yet these continue to be limited in scope. .
- Lack of a medical home model to promote both physical and mental health of parents and their children. In order for parents to support their children, both parents and children must be physically and emotionally healthy.
- Limited use of an evidence-based family engagement model to expand the engagement of families in their children's mental health plan of care. These practices are currently limited to the Extended Day Treatment program.
- Incomplete integration of child welfare and behavioral health services systems. There are overlapping mandates without overlapping jurisdictions; there is a need for cross-training of behavioral health and child welfare staff; and there are a lack of structures to support joint decision-making and the establishment of priorities for program development.
- Too few youth and families actively involved in their own plans of care. Family involvement is one of the core values of the CT Kid Care system. Research has shown that family involvement makes a difference in many ways including improved outcomes (i.e. reduces emotional and behavioral symptoms; promotes competence; prevents placement in more restrictive settings); maximizes treatment effectiveness, and facilitates generalization of skill acquisition and treatment gains to home, school and community settings. Yet across the spectrum of services few families are involved in the initial assessment process, treatment services, and discharge planning. Too many children and youth are treated in isolation of their family system, and thus it is difficult to sustain treatment gains once services terminate. This was one of the major findings of the Mental Health Needs Assessment and Resource Inventory Summary Report (June 2007) funded by the Mental Health Transformation State Incentive Grant.
- Too few opportunities for involvement of individuals with lived experience with mental illness or being the family member of an individual with mental illness
- Too few youth and families with leadership roles and active involvement in system planning and oversight of the behavioral health services system.
- Too few employment opportunities for consumers and family members in state and private non-profit agencies.
- Too few program improvement and resource allocation decisions are informed by quality improvement data and processes. Although many programs now include a quality improvement component, many do not and the level of quality improvement is not uniform across programs.
- Insufficient funding to raise public awareness and educate the general public. Many children and families lack knowledge of behavioral health disorders and/or avoid help due to discrimination and stigma. Many in the general public and in the child-serving system lack sufficient understanding of mental health disorders to be of assistance.

- Failure to fully align funding sources to improve access to care and support best practices. Further steps are necessary to maximize the available revenue. These include conversion of grants to fee-for-service, reducing categorical barriers to access, increasing utilization of joint contracting mechanisms, and further removal of regulatory barriers to evidence-based and best practices.

Coordination Across Services and Systems

Although DCF is a consolidated children's services agency within a single department, there are many other agencies and systems that provide, fund and/or coordinate behavioral health services for children, adolescents and their families. These entities include: Department of Mental Health and Addiction Services; Department of Social Services; Department of Public Health; Judicial Branch Court Support Services Division; Department of Corrections (16 & 17 year olds); Department of Developmental Services; Department of Education; local school districts, primary care providers, early intervention specialists, and other public and private service systems. This reality, and the continuing challenge to better integrate DCF's multiple mandates has, at times, resulted in a perception of the behavioral health system for children and families as under-performing due to system fragmentation and competition for resources between agencies and mandates. The distribution of funding by agency and program is difficult to understand and to navigate, especially for consumers and their families. Often there is a lack of coordination of care within and across service systems.

Child and adult system transitions continue to be challenging. There are escalating numbers of DCF-involved youth that require early identification and transition planning for entry into various adult service systems. Although legal and service systems divide youth from adults at the age of their 18th birthday, the reality is that youth between 17 and 23 are arguably neither children nor adults and have unique needs requiring a high level of coordination between the child and adult systems. Often youth may straddle two or more systems and coordination of care is paramount for successful outcomes.

Workforce Issues

Connecticut continues to experience a shortage of trained professionals, paraprofessionals, and adequately trained and supported consumers and families and provides few meaningful formal opportunities for consumers and family members to participate in the children's behavioral health workforce. In addition, once individuals enter the workforce there is often a lack of quality supervision and continuing educational opportunities to retain existing competencies and acquire new ones.

Like every other state in the nation, Connecticut is experiencing a shortage of psychiatrists, in particular a shortage of board eligible/certified child and adolescent psychiatrists. During the last four years, as programs requiring masters level clinicians have expanded, the shortage of clinician's has contributed to higher vacancy rates and staff turnover. Trends in higher education indicate that more students are seeking degrees in higher paying professions such as business, finance, and technology. Also, while the trend is towards implementing evidence-based practices, higher education has not kept pace and few trained professionals enter the workforce with the knowledge, skills, and competencies to deliver these effective treatments. Much of the curriculum in social work, psychology, and family therapy programs is disconnected from contemporary behavioral health practice.

In light of the shortages of physicians and clinicians outlined above, an expanded role for paraprofessionals has been recommended. However, the way in which the current workforce is

organized includes relatively few opportunities for paraprofessional staff. Even with assertive recruitment efforts, the demand is likely to continue to outstrip supply.

Supervision of professional and paraprofessional staff has suffered in response to flat funding and budgetary limitations. In many cases, supervision is either not provided, is infrequent, is limited to "administrative" supervision, or a low priority. Even when supervision is provided, supervisors may not have been adequately trained or provided with resources to support the supervisory role.

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

C. PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS AND CRITICAL GAPS

The Department plans to address the unmet needs and critical gaps, identified in Section II B, to the best of its ability within the budgetary limits. Connecticut, like other states in the nation, faces tremendous challenges in addressing the statewide budget deficit. This impacts the Department's budget in many ways. For example, it will not be possible to continue to expand the array of community-based services, but instead, the focus will be on maintaining the existing continuum of services. Other priorities include: continuing to improve the quality of care; promoting youth and family involvement in all aspects of individual care and system reform; enhancing coordination of care across systems and programs; and supporting the workforce through education and training.

1. Service Capacity

The Department will continue its efforts to maintain and strengthen the network of statewide community-based services. This includes but is not limited to the following areas:

- Support for the local Systems of Care/Community Collaboratives including Care Coordination Services to provide wrap-around services;
- Support for the Managed Service System to find community-based solutions for DCF-involved youth with complex behavioral health needs;
- Partner with the CT BHP to assure access to, and coordination of, a more effective system of community-based care;
- Improve utilization and management of Emergency Mobile Psychiatric Services (EMPS) through: re-procurement and enhancement of EMPS to include a statewide call center; expanded hours of mobility; enhanced outreach and marketing; implementation of an external quality assurance and training component; and provision of incentives for EMPS/Emergency Department (EDs) collaboration to reduce the number of youth seeking behavioral health services at EDs;
- Continued support for intensive in-home services including MST, MDFT, FFT, IICAPS, FST and hybrid variants of these programs;
- Support for two crisis stabilization programs, the Short-Term Assessment and Respite (STAR) Homes and Therapeutic Group Homes;
- Continued support for the Child and Adolescent Rapid Emergency Services (CARES) program that provides six short-term crisis stabilization beds to reduce emergency department overstays;
- Continued roll-out of performance measures and ongoing monitoring and related performance improvement plans for Enhanced Care Clinics;
- Sustainability planning for Extended Day Treatment Model of Care initiatives including family engagement protocols, multi-family groups, Ohio Scales implementation/assessment, application of Risking Connection trauma framework within the milieu setting, and continuation of Project Joy including training of the remaining providers;
- Support for the statewide and other family advocacy organizations;
- Continued collaboration between DCF/DMHAS and DCF/DDS to address the needs of children/youth with mental health and/or developmental disabilities, including those youth who are transitioning to the adult systems; and
- Continued commitment to deliver early intervention and prevention activities such as suicide prevention training and consultations for child care providers working with young children.

2. Service Needs and Gaps

- Explore opportunities to re-allocate resources allotted to residential care to community-based treatment alternatives;
- Continue to align authorization procedures and processes with the goals of increasing outpatient and community-based utilization and reducing residential and inpatient utilization;
- Continue to utilize and strengthen additional CT BHP strategies to reduce inpatient overstays through a combination of provider profiling, incentives/penalties, consultative services, development of alternative services, and other management processes such as data and case review of "stuck children;"
- Continue to explore the feasibility of blending DCF/CT BHP funds to convert the Extended Day Treatment Program from a grant-funded to a fee-for-service program;
- Move forward with re-procurement for selected programs and services, in spite of a moratorium on an Office of Policy and Management directive to re-procure service contracts, with the intent of evaluating each service against available alternatives in an effort to improve the overall effectiveness of the service system (Those services that are less effective, efficient, or valuable may no longer be supported);
- Include a feasible sustainability plan in each funding application and require periodic reviews of sustainability throughout the funding period;
- Work towards designing an integrated system of comprehensive screening and assessment that includes an infrastructure for the dissemination of data to key users and integration of data reports into daily practice;
- Continue to fund evidence-based treatments including the intensive in-home services such as MST, MDFT, and IICAPS to assure the delivery of the most effective services;
- Continue to support the dissemination of evidence-based practices such as the Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative that trains clinical teams from outpatient psychiatric clinics for children to address the treatment needs of traumatized children, adolescents and their families;
- Support the implementation of research-based family engagement protocols within the Extended Day Treatment Program and find ways to expand to other services;
- Cultivate a "data and information culture" through education and training of DCF staff and key stakeholders, establish data-driven processes at all levels of practice, and review and identify improvements of existing data reports; and
- Continue to explore strategies such as requirements within contract documents to support the delivery of culturally competent services.

3. Coordination Across Systems and Services

- Continued exploration of strategies to further integrate Child Welfare (CW) and Behavioral Health (BH) Services within DCF that includes co-leadership strategies at the Area Office level, support for the cross-training of CW and BH staff, and development of methods, such as formal local service system reviews that require joint decision-making and establishment of priorities for program development;
- Continued efforts to generate ways to transition individuals with serious mental health needs from one system to another and for ongoing collaboration among agencies, including Department of Education, juvenile court, Department of Corrections, Department of Mental Health and Addiction Services, Department of Developmental Services, and Department of Social Services;
- Advance the integration of behavioral health and primary care by finding ways to support pediatricians and APRNs in managing psychiatric medications, thus decreasing the demand for psychiatrists;

4. Workforce Issues

- Continue to expand the delivery of training in behavioral health to DCF workers within child welfare and juvenile justice;
- Continue to expand DCF's internal behavioral health expertise through targeted hiring and expansion of consultative capacity;
- Continue to seek approval from the Office of Policy and Management for a sole source contract with an expert consulting entity;
- Continue to support training in system of care principles to multiple child serving agencies as in the MHT-SIG Wrap-Around Project and support implementation through consultation, data tracking, coaching, and fidelity measures;
- Utilize the newly established Connecticut Workforce Collaborative to develop multiple strategies to address the lack of bilingual resources in the Behavioral Health Workforce;
- Promote methods for increasing consumer/family member opportunities for employment within the behavioral health system, especially those with lived experiences;
- Within available resources, expand training opportunities, access to stipends and employment opportunities for children, youth and families to serve on various boards and committees as a further step towards consumer-driven care;
- Address the disconnect between the existing curricula and the knowledge and competencies required in the current behavioral health workforce through building collaborations with higher education (as is occurring under the CT Workforce Collaborative of the MHT-SIG) and developing curricular materials, training/supporting instructors within higher education (i.e. the intensive in-home curriculum project also under the MHT-SIG) and coordinating with national efforts at curriculum reform (National Association of Social Workers (NASW), American Association of Marriage and Family Therapists (AAMFT), American Psychological Association (APS), American Psychiatric Association (APA), etc.; and
- Identify clinical supervision models and support their implementation in the workplace through a variety of methods including pilot projects (such as occurring under the MHT-SIG), implementation of evidence-based practices with embedded supervisory and consultative components, funding and reimbursement support of supervisory practice, and training and support programs.

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

D. RECENT SIGNIFICANT ACHIEVEMENTS THAT REFLECT PROGRESS TOWARDS THE DEVELOPMENT OF A COMPREHENSIVE COMMUNITY-BASED SYSTEM OF CARE

DCF and its' community partners have demonstrated significant progress in all areas outlined below.

1. Service Capacity and Access

Increasing Capacity - Achievements: Between 2000 and 2008 the capacity of the community service system has expanded significantly to better serve the children and youth of Connecticut. Through a combination of DCF & Court Support Services Division (CSSD) grant funding, the availability of evidence-based and intensive outpatient services in Connecticut has exploded resulting in one of the most comprehensive service arrays in the nation. In addition, the CT BHP has developed the Enhanced Care Clinic Program to increase the service capacity and access to care for outpatient clinics across the state. DCF's development of over 50 Level II Therapeutic Group homes created the opportunity for hundreds of children with complex needs to receive intensive services and attend school in the community. Specific examples of service expansion are described below.

Care Coordination: A community-based service where paraprofessional staff members provide care management services and access to flexible funding to families of children with serious emotional disturbance.

Target Population: Children with serious emotional disturbance at risk for or returning from out of home care and engaged in 2 or more services requiring coordination of care.

Capacity: In 2002-2003 the department expanded care coordination capacity from 16 to 60 care coordinators to serve children and families with serious emotional disturbance. The current care coordination program has the capacity to serve approximately 1400 families per year.

Outcomes: In 2004, an evaluation completed by the Child Health and Development Institute (CHDI) found that the children and youth being served in the care coordination program met target population criteria, the program "had considerable success in securing services" to meet family needs, parents and youth highly valued the program, and the program adequately reflected system of care principles as indicated by the Wraparound Fidelity Index.

Multi-Systemic Therapy (MST): MST is one of the most well researched and effective evidence-based programs in the world. MST provides intensive services in the home and community to youth and their families.

Target Population: Youth 12-17 with serious behavioral disorders and their families.

Capacity: In 1998 the first MST team in CT was funded as an aftercare program for Juvenile Justice youth discharged from residential care. Since 1998 the program has been growing steadily through the addition of MST teams by both DCF and CSSD, and the development of in-state capacity to provide quality assurance, fidelity management, consultation and support to providers. DCF added additional teams in 2000 and 2002. In 2003 & 2004, the department introduced two MST programs for specialty populations: MST-Building Stronger Families designed for children and families involved with the child welfare system, and MST-Problem Sexual Behavior which provides follow-up care to youth discharged from residential care and on parole for problem sexual behaviors. In 2006, DCF funded 2 additional MST teams to serve Bridgeport and the Manchester/Hartford areas. Between 1999 and 2008, DCF funding of MST has grown from 400,000 to 4,556,403.00. Currently there are 27 MST teams funded by both DCF and CSSD, serving over 1000 families annually. Of these 1000 families, the ten DCF-funded teams serve 380 families annually.

Outcomes: An evaluation of MST implementation in Connecticut conducted by the Connecticut Center for Effective Practice (CCEP) in 2007-2008 found that the Connecticut teams were having rates of success comparable to those reported in the literature for implementation of MST with fidelity. According to the study "the majority of children and youth who completed MST were living at home, attending school, and had not been arrested since the beginning of the program." In addition, the study tracked the post treatment recidivism of MST recipients and found that they were 15%-20% less likely to recidivate compared to comparable youth receiving comparable care. Although this may seem like a relatively small improvement the report notes that previous analyses suggest that "even a small reduction in recidivism (anywhere from 7%-10%) would be sufficient to pay for all of the juvenile justice services currently being offered by the state."

Multi-Dimensional Family Therapy (MDFT): This is an intensive family and evidence-based treatment for children and youth based on the principles of strategic and structural family therapy.

Target Population: Children aged 11-17.5 present with a DSM-IV Axis 1 diagnosis, exhibit complex behavioral health service needs and are either returning from or approved for residential placement, or are at imminent risk for out-of-home treatment. These youth often have a substance abuse problem.

Capacity: In April 2002 CT got its 1st MDFT team when it launched the Hartford Youth Project as a part of the federal initiative called the "System of Care for Youth." MDFT was one of the services provided to the substance abusing youth served by this project. In 2003, four additional MDFT teams were funded to serve substance abusing youth & their families in 4 DCF area offices. In 2004, DCF established in-state capacity to provide MDFT consultation & training for regular MDFT teams to occur by a provider in CT. In 2005 & 2006, the equivalent of four additional teams was added to the service system, both jointly funded by DCF & CSSD. These programs provide MDFT to families of girls discharging from the CSSD brief respite programs in Waterbury & New Haven. In 2006, 5 providers were funded to provide MDFT - Family Substance Abuse Treatment Services (FSATS). Funding for MDFT has grown from \$440,000 in 2004 to \$2,177,621 in 2008. The 14 teams serve 330 families annually.

Outcomes: Recent program improvements include the integration of the Global Assessment of Individual Needs (GAIN) nationally recognized standardized assessment process into MDFT practice, and training in and delivery of a group curriculum for adolescents focusing on preventing sexually transmitted disease and HIV. Similar to the implementation of MST, Connecticut has been successful in implementing MDFT with fidelity to the evidence-based model and is achieving comparable outcomes to those documented through randomized controlled trials and that are superior to residential care and/or "treatment as usual."

Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS): This service is designed to address the behavioral health needs of children/adolescents and their families.

Target Population: Children experiencing emotional, behavioral, and/or psychiatric difficulties at risk of requiring out-of-home clinical care (psychiatric hospitalization or residential treatment), or returning home from out-of-home care, and their families.

Capacity: Developed at Yale Child Study Center, DCF funded an expansion of IICAPS throughout Connecticut beginning in 2002. Initially funded by state grants, IICAPS transitioned to fee-for-service under the Connecticut Behavioral Health Partnership in 2006. This change in reimbursement methodology, coupled with a rate increase by the Department of Social Services enabled providers to slowly grow their programs based on local needs. Family and Children's Aid of Danbury is an example of outstanding provider-led growth, increasing from one team four years ago to more 27 teams today. Additionally, during SFY08, DCF collaborated with CSSD and DSS to expand statewide access to IICAPS for youth involved with juvenile probation. Currently there are 14 provider agencies delivering IICAPS services, with some agencies operating more than one IICAPS site. The number of cases served during each of the last three fiscal years is presented below.

SFY06	SFY07	SFY08
598	702	1035

Outcomes: The most recent QA report on IICAPS for the 07-08 fiscal year "indicate that there were 45.2% fewer psychiatric inpatient admissions, 22.6% fewer ED visits, and 44.0% fewer residential treatment admissions during the IICAPS intervention than for the 6 months prior to IICAPS."

Functional Family Therapy (FFT): This is an evidenced-based model of clinical service developed by researchers and clinicians at the University of Utah and the University of Indiana approximately 30 years ago.

Target Population: FFT is considered a model program for the treatment of youth at risk for juvenile justice system involvement or involved with the juvenile justice system. DCF has funded FFT to address the needs of children/adolescents, and their families, experiencing emotional, behavioral, and/or psychiatric difficulties at risk of requiring out-of-home clinical care or returning home from out-of-home care.

Capacity: FFT was first introduced to Connecticut in 2002. In 2006 DCF expanded FFT services statewide. During SFY07 the DCF Bureau of Behavioral Health and Medicine partnered with the DCF Division of Juvenile Services to make FFT more available to children and youth involved with DCF Juvenile Services. Additional funding was provided to each FFT program to develop service capacity reserved specifically for youth on parole. An additional FFT program was added to serve youth from the Bridgeport, Norwalk, and Stamford areas. Between 2002 and 2008, funding for FFT increased from \$210,000 to \$1,875,785. All FFT programs are funded by state grants, and these services are also eligible for reimbursement under the CT BHP. Currently there are five provider agencies delivering FFT services. The number of cases served during each of the last three fiscal years is presented below.

SFY06	SFY07	SFY08
108	280	427

Outcomes: FFT has a rigorous model of training and ongoing quality assurance. QA data indicate that FFT is being delivered with fidelity in Connecticut and is achieving comparable rates of treatment completion and positive outcomes as documented in controlled outcome studies.

Family-Based Recovery (FBR): This is a new model of service for children and families introduced in 2007. FBR combines a well supported promising practice for infants and toddlers who have been exposed to substance abuse (The Yale Coordinated Intervention for Women and Infants) with an evidence-based treatment for adult substance abuse (Reinforcement Based Therapy). The program promotes language development, appropriate medical care, and parent-child attachment through the provision of intensive in-home services to the mother and child. This focus on early childhood development is augmented by a simultaneous focus on supporting parent's recovery from substance abuse.

Target Population: FBR serves children birth to 24 months and their families targeting cases where parental substance abuse has or may place the child at risk for removal from the home.

Capacity: The program originally consisted of four teams but has expanded to six teams statewide with a capacity to serve 120 families annually. Current funding is at \$2,075,595.

Outcomes: During this period of initial implementation the program has been refined to provide clearer directions and standards regarding: staffing, supervision, consultation practices, social club features, length of stay, recovery management approach, staff training, and relationship with DCF area offices. Quality assurance and credentialing of providers is performed by a contracted quality assurance and

training vendor. An outcome assessment is in progress with researchers from the University of Connecticut School of Medicine.

Family Support Teams (FST): FST were developed by DCF in 2004 to address the needs of children/adolescents, and their families, experiencing emotional, behavioral, and/or psychiatric difficulties at risk of requiring out-of-home clinical care or returning home from out-of-home care. An initial focus of Family Support Teams was also to provide clinical support for children entering into Treatment Foster Care.

Target Population: Children and youth involved with DCF protective services who are at risk for out of home care or who are returning from out of home care and require intensive services to effectively transition to the community.

Capacity: FST programs are funded by state grants of \$7,548,560, and these services are also currently eligible for reimbursement under the CT BHP. A year of treatment in FST costs approximately \$16,500 compared to over \$80,000 for a comparable treatment episode in residential care. Currently there are nine provider agencies delivering FST services. The number of cases served during each of the last three fiscal years is presented below.

SFY06	SFY07	SFY08
336	422	464

Outcomes: An analysis of the FST program is ongoing. The program is scheduled to be re-bid during SFY10 or SFY11. This may present an opportunity to implement modifications to the current practice. Such modifications may include: implementing a more standardized model of care statewide; identifying specific target populations best served by this resource (e.g., youth returning to the community from congregate care settings); and implementing standardized training and quality assurance activities on a statewide basis.

Level II Therapeutic Group Homes (Level II TGH): In 2004, DCF began planning for the development of a new level of care to be added to the existing array of services: Level II Therapeutic Group Homes (Level II TGH). Therapeutic group homes are small (4-6 bed) congregate care facilities with integrated clinical services designed to serve children and youth with moderate to severe behavioral health disorders. Established in homes in the community, these programs represent the least restrictive treatment option for many youth who do not require residential care but who are not yet appropriate for reunification with their family or placement in a foster care setting.

Target Population: Children and youth with intensive and complex service needs who require highly supervised clinically intensive care in the community but do not require residential care.

Capacity: Between 2004 and 2008 a total of 54 level II group homes have been established with a capacity to serve approximately 260 youth.

Outcomes: This community-based alternative to residential treatment allows youth to attend school in the community and to maximize community living while receiving intensive clinical services and supports. Level II TGHs have filled a gap in the continuum of care and represent over \$ 48,000,000 of new behavioral health funding since 2004. The department has funded a contract with the Public Consulting Group to evaluate the program model and to establish a quality assurance program and system for tracking outcomes going forward.

Short Term Assessment and Respite (STAR) Homes: For many years, DCF operated shelters to provide temporary placements for youth involved in the child welfare system. These programs provided basic housing and staff supervision for youth but did not provide behavioral health evaluation, treatment, or support. In recognition of the significant behavioral health needs of youth in shelter placements and concerns about their care in these settings, between 2006-2008 the department closed all existing shelters and replaced them with STAR homes. The STAR program model was built on existing knowledge

regarding effective care and many program improvements were incorporated into the new design. One of the most significant program improvements is the requirement for a trauma informed clinical model and staffing/program requirements to provide on-sight clinical assessment and treatment.

Target Population: Children in DCF care requiring short-term emergency placement.

Capacity: This program re-design has increased the capacity in each community for many youth to receive a comprehensive assessment and short-term intervention and support during temporary placement. Fourteen licensed/license eligible clinical directors and fourteen master's level clinicians were hired statewide to expand the clinical capacity of these programs.

Outcomes: A new data system has been designed. Recent data suggest that average length of stay is beginning to decline and that a comprehensive evaluation is being completed for all youth that remain in care a month or longer.

Emergency Mobile Psychiatric Services (EMPS) Redesign: The EMPS provides mobile in-home psychiatric crisis intervention, short-term follow-up stabilization services, and linkage to continuing care.

Target Population: Children in psychiatric crisis in the community and their families.

Capacity: Established in 2002, EMPS is currently being re-designed and re-procured to improve performance and expand service capacity. The program serves all 169 towns in the state. Hours of mobility had previously been limited to 10:00 AM to 7:00 PM Monday through Friday, and 1:00 PM to 7:00 PM weekends and holidays. Under the new program model that is being procured, the hours of mobility have been expanded by over 50%.

Outcomes: An infusion of nearly \$2,000,000 of state funds will also allow for establishment of a state-wide call center, external quality assurance and training, enhanced outreach and marketing, and improved rates of mobility.

Child and Adolescent Rapid Emergency Service (CARES): Under the leadership of DCF, DSS, Office of Health Care Advocacy and in partnership with Hartford Hospital, The Institute of Living, and Connecticut Children's Medical Center (CCMC), the CARES unit opened in October of 2007 as a short-term (3-day) stabilization inpatient service supporting the CCMC Emergency Department.

Target Population: The unit is designed to serve those children for whom additional evaluation is required in order to determine a disposition or who are expected to be able to avoid a lengthy hospitalization and return to the community following a brief stabilization and intervention period within CARES.

Capacity: The CARES Unit opened in October of 2007 with six short-term crisis stabilization beds designed to reduce emergency department overstays and decrease the rate of hospitalizations from the emergency department.

Outcomes: Since its inception, the CARES unit and other targeted interventions have significantly reduced the number of children and youth who are stuck in the CCMC Emergency Department.

Service Array-Achievements: In addition to expanding overall service capacity, there has been significant progress in expanding the array of available services. In particular the state has seen the development of various approaches to the delivery of in-home services, the development of therapeutic group homes, implementation of evidence-based trauma-specific treatments and the development of resources to reduce ED overstays.

In-Home Services: Through the addition of MST, MDFT, FFT, IICAPS, & FST and hybrid variants of these programs, Connecticut has built one of the most impressive arrays of evidence-based practices in the country. These programs provide a level of treatment intensity previously unavailable in a home and community setting. In addition they represent a degree of family-focused intervention that matches the emerging knowledge about the effectiveness of family based treatments for children and families. No

program works for every family and the variety and choice afforded by this expanded service array is a positive feature of the Connecticut system.

Level II Therapeutic Group Homes: Similar to Intensive In-home services, Level II Therapeutic Group Homes offer a type of service and level of care previously unavailable to children and youth. Almost three hundred children each year are afforded an alternative to residential care where they can receive intensive services and supervision while living in the community. Prior to the implementation of these programs, these children would have had no other choice but institutional care.

Trauma-Specific Services: Two training initiatives established in 2007 have brought two of the most well researched and effective trauma-specific treatments to Connecticut: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Dialectical Behavioral Therapy (DBT). TF-CBT is being implemented in outpatient clinics across the state and DBT is being widely implemented in state run and privately operated residential treatment programs. For the first time, the many children who experience psychiatric distress due to exposure to trauma will have access to treatments specifically designed for this population. In addition, DCF has recently implemented a nationally recognized core curriculum on trauma for the child welfare workforce.

Girls Services: In February 2008 DCF was charged with developing a plan to ensure implementation of gender-responsive and trauma-informed practices in all DCF state run and contracted facilities by January, 2010. In February 2008 a Trauma Summit was held to assist in the development of a strategic plan for implementing gender responsive and trauma-informed services throughout DCF. This plan has been established and many aspects of it are presently being implemented.

The Bureau of Behavioral Health and Medicine has overseen the training of trauma-specific services such as DBT, TF-CBT, TARGET, VOICES and Girl's Circle within our DCF facilities as well as in programs operated by private agencies. Each DCF facility has also been trained by national experts and is also participating in trauma-informed and gender sensitivity training through NASMHPD. Each DCF facility utilized these trainings to develop their individualized gender-responsive and trauma-informed approach to service and will undergo a review to determine their degree of success.

The Bureau of Behavioral Health and Medicine and DCF Training Academy will begin training all levels of DCF CPS staff in a gender-responsive and trauma-informed approach to child welfare work in March 2009.

The Bureau of Behavioral Health and Medicine has a team of consultants that provide a trauma-informed and gender-responsive approach for case conferences and consultations. These services are available to all area offices requesting a case conference.

The DCF gender-responsive and trauma-informed committee recognized the need to develop a gender sensitive universal screening tool that identifies trauma histories and its impact on a child's functioning. This group will identify experts to support us in that project. This group is also working with the consultant hired to design the new practice model for DCF to insure that it is gender-responsive and trauma-informed.

The Bureau of Juvenile Justice has enhanced girl's services with the rollout of the Program Guidelines for Girls Services in CT in parole effective Oct 2008. A gender-responsive practice model for girls in the new Parole Girls Unit is being implemented. DBT is being trained throughout Juvenile Services. Assessment tools are being developed to assess trauma and risk for all juveniles.

Flexible Funding: Over the last several years there has been significant growth in the availability of flexible funding to meet child and family needs that can not be accessed through Medicaid or other funding sources. Typically, these programs help to meet one-time emergency family needs, service needs where reimbursement is unavailable, or payment for non-traditional supports that promote social development in the community. For children and youth participating in DCF-funded care coordination programs in the community, flexible funds grew from approximately \$200,000 in 2005 to over \$1,500,000 in 2008. Over the last five years there has also been multi-million dollar growth in DCF flexible funding for families involved in the child protective service system. In the interest of maximizing efficiency, in 2007 both DCF Juvenile Services and CSSD added millions of dollars of funds to DCF's flexible funding contract to meet the care needs of their respective populations.

CARES: The CARES program described above, is a new treatment service (2007) that provides a short-term stabilization program at an inpatient level of care. The program expands the service array by providing an option for those children who may benefit from a brief period of intensive evaluation and intervention as an alternative to a longer term hospitalization.

Re-allocation of Resources and Access to Care - Progress: The defunding of Substance Abusing Families at Risk (SAFAR) program and community shelters along with the reduction of residential utilization and expansion of community-based services represent the most prominent recent re-allocation efforts within behavioral health.

Substance Abusing Families at Risk (SAFAR) to Family Based Recovery Program (FBR): In 2006 DCF defunded 9 of the 11 SAFR programs in order to develop FBR programs described above. The SAFAR programs lacked a defined model of care and had been funded for years with little or no evidence of their effectiveness. The funds were reinvested in the development of an innovative treatment program that combined two evidence-based programs to serve an extremely high risk population: young children living at home in the care of a substance abusing parent.

Shelter to Short Term Assessment and Respite (STAR) Homes: In 2006 DCF defunded the existing emergency shelter system and replaced them with fewer beds, in smaller home-like settings, that incorporated best practice approaches to screening, assessment, and trauma-informed care.

Re-allocation of Residential Resources and Increased Access to Community-Based Care: The utilization of residential care by DCF has declined significantly since 2004. DCF has met and sustained the exit outcome for residential reduction for the past several years posting the lowest level of utilization in the last quarter of FY2007-2008. Between 2001 and 2007 DCF also recorded a significant reduction in the utilization of out-of-state residential care moving from 479 children in out-of-state placements in 2001 to 292 in 2007. The trend for utilization of out-of-state placements was up in 2008 due to high numbers of referrals of youth with specialty needs that could not be met in state.

There are several reasons for the decline in residential placements including more assertive management of residential programs by Value Options of the CT BHP and DCF area Offices, and the increased utilization of community-based and intensive in-home services. Recent data collected by the CT BHP demonstrated an increase in utilization of outpatient services, home-based services and group home services between 2006 and 2008. These trends parallel the expansion of IICAPS and other in-home services. The number of children utilizing outpatient services increased by 11% and those utilizing intensive in-home services expanded by 46%.

Group home expenditures increased by approximately 174% between 2006 and 2008.

Medicaid Enrollment: Another means of expanding access to services is to expand enrollment of Medicaid allowing more qualified children and families to utilize the benefit. The CT BHP has been successful at increasing Medicaid enrollment. Between September 2007 and August 2008, although Husky B enrollment declined by 3027 members, Husky A enrollment grew by 20,846 for a net expansion of 17,459 members.

Enhanced Care Clinics (ECC): The ECC program developed under the CT BHP provides financial rate incentives to outpatient behavioral health clinics that meet a series of performance standards including improved access to care. Currently thirty-nine clinics have attained Enhanced Care Clinic status throughout the state. Access requirements under the ECC include emergency visits within two hours, urgent visits within two days, and routine visits within two weeks. Provider performance related to access requirements is in the process of being evaluated by a combination of data analysis and secret shopper methodologies. Where implemented these programs reduce waiting time for treatment and help divert children from unnecessary visits to Emergency Departments.

Authorization Requirements and Processes: Through the implementation of the CT BHP, Connecticut has aligned authorization procedures and processes with the goals of increasing outpatient and community based utilization and reducing residential and inpatient utilization. Initial authorizations for outpatient care have been significantly relaxed allowing for up to 20 visits prior to re-authorization. On the opposite end of the spectrum authorization and review processes for inpatient and residential care have been more rigorously designed and applied to achieve better management of these services. As a result, overstays in inpatient care have been significantly reduced. Newly achieved capacity to measure and more aggressively manage residential lengths of stay is expected to further decrease residential utilization by reducing length of stay.

2. Service Effectiveness and Quality

Enhancing Service Effectiveness and Quality - Achievements: The behavioral health system requires services that work and that are efficiently managed. A variety of resources and coordinated strategies are required to produce consistently good care across the service array. Good care is characterized by: effective screening and assessment, intervention at the earliest possible point, maximum use of evidence-based interventions and best practices, development and support of the behavioral health workforce, continued research to support practice, increased use of technology to support care, and continuous quality improvement to support results-based accountability

Screening and Assessment: The implementation of trauma screening, alone, and in conjunction with the dissemination of trauma-specific services, along with the implementation of the Global Assessment of Individual Needs (GAIN) within DCF area offices and substance abuse services, are significant achievements in DCF's effort to improve screening and assessment.

Trauma Screening: Each of the ten outpatient clinics currently engaged in the TF-CBT Learning Collaborative (6 more clinics will be added each year) has implemented a trauma screening process to correctly identify candidates for trauma treatment. Trauma screening has also been effectively implemented in DCF facilities including Riverview, High Meadows, The Connecticut Children's Place and The Connecticut Juvenile Training School. Trauma screening is also a required component of the standard psychosocial evaluation conducted at all STAR homes. Work is also underway to select a

standardized trauma screen which will be potentially used as a component of the multi-disciplinary evaluation required of all children in first time placements.

Global Appraisal of Individual Needs (GAIN): The Global Appraisal of Individual Needs is a vigorously validated, standardized screening and assessment instrument used in substance abuse treatment settings and in populations where there is a high rate of substance abuse (such as child welfare cases). The GAIN has been implemented as a screen for substance abuse and other service needs completed by DCF workers in the course of their assessment process. Standardized training, data systems, and consultative support have been provided to support implementation. The GAIN is also utilized as the primary assessment and screening instrument utilized by DCF-funded substance abuse residential and outpatient providers.

Treatment Outcome Package (TOP): The Treatment Outcome Package (TOP) is currently under consideration as a standardized assessment and outcome tracking tool for use with DCF-funded residential providers and State Operated Facilities (Connecticut Children's Place, High Meadows, & Riverview). In addition to measuring outcome effectiveness, the TOPS is also useful in care planning and service delivery.

The Ohio Youth Problems, Functioning and Satisfaction Scales (OHIO SCALES): The Department has supported the partial implementation of the OHIO Scales with its community-based providers over the last several years. In conjunction with the development of a new Programs and Services Data Collection and Reporting System (PSDCRS), DCF is fully implementing the OHIO Scales across all community-based behavioral health service programs beginning in July of 2009.

Prevention and Early Intervention: A well functioning behavioral health system provides sufficient resources for prevention, early screening, detection and intervention to promote healthy functioning.

DCF Head Start Statewide Collaboration: The Collaboration promotes the strengthening of child and family relationships by developing a protocol for enhancing communication between each agency. As a result of the protocol, DCF and Head Start staff know more about one another's programs and services, thus they can use each others resources more effectively, and each agency can make and receive appropriate referrals to/from their partner agency. Head Start and DCF staff work collaboratively to identify mutual families served and participate in all aspects of service provision to children and families including: DCF referral, investigation, and treatment planning; and referral, enrollment and case management in Head Start. Through partnering, both agencies build capacity in communities in the area of cross training and resource development.

The Early Childhood Consultation Project (ECCP): This DCF-funded initiative has just entered the first quarter of its sixth year. ECCP stands out as one of the first statewide Early Childhood Mental Health Consultation Programs in the country. Early childhood mental health consultations are provided to early care and education centers and for children at risk of disruption from these centers. ECCP is a nationally-recognized model of best practice. It is the only such program today to have had a large scale research evaluation conducted using a random assignment experimental design. The results show a reduction of preschooler's suspension/expulsion rate of 98% at one month and 96% at six months.

Early Childhood Behavioral Consultation (ECBC) - This is a pilot project co-funded with State Department of Education to provide long term (year long) intensive consultation and support to change

center-wide policies in large urban centers. The goal is to support mental health and wellness of children in large urban preschools. Behavioral Health Teams are assembled and trained by ECBC to:

- promote children's mental health and safety;
- educate teachers regarding social-emotional development of children; and
- assist teachers to develop strategies including positive behavioral supports.

The target population is families of children with challenging behaviors.

Building Blocks for Brighter Futures provides mental health services to young children (birth to under six) with diagnosed mental health conditions. Building Blocks is located in New London, Groton and Norwich counties. Services are provided in the family's home. Comprehensive plans are developed which include: diagnostic evaluation; therapy; play therapy; art therapy; therapeutic play groups; community resourcing; individualized family support plans; family support funds; family social activities; and sibling groups.

Evidence-Based Practices: The President's New Freedom Commission identified the research to practice gap noting that it can take 20 years for an effective treatment intervention to move from development in a university research setting to implementation in the real world. Over the past nine years Connecticut has seen an explosion of evidence-based program implementation in children's behavioral health resulting in one of the most comprehensive arrays of evidence-based and best practices in the nation.

During the past eight years, DCF has implemented the following evidence-based and best practices across the state.

Multi-Systemic Therapy (MST) - As previously described over 380 youth and their families in CT can receive this intensive community-based program for youth with primary behavior disorders through the ten DCF-funded MST Teams.

Multi-Systemic Therapy - Building Stronger Families (MST-BSF) - This variant of MST is currently available in two communities and specializes in serving families involved with the child welfare system where there is parental substance abuse.

Multi-Systemic Therapy - Problem Sexual Behavior (MST-PSB) - This targets youth with problem sexual behaviors and their families in the community. It is one of the few evidence-based practices for this difficult to treat population.

Multiple Dimensional Family Therapy (MDFT) - As described above, this family-based treatment focuses on youth with substance abuse and behavior disorders.

Functional Family Therapy (FFT) - FFT was originally developed over 30 years ago and is one of the first evidence-based practices to be widely disseminated.

Intensive In-Home Psychiatric Service (IICAPS) - This model was developed at the Yale Child Study Center, is available statewide to over 100 youth/families, and is one of the few intensive in-home programs serving children with complex psychiatric disorders.

Dialectical Behavior Therapy (DBT) - DBT is a well-researched cognitive and behavioral treatment for a range of traumatic stress, anxiety, and personality disorders that has been adapted for the treatment of adolescents.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - TF-CBT is one of the most well-supported treatments for children who have experienced traumatic stress. Originally developed to serve

childhood victims/survivors of child abuse, TF-CBT has been broadened to address multiple sources of trauma.

Trauma Adaptive Recovery Group Education and Therapy for Adolescents (TARGET-A) -

TARGET-A is an adolescent adaptation of an adult model for the treatment of traumatic stress disorders developed by Dr. Julian Ford of UCONN. The program has been implemented in a number of DCF-operated and funded residential treatment programs.

Positive Behavioral Interventions and Supports (PBIS) - PBIS is a school-based program that reduces behavior problems by promoting positive behaviors in all aspects of school functioning. This non-punitive approach was successfully implemented in the Bridgeport Public School System with funding provided by a SAMHSA Grant.

Family-Based Recovery (FBR) - DCF worked with two University-based treatment developers to combine an intervention to promote attachment between young children and their mothers with an in-home substance abuse treatment program. Similar to MST-BSF, this program targets younger children and their parents involved in the child welfare system.

Aggression Replacement Therapy (ART) - True to its name, ART is a cognitive behaviorally based anger management program that teaches thinking styles and behaviors to better manage aggressive impulses and behaviors.

Motivational Enhancement Therapy (MET) - MET is a therapy for youth with substance abuse disorders that is provided in outpatient treatment settings and in some residential programs.

Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) - MET/CBT combines two treatment approaches to address adolescent substance abuse.

The Seven Challenges - The Seven Challenges is a substance abuse treatment model designed for application within a therapeutic milieu and also adaptable to outpatient treatment. Seven Challenges is available in all outpatient and residential substance abuse treatment programs funded by DCF.

Community-Based Wraparound - Fifty-eight Care Coordinators established in 2002 provide community-based wraparound across the state with newly established training, consultation, and assessment to support fidelity. Over 1100 families are served each year.

Local Systems of Care (SOC) - Local System of Care is a National Best Practices Model supported and promoted by the Children's Division of the Center for Mental Health Services of SAMHSA. There are 25 Local Systems of Care operating across Connecticut.

Signs of Suicide (SOS) - This evidence-based curriculum is made available to school staff as early interveners in identifying the signs and symptoms of suicidality.

Assessing and Managing Suicide Risk (AMSR) - This practice was developed by The American Association of Suicidology in partnership with the Suicide Prevention Resource Center. A Connecticut-based trainer provides training and support to a variety of treatment providers and the state's providers of Emergency Mobile Psychiatric Services.

In addition, the Court Support Services Division of the Judicial Branch supports the following Evidence Based Practices.

IICAPS - CSSD has expanded access to IICAPS and has been working collaboratively with DCF on joint contracts to provide quality assurance and training.

Brief Strategic Family Therapy - (BSFT) is an outpatient family-based treatment that works with youth demonstrating conduct problems such as delinquency and early drug use.

MST - CSSD funds fifteen MST teams across the state and has collaborated with DCF on the funding of a Connecticut-based quality assurance, technical assistance, and training center to support MST implementation.

MET/CBT - CSSD provides access to outpatient MET/CBT through its Juvenile Risk Reduction Centers (JRRC).

Workforce Development: During the past five years, Connecticut's children's behavioral health system has made significant progress in recognizing workforce issues and developing a range of programs and initiatives. Progress includes the development of training centers/contracts for support of evidence-based and best practices, participation in the Connecticut Workforce Collaborative of the Mental Health Transformation Grant, training initiatives, parent leadership projects, family advocacy programs, and projects with higher education

Training Centers for Evidence-Based Practices and Best Practices: DCF works with several contractors who provide ongoing training and consultation to support the provision of evidence-based practices with fidelity to the program model. Contracts are in place to support MDFT, IICAPS, MST, FBR, MST-BSF, and MST-PSB. In several cases contracts have been entered into jointly with CSSD to achieve maximum efficiency. These contracts insure a timely and ready supply of staff trained in the specific treatment model. In addition, DCF is in the process of procuring a training center to support the emergency mobile psychiatric service system statewide. Similarly, the Connecticut Family and Community Wraparound Project employs a vendor to provide training, consultation, and program fidelity assessment in support of wraparound service delivery.

Connecticut Workforce Collaborative: Under the auspices of the Mental Health Transformation Grant, Connecticut has launched the Connecticut Workforce Collaborative to support: the development of the mental health workforce, increased and enhanced roles for consumers in the workforce, and the occupational attainment of individuals in recovery. DCF is a leading partner in this initiative and has strong representation on the Executive Committee and at various levels within the collaborative. DCF also oversees several projects funded under the collaborative including the following.

Parent Leadership Training: A training curriculum on leadership skills has been developed and will be offered repeatedly throughout the state to the parents of children with emotional/behavioral difficulties. This initiative will (1) facilitate parents' increased participation and influence in their child's treatment team; (2) prepare parents for paid and volunteer Family Advocate roles on behalf of other families and their children; and (3) assist parents in developing skills to shape state policy, thereby moving Connecticut closer to a family-driven system of care.

Higher Education: This program is designed to develop the "pipeline" for professionals prepared to work within the state's array of intensive in-home evidence-based practices. This strategy, in the early stages of implementation, will engage 15 university faculty members in year long fellowships (5 per year over 3 years) to learn these treatment approaches. Subsequently, the faculty will implement courses for students on intensive, home-based services and assist in placing these students in internships where they can gain practical experience. University and mental health systems will coordinate recruitment and job placement efforts to engage these students in the workforce after graduation.

Consumer/Family Support to the CT BHP: Increased consumer and family involvement in the planning and design of behavioral health services is necessary. However consumers and families require

preparation, support, and assistance to meaningfully participate in planning processes. Under the auspices of the CT BHP Oversight Council, a training program of orientation and support is being developed to bolster parental and youth participation in the council.

Training in TF-CBT and DBT: Both of these statewide training initiatives represent ongoing efforts to implement trauma-based treatment in the children's behavioral health system and support the competency of the workforce in delivering state of the art treatment. Each of these initiatives goes beyond the delivery of training and includes consultation, feedback, and measurement systems to support sustainability of skills in the field.

Family Advocacy Program: DCF funds 10 family advocates assisting families in navigating the behavioral health and educational systems regarding their child with a serious emotional disturbance. This program directly funds a family role in the behavioral health workforce and is highly utilized by families throughout the state.

Research and Best Practice: In the last five years, DCF has expanded its expert knowledge in behavioral health treatment and best practice through an influx of highly trained and credentialed behavioral health professionals, establishment of university affiliations, participation in federally funded research and technical assistance grants, and the development of consultative contracts.

Behavioral Health Professionals: Since 2004, the department has expanded its in-house behavioral expertise through the hiring of highly trained professional staff including: 2 Pediatricians hired (1 Director of Pediatrics and 1 Regional Pediatrician) and 2 to be hired; 4 Child Psychiatrists (1 Psychiatric Medical Director and 3 regional psychiatrists); 8 Ph.D. Psychologists; 3 Advanced Practice Registered Nurses; many other nurses, licensed social workers, and other professionals.

University Affiliations: DCF has established relationships and worked on collaborative research projects with: UCONN Department of Psychiatry; UCONN School of Social Work; Yale University Medical School - Consultation Center; Yale University Medical School - Child Study Center; Yale University Medical School - Department of Psychiatry; New York - Mt. Sinai School of Medicine; Fordham University; University of Miami; Johns Hopkins University; Medical University of South Carolina; Central Connecticut State University; National Center for Child Traumatic Stress/ Duke University; and Wesleyan University.

DCF has also participated in the development and extension of MST, MDFT, and FBR and implementation of the Global Assessment of Individual Needs. Each initiative has contributed to the body of scientific knowledge and advanced the state's efforts in developing the behavioral health service system for children and families.

Examples of Research and Technical Assistance Grants

SAMHSA System of Care - 9 Million Dollar grant to develop a school-based system of care in Bridgeport, Connecticut

SAMHSA System of Care - 9 Million Dollar grant to develop an early childhood system of care in southeastern Connecticut.

Mental Health Transformation Grant - Recipient of 1.5 Million to support high fidelity wraparound implementation.

Federal Mental Health Services Block Grant - DCF receives 1.3 million for children's behavioral health services.

In-Depth Technical Assistance (IDTA) - SAMHSA and Administration for Children and Families jointly funded programs to support integration of child welfare and substance abuse services.

Connecticut Adolescent Substance Abuse Coordination (CASAC) - Center for Substance Abuse Services 1.2 million dollar grant to support implementation of the GAIN and improvement of substance abuse services.

Development of Consultative Contracts: Since 2003 DCF has contracted with the Child Health and Development Institute (CHDI) - Connecticut Center for Effective Practice (CCEP) to provide expert advice, consultation, program evaluation and analysis regarding the children's behavioral health service system. In a recent report of the Legislative Program Review and Investigations Committee (LPRIC), DCF's contract with CHDI was held out as an "example of a monitoring and evaluation system strength" for DCF.

Use of Technology to Enhance Services - Achievements: DCF has made targeted improvements in the use of technology to support quality improvement efforts. These include the use of the internet to promote awareness and support recovery/resilience, computer-based data systems to support treatment, track outcomes, and assist in the management of psychiatric medications for DCF-involved children.

Internet: The internet is being utilized to connect consumers, family members, and youth with behavioral health knowledge and resources. Through the Mental Health Transformation Grant the State has established the Network of Care Website ([www. Networkofcare.org](http://www.Networkofcare.org)) as a site to learn about mental health disorders and treatment options, find resources, track one's own record of care, and connect with others. In a similar manner, DCF has contracted with Connecticut's 211 to provide an online resource directory to its staff of DCF workers.

Data System: In development for the past year, DCF is in the process of rolling out the Programs and Services Data Collection and Reporting System (PSDCRS). PSDCRS is a redesign of the department's Behavioral Health Data System (BHDS) that has been in place since 2002. The BHDS has functioned as the primary source of program data for DCF contracted behavioral health programs. This data allows the department to track utilization, populations served and selected outcomes for behavioral health services. Notable improvements to the new PSDCRS include: a web-based interface that will allow for direct entry or batch submission from the provider agencies and easier access to data; a probabilistic case matching methodology that will assist in tracking outcomes across time and program participation; reduction in the overall quantity of data collected to achieve parsimony; data entry tools to reduce errors and ease data input. The new PSDCRS will be phased-in for community behavioral health services beginning July 1, 2009. Child Welfare, juvenile justice and behavioral health congregate care programs and services will be rolled out in later phases of the project.

Psychotropic Medication Consent: In September of 2007, DCF automated the process of obtaining consent for psychotropic medication for DCF-committed children and youth. Previously the process was administered regionally, required multiple levels of approval, and records were kept in hard copy. With the centralization of the medication consent process and creation of the MedLink System, the department streamlined the authorization process and computerized the data capture system. These improvements have significantly shortened the time between the request and the granting of consent. Also, data regarding a child's history of psychotropic medication trials are now stored in an electronic format for ease of access.

Continuous Quality Improvement - Achievements: The Department has recognized the importance of quality improvement in behavioral health programming through its experience implementing evidence-based practices and has worked to incorporate the principles of "implementation science" (Fixsen, 2003) into its management of programs and services. Quality improvement activities relevant to behavioral health include activities directed by the Bureau, activities contracted out to private contractors, and activities overseen by the Department's Division of Continuous Quality Improvement. Progress includes the redesign of the PSDCRS, licensing processes, incident reporting systems, expanded QI contracting, implementation of QI processes within the CT BHP, the procurement of programs that include a strong QI element, and the development of logic models as a foundation for QI processes.

PSDCRS: As referenced earlier in this report, the PSDCRS is the Department's new data system for programs and services. The system was designed as a quality improvement tool to be utilized by the department, providers, and stakeholders to monitor program and system functioning and track performance over time.

Licensing: DCF's licensing unit is located within the Division of Continuous Quality Improvement, which is external to the Division of Behavioral Health. The licensing unit conducts annual licensing visits to verify that licensing standards are adhered to and investigates complaints that may be reflective of licensing violations. Licensing inspectors provide feedback to providers on areas of compliance and non-compliance and follow up to insure that licensing deficiencies are corrected in a timely manner.

Incident Reporting: DCF's Division of Continuous Quality Improvement conducts risk management analyses of DCF-licensed congregate care programs. All licensed congregate care programs are required to submit reports of significant events to the department and these reports are aggregated for analysis by risk management staff. Criteria for follow-up on incidents includes both incident-specific thresholds (e.g. serious injury to a child, police call, death, etc.) and rate-based thresholds (increase in rates of restraint, outlier status on rates of minor injuries to children, etc.). Data and trends are also analyzed by service type (group home, STAR Home, residential program) to identify opportunities for improvement (e.g. high rates of ED visits by residents of group homes).

QI Contracting: DCF currently contracts for QI systems to support a number of program implementations including: MST; MST-BSF; MST-PSB; MDFT; IICAPS; GAIN; FBR; The Seven Challenges; and Flex Funds for non-DCF children.

Several other QI programs are currently in development including programs to support newly contracted EMPS programs and therapeutic group homes. In addition, DCF funds FFT providers to directly procure QI from the FFT model developer.

CT BHP: The CT BHP and the contracted Administrative Services Organization, Value Options, perform a number of quality improvement functions including provider profiling, utilization analysis, performance profiles for area offices, and inpatient and discharge delay projects. Value Options authorization and concurrent review databases are valuable in and of themselves but can also be combined with billing data from DSS and program level data from DCF's PSDCRS. Currently, VO data is demonstrating the success of efforts to reduce overstays in EDs, discharge delays in inpatient psychiatric hospitals, and utilization of residential care while increasing enrollment into Medicaid and utilization of community based services.

Program Selection: Since 2004, DCF has been increasingly focused on making sure that new programs and services include a quality improvement component that measures fidelity to the program model and performance on key outcomes. The Dean Fixsen (2003) monograph referenced above clearly articulates that it is not enough to simply select an effective program and contract to provide it locally. The

implementation of that program needs to be supported by a long-term commitment to delivering standardized training, ongoing consultation, insuring that the program is serving the intended target population, and QI processes including measurement of fidelity and outcomes. The presence of a well-designed quality improvement program has been an important criterion in the selection of programs to implement in the children's behavioral health service system.

Logic Models: Logic models are tools that are used to identify the logic underlying programs or services. Logic models describe how a program is believed to work including the assumptions & resources, actions or outputs, and their relationship to program outcomes. Logic Models are extremely helpful in designing programs and developing quality improvement activities. DCF Behavioral Health has developed logic models for all program types that it funds. These logic models form the basis of quality improvement processes and efforts to redesign programs.

3. Stakeholder Involvement in Planning and Oversight

Stakeholder Involvement in Planning and Oversight - Achievements: The implementation of CT KidCare by DCF in 2001 accelerated the Department's progress in increasing stakeholder involvement in planning and oversight, particularly the expansion of consumer and family involvement. Progress has been made in improving consumer, youth, and family involvement in their own service planning and care, as well as involvement in planning, design, evaluation, and oversight.

Consumer, Youth & Family Involvement in Their Own Service Planning and Delivery

Care Coordination: The best example of DCF support of family-driven service planning has been the implementation of the Local Systems of Care and the Care Coordination Program. Based on the Core Values of the System of Care approach these interventions recognize the critical importance of putting families at the center of the care planning process. Recently, the Department re-invested and re-invigorated the Care Coordination program by developing and implementing a program of workforce development that includes pre-service and in-service training, program consultation, and fidelity measurement to support service delivery that is child-centered, family-driven, culturally competent and community-based.

Family Conferencing: Within child protective service practice, the Department implemented the Family Conferencing Model in all area offices between 2006 and 2008. The family conferencing approach is quite similar to the System of Care and shares the core values, particularly regarding the central role of family in the care planning process and the importance of family engagement.

Family Based In-Home Models: The Department has taken considerable measures to promote family-driven service planning and delivery by promoting treatment models that focus on family engagement. Over the past eight years DCF (and to some degree our partner agency CSSD) has implemented an array of family based intensive in-home services that focus on family engagement by placing family and child goals, preferences, and needs at the center of the care planning process. These programs include evidence-based programs such as MST, MDFT, & FFT, best practices such as IICAPS, and promising practices such as FST.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): DCF has signed a Personal Service Agreement with the Child Health and Development Institute of Connecticut, Inc./Connecticut Center for Effective Practice to administer three Learning Collaboratives focused on the adoption of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at licensed outpatient psychiatric clinics for children during SFY 2007 through 2010. TF-CBT is an evidence based model of treating children who have been exposed to traumatic experiences and are experiencing or demonstrating distress in connection with the traumatic exposure. This highly effective intervention includes a family component that identifies family

goals for the intervention and incorporates the family into care to support the generalization and transfer of treatment outcomes.

Engaging Families in Services Learning Collaborative: In April 2008 all members of the twenty-two Extended Day Treatment Teams including direct care staff, clinicians, program directors, senior leaders and parents/caregivers began participating in a 9-month learning collaborative focused on engaging families in services. Based on evidence-based research and developed by Dr. Mary Mckay, Ph.D./Mt. Sinai School of Medicine, the training applies a learning collaborative methodology to introduce family engagement protocols and multiple family group sessions. The approach focuses on listening to families and adapting program rules and structures to family needs and preferences.

Family Advocacy Services. Family Advocacy is a DCF-funded program that pairs families receiving services, with peer-advocates who are current or former recipients of services. Family Advocates gain their expertise via their own experiences navigating the service system and coping with the stresses of parenting a child with serious emotional disturbance. They provide advice, support, and advocacy and help to empower the family to take charge of their treatment experience. Family advocates also assist in developing support groups and educational experiences for the families they work with to promote each family's knowledge and competence.

Peer and Family Specialists: Families and individuals often gain the most support and feel most empowered when assisted by other people like them who have successfully coped with similar challenges. Under the Auspices of the CT BHP, Value Options employs family and peer specialists who utilize their own lived experience in supporting and advocating for families and individuals. All CT BHP members are eligible to receive peer or family support services.

Mental Health Transformation State Incentive Grant (MHT SIG): Newly implemented jointly by DCF and CSSD in late 2008 as a component of the MHT SIG this program focuses on the implementation of the Community-Based Wrap-Around Model in two pilot communities to divert children and youth from the juvenile and criminal justice systems. This collaborative project will implement the wraparound approach across multiple systems. A core goal of the project is to promote family-driven care within the behavioral health, juvenile justice, child protection, and educational service systems.

Licensing Regulations: DCF licensing regulations require consumer/family sign-off on care plans as a means of documenting family participation in the design and approval of their own treatment.

Consumer, Youth & Family Participation in System Design, Planning, Evaluation, and Oversight:

Advisory Bodies & Advocacy Groups: DCF supports and participates in many groups that provide opportunities for families to participate in planning evaluation and oversight. Through a combination of Local Systems of Care, Regional Advisory Councils, State Advisory Councils, Children's Behavioral Health Advisory Committee (CBHAC), Oversight Council of the CT BHP, Youth Advisory Council, and regional and statewide family advocacy organizations including FAVOR, African Caribbean American Parents of Children with Disabilities (AFCAMP) , Padres Abriendo Puertas (PAP), Families United for Children's Mental Health (Families United), National Alliance for the Mentally Ill - CT (NAMI-CT), the Connecticut Association of Foster and Adoptive Parents (CAFAP) and other grassroots organizations, families and consumers have the opportunities to provide input into system design, planning, evaluation, and oversight.

Beginning in 2003, DCF provided funding for the establishment of a statewide family advocacy organization, FAVOR. More than 4300 families are impacted by FAVOR services including at least 450 families who receive direct family advocate support. Examples of statewide leadership include providing

input regarding statewide policy, legislative agendas and committee reviews, and providing grant support to local community collaboratives by hiring, training and placing family members into the infrastructure and family advocacy positions. FAVOR, Inc. has also provided mini-grants to 20 local grass roots family support groups, has served as fiduciary to local systems of care and has awarded funds to its local family advocacy member organizations.

Procurement of Behavioral Health Services: Procurement of behavioral health services routinely includes family members in the review of proposals. This practice puts families in an important role assisting the department in making critical decisions regarding the awarding of service contracts.

Practice Standards Review: DCF has utilized the Children's Behavioral Health Advisory Council (CBHA) to participate in the development, review, and modification of practice standards for community-based services to promote family-friendly service provisions.

Data Analysis: Several consumer-led entities have begun to focus on system data to assist in making recommendations for system improvements. The Quality Improvement Committee (QuIC) is a consumer, youth, and family-driven quality improvement process for mental health services evaluation that is a component of the Mental Health Transformation Grant. The QuIC has selected a vendor to collect and analyze survey information and other system data. CBHAC, one of the primary behavioral health advisory bodies with a majority of family and consumer participation, also operates a data subcommittee devoted to the use of data to monitor system performance.

Consumer Surveys: In conjunction with the Mental Health Services Block Grant, DCF collects consumer survey data through the nationally recognized Youth Services Survey for Families (YSS - F). DCF has contracted with the University of Connecticut to establish a web-based system to support data collection and analysis.

Outcome Tool: DCF has selected a clinical measurement tool, the Ohio Youth Problems, Functioning and Satisfaction Scales as a foundational element of its new performance measurement system, the PSDCRS. The Ohio Scales are a family-friendly instrument as they include measures of strengths, family and youth satisfaction with services, and hopefulness.

Local Community and Provider Representation: DCF continues to support the local community collaboratives in their efforts to organize various stakeholder groups, including community representatives and providers. In addition DCF has developed a standard process for obtaining stakeholder input during the planning, design, and process of procuring and re-procuring DCF funded programs and services. DCF also maintains relationships with each of the major trade associations including the Children's League, Connecticut Community Provider Association (CCPA), Connecticut Association of Foster and Adoptive Parents (CAFAP), and the Connecticut Association of Non-profits (CAN).

Managed Service System: The Managed Service System (MSS) was implemented in 2005 by DCF as a means of better serving children with behavioral health needs who are involved with DCF. Although the primary function of MSS is to assist in the management of services (as described below) it is also intended as a vehicle to solicit provider input and identify service gaps within the community.

Legislative and Governmental Participation: Legislators actively participate in the development and oversight of the behavioral health service system through their support of funding and legislation affecting behavioral health services, direct participation in oversight committees such as the CT BHP Oversight Committee, appointment of representatives to CBHAC and other committees concerned with mental health services and systems, participation in the Human Services, Select Committee on Children, Early Childhood Cabinet and other legislative committees of cognizance, through local groups and

organizations, and through direct consultation with the leadership of the Department. The Governor's office, Office of Policy and Management, and executive branch staff have direct input and oversight of major policy, funding, and strategic planning initiatives.

4. Management of Systems and Services

Management of Services - Achievements: There is significantly more effective management and collaboration/coordination occurring within the behavioral health services system and across service sectors than had been the case prior to the roll-out of Kidcare, the establishment of the CT Behavioral Health Partnership, and recent behavioral health initiatives. Progress has been made in the coordination of services across mandates and systems, management of services through the CT BHP and other entities, contracting for services, and use of information and technology.

Coordination Across Systems/Sectors

Child Welfare & Behavioral Health

The overlap in the populations served within the child welfare and public sector behavioral health service systems is substantial. Rates of serious emotional disturbance, as defined by the presence of a diagnosable psychiatric condition and significant functional impairment are present in 78% of children in foster care and similar elevated prevalence rates are observed for other children and youth involved with the child welfare system. The combined effects of neglect, abuse, exposure to drugs and alcohol, and the impact of educational and economic deprivation, all common features of children and families served within the child welfare system, create high risk for behavioral health disorders. Below are concrete examples of the progress made to improve coordination between behavioral health and child welfare services.

BH Program Directors: Developed in 2004, in conjunction with the development of the local area office structure, DCF developed the position of Behavioral Health Program Directors (BHPDs) within the Child Welfare System. BHPDs function as the point person on behavioral health issues within the area office and split their time between behavioral program planning and oversight and consult with Area Resource Group and DCF Social Workers on child and family behavioral health needs and care plans. BHPDs meet regularly with the Bureau Chief for Child Welfare and representatives of the CT BHP and serve as a liaison between the behavioral health and child welfare systems. BHPDs regularly participate in review and procurement of behavioral health services for their service area.

Area Office Resource Group: Each area office maintains an Area Office Resource Group that provides consultation on behavioral health, substance abuse, and physical health to DCF workers and supervisors. The staff within these units is an invaluable resource to the area office.

Regional Psychiatrists & Medical Director: Established in 2006, DCF Regional Psychiatrists, along with the DCF Medical Director, provide expert psychiatric evaluation and consultation to children and families involved with the Department as well as DCF staff and community providers. The three regional psychiatrists each oversee 4-6 area offices and are supervised by the Medical Director. All are board certified child and adolescent psychiatrists and provide input regarding policy as well as direct and indirect educational services.

Advanced Practice Registered Nurses (APRNs): During 2007 DCF expanded the ranks of APRNs to provide consultation/authorization regarding medication orders for children committed to DCF. Working under the supervision of a physician, the APRNs review medication orders for appropriateness and track prescribing practices through the MEDMAC system that manages the prescribing of psychoactive drugs

to committed children and youth. APRNs also participate in case conferences and provide education/consultation to DCF staff on behavioral health issues.

Psychiatric Medication Advisory Committee (PMAC): PMAC oversees the DCF formulary for psychoactive drugs and tracks trends and policies related to the use of these medications in DCF facilities and with DCF committed youth. Chaired by the DCF Medical Director, PMAC includes DCF facility staff, community psychiatrists, pharmacists, and others involved in the management of psychoactive medications. They provide direct oversight and policy development for DCF child protective services.

Clinical Case Conferences: Established in 2005, and expanded in the years following, clinical case conferences can be convened to bring expert knowledge and resources to care planning for children/families involved with the child welfare and voluntary services systems. Formal case conferences are chaired by the Bureau Chief for Behavioral Health and/or his designee, regional psychiatrists, and/or the agency medical director and typically include the child, youth, and/or family where appropriate, the DCF worker/supervisor, behavioral health program director, area resource group staff, community behavioral health providers, behavioral health program leads, and other resources to assist in case planning. Clinical case conferences bring a clinically sophisticated analysis to care planning and may also serve a gate-keeping function in relation to access to higher levels of care. These conferences also serve to educate staff regarding BH issues.

Trauma-Informed Services: In recognition of the prevalence of trauma, particularly in the population of parents, children, and youth involved with DCF protective services, DCF has developed a series of interventions to improve the trauma responsiveness and competency of the CPS system. Training in DBT, TF-CBT and Risking Connections has been provided to DCF facilities and contracted agencies that serve a child welfare population. Facilities and providers have begun implementation of trauma screening and assessment. A nationally recognized trauma training curriculum is being incorporated into the DCF training academy so that all DCF staff receives state of the art education in the effects of trauma on children, youth and families.

MSS: The managed services system was designed to bring all local behavioral health and support resources together on a weekly basis to assist those children and families in the child welfare system with needs that exceed existing service plans. DCF and community behavioral health providers team up to brainstorm and develop innovative service plans for the children, youth and families in their care.

STAR Program Redesign: As noted above, DCF dismantled the existing shelter system and replaced it with smaller, community based, Short Term Assessment and Respite Homes for DCF youth involved with the CPS system who are in need of emergency placement. Unlike the shelters, STAR Homes include integrated behavioral health services and are charged with developing a comprehensive psychosocial assessment and care plan. Through bimonthly reviews in the STAR home, behavioral health services are integrated into CPS case practice.

Therapeutic Group Homes (TGHs) - TGHs provide an intensive level of clinical services in an open community-based program. Designed specifically for children and youth involved with the child welfare system who require a period of intensive treatment prior to returning to a family setting, the TGHs may be utilized as an alternative to, or step-down from a more restrictive residential treatment program. Unlike previous DCF-funded group home programs, true to their name, TGHs are staffed to provide clinical evaluation, treatment, and discharge planning within a DCF CPS placement.

CT BHP: The CTBHP provides authorization and concurrent review for behavioral health services available to DCF involved youth, intensive care managers to assist in care planning, and peer and family support staff to assist parents in accessing services and advocating for their rights within the system. A

significant focus of the BHP has been to address system gridlock, thereby improving system capacity. Delays in hospital emergency departments have decreased by 50% this calendar year and delays in the inpatient setting have decreased by over 10%.

EMPS & Foster Care: Children with behavioral health disorders are at high risk for disruptions in foster care placements. Disruptions can also exacerbate behavioral disorders by increasing anxiety and disturbing attachment bonds. Disruptions also contribute to high rates of turnover of foster families due to burnout and frustration with the foster parent role. In recognition of these sobering facts, DCF behavioral health has partnered with foster care and adoption services to develop improvement to the EMPS system to provide improved crisis intervention services to adoptive and foster families. The project is designed to better educate foster and adoptive families about EMPS services, improve the relationships between the foster and adoptive systems and EMPS providers, better educate EMPS providers regarding foster and adoptive settings, and incorporating aspects of evidence-based practices shown to reduce rates of disruption.

Juvenile Justice and Behavioral Health

The population of children and families seen in the juvenile justice system overlap considerably with those in need of behavioral health services. The prevalence of substance abuse and behavioral health disorders is higher in the juvenile justice population than normative groups. Many youth enter the juvenile justice system due to the progression of untreated psychiatric disorders and many would be better served by treatment vs. incarceration and/or involvement with the legal system. Below are some examples of areas of progress towards effective integration.

Shared Service Networks: DCF's Bureau of Behavioral Health (BH) and Bureau of Juvenile Justice (JJ) along with the Judicial Branch's Court Support Services Division (CSSD) have been working to develop a shared service network for the past 4-7 years. DCF JJ and BH service systems currently share contracting for and access to MST, MDFT, FFT, and the flexible funding program. In addition, DCF BH and CSSD share MST, flexible funding and are working on a collaborative arrangement for the sharing of the IICAPS service network.

Collaboration on Foundation and Federal Grants: DCF BH, JJ, & CPS Bureaus & CSSD have collaborated on a number of private foundation, state, and federally funded initiatives to better integrate care:

MacArthur Foundation MH/JJ Action Network: This is a private foundation funded program to improve behavioral health services to youth involved in the criminal justice system. The project includes three components: 1) a program to divert at risk youth from criminal justice system involvement through the provision of crisis intervention and linkage services in the schools; 2) the identification, selection, and implementation of behavioral health screening, assessment, and risk assessment instruments in juvenile justice settings; and 3) the development of a best practice behavioral health curriculum for JJ system staff.

MHT-SIG Wraparound Project: The federally funded Mental Health Transformation State Incentive Grant administered by SAMHSA has provided funding to DCF (BH, JJ & CPS) and CSSD to implement high fidelity wraparound across service sectors in two pilot communities. The project will provide training to a diverse set of stakeholders (schools, BH service providers, CPS workers, probation and parole staff, BH providers, etc) and support fidelity to wraparound practice through consultation, coaching, fidelity assessment and quality assurance practices.

DCF-CSSD Joint Strategic Plan: During 2006, DCF and CSSD worked to align their policy and service development plans through the construction of the DCF-CSSD Joint Strategic Plan. Many current CSSD and DCF initiatives can be traced back to recommendations produced under the Joint Strategic Plan.

Screening and Court-Ordered Evaluations: Behavioral health screening and assessment have been supported by a number of joint JJ and BH initiatives. Connecticut is one of the few states that provide access to inpatient psychiatric evaluation for pre-adjudicated youth entering the JJ system. In an effort to expand access to expert evaluation for those youth that do not require placement in an inpatient setting, DCF developed the Juvenile Justice Intermediate Evaluation (JJIE) that provides a comparable multi-disciplinary evaluation to JJ involved youth in the community. CSSD has also developed standards for court-based assessments. Through a component of the MHT-SIG Wraparound Project outlined above, all three assessment programs are being shaped to be consistent with wraparound practice.

Gender Specific Services for Girls: In the past, the JJ system was organized around services for the predominant population of adolescent boys. Over the years, gender differences in drug abuse, conduct disorders, and JJ risk factors began to disappear and more young women began entering the JJ system. Although the system was originally slow to adapt to the changing population, there is now recognition of the importance of gender-specific services and programs for girls. Several therapeutic group homes, residential treatment centers, and planned JJ facilities have been designed based on specific gender-based knowledge of growth, development, manifestations of pathology, and response to treatment. In light of the demand for gender-specific services for girls, service for boys also began to be evaluated and adapted according to knowledge of male development. These program developments represent practical examples of the incorporation of behavioral health into JJ practice.

Developmental Services & Behavioral Health

The Diagnostic and Statistical Manual of Mental Disorders – IV – Technical Revision (DSM-IV-TR) divides all psychiatric disorders into Axis I & Axis II Disorders. Axis I contains psychiatric disorders and Axis II contains developmental disorders including mental retardation, autism, and pervasive developmental disorder. Separate and distinct service systems for behavioral health and developmental disorders reflect the bifurcation evident in DSM-IV-TR. In Connecticut DCF and DMHAS are responsible for individuals with Axis I disorders and the Department of Developmental Services (DDS) is responsible for Axis II diagnoses. However, DDS is not fully funded to provide services for either children or adults with autism spectrum disorders unless they are also diagnosed with mental retardation (i.e. Pervasive Developmental Disorder NOS, Asperger's Syndrome), therefore DCF has to work closely with both DDS and DMHAS to determine which agency will provide services at transition. For those individuals who present with co-occurring psychiatric and developmental disorders, integrated treatment is required and DCF works with both DMHAS and DDS. Efforts to better coordinate care across service systems is evident through a Memorandum of Agreement and between DCF and DDS, the joint development of residential and group home services for those with co-occurring disorders, collaborative planning meetings at DCF facilities, joint case conferences and the development of utilization data by the CT BHP illuminating the unique needs of the co-occurring population.

Residential and Group Homes Services: DCF and DDS have collaborated on the development of specialized residential and therapeutic group homes for children and youth with co-occurring developmental and psychiatric disorders. Justice Resources Incorporated and Ability Beyond Disability have recently contracted with DCF for the development of specialized treatment programs. Several group homes are already in operation and a new continuum of residential and group home services is under development in northwest Connecticut.

Memorandum of Agreement with DDS for Voluntary Services: There are two main areas of interface between DCF and DDS. The first is for youth who have been committed to the care and custody of DCF

and who "age out" to DDS at age 21. The second is for children who are participating in services as part of the Voluntary Services Program.

Effective July 1, 2005, DCF and DDS embarked on an initiative to transfer responsibility for Voluntary Services for children with mental retardation from DCF to DDS. With extensive interagency collaboration the following summarizes specific highlights of the Voluntary Services Program:

- Identification and transfer of existing voluntary caseload from DCF to DDS for a total of 334 between FY 2005 and FY 2009;
- Development of new protocols for the annual transfer of cases from DCF to DDS (those children who have become DDS eligible since entering the DCF Voluntary Services Program);
- Development of a specific protocol for new referrals to go directly to DDS from the DDS HOTLINE; and
- Development of a Children's Services Committee which reviews any requests within the DDS Voluntary Services Program for out-of-home placements; the committee includes representatives from DCF, DDS, the State Department of Education, the Office of the Child Advocate, and family advocates

In addition to the above, DCF and DDS have worked extensively to improve the interface at all levels, on behalf of both committed and voluntary children. The goal has been to improve the outcomes for children through: a) achieving a greater understanding and appreciation of each others work; b) moving towards standardization of protocols between the agencies; and c) increasing options for shared programming. The following are initiatives undertaken to meet these objectives:

- Annual training of DDS Case Managers and other DDS staff done by the DCF Training Academy; this is a 6-day program with a curriculum prepared by the DCF Training Academy in conjunction with DDS and DCF liaisons;
- Quarterly training of DCF staff done by DDS staff under the auspices of the DCF Training Academy;
- Completion of a joint RFQ and award of contract for a residential Center for Excellence in the state of CT to serve youth with mental retardation and other developmental disabilities who may also have a history of trauma;
- Development of internal DCF process for approval of specialized individual plans done in coordination with DDS;
- Local DCF/regional DDS coordination meetings;
- Monthly interagency administrative/policy meetings;
- Statewide standardized screening and monitoring process within DCF to identify youth by age 15 who may need a referral to DDS and assure referrals are made;
- DCF participation on the DDS autism spectrum pilot project advisory council;
- Memorandum of Agreement that outlines the working relationship between DCF and DDS for children who are both in the Voluntary program as well as those who are committed to DCF or in some protective services status; and

- Monthly or bi-monthly meetings with representatives of DDS and the DCF facilities (Riverview Hospital, Connecticut Children's Place and High Meadows) for the purpose of identification of appropriate referrals and resolution of eligibility issues.

Child and Adult System Transitions

A high functioning Behavioral Health Service System a) identifies youth likely to require continuing services into adulthood; and b) allows time for planning prior to the time of transition, develops formal protocols to assist the transition process, and tracks the both the process of transition and rate of success. Steady progress has been made in DCF's ability to identify, plan for, provide services to, and refer youth who are transitioning to the adult system.

Memorandum of Agreement with DMHAS: DCF and DMHAS have developed and updated the agreement that governs the identification, evaluation, referral, and service provision for transitioning youth.

Exit Outcome on Referral to DMHAS: The Department's Juan F. Exit Plan has tracked the Department's performance on the early identification and referral of youth with Mental Health or Developmental Disorders that require referral to the adult system through Exit Plan Outcome Measure #21. Performance on this measure has been steadily improving and the most recent review for the period of April to June 2008 demonstrated "(98%) youth had referrals made to DMHAS or DDS for eligibility determination for adult services."

Therapeutic Group Homes, Age Extension: Initially implemented in 2003, the Therapeutic Group Home Initiative has been adapted to better serve transitioning youth by extending the eligible age for placement in a therapeutic group home from 18 to 21 for those youth who continue in an approved educational or vocational training program.

Educational Services and Behavioral Health

Children and Youth spend a significant portion of their waking hours in school and educational competence is arguably one of the most important factors in a child's growth, health, and development towards assuming the role of a productive citizen. Schools are a primary provider of behavioral health services to children and are uniquely positioned for early identification and intervention and support of behavioral health treatment. Despite this pivotal role, the relationship and level of collaboration between the BH System and the Educational System is variable and seldom well-integrated. Although supporting behavioral health is not the primary focus of schools and educational systems, BH remains such a critical factor in educational success that better integration between systems is required. Many barriers to collaboration and integration exist. Disparate funding streams, conflicting legal statutes and contrasting priorities and methods contribute to fragmentation and the organization of the educational system into relatively autonomous districts requires a school by school or district by district approach.

Every school age child should have access to a full array of mental health screening, evaluation, and treatment services and care plans that guide behavioral health care must incorporate the school setting as a primary ecosystem on par with the family environment. A variety of practice improvements, Memorandum of Agreements, pilot projects, reimbursement policies, federal grant initiatives, community collaborative actions, and other activities support the integration of behavioral health and educational services.

Medicaid Reimbursement of School Based Behavioral Health Services: Changes in Medicaid rules regarding off-site and school-based reimbursement of behavioral health services has removed a significant financial barrier to the integration of behavioral health services into the schools.

School Participation in local Systems of Care: The creation and support of local systems of care in conjunction with the KidCare initiative promoted the inclusion of schools and other community stakeholders in local planning and service delivery efforts.

Park Project and Bridgeport Schools: Funded by SAMHSA, the 6 year Park Project federal grant supported and promoted the development of a school-based model of community behavioral health care coordination and the implementation of Positive Behavior Interventions and Supports (PBIS - an evidence based practice) in the schools. The innovative school based care coordination model is now supported by state funds administered by DCF.

EMPS Support to the Schools: DCF is currently engaged in a re-procurement of the Emergency Mobile Psychiatric Service statewide. A major focus of the re-procurement is the improvement of EMPS service to schools. DCF has engaged with many school groups and organizations to identify opportunities for program improvement and barriers to schools effective use of EMPS services. EMPS providers are required to provide outreach and education to schools, prompt response to school-based crises, and must work with schools to obtain as many advance parental consents as possible for children at risk of behavioral health crises in the school.

MHT-SIG Wraparound Project: Under the MHT-SIG, DCF and CSSD have partnered with the Connecticut Center for Effective Practice to implement high fidelity wraparound in two communities in Connecticut: Bridgeport and Bristol/Farmington. A major component of the project is to engage the schools to divert youth from the juvenile justice system through improved behavioral health intervention.

MacArthur Foundation Mental Health/Juvenile Justice Action Network: CSSD as the lead, and DCF as a partner have been working with MacArthur Foundation funding to better integrate Juvenile Justice and behavioral health services. One component of this initiative is a program to divert at risk youth from criminal justice system involvement through the provision of crisis intervention and linkage services in the schools.

DCF Coordination with School Related Associations: Over the past six months DCF has engaged the following organizations and committees to promote improved coordination between educational and behavioral health systems: Regional Superintendents of Schools, Statewide & Regional Associations of Special Education Directors, CT. Chapter of the American Academy of Pediatrics-School Health Committee, Connecticut Association of School-Based Health Centers, State Department of Education and Legislative Committee on School Nursing.

Memorandum of Understanding with State Department of Education (SDE) - McKinney-Vento: The federal McKinney-Vento Homeless Children's Act provides protections to youth considered homeless including retaining the right to be transported to and educated in their school of origin even when relocation moves them outside of the school district. McKinney-Vento is interpreted in Connecticut to apply to children placed in DCF short-term placements including STAR Homes and SAFE Homes. Through an MOU between DCF and SDE, children receiving care in STAR Home or SAFE Homes must be transported to their school of nexus to promote educational continuity. In this way, efforts to provide short-term behavioral health intervention do not inadvertently interfere with education.

DCF Educational Consultants: Each DCF Area Office has access to trained educational consultants to assist in advocating for appropriate educational services for children in DCF care.

Therapeutic Group Homes and Short-Term Assessment and Respite (STAR) Homes: The design of the Therapeutic Group Homes and STAR homes are designed to promote youth continuing to receive public education in the community while receiving intensive behavioral health services.

Youth Suicide Prevention Training Initiatives with SDE: DCF's Prevention and BH Divisions have been engaged with the State Department of Education to support suicide awareness training in Connecticut Public Schools. In a recent initiative, the State's network of vocational and technical schools received specialized training in recognizing the signs and symptoms of suicide and guidance in effective intervention.

Primary Care and Behavioral Health

A strong integration between behavioral health and primary care is evident when effective communication between primary care and behavioral health providers is the norm, when treatment services are coordinated, and when primary care settings are provided with the resources and supports to provide and/or support routine behavioral health care. Numerous initiatives developed by the CT BHP and DCF Behavioral Health and Child Welfare Bureaus demonstrate steady progress towards better integrating behavioral health and primary care.

Enhanced Care Clinics (ECC): Launched in 2006 under the auspices of the CT BHP, the ECC initiative provides a financial incentive to outpatient behavioral health and substance abuse clinics that meet a series of performance improvement standards. One of those standards includes the coordination of behavioral health and primary care. Clinics are responsible for developing Memorandum of Agreements with at least two primary care providers in their service area and to develop relationships and activities that promote improved coordination of care. In particular the ECC primary care component provides psychiatric consultation to primary care providers to assist in their provision of psychiatric medication management to children and youth in their care. This helps to expand access to medication management and to promote coordination between medical and psychiatric care.

MHT-SIG Coordination Project: Final steps are being made to identify the successful (RFP) applicant to implement a pilot program to improve the ability of primary care providers to identify, diagnose, refer and treat individuals with mental illness.

Children with Complex Medical Needs: Through joint action of the Bureaus of CW and BH, progress is being made in improving the monitoring, oversight, and support of the medical care of children in DCF Care, particularly children with complex medical needs. These actions include the development of flexible funding streams to access medical resources in emergencies and improvements in the department's network of health advocates. Availability of expert medical consultation from several DCF employed pediatricians also further supports the medical expertise of the department and coordination with Behavioral Health.

Improvement of Multi-Disciplinary Exam Process: All children experiencing a first removal from home are required to receive a Multi-Disciplinary Exam (MDE) within thirty days of removal. The MDE was initially designed to include medical, dental, developmental, and behavioral screening and assessment. However, initial attempts at standardizing the MDE were not successful and the program is currently undergoing redesign to insure consistent quality and the use of standardized, reliable, and valid instruments wherever possible.

Establishment of Foster Care Clinics: The CW Bureau established Foster Care Clinics to provide access to evaluation and treatment services for children in DCF care. This model has been found to promote more responsive medical care.

5. Management of Services

Management of Services - Achievements: Several administrative structures have significantly improved the management of behavioral health services. These include: the CT BHP and the administrative services organization - Value Options; the Managed Services System (MSS); local Systems of Care; contracting methodologies; and technological improvements in support of management.

Connecticut Behavioral Health Partnership (CT BHP): Since January 1, 2006 the CT BHP, which is administered by Value Options under contract with DCF and the Department of Social Services (DSS), has managed Medicaid mental health and substance abuse services. The goal is to provide enhanced access to, and coordination of, a more complete and effective system of community-based behavioral health services and supports for children and families. The CT BHP offers specific services for children and families who are eligible for the HUSKY Part A or HUSKY Part B programs or the Limited Benefit Program through DCF. For the latter program, children who do not qualify for HUSKY Part A or HUSKY Part B may be eligible to apply for services if they have complex behavioral health needs and are involved with DCF.

Service Authorization and Level of Care Guidelines: An essential activity of the CT BHP is the review and authorization of care to insure that proper services are obtained and that they are properly utilized. Utilizing Level of Care Guidelines developed by the CT BHP, Value Options provides initial authorizations, concurrent reviews, continuing care authorizations, and prompts discharge plans. Through focused reviews, provider profiling, case consultation, data collection & analysis, and assistance with care management, Value Options promotes optimal utilization and flow through the service system. As reported earlier, significant improvements have been made in the overall utilization of community based services and reduction in overstays in psychiatric hospital inpatient settings. These same methods have also reduced psychiatric overstays in Emergency Departments. The Value Options contract is itself managed by a series of performance standards with associated penalties and incentives.

Network Managers: Value Options employs 6 regional network managers who remain assigned to specific DCF area offices, community collaboratives, and program/facilities. These network managers, while still locally assigned to ensure community involvement, work to achieve the overall CT BHP goals of increased access to care and improved quality of care. Working with provider data (most notably inpatient) and Intensive Care Managers, and Care Managers assigned to the same geographic region, during the past two years the network managers focused on reducing lengths of stay and reducing discharge delays at local hospital emergency and psychiatric inpatient departments.

Intensive Care Managers: An intensive care manager (ICM) has also been assigned to each area office to assist with clinical treatment planning for complex cases. Among other activities the intensive care managers track and monitor the status of children seen throughout the state's Emergency Departments and assist in identifying appropriate resources when diversion is indicated. They attend discharge planning meetings on inpatient units and work with DCF area office staff and family members to effectuate timely discharges.

Peer & Family Support Specialists: Other Value Options' staff members that work at the local levels include peer support specialists who are adults that have had personal experiences with the mental health and/or substance abuse services system, and family support specialists who are trained parents of children with behavioral health needs. These specialists provide education and outreach to families, help families identify resources including natural support networks, engage in treatment, and navigate the service system. They provide information, identify individual barriers to care, and work closely with the intensive care coordinators and care coordinators to address barriers. Each of the described staff members

are organized into "geo teams" that cover a specific area within the state. These teams meet weekly to share information and to develop provider specific or community specific interventions that support the goals of the CT BHP.

Local Systems of Care (LSOC): LSOC were formalized and expanded through the Kidcare Initiative beginning in 2000. LSOC perform two essential functions: they coordinate and oversee service delivery to individual children and families, and they are charged with making improvements to their local behavioral health service system.

Managed Service Systems: The Managed Service System structure was added in 2004. This represents a consortium of DCF staff and DCF-funded provider agencies convened under the authority of the 15 DCF local area offices to assure that a comprehensive and coordinated array of services are available at the local level to meet the needs of the DCF target population, especially those clients with the most complex behavioral health needs. The goal is to reduce the number of children in residential care and manage access to appropriate levels of care in a timely manner. The bi-monthly meetings focus on coordinating services for all children in DCF facilities, shelters and short term assessment homes, safe homes, inpatient settings, and residential treatment facilities. Key leaders are the DCF behavioral health program directors who have expertise in behavioral health issues, and the DCF area resource group (ARG) specialists from each area office that are comprised of psychiatric social workers, nurses, substance abuse specialists, domestic violence specialists and others to provide consultation and other supportive functions to the DCF social work staff and broader community.

Contracting: DCF has been utilizing their contracts with behavioral health providers to help manage and improve service delivery. Contract elements that have contributed to improved management include requirements regarding data, quality improvement activities, measurable performance standards and outcomes, clearer explication of program requirements, prescription of program models/approaches, and other contract components.

Information & Technology: DCF has been increasingly utilizing information technology in the management of services. They have already transitioned many data collection processes to web based interfaces and more will be transitioned under the new Programs and Services Data Collection and Reporting System (PSDCRS). Data collection to support program fidelity has been implemented with MST, MDFT, FFT, IICAPS, TF-CBT, DBT, Engaging Families, EMPS, and other contracted behavioral health services. A new data system supports the oversight of medications prescribed to children in DCF care in order to improve care and reduce poly-pharmacy, over-medication, and other unwanted outcomes.

6. Cultural Competence

Cultural Competence - Achievements: Progress in the area of the cultural competence of the behavioral health service system has been slow but steady. The department has made advancements through a variety of approaches including training initiatives, activities of the DCF Division of Multi-cultural Affairs, personnel practices within DCF and the private sector, special projects, use of block grant funds, and data strategies.

Training Initiatives: Through the Training Academy, DCF provides basic training in culturally competent care and special trainings on specific cultural issues including:

- Hip Hop Culture
- The Native American Child
- Lesbian, Gay, Bisexual, Transgender Youth

- Parents with Cognitive Limitations
- Human Trafficking
- Immigration
- Gender and Transgender
- The Puerto Rican Experience
- Islam & the Muslim Child

In addition, cultural competence training is a standard requirement in contracts for all behavioral health services.

Personnel Practices: DCF utilizes a strong program of affirmative action to promote a diverse workforce that is a reflection of the clients the agency works with. DCF Interview Panels are composed of culturally and linguistically diverse staff. DCF also works with its contracted providers to support diversity and cultural competence including allowing longer periods for recruitment of linguistically and culturally competent staff.

DCF Division of Multi-Cultural Affairs: Headed by William Rivera, MATS, M.Ed. the Division of Multi-Cultural affairs is responsible for developing, implementing, and sustaining diversity initiatives and policies designed to support the diverse needs of staff and clients regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social economic status, or language. This division also oversees the Commissioner's statewide Multicultural Advisory Council and provides consultation to each of the area office and facilities' Diversity Action Teams. In addition to this, the division director chairs the statewide Deaf and Hard of Hearing Persons Advisory Council.

Request for Proposal (RFP) Reviews: When a DCF behavioral health service is procured through competitive procurement processes, a component of the scoring criteria concerns the diversity and cultural competence of each proposal. This insures attention to the need for linguistically and culturally competent care at the outset of program/service initiation.

Culturally Specific Projects: DCF sponsors and co-sponsors a number of events that promote the celebration of diversity and increased cross-cultural understanding. These events include the annual True Colors Conference, The Quinceañera Celebration, the Escúchenos conference, the Historically Black Colleges college tour, ethnic and culture-specific celebrations for staff and youth in care, and other Culturally Specific Projects.

Data Collection: DCF has been improving its data collection capacity and that of its contracted providers to better capture data relevant to race, gender, ethnicity, language and other information necessary to assess the cultural competence of the system. In December 2008 the Executive Team approved the implementation of a set of "Recommendations on the Measurement of Race and Ethnicity."

7. Public Awareness

Public Awareness – Achievements: DCF, along with state and community partners, has supported media events and projects, educational activities, and advocacy organizations, and promoted the re-framing of behavioral health in terms of resiliency and recovery.

Anti-Discrimination Campaigns: Through the Mental Health Transformation Grant DMHAS and DCF have partnered to oversee several projects to reduce discrimination against individuals due to the presence of psychiatric disorders. A series of Public Service Radio and Print Ads has been produced by the advertising agency of Mintz and Hoke to de-stigmatize mental illness. These ads have appeared in national media including Time, Newsweek, Sport Illustrated, and other comparable publications. DMHAS and DCF have also partnered with Connecticut Public Television to produce a live public forum on mental health and commissioned a three part documentary series "Opening Doors, Opening Minds" to help reduce misconceptions that may contribute to discrimination. DCF has also produced other media that educates the general public.

Recovery & Resilience: DMHAS and DCF have both adopted recovery/resilience oriented philosophies for the design and delivery of behavioral health services and supports. For DCF, this orientation is embodied in the System of Care Values and Principles.

Suicide Prevention and Education: In partnership with the Department of Mental Health and Addiction Services' federally funded CT Youth Suicide Prevention Initiative and the State Department of Educations, DCF has supported various trainings including Signs of Suicide (SOS) and Assessing and Managing Suicide Risk (AMSR).

Education in Behavioral Health: The DCF Training Academy provides basic education in behavioral health for DCF staff so that they may educate the families they work with on behavioral health issues. The 25 DCF-funded child guidance clinics also provide education and consultation to schools and other community agencies in their service area. DCF has also supported conferences and special educational events on behavioral health regarding trauma and services for juvenile offenders. DCF-funded family advocates and local systems of care also provide individualized education and support to families in need.

Support of Grassroots Advocacy: DCF funds support local and statewide advocacy organizations that promote awareness of behavioral health. These organizations include FAVOR, AFCAMP, NAMI, PAP, and Families United.

8. Funding and Revenue Maximization

Funding and Revenue Maximization – Achievements: Establishment of the CT BHP has been a primary factor in DCF's efforts to improve alignment of funding sources and maximization of revenue. Progress is clear as evidenced by increased Husky enrollment, movement from grants to fee-for-service, blending of DCF grants and Medicaid funding, use of performance incentive processes, utilization of shared contracts across agencies, and efforts to align Medicaid reimbursement to promote best practice.

Increased Enrollment in Husky Plans: Under the CT BHP enrollment of children and families in Husky A has significantly expanded resulting in improved access to the array of covered behavioral health services and a greater share of federal revenue to support service delivery.

Shift from Grants to Fee-For-Service (FFS): Through the CT BHP, DCF and DSS have been working on converting key grant-based programs to fee-for-service reimbursement under Medicaid. This change in the mechanism of funding allows for a greater federal match and ability for services to grow to meet demand rather than be limited by arbitrary grant funding levels. The clearest example of this type of conversion is the IICAPS program. IICAPS is an intensive in-home service that was originally grant funded by DCF. At the time of the conversion to fee-for-service there were a total of 14 IICAPS providers and 16 IICAPS teams. After the recent completion of the conversion, there are now over 28 IICAPS teams and families served have increased from 500 to over 1000.

Blending of Medicaid and DCF Grant Funds through the CT BHP: The CT BHP provides an opportunity to blend Medicaid, DCF BH, and CPS funds and to jointly manage funded services through the ASO - Value Options as described above. This removes some of the barriers to service access created by categorical funding streams.

Pay for Performance: Several Pay for Performance initiatives have been developed within the CT BHP to support practice improvements in the delivery of behavioral health service. For example, EDs that collaborate with EMPS providers to develop MOAs that promote diversion from ED visits and inpatient admissions will be eligible for financial bonuses.

Shared Contracts Across Divisions/Agencies: DCF Behavioral Health has partnered with CPS and JJ Divisions and DMHAS, DDS, and CSSD to develop shared service and Quality Assurance Contracts that save money through improved efficiencies and economies of scale and also promote integrated service delivery. DCF and CSSD jointly contract for MST and IICAPS services, flexible funding, and the MHT-SIG Wraparound Project. Similarly DCF Behavioral Health partners with both the JJ and CW divisions to provide access to Family Support Teams, FFT, MDFT, Project SAFE Services and other community based and residential treatment services. DCF and DDS have jointly developed residential and group home services for youth with co-occurring BH and developmental disorders. Finally DCF provides funding to the DMHAS treatment network for transitioning youth and to support Project SAFE that targets adults with substance abuse disorders who are involved with DCF CPS.

Aligning Medicaid with Best Practices: The rules and guidelines of Medicaid, one of the primary funders of public behavioral healthcare, often do not support best practice or evidence-based treatments. For example, DSS rules regarding clinic-based behavioral health services did not allow the provision of off-site services, such as in a school. However, best practice indicates that school-based care and other outreach to provide the service in the natural ecology in which the child lives and problems are observed require that such interventions be reimbursed. Through the CT BHP and DSS revision of the clinic option, school based services are now reimbursable. Similarly, Medicaid rules had to be adjusted to support evidence-based treatments that utilize paraprofessional staff working under the supervision of licensed clinical professionals. Through a Medicaid Rehabilitation Waiver the CT BHP intends to fund a range of community based services that in the past could not be fully funded under Medicaid. Also, the pending DCF-DSS Certification Regulation will allow the departments to selectively certify evidence-based and promising practices for Medicaid reimbursement thus shaping the service system towards effective best practices.

Use of Private Non-Medical Institution (PNMI) Designation: PNMI provides a mechanism to maximize Medicaid reimbursement for clinical components of services provided in DCF-funded therapeutic group homes. Through implementation of the PNMI program DCF is able to draw down millions of dollars of federal Medicaid funds that return to the State General Fund.

PART C SECTION 11: IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES - CHILDREN

E. A BRIEF DESCRIPTION OF THE COMPREHENSIVE COMMUNITY-BASED PUBLIC MENTAL HEALTH SYSTEM THAT THE STATE ENVISIONS FOR THE FUTURE

Connecticut's vision incorporates a comprehensive, well-functioning community-based public mental health system of care. This is a transformed system of care where every child and adolescent with a serious emotional disturbance and their families have timely access to appropriate, effective treatments and supports in order to live a full life in the community. Children and youth will live safely with their families, participate in the social and cultural life of their communities, succeed in school, and develop the skills necessary to live independently as young adults. Families will be full partners with the professional and natural helpers. Families will provide information and guidance to the helping network, share what they believe might work, and describe what supports and other resources they need to realize their goals. All Connecticut citizens will be involved in taking action at individual, community and state levels to maximize the mental health of all residents.

The components of the transformed behavioral health services system are described below.

- **Service Capacity and Access:** Service capacity matches need, services can be easily accessed, and the service array matches the diversity of client needs.
- **Service Effectiveness and Quality:** To achieve maximum success, only the most effective services are funded and delivered and the system possesses the necessary infrastructure to evaluate and maintain a high quality of care.
- **Stakeholder Involvement in Planning and Oversight:** To be truly responsive to the needs of the population served, the children's system has an effective means of including consumers, youth, family members, and other key stakeholders in the planning, development, delivery, and oversight of behavioral health services.
- **Management of Systems and Services:** The effective behavioral health service system organizes, manages and coordinates care to promote improved service, ease of use, and cost-effectiveness. Management strategies include coordinating and integrating various child serving systems, policy development, care management practices, contracting mechanisms, and effective use of information and technology.
- **Cultural Competence:** The system insures effectiveness for all of the children and families that it serves. The system is knowledgeable of, informed by, and responsive to the variety of ethnic and cultural groups in need of care. Education and training, workforce development, and practice modifications are in place to effectively engage and care for all cultural groups.
- **Public Awareness and Policy:** The system educates the public about behavioral health care and addresses policies that are discriminatory against those with a behavioral health disorder. There is acceptance of mental illness and general public awareness that emotional and psychiatric problems are medical conditions, that there is no shame in seeking care, that disorders can be effectively treated, and that a productive life in the community is available to all with the proper services and supports.
- **Funding and Revenue Maximization:** Connecticut maximizes all available sources of revenue and blends or braids funding streams to enhance the service array and improve access to care. The

behavioral health service system is no longer funded by a patchwork quilt of state, federal, and local programs, private insurance, philanthropic organizations, school districts, individuals, families, and others.

Part C Section III: State Mental Health Plan

Criterion 1A: Establishment and implementation of an organized community-based system of care for individuals with mental illness

DCF will maintain a diverse array of community-based behavioral health treatment services and related supports within a continuum of care to meet the range of needs of children, adolescents and their families. These services include the following:

- Care Coordination Services;
- Intensive In-home Services;
- Outpatient Psychiatric Services (Child Guidance Clinics/Enhanced Care Clinics);
- Extended Day Treatment;
- Intensive In-home Services;
- Family Support Teams;
- Crisis Stabilization Services
- Child and Adolescent Rapid Emergency Services (CARES) Program;
- Short Term Assessment and Respite (STAR) Homes;
- Therapeutic Group Homes;
- Respite Services; and
- Family Advocacy Services.

Please refer to Section II D for details regarding these services.

DCF will focus on strengthening the system of care including Care Coordination and the wrap-around service delivery model through training, technical assistance, and pilot projects. DCF will lead and support the Managed Service Systems in the local area offices and continue to fund the care coordinator positions through the Systems of Care/Community Collaboratives. Further, DCF will continue to fund family advocate positions to enhance effective consumer and family participation in the overall system. As described in previous sections, DCF plans to improve utilization and management of Emergency Mobile Psychiatric Services. Additionally, performance measures will be developed in several areas including co-occurring treatment at the Enhanced Care Clinics. A family engagement model of practice will be a critical focus of intervention and care, with continued support of this initiative with Extended Day Treatment providers. Quality assurance including fidelity measures and monitoring will continue for the array of Intensive In-home Services.

In order to maintain services and supports, DCF-funded care coordinators will continue to have access to flexible funding during FFY 2010. These flexible funds are an integral resource to ensure that children and their families have the services, supports and other resources needed to successfully remain in their homes and communities, and/or facilitate children's return from inpatient and residential levels of care. Care coordinators are able to distribute these funds to assist with security deposits, outstanding utility bills, delinquent rent, furniture and other needs to support safe and stable housing for children and families who are served through the Systems of Care. As in years past, DCF includes as one of its outcome measures the impact of care coordination on placement stability. DCF expects that at least 85 % of children, while receiving Care Coordination, will maintain stable placements and/or be stepped down to a less restrictive setting of care.

To meet the specialized education, employment and housing needs of adolescents and young adults, DCF will work to maintain a continuum of transitional and independent living options that aid young adults to live successfully in the community. This will be evidenced by maintaining an Independent Living Program that will offer young people a continuum of services to ensure their transition from substitute care to a productive community life.

DCF will support early intervention and prevention activities that seek to lessen or abate risk for serious emotional disturbance. These will include continued funding of the Early Childhood Consultation Partnership (ECCP) initiative, the Youth Suicide Advisory Board, and the Positive Youth Development/Family Strengthening initiative. Further, DCF will continue to promote mental health awareness and youth suicide prevention within local communities. Many of these activities will occur in school environments. Examples of these activities include education and training across communities, dissemination of evidence-based suicide prevention programs, and further dissemination of the State Department of Education Suicide Prevention Guidelines.

Workforce development and transformation is another critical area of focus. DCF staff will join with other interested stakeholders including members of various workgroups that have been formed through the MHT SIG to seek and implement solutions. Yale University continues to lead several workforce development initiatives including Parent Leadership Training, Intensive Home-Based Evidence-Based Practices Training in Graduate Schools; and Supervisory Competencies Training. In addition to examining staff development and training needs from the larger system of care perspective, DCF will examine ways to work differently in order to integrate the work of the DCF behavioral health team with child welfare, juvenile justice and substance abuse colleagues.

Further, DCF will continue to support the expansion of evidence-based and/or promising practices. DCF will continue to sponsor the Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative and support the ongoing work of those professionals who have been trained in Dialectical Behavior Therapy. The sustainability of a new initiative, Engaging Families in Services will be monitored for Extended Day Treatment teams across the state.

DCF will continue to utilize technology to support an integrated, coordinated and effective system of care for children and families obtaining services through the publicly funded behavioral health system. Intensive efforts are being made to improve the behavioral health data system through the planning and development of a web-based information system, known as Programs and Services Data Collection and Reporting System. The primary goals are to improve user friendliness, make the data more useful for program and clinical management, and create a more efficient and parsimonious system. The newly designed system, which is expected to be launched in mid 2009, will also aid decision-making, support program monitoring and continuous quality improvement initiatives.

Criterion 1B: Description of the available services and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse, and including the description of services in the comprehensive system of care to be provided with Federal, State and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Below is a description of the various clinical services and programs. These services are available statewide unless otherwise noted.

- **Crisis Stabilization Services.** There are two crisis stabilization programs in the state that offer 24-hour, short-term residential care for children, ages 7 to 18 with behavioral health needs who require a temporary "cooling off" period after experiencing a crisis. These grant-funded providers conduct assessments and deliver short-term interventions aimed at stabilizing the child and family. The assessment integrates medical, psychosocial, educational and previous treatment history and addresses the needs of the child/youth within the context of their ecosystem. Clinical services include screening and referral, individual, group and family treatment, consultation, parent education and instructional modeling, and linkage to family substance abuse screening. Medication management includes consultation and assessment from a psychiatrist or an APRN under the direction of a psychiatrist.
- **Emergency Mobile Psychiatric Services (EMPS).** These community-based crisis intervention and assessment services include mobile response, psychiatric assessment, medication assessment/short-term medication management, behavioral management services, substance abuse screenings and referral to traditional and non-traditional services for any child or youth in crisis. These services will continue to be available across child welfare, juvenile justice, prevention and behavioral health systems.
- **Intensive In-Home Services.** These services are designed to enable children and adolescents to remain in their own homes, with the goal of preventing hospitalization or residential placement and/or assuring a successful transition to their own communities following out-of-home clinical treatment. These programs have the capacity to serve more than 2,000 children and their families annually.
 - **Family Support Teams (FST).** For children/youth, ages 3 to 19 with complex psychiatric and family difficulties who are at imminent risk of out-of-home care, returning to the community from out-of-home care, or entering treatment foster care, these services are provided by an integrated team of licensed professional staff who offer a range of therapeutic services in the home environment. These include psychiatric, medical, educational, vocational, and rehabilitative services for a period of 9 to 15 months. Children must be DCF involved or receive voluntary services. Currently, there are 9 providers throughout the state, with a capacity to serve approximately 460 children/adolescents and their families (biological or foster families).
 - **Intensive In-home Child and Adolescent Psychiatric Services (IICAPS).** For children/youth, ages 3 to 18 with complex psychiatric disorders (DSM-IV Axis 1 diagnosis) who are at imminent risk of hospitalization or who are being discharged from psychiatric hospitalization, the treatment focuses on psychiatric symptoms within an eco-systemic model for a period of less than six months. DCF involvement is not required.

Currently there are 14 provider agencies delivering IICAPS services, with an estimated statewide service capacity of more than 1000 cases.

- Multisystemic Therapy (MST). For children/youth, ages 12 to 17 with delinquent behavior and/or substance abuse problems, living at home with or returning to a primary caregiver, the treatment focuses on adolescent development, substance abuse, peer influences and parenting for a period of 3 to 5 months. DCF involvement is not required. Currently there are 25 MST teams funded by DCF and CSSD with a capacity of serving more than 1000 families annually. The ten DCF teams serve about 350 families annually.
- Multisystemic Therapy – Problem Sexual Behavior (MST-PSB). These services are available for children/youth, ages 10 to 17.4 with problem sexual behaviors who are either living at home or returning home to a primary caregiver. Treatment focuses on problem sexual behaviors, substance abuse, peer influences, and parenting for a period of 6 to 8 months. The youth are usually involved with DCF Parole Services during their treatment. This is a small, yet effective program that serves about 13 families annually.
- Multisystemic Therapy – Building Stronger Families (MST-BSF). For children/youth, ages 6 to 17 who are involved with DCF for child abuse/neglect at risk of out-of-home placement and who have parents with an alcohol/drug problem. The primary work addresses safety, permanency, and well-being of the children and parental substance abuse for a period of 6 to 8 months. There must be DCF child protective services involvement. The services are offered in New Britain and New Haven. The latter site works with children who have been in detention to prevent a residential placement. The two BSF teams serve about 40 families annually.
- Multidimensional Family Therapy (MDFT). For youth, ages 11 to 17.5 who are substance abusing or at risk for substance abuse, at imminent risk of removal from their home or returning home from residential care. The treatment focuses on adolescent development, family systems issues and extra-familial systems for an average of 6 months. DCF involvement is not required. These services are located in Hartford, New Britain, Waterbury, New Haven, Manchester, and Norwalk-Stamford. The nine MDFT teams serve about 230 families annually.
- Family Substance Abuse Treatment Services (FSATS). For children/youth, ages 12 to 16 who have been in detention, where there is evidence of either youth and/or parental substance abuse. Treatment focuses on providing substance abuse treatment, addressing family systems issues and extra-familial systems for a period of twelve months. DCF involvement is not required. These services are available in Hartford, New Britain, Willimantic/Manchester, Norwich and Bridgeport. The five FSATS teams serve about 100 families annually.
- Functional Family Therapy (FFT). For children/youth, ages 11 to 18 with problems ranging from mood to conduct disorders, the primary treatment focus is on the function of maladaptive behavior within the family structure, problem solving, encouraging/supporting positive relationships, family support and empowerment, access to medication evaluation and management, crisis intervention and case management for a period of 10 to 20 weeks.

DCF Bureau of Behavioral Health and Medicine recently partnered with the DCF Division of Juvenile Services to increase the availability of FFT for children and youth involved with juvenile parole services. Additional funding was provided to each FFT program to develop service capacity reserved specifically for youth on parole status.

There are currently five provider agencies delivering FFT services. For SFY 2008 more than 400 families were served.

- Family-Based Recovery (FBR). The target population is infants/toddlers, ages birth to 24 months who have been exposed to parental substance abuse in utero and/or environmentally, their parents and siblings. Adult substance abuse treatment is integrated with family treatment designed to enhance parenting and parent/child attachment for a period of one year. This initially requires DCF involvement and is offered in six locations throughout the state. FBR serves about 120 families annually.
- Outpatient Psychiatric Clinics for Children (Child Guidance Clinics). DCF maintains grant-funded contracts with child guidance clinics to provide behavioral health services for children, under age 18 and their families. A multidisciplinary team of psychiatrists, psychologists, masters' level clinicians and other behavioral health professionals provide diagnostic and treatment services. The goals are to promote mental health and improve functioning, and to decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. These providers deliver a variety of clinical treatment and rehabilitative support services that include but are not limited to: assessment (psychosocial, psychiatric and psychological); medication evaluation/management; crisis intervention services; individual, group and family therapies; play therapy; home-based interventions; substance abuse treatment; parenting skills development and parent training.
 - Enhanced Care Clinics. Through the CT BHP specially designated mental health clinics, referred to as Enhanced Care Clinics have been established to enhance access and improve the quality of care. To date 37 clinics have received approval status. These clinics are required to meet specific access requirements in order to receive enhanced Medicaid rates.
 - Specialty Clinics. Some clinics offer specialized services to treat problem sexual behaviors, obsessive-compulsive disorders, pervasive developmental disorders, traumatic stress disorders, and tourette's disorder.
 - Substance Abuse Clinics. Several clinics also provide outpatient substance abuse evaluation and treatment services.
- Extended Day Treatment (EDT) Services. DCF contracts with providers to administer 22 community-based programs that offer a structured, intensive, therapeutic milieu with integrated clinical treatment and rehabilitative support services for children, ages 5 to 17 who experience behavioral and emotional disturbances. A team of multi-disciplinary staff deliver a broad range of treatment services and psycho-social interventions through after school and summertime programming. The target population includes children who have returned from out-of-home care or are at imminent risk of placement due to mental health issues or serious emotional disturbance.
- Extended Day Treatment (EDT) Services – Juveniles Opting For Treatment To Learn Appropriate Behaviors (JOTLAB) Program. This is an extended day treatment program for children with problem sexual behavior who can safely reside in the community. Both adjudicated and non-adjudicated youth, ages 8 to 17 that may or may not be involved with DCF are eligible for services.
- Short-Term Assessment and Respite (STAR) Homes. DCF awards grant-funded contracts for congregate-care programs that provide temporary, short-term care, evaluation and a range of clinical and nursing services to children who are removed from their homes due to abuse, neglect

or other high-risk circumstances. Services include a structured milieu with clinical supports, assessments and evaluations, and other behavioral health and medical services.

- Therapeutic Group Homes. DCF provides grant-funded contracts for congregate-care behavioral health treatment settings for children and youth. A combination of treatment and intervention approaches may include, but are not limited to: clinical services (individual, group and family therapy); milieu therapy; empowerment and family support services; case management; and aftercare services.

Community Support Services

- Care Coordination Services. These services are provided to children and youth enrolled in Husky Part A and Part B and DCF's Voluntary Services program that have complex service needs and require Level III Care Coordination. Services include assessment, service planning via the Child Specific Team, and service brokering.

DCF continues to fund 5.5 care coordinator positions and .5 supervisor position to serve children with SED and their families, through a unique school-based system of care model, formerly known as the Partnership For Kids (PARK) Project in Bridgeport. This initiative assists approximately 75 – 100 children and families in accessing clinical and non-traditional community-based services to maintain children in their communities and to return children with SED from out-of-district placements. These specialized care coordinators work with Bridgeport teachers, guidance and social work staff, and administrative professionals to ensure that children's individualized System of Care Service Plans are coordinated with educational and other needs.

- Therapeutic Mentoring, Therapeutic Support Staff, and Support Staff Services.
Therapeutic Mentoring. Through a one-to-one relationship between a trained, supervised, caring adult mentor and a child with significant mental health issues, usually ages 5 to 17 who is involved in the local System of Care or has some other child-specific team forum, interventions are developed and tailored as part of an individualized treatment plan. The adult serves as a role model and offers support and guidance. Mentor activities focus on increasing self-esteem, habilitation, resiliency, the development and/or improvement of social skills and peer relations, and promoting age appropriate behaviors in a normative, non-clinical setting. These mentoring contracts support the development of lifelong mentoring relationships.

This service is primarily for youth who have returned or are returning from out-of-home care. There are several mentoring initiatives for various target populations including youth at the Connecticut Juvenile Training School, gay/lesbian/bi-sexual/trans gender youth, and children in out-of-home placement through the child welfare bureau.

Therapeutic Support Staff and Support Staff. DCF recently completed a credentialing process for the following provider types: Therapeutic Support Staff and Staff Support Services. Therapeutic Support Staff (TSS) is provided for children and youth who present as having significant difficulty dealing with the stressors of daily living due to previous or current trauma, psychiatric impairment, or out-of-home placement. These children/youth demonstrate moderate to acute behaviors in at least one domain of family, community or school (i.e. substance abuse; issues of trauma, separation or loss, runaway behaviors, etc.) TSS may be approved for up to 8 hours per week for up to 26 weeks for children and youth who are living in the community. Support Staff (SS) is provided for children and youth who present as having mild to moderate difficulty in social and recreational activities and do not meet the criteria for TSS. These children/youth

exhibit mild to moderate behaviors in at least one domain of family, community or school (i.e. negative peer associations; lack of peer connections; lack of positive family or community supports.) SS may be approved for up to 5 hours per week for up to 26 weeks.

- Respite Services. Respite service providers offer temporary care in the home or community to children and adolescents, under age 18, who have emotional and/or behavioral needs that require constant attention from their caregivers. This is intended to prevent family disruption by reducing stress and burnout by caregivers and to provide age appropriate social and recreational activities. Respite care is intended for DCF involved children and non-DCF involved children from the local systems of care.
- Family Advocacy Services. FAVOR is a statewide organization that has been created to educate and support families in their advocacy efforts. Emphasis is placed on empowerment, cultural competency, family strengths, parent/consumer leadership and self-determination. Paid and volunteer family advocates work in tandem with care coordinators to aid in producing positive outcomes for children with SED and their families. Member agencies include: African Caribbean American Parents of Children with Disabilities; Families United for Children's Mental Health, National Alliance for the Mentally Ill of Connecticut (NAMI-CT), and Padres Abriendo Puerta (PAP).

Other Specialized Resources

- Prevention and Early Intervention Services. Staff works closely within and outside the agency to integrate prevention initiatives and promote positive youth development activities across the state. Some examples include: suicide prevention and education activities; supported local youth-driven activities; and mental health consultation to child care agencies.

Funding for the statewide Early Childhood Consultation Partnership (ECCP) will continue during FFY 2010. The ECCP is a mental health consultation program designed to meet the social/emotional needs of children birth to five by offering support, education and consultation to those who care for them. A primary goal of ECCP is to reduce/eliminate the incidence of suspension/expulsion of young children from their care and education setting. Consultation is provided in homes, early care and education centers and home day care centers. Current funding of \$ 2.6 million supports 20 early childhood mental health consultants, serving all areas of the state. Each major urban city has a dedicated consultant, in addition to a second consultant serving the surrounding communities. All towns and cities have access to consultation.

Early Childhood Behavioral Consultation. This is a small pilot funded jointly by DCF and the State Department of Education (SDE) that focuses on two major urban areas to provide year-long consultation to large centers in need of intensive supports. The goal is to develop self-sustaining Behavioral Health Teams who are able to provide assistance to staff experiencing difficulty with children who have challenging behaviors. Funding for this pilot is shared by DCF and SDE and totals \$ 400,000 for two years. To date, ECCP has served 7,794 children in core classrooms with a 98% success rate in placement retention. The first year of the ECCP pilot indicates that 835 children were served with a record of no suspensions/expulsions.

Activities to prevent youth suicide will also be continuing. In compliance with Public Act 89-191, the Department convenes and staffs the Youth Suicide Advisory Board. During FFY 2010, the DCF Prevention Unit will be overseeing suicide prevention activities that include training and education for parents, youth, providers and DCF staff; development and distribution of suicide prevention brochures and information packets, and purchasing of a membership to the

Connecticut Clearinghouse and its library of resources pertaining to suicide, child abuse/ neglect, mental health and substance abuse.

Building Blocks for Brighter Futures offers mental health services to young children, ages birth to six, with diagnosed mental health conditions. Services are available in New London, Groton, and Norwich counties. These include: diagnostic evaluation; therapy; play therapy; art therapy; therapeutic play groups; community resourcing; individualized family support plans; family support funds; family social activities; and sibling groups.

- Positive Youth Development/Strengthening Families. Seven programs around the state (West Haven, Torrington, Enfield, Hartford, Willimantic, New Haven and Bridgeport) focus on high-risk families with children age 6 to 13 to support parents in their role as parents. Based on local need, community providers under DCF contract have selected their program models from available evidence-based programs. Parents learn how to become more effective in their role and how to build stronger relationships with their children and stronger families overall. The Positive Youth Development Initiative (PYDI) served 105 parents/caretakers and 875 children from July 1, 2007 through July 2008.
- Parents with Cognitive Limitations Workgroup. The Parents with Cognitive Limitations Workgroup (PWCL) consists of state agencies, community-based service providers, and other stakeholders. The group is working to raise awareness regarding the existence of this population and the needs of their families. Major accomplishments include the development of an assessment guide and a day-long training on identifying and working with parents with cognitive limitations (with CEUs for social workers). The Workgroup developed a website as well as recommendations regarding use of plain language. The Department's Training Academy is now offering courses on parents with cognitive limitations through their pre-service programming.
- Voluntary Services. Numerous behavioral health services and programs are offered on a voluntary basis to families who have children with complex behavioral health needs who are unable to access care for their children. These children are not committed to DCF and do not require protective services intervention.

Children with behavioral health needs and mental retardation are now being served by the Department of Developmental Services (DDS) Voluntary Services Program.

- Flexible Funding. Children with SED who are at risk of out-of-home placements, have limited resources or have exhausted resources including commercial insurance, and have complex needs that require multi-agency involvement are eligible to receive flex funds for a range of clinical and non-clinical services.
- Child Welfare Services. Staff from the Bureau of Child Welfare Services including foster/adoption services and adolescent and transitional services develop and support the provision of numerous specialized services that have clinical components. Some examples include: specialized in-home services to strengthen families and reduce the risk of abuse/neglect; safe homes that provide short-term care with a range of clinical and nursing services; foster and adoptive support teams; specialized sexual abuse evaluations; therapeutic child care; therapeutic foster care services; and staffed apartments with supported work, education and transition programs for committed adolescents who are exiting care. Details regarding some of these services are outline below.
 - Foster Care Clinics. There are 16 DCF-funded clinics that serve DCF-involved children and youth, ages birth to 21 who are placed in foster care for the first time. The purpose is

- to provide a comprehensive multi-disciplinary evaluation including comprehensive mental health, medical and dental evaluations.
- Therapeutic Foster Care Services. For DCF-involved children and youth who need specialized foster care, this is a family-based service delivery approach providing individualized treatment. The treatment focus is on emotional and behavioral issues that prevent the child/youth from participating fully in family and community life. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by treatment foster parents who are trained, supervised and supported by qualified contractor staff.
 - Transitioning Youth. For those youth with mental illness who will age-out of the DCF system, referrals are made to the DMHAS Young Adult Services System for ongoing psychiatric services and other significant supports.
 - Supported Work, Education and Transition (SWET) Program
These programs are designed to work with youth, ages 16 and older that are ready to be involved in a supervised, independent living program. These 8-bed programs are located throughout the state and offer youth an opportunity to remain in fairly close proximity to their home community. The goal is to support youth as they move towards vocational and college aspirations.
 - Community Housing Assistance Program (CHAP)
This is a semi-supervised, subsidized housing component for youth ready for less supervision and more independence. Youth, ages 18 to 23 who have graduated from high school or received their GED can reside in a semi-supervised setting, with a minimum of 5 hours of case management services per week. This enables youth to gradually transition to their own living arrangement with community ties, supports and living skills.
 - Foster Parent Community Housing Assistance Program (Foster Parent CHAP)
Youth, ages 17 and older who are ready to assume some of the responsibilities of their own care with the support of a trained, caring foster parent are eligible to participate in this pilot program.
 - Life Skills Training
DCF-involved youth, ages 15 to 21 may participate in a community-based life skills training program to enhance their knowledge of essential life skills, to increase self-reliance and to prepare for successful adulthood. There is a core life skills curriculum that includes employment, housing, financial management, health and other critical topics. The standardized curriculum, the Ansell-Casey Life Skills Model is utilized by all contracted service providers.
 - Post-Secondary Education
Youth may be assisted, as appropriate and based on eligibility, to enroll in two- and four-year colleges, as well as vocational, technical and certification programs. Additionally, DCF has hired two Pupil Personnel Specialists to work with all youth in care to make appropriate plans for their post-secondary educational or vocational programming. The specialists meet regularly with DCF social workers and providers, offer college and vocational fairs, college tours, tutoring resources and other related services.
 - Community, Housing, Educational and Enrichment Resources (CHEER) Program

Financial assistance is provided to youth, 18 years of age and older, who have graduated from high school or obtained a General Equivalency Diploma (GED) and demonstrated an interest in pursuing post-high school employment services and apprenticeship programs.

- Jim Casey Initiative

Youth who are aging out of the foster care system have increased opportunities for a successful transition to adulthood in the following areas: youth leadership; youth engagement; employment; housing; and physical/mental health. Three programs that will operate in 2010 include the following.

- Our Piece of Pie (OPP) Program. This is a comprehensive work/learn model that helps youth to access and attain a mix of educational, employment and personal development opportunities that lead to their success.
- Family Services of Woodfield. Youth work with technical experts and role models in a youth-centered small business. They develop transferable skills, identify goals and reinforce the personal skills needed for successful employment.
- New Haven Work To Learn Project. Individual service plans will be developed for DCF-involved youth in New Haven, ages 14 to 21 to enhance their financial literacy, life skills, educational, vocational, and employment assets. This involves a collaboration of many public agencies including CT Department of Labor, Governor's Prevention Partnership, State Board of Education, CT Court Support Services Division, and the New Haven Board of Education.

- Juvenile Justice Services. The Bureau provides and funds residential and community-based services to over 1,000 delinquent children and youth on an annual basis. These include specialized evaluations, counseling and outreach services for families with high risk adolescents and for those families experiencing substance abuse and/or domestic violence.

- Substance Abuse Services

DCF contracts for outpatient substance abuse treatment services. The six outpatient providers offer evaluation, outpatient and intensive outpatient services to about 600 adolescents annually. These providers have implemented a standardized assessment called the Global Appraisal for Individual Needs (GAIN-1). The GAIN is used nationally by the Center of Substance Abuse Treatment for all adolescent substance abuse programs to monitor performance. The GAIN-1 provides assessment for co-occurring disorders and flags mental health issues needing further assessment and treatment, in addition to problems with crime/violence, vocations/education, health, stress, trauma and environment. The GAIN-1 provides quantitative clinical data in multiple domains to improve client and program level effectiveness and to provide follow-up level of care. The GAIN-1 has been implemented in all DCF funded adolescent substance abuse treatment programs and is used for in child welfare services as a substance abuse screen for primary caregivers. It will also be piloted in some outpatient mental health clinics for children.

As a result of the Connecticut State Adolescent Substance Abuse Treatment Coordination (CASAC) grant, standardized statewide screening and assessment as well as the development of a family advocacy group for adolescent substance abuse treatment have been implemented. GAIN is now a contractual requirement for all DCF-funded adolescent substance abuse treatment providers. From this initial deployment, interest in the Gain instruments has grown. Currently DCF's child welfare system is implementing the GAIN-Short Screen (GAIN-SS) across 14 Area

Offices. Area Offices have expanded use of the GAIN-SS to adolescents within families referred to DCF as well. The child welfare system also adopted the GAIN-Quick for use in two specialty programs: Intensive Family Preservation and Intensive Safety Planning to identify treatment need among caregivers. The DCF Bureau of Juvenile Justice has trained provider staff who work for the JJ Intensive Evaluation programs in GAIN-1 and are in the early stages of implementing a progressive assessment approach with youth they serve. Riverview Hospital, the state's only psychiatric hospital for children, also is piloting the GAIN-1. The Bureaus of Behavioral Health and Medicine and Child Welfare also have implemented the new GAIN ABS system and contracted with Chestnut Health Systems for data management to provide enhanced reporting for program planning and evaluation.

The grant grew family advocacy for adolescent substance abuse treatment where there was none. The family advocacy group has been providing training and coaching to families, providing family support, and launched re-designed family and youth website.

The Hartford Youth Project (HYP) that was initially funded through federal resources to enhance the alcohol and drug abuse treatment delivery system for youth in Hartford continues and is partially supported by state funds. A community-based outreach, education and treatment initiative, the continuum of services includes early identification, screening, family-focused treatments, models appropriate to dual diagnosed clients, case management, and after care services for youth ages 11 to 17.5. These include: GAIN screening and assessment; intensive in-home treatment models; Motivational Enhancement Therapy (MET); and Cognitive Behavior Therapy (CBT). The length of stay is up to 12 months. HYP serves about 70 youth and their families annually.

- Medical And Dental Services

Routine medical and dental services are available through the private network of providers as well as the Medicaid provider community. Additionally, there are 16 DCF-funded diagnostic clinics that serve DCF-involved children and youth, ages birth to 21 who enter the foster care system. Clinic staff provides comprehensive multi-disciplinary exams including mental health, medical and dental evaluations for every child who enters the foster care system for the first time. The purposes are to achieve early identification of and intervention for medical, dental, and behavioral health needs. DCF has consistently met the federally mandated Juan F. Exit Plan measure for multi-disciplinary exams by providing timely exams for children who enter the foster care system.

The DCF Bureau of Behavioral Health and Medicine continues to manage and enhance the Health Advocate Program. There are six Health Advocates and a Nurse Supervisor, under the direction of the Department's Medical Director of Pediatrics. The health advocates who are each assigned to two or three areas of the state serve as invaluable resources to assure appropriate and timely behavioral and medical health care as well as dental care for DCF-involved children and youth. They perform a variety of functions such as assisting with HUSKY plan selection and enrollment, locating in-network providers or specialty providers, locating out-of-state providers for children and youth who reside in out-of-state facilities or foster homes, facilitating the multi-disciplinary exam referral process for foster children at entry into care, and conducting training for DCF staff and foster parent support groups. As part of its Positive Outcomes for Children developed under the Juan F. lawsuit, DCF requires that at least 80 % of all families and children shall have their medical, dental, mental health and other service needs provided as specified in the most recent treatment plan.

The Bureau of Behavioral Health and Medicine has regional medical teams across the state. Staff includes: regional medical directors; pediatricians, APRNs and nurses. These medical teams oversee medical/psychiatric services in the area offices to improve the timeliness and quality of care for DCF-involved children and youth.

- Housing Services

DCF continues to provide a continuum of living options for children and youth. There are plans to re-design the statewide therapeutic foster care program for children with complex behavioral health needs.

Further, DCF continues to enhance and expand the network of community-based group homes. There are three levels of care: Level 1 (Preparing Adolescents for Self-Sufficiency); Level II (Therapeutic); Level III (Therapeutic—Medically Fragile). The Level 1 homes are designed for youth ages 14 to 21 with mild to moderate emotional problems. Staff consists of a program director, transitional living coordinators, education/vocational specialists, nurses and transitional coaches. Teaching life skills and working with youth to move them successfully through the public school system are key functions. The Level II homes, which are for youth with significant behavioral health issues, are conceptualized as being a higher level of care than the traditional residential treatment centers. These are small homes (e.g. 5-6 beds) in the community where youth can experience a far more normalized existence than is possible in a residential setting. A strong point of emphasis continues to be that these community-based homes are integrated into residential neighborhoods. Further, these providers are expected to integrate normative community, family and peer activities and interaction into the day-to-day care of the children and youth served.

Connecticut will maintain two crisis stabilization programs that provide 24 hour, short term residential care for children/youth, ages 7 to 18 who need a temporary “cooling off” period after experiencing a crisis. Crisis staff conducts assessments and deliver short-term interventions aimed at stabilizing the child and family. The assessment integrates medical, psychosocial, educational and previous treatment history and addresses the needs of the child/youth within the context of their ecosystem. Clinical services include screening and referral, individual, group and family treatment, consultation, parent education and instructional modeling, and linkage to family substance abuse screening. Medication management includes consultation and assessment from a psychiatrist or an APRN under the direction of a psychiatrist.

Short-Term Assessment and Respite (STAR) Homes have replaced the emergency shelter system across Connecticut. Staff provides treatment and support planning for a more effective course of care. The new system has the capacity to serve 84 children through fourteen program sites.

There are several supported independent living options for youth, ages 14 to 23 that are moving towards independent living. The goal is to offer the least restrictive, most community-based resource. The Bureau of Adolescent and Transitional Services maintains responsibility for these services that include: SWET, CHAP, and Foster Parent CHAP. For program details please see the section above under Child Welfare Services.

- Multiculturalism Initiatives

The Multiculturalism Subcommittee, convened under the Children’s Behavioral Health Advisory Council (CBHAC) will continue to work with the community collaboratives to offer technical assistance and educational activities, and to identify and develop locally informed opportunities to enhance cultural competence throughout the service system.

The DCF Task Force on Deaf and Hard of Hearing Persons hosted another annual conference. The agenda included topics relating to assessing and supporting the mental health needs of the deaf and hard of hearing children and families who have cases with DCF. The targeted audience was foster parents, social workers, supervisors, managers, and Area Resource Group (ARG) specialists.

- Network of Care Website (MHT SIG Initiative)

It is recognized by all stakeholders that the behavioral health services system is extensive, complex and often difficult to understand and access. For these reasons, one of the MHT SIG Workgroups applied technological resources to design a comprehensive website to improve access to mental health information, programs, services and other resources. Key features include a website that is current, easy to navigate, available in multiple languages, contains age and reading-level appropriate materials, and allows for searches based on various questions/needs, as well as the potential for individuals to rate programs and services.

Criterion 2A: Estimate the incidence and prevalence of serious emotional disturbance among children in Connecticut

It is estimated that the Connecticut Kid Care behavioral health services system will serve at least 27,000 children who meet the functional and diagnostic criteria for Serious Emotional Disturbance (SED) or who are at high risk for emotional disturbance. Connecticut's methodology for estimating prevalence is based on definitions published in the federal register in 1998. No less than 6 % of the 841,175 children ages 0 to 17 would meet the SED criteria. The defined population, the methodology for determining a count of children with SED receiving public sector services is based upon an evaluation of the state's behavioral health system for children that estimate that such services are provided to approximately 3+ % of the children ages 0 to 17.

DCF, in partnership with stakeholders, is undertaking a critical project to develop, implement and evaluate an enhanced data collection and reporting system for DCF funded programs. The purpose of this initiative, Programs and Services Data Collection and Reporting System (PSDCRS), is to create an effective, efficient, and value-laden information system for describing the populations served and identifying client and program level outcomes. PSDCRS, which will be a web-based application, is expected to be implemented late fiscal year 2009. DCF has contracted with the Corporation for Standards and Outcomes for the development of this new data system. It is expected that this system will improve the data pertaining to children with SED.

Criterion 2B: Identify quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The Department will seek to maintain services at the following levels during FFY 2010.

Care Coordination	1,300
Emergency Mobile Psychiatric Services	5,800
Extended Day Treatment	900
Family Advocacy	4,475
Child Guidance Clinics	12,500
Family Support Teams	375
Respite	180
Crisis Stabilization	275
Intensive In-home	2,000
Short-Term Assessment & Respite Homes	88
Therapeutic Group Homes	290

Criterion 3A: Provide for a system of integrated social services, educational services, juvenile justice services, substance abuse services, health and mental health services appropriate for the multiple needs of children

DCF staff works collaboratively on multiple fronts to support and enhance an integrated and coordinated statewide behavioral health services system. Within the Department the Bureau Chiefs for prevention, child welfare, behavioral health including substance-related services, and juvenile justice services report directly to the Commissioner and meet regularly to plan, assess statewide operations including the interrelatedness across service sectors, and evaluate outcomes. Staff from the various bureaus, divisions and units operates under a unified mission, vision and philosophy of care. All activities are focused on improving a community-based system of care that emphasizes the needs and strengths of the child and family, individualized treatment plans, evidence-based treatments and interventions, cultural competency, family involvement, child/family/system outcomes, and a continuous quality improvement approach.

DCF also has a long-standing history of collaborating with its fellow state agencies to support coordinated care for children with behavioral needs who may be receiving services from various systems. DCF participates on a number of statewide committees, councils and workgroups, including the Behavioral Health Partnership Oversight Committee, Mental Health Transformation State Incentive Grant Oversight Council, the Interagency Suicide Prevention Network, Parents with Cognitive Limitations Workgroup, and the CT Coalition To End Homelessness.

Further, DCF continues to cultivate partnerships with other state agencies. DCF continues to maintain a Memorandum of Understanding (MOU) with both DMHAS and DDS. The MOU with DDS is to facilitate the coordination of services for clients who may be eligible for Voluntary Services through DCF and are eligible for services through DDS, as well as the coordination of services for protective services cases. The MOU with DMHAS supports activities to transition young adults requiring on-going behavioral health care to the adult service system. In partnership with DMHAS' Young Adult Services program, DCF provides funding to facilitate supported community-based living and behavioral health care for youth and young adults with very complex mental health needs. In addition, DCF continues to work collaboratively with the Judicial Branch. DCF and CSSD have entered into a variety of joint Memorandum of Agreements (MOAs) over the years. Some of the MOAs include a Juvenile Review Board program and a trauma initiative for assessing and addressing the trauma needs of juvenile justice involved children. The Department also works in collaboration with the Department of Labor's Office of Workforce Competitiveness and the Workforce Investment Boards, which assist youth and community stakeholders in the planning and creating of employment opportunities for youth across Connecticut. DCF's Bureau of Adolescent and Transition Services has become a strong partner with the Department of Labor.

One of the Department's goals is to ensure that children and youth's educational needs and programming are integrated into and supported through their individualized behavioral health services plan. Education consultants will continue to be employed within each of the Local Area Office's - Area Resource Group (ARG) networks. These professional consultants are experienced in assessing children's educational needs and progress, including the child's eligibility for special education services. Activities include, but are not limited to: review of client educational records to evaluate the appropriateness of the present education program, assess progress and make recommendations for educational programming; observation of the child and consultation with foster parents and other involved professionals, as appropriate; participation in special education planning when children are referred to Pupil Placement Teams and consultation with assigned social workers and/or surrogate parents, when requested; and work with the education community to improve access, coordinate services and facilitate problem resolution, as needed. In addition, the DCF Bureau of Adolescent and Transitional Services has created two Pupil Services positions to assist youth enrolled in two- and four-year colleges as well as vocational,

technical and certification programs. Staff coordinates activities and collects and manages data on youth involved in post secondary services.

Another goal of DCF is to improve the array, coordination and integration of services for children and youth who are court-involved. Gender-specific programming for girls will be maintained or expanded to serve girls who are committed to the Department as delinquent. DCF will further continue to seek to serve children who are court involved through the System of Care and other wraparound processes. A newly planned pilot project under the MHT SIG focuses on the implementation of the Community-Based Wrap-Around Model in two communities to divert children and youth from the juvenile and criminal justice systems. This collaborative project builds on existing resources in the community including local community collaboratives, local family support organizations, DCF-funded care coordinators, DCF and CSSD flexible funding, parole, probation and protective services workers, local mental health service providers, local juvenile review boards, court-based assessment programs, and other complementary initiatives. Infrastructure support will consist of training, in-vivo coaching, fidelity monitoring, administrative supports, clinical quality reviews, and a quality assurance and outcome assessment. This initiative emphasizes community-based service delivery by a diverse blend of practitioners, family voice and choice, culturally competent services, and a strengths-based approach. At least 18 % of court-involved youth will receive care coordination services through the System of Care/ Community Collaboratives.

DCF will continue to integrate youth's substance abuse treatment needs within the context of their broader, holistic service plans. Adolescent Substance Abuse Treatment Outpatient Programs will continue to be funded during SFY 2010. There are six providers who have capacity to service 670 adolescents, annually.

DCF will provide intensive in-home, evidenced based treatment programs for youth with substance use issues, including providing multi-systemic therapy (MST) for youth who are court involved. In addition, Multi Dimensional Family Therapy (MDFT) will be funded. The nine MDFT teams provide clinical services that target interventions with the adolescent, parents, family interactions & relationships, and extra-familial systems. MDFT works through 3 phases to build alliances and motivation, request changes, and seal the changes before discharging the family. This services targets children who have a mental health and/or substance abuse diagnosis, exhibit complex behavioral health service needs, and are either returning from or approved for a residential placement, or are at imminent risk for an out-of-home placement. Two sites (a total of 4 teams) provide services to girls in a juvenile diversion program in New Haven and Waterbury. These girls are court-involved clients and on probation. Five providers serve youth who have been in detention (Emily J class) and their families.

Finally, DCF will continue implementation of the statewide standardized screening and assessment tool - GAIN, which was initially developed through the Connecticut Adolescent Substance Abuse Coordination (CASAC) Project. A family advocacy group for adolescent substance abuse treatment will continue to be supported. There is a focus on intra and inter-state collaboration and internal DCF quality improvements. The inter-agency integration targets adolescent substance abuse standards, screening and assessment, and cross training for child protection, juvenile justice and children's mental health providers. Also, the establishment of agreements at the local and state-levels with agencies, families, local government and local educational systems continues simultaneously with the implementation of collaborative community models.

DCF will work to ensure that children and youth's behavioral health needs are understood and coordinated with their overall health. Health Care Advocates will be maintained to serve all the DCF geographical Area Offices (14 Area Offices covering 169 towns across Connecticut). These staff will assist in ensuring that DCF involved children and youth receive timely access to medically necessary and appropriate primary health, behavioral health and dental services. Furthermore, the health advocates will

assist with ensuring that all DCF children have all their medical, dental, mental health and other service needs provided as specified in their most recently approved treatment plan.

DCF will also continue to fund programs and include contractual provisions that require a holistic care approach for children. Providers that operate therapeutic group homes, STAR homes, safe homes and foster care clinics will be expected to ensure that children have and receive timely access to medically necessary care. Certain services are also charged with coordinating children's receipt of a multidisciplinary examination and other evaluations. Flexible funding will be available for both DCF- and non-DCF involved children served through the System of Care Community Collaboratives to better ensure that they and their families receive necessary support and social services.

DCF will participate in collaborations and partnerships to support integration of multiple systems that serve children with serious emotional disturbances and their families. Linkages with various service systems and sectors will ensure that families' varied needs are met. For example, DCF will maintain a Voluntary Services Program to provide care coordination/case management services and fiscal resources for children with serious emotional disturbance who meet eligibility criteria, in conformance with the current regulations and DCF policy. In addition, within each DCF Area Office, the capacity for collaborative health, dental, mental health, substance abuse and other support service consultation will be maintained or further developed through the existence of Area Resource Group (ARG) teams, the Administrative Case Review process, the Health Advocates program, and the existence of the local Systems of Care/ Community Resource Committees and Child Specific Teams.

The Managed Service Systems (MSS) and the System of Care/Community Collaboratives will be maintained to provide access to children with complex behavioral health care needs and their families across the state. The MSS are to include participation from DCF Area Office staff, providers, families and the Administrative Services Organization. Similarly, the System of Care/Community Collaboratives include membership from a variety of service sectors such as mental health, families, insurance, education, juvenile justice, health, substance abuse, recreation, advocacy, and faith-based organizations for the purpose of ensuring an integrated and holistic service approach to serving children with SED and their families, and increasing children's access to community-based care. Enhanced Care Coordination positions through the Managed Service Systems will be available during FY 2009. These positions will assist in increasing the number of children who access community-based treatment options by identifying appropriate treatment, social services and supports to successfully transition and/or maintain a child in their community.

Criterion 3B: Establishes defined geographic area for the provision of the services of such system.
Services are delivered statewide unless otherwise noted in the narrative under Criterion 1 B.

Criterion 4A: Outreach And Community-Based Services For Children/Youth Who Are Homeless

Connecticut's community-based service system provides for outreach and services for children and adolescents with serious emotional disturbance who are homeless. As described in Criterion 1 B, DCF offers a variety of housing/placement options and services for children and youth, including those who are defined as homeless. For example, therapeutic foster care services are available for DCF committed children/youth with complex behavioral health needs who are at imminent risk of entering or returning from residential treatment or those discharged from hospitals and who do not have a home or readily available family resource.

DCF also operates CT Children's Place (CCP). CCP is a 54-bed residential diagnostic center for children and youth, ages 10 to 18, in need of protection due to abuse, neglect, abandonment, unmanageable behavior or sudden disruption in their current placement or residence. An emergency component responds to those in need of immediate removal from their current setting and for whom there are no interim placement resources. Diagnostic and evaluation services are available for children and youth requiring a therapeutic plan for future placement. CCP also provides brief treatment until a more permanent setting can be provided for the child.

Other significant resources include but are not limited to: Crisis Stabilization Programs; Short Term Assessment and Respite (STAR) Homes; Preparing Adolescents For Self-Sufficiency (PASS) Group Homes; Therapeutic Group Homes; Supportive Work, Education and Transition (SWEAT) Program; Community Housing Assistance Program (CHAP) ; and Foster Parent Community Housing Assistance Program (Foster Parent CHAP). Please see previous sections for details.

Assistance for DCF families in need of housing is addressed through the DCF Supportive Housing Program. The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF. Housing is funded through a combination of DCF funds, DSS Rental Assistance Program Certificates, and federal Section 8 housing vouchers.

Also, through the Supportive Housing for Recovering Families program, parents receive substance abuse treatment, stable housing and case coordination. DCF has also been working closely with the Governor's Interagency Council on Supportive Housing and Homelessness.

Ensuring that homeless children receive appropriate education is also a priority. Providers who operate safe homes, permanency diagnostic centers and STAR homes are required to comply with the McKinney-Vento Homeless Assistance Act. The contract for STAR home providers specifically states: "The contractor will ensure the continuity of educational programming in accordance with the Connecticut legislature's Public Act 03-6, which ensures compliance with the federal McKinney-Vento Homeless Assistance Act (42 USC §§ 11431 et seq.)(McKinney-Vento). This Act includes protections for homeless children, including those residing in Short Term Assessment and Respite Homes."

Children who are placed on an emergency basis in a transitional foster home with the plan of being moved within 30 days to a more permanent foster or adoptive home may be considered covered by McKinney-Vento on a case-by-case basis. Similarly, the CT Department of Education and DCF will also consider applying McKinney-Vento on a case-by-case basis to children who have experienced more than three placements in a 12-month period.

Criterion 4B: Community-Based Services For Children/Youth Who Reside In Rural Areas

Concerning rural populations, Connecticut has defined “rural” based on the US Census Bureau data and definition. Using current census data, there are approximately 29 towns in Connecticut, many in Windham and Litchfield County, which meet the population size criteria for a rural area. Ensuring a comprehensive, coordinated array of services in these rural communities is important to the Department. While the issues of transportation, wait lists and limited service options remain as challenges in Connecticut’s rural areas, DCF continues to recognize and support the need for community programming to meet the unique, local needs. Competitive bidding processes issued by the Department continue to require that applicants model their services in a manner that is cognizant of the area and population to be served. Issues such as transportation, service fees and service location are key elements that must be considered in designing and administering programming in rural areas.

During 2009 DCF will maintain and/or enhance the following core services within the rural areas of Litchfield and Windham County:

- Core Services For Rural Communities
- Care Coordination
- Child Guidance Clinics
- STAR Homes & Group Homes
- Emergency Mobile Psychiatric Services
- Family Support Teams
- Therapeutic Foster Homes

In addition, through the Multiculturalism Subcommittee, a broad definition of culture that includes geographic diversity will continue to be promoted in order to support the provision of appropriate care for persons in rural communities.

In support of Connecticut’s transformation efforts under the MHT SIG, the Department co-lead a workgroup with DMHAS to develop recommendations to eliminate disparities in mental health services. This body was charged with improving access to quality care that is culturally competent and to improve access to quality care in rural and geographically remote areas. This workgroup recommended infrastructure improvements that include maximization of technology and use of telemedicine. Given financial constraints at this time, it is expected that progress will be slow, but steady.

Criterion 5A: Financial Resources, Staffing and Training For Mental Health Services Providers

DCF will maintain sufficient staff and other resources to plan, develop and monitor the behavioral health system. These resources include but are not limited to: community-based services program directors and behavioral health managers; consulting psychologists; health management administrators including pediatricians, psychiatrists, APRNs and RNs; and substance abuse specialists. Further, DCF has contracted with the Corporation on Standards and Outcomes to develop an information system that provides value-laden data, outcomes and performance measures as well as the capacity for online analytical processing.

DCF will support ongoing training and technical assistance to enhance the knowledge and expertise of its staff through the DCF Training Academy. Established in 1997, as a result of the Juan F Consent Decree, the Training Academy's mission is to provide high quality, competency and outcome based, culturally responsive training in accordance with the agency mission and national standards for practice, to encourage staff to attain professional education, and to utilize current research to improve pre-service and in-service training. The goal is to provide opportunities for every staff member to develop the competencies needed to fulfill the mission of the Department and improve the services to children and their families. The Training Academy also seeks to support managers and supervisors in their efforts to create a positive working environment conducive to fostering the development of staff. Staff from the Bureau of Behavioral Health and Medicine serves as adjunct trainers to offer trainings specific to their areas of expertise.

In order to assist our providers (both private, non-profit and state facility staff) to better understand the impact of trauma on behavior, and to support staff, both line and clinical staff, to better manage children with behavioral and affective dysregulation, DCF continues to support the delivery of Dialectical Behavior Therapy (DBT). DBT is a well-established, evidence-based practice that is of enormous practical utility to both staff and clients. It is embedded in a trauma-sensitive framework, and it is frequently used in gender-specific applications.

DCF has signed a Personal Service Agreement with the Child Health and Development Institute of Connecticut, Inc./Connecticut Center for Effective Practice to administer three Learning Collaboratives focused on the adoption of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at licensed outpatient psychiatric clinics for children during SFY 2007 through 2010. The contractor has established a Coordinating Center for the purposes of planning, managing, overseeing and evaluating the activities and tasks necessary to integrate TF-CBT as a primary treatment at up to eighteen clinics. The contractor executes a critical leadership role to advance evidence-based culture and continuous quality improvement to achieve sustained organizational and practice changes that will result in an enhanced quality of care. Consultants from the National Center for Child Traumatic Stress and Yale University are being utilized.

Also, mental health block grant funds will be applied to increase training for the System of Care/Community Collaboratives. This initiative will support the infrastructure and workforce development needs of those local Systems of Care. There will be three components to this initiative. Pre-service Training, In-service Training, and Consultation will be offered to the community collaboratives to establish/enhance basic competencies for care coordinators and other stakeholders. Training will include: the wrap-around model and individualized planning process including building teams and locating natural supports; crisis and safety planning; developing and implementing individualized plans of care; transition and discharge planning; and incorporation of CT-specific practices and standards such as the Ohio Scales, System of Care, natural supports and resources, and parent perspectives. This initiative will also include funding for individual consultation to each collaborative that will assist them in the assessment and

improvement of their care coordination practices and system development efforts, and the maintenance of fidelity to the wrap-around model of care.

Another major training initiative, supported by mental health block grant funds is the development of a standardized model of care for the Extended Day Treatment program. One component includes the Engaging Families in Services Learning Collaborative for frontline direct care workers, clinicians, supervisors, and program managers. The intent is to improve outreach and engagement activities with families through application of research-based engagement protocols and multi-family groups.

At the statewide level, DCF continues to work with the MHT SIG stakeholders to establish the Connecticut Mental Health Workforce Collaborative as a permanent infrastructure charged with planning, coordinating, and implementing interventions to strengthen the behavioral health workforce. The Collaborative will leverage existing resources, link Connecticut's mental health and higher education systems, routinely assess the mental health workforce needs, develop a strategic workforce development plan, implement interventions to strengthen the workforce, promote cultural diversity, disseminate best practices, and advise the executive, legislative and judicial branches relative to workforce issues and policy. Particular areas of focus for children's services will include building a skilled workforce to deliver both intensive home-based services and wrap-around services and strengthening the role of parents in the workforce,

Criterion 5B: Training Of Providers For Emergency Health Services

First responders to youth suicide in CT are the Department's Emergency Mobile Psychiatric Services (EMPS) staff. Due to the generosity of the Garrett Lee Smith federal suicide prevention grant to the Department of Mental Health and Addiction Services, the EMPS staff has been trained in Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals in the state fiscal year of 2008-2009. AMSR was produced by the Suicide Prevention Resource Center (SPRC) and the American Association of Suicidology (AAS) and funding to develop the curriculum was provided by the Substance Abuse and Mental Health Services Administration. DCF and DMHAS staffs worked in partnership to coordinate the training.

Criterion 5C: Mental Health Block Grant Fund Expenditures

The Department plans to utilize MHBG funds to support the planning, delivery and administration of a transformed, comprehensive and integrated community-based system of care for children with behavioral health needs, and their families.

During FFY 2010, the Department proposes to expend the CMHS Block Grant funds for the following types of services:

Service Type	Total by Service Type
Respite Services	\$ 425,992
Family Advocacy Services	\$ 467,300
Youth Suicide Prevention & Mental Health Promotion	\$ 50,000
CT Community Kid Care (System of Care) <ul style="list-style-type: none"> o Workforce Development & Training o Multiculturalism Initiatives 	\$ 110,000
Trauma-Focused Cognitive Behavior Therapy Learning Collaborative	\$ 435,000
Extended Day Treatment – Model Development & Training	\$ 90,000
Best Practices Promotion & Program Evaluation	\$ 100,000
Other Ct Community Kid Care Activities	\$ 20,000
Statewide Total	\$ 1,698,292

Transformation Expenditure: Family Advocacy Services

Consonant with Goal 2 of the New Freedom Commission Report, DCF will expend funds to support activities that are child-centered and family-driven. During FFY 2010, DCF has allocated \$ 467,300. from its MHBG to fund family advocacy services.

The inventory of mental health providers/agencies who will directly receive CMHS Block Grant Allocations is as follows:

State Identifier: Connecticut DCF				
Agency Name	Address	Name of Director	Phone #	Amount CMHS BG
FAVOR, Inc. FAMILY ADVOCACY SERVICES	2138 Silas Deane Hwy, Suite 103 Rocky, Hill CT	Director, Hal Gibber	(860) 563- 3232	\$467,300
Family and Children’s Agency, Inc. RESPITE SERVICES	9 Mott Ave. Norwalk, CT 06850	Vice President, Theda Tucci	(203) 855- 8765	\$ 74,600

CMHS BG Connecticut FFY 2010 State Plan and Application

Agency Name	Address	Name of Director	Phone #	Amount CMHS BG
Family and Children's Aid, Inc. RESPITE SERVICES	75 West Street Danbury, CT 06810	Director, Irvin Jennings, MD	(203) 748- 5689	\$76,367
Jewish Family Services, Inc. RESPITE SERVICES	1440 Whalley New Haven, CT 06515	Director, Barney Yellen	(203) 389- 5599	\$46,133
Klingberg Comprehensive Family Services, Inc. RESPITE SERVICES	370 Linwood St. New Britain, CT 06052	Director, Rosemarie Burton	(860) 224- 9113	\$106,394
United Community & Family Services, Inc. RESPITE SERVICES	77 East Town Street Norwich, CT 06360	CEO/ President, Charles Seeman	(860) 889- 2375	\$76,367
United Way of Connecticut SUICIDE PREVENTION	1344 Silas Deane Highway	Vice President, Mary Drexler	(860) 571- 7528	\$50,000
YMCA of No. Middlesex Co. Inc. RESPITE SERVICES	99 Union Street Middletown, CT 06457	President, Frank Sumpter	(860) 347- 6907	\$46,133
Report Year: FFY 2010				

C. GOALS, TARGETS AND ACTION PLANS

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 1: NOM - Increased Access to Services (Service Capacity)

Name of Performance Indicator: Increased Access to Services (Service Capacity)				
Population: Children/youth with complex behavioral health needs			Criterion: 2 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (# of clients served)	27,330	28,815	28,200	28,250*
Numerator	NA	NA	NA	NA
Denominator	NA	NA	NA	NA

Goal: To ensure access to publicly funded behavioral health services

Target: Increase the level of access to publicly funded behavioral health services at 28,250*

Population: Children and youth with complex behavioral health care needs

Criterion: Criterion 2 – Estimates of Prevalence and Treated Prevalence of Mental Illness
Criterion 3 - Children's Services

Indicator: Number of children/youth with complex behavioral health needs that receive services

Measure: Number of clients served (Numerator and Denominator not applicable.)

Source of Information: Programs and Services Data Collection and Reporting System *

Special Issues: * A new data system, Programs and Services Data Collection and Reporting will begin on July 1, 2009. The existing data system (Behavioral Health Data System) will be terminated. There will be no data import from the current system to the new system, thus we anticipate some data issues in the first year of operation. There may be a decrease in cases due to a lack of diligence by providers in continuously "scrubbing the data in the current system (resulting in higher numbers now versus the new system) coupled with the difficulties inherent in entering all cases, existing and new into a new database.

Significance: This measure identifies the number of children and youth who receive behavioral health services funded by the Department of Children and Families.

Action Plan: DCF will continue to maintain the array of community-based behavioral health services available to children with complex behavioral health care needs, as identified in Section III Criterion 1A - Description of Services. In addition, the Department will continue to fund family advocacy services to support children, youth and their caregivers' increased access to necessary behavioral health services. The CT Behavioral Health Partnership will continue to support activities that assure access to behavioral health care including monitoring and evaluation of the Enhanced Care Clinics.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 2-1: NOM - Reduced Utilization of Psychiatric Inpatient Beds - 30 Days Readmission

Name of Performance Indicator: Re-admission rates within 30 days of discharge from inpatient care				
Population: Children/youth in need of inpatient care at Riverview Hospital			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (% of clients re-admitted)	.004%	1.27%	2.50 %	2.50 %
Numerator	1	3	NA	NA
Denominator	243	236	NA	NA

Goal: To reduce use of psychiatric inpatient services

Target: Maintain the percent of readmissions at 2.5 % or less.

Population: Children/youth in need of inpatient care through Riverview Hospital

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services

Indicator: Children/youth who are re-admitted to Riverview Hospital within 30 days of discharge

Measure: Percent of children/youth who are re-admitted to the hospital within 30 days of discharge

Numerator: Number of individuals who are discharged from Riverview Hospital and readmitted within 30 days

Denominator: Total number of individuals who are discharged from Riverview Hospital during the reporting year

Source of Information: Riverview Hospital Data System

Special Issues: None

Significance: Inpatient care should be utilized only when clinically indicated and time-limited.

Action Plan:

DCF will provide multiple, diverse activities to support the reduction in use of inpatient psychiatric care. These include, but are not limited to: a recovery-focused model of care at Riverview Hospital; continued use of the Residential Care Team to screen all referrals for inpatient level of care; maintenance of the

community-based service system; continued use of the Managed Service System and the System of Care Community Collaboratives/Care Coordinators to identify, assess, and appropriately plan for the least restrictive resources to meet the clinical needs of children/youth with SED; and enhanced targeted utilization management activities by the CT BHP to identify high-end service users and facilitate service planning that supports community-based care. Riverview continues to enhance programming to focus on trauma reduction and successful transition into the community. There is ongoing collaboration with private providers and communities to support patients and prevent further hospitalizations.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 2-2: NOM- Reduced Utilization of Psychiatric Inpatient Beds - 180 Days Readmission

Name of Performance Indicator: Re-admission rates within 180 days of discharge from inpatient care				
Population: Children/youth in need of inpatient care at Riverview Hospital				Criterion: 1 and 3
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (% of clients re-admitted)	.41%	3.38%	2.00 %	2.00 %
Numerator	1	8	NA	NA
Denominator	243	236	NA	NA

Goal: To reduce use of psychiatric inpatient services

Target: Maintain the percentage of readmissions at 2 % or less

Population: Children/youth in need of inpatient care through Riverview Hospital

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services

Indicator: Children/youth who are re-admitted to Riverview Hospital within 180 days of discharge

Measure: Percent of clients who are re-admitted to Riverview Hospital within 180 days of discharge

Numerator: Number of individuals who are discharged from Riverview Hospital and re-admitted within 180 days

Denominator: Total number of individuals who are discharged from Riverview Hospital during the reporting year

Source of Information: Riverview Hospital Data System

Special Issues: None

Significance: Inpatient care should be utilized only when clinically indicated and time-limited.

Action Plan:

DCF will provide multiple, diverse activities to support the reduction in use of inpatient psychiatric care. These include, but are not limited to: continued use of the Residential Care Team to screen all referrals

for inpatient level of care; use of a trauma-based, recovery-focused approach at Riverview Hospital; maintenance of the community-based service system; continued use of the Managed Services System and the System of Care Community Collaboratives/Care Coordinators to identify, assess, and appropriately plan for the least restrictive resources to meet the clinical needs of children/youth with SED; and enhanced targeted utilization management activities by the CT BHP to identify high-end service users and facilitate service planning that supports community-based care. Riverview continues to enhance programming to focus on trauma reduction and successful transition into the community. There is ongoing collaboration with private providers and communities to support patients and prevent further hospitalizations.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 3: NOMS - Use of Evidence Based Practices

Name of Performance Indicator: Use of Evidence-Based Practices (EBPs)				
Population: Children/youth that receive evidence-based treatments			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Number of Evidence-Based Practices)	7	11	11	12*
Performance Indicator (Percent of Individuals Receiving EBPs)	7.65%	10.87%	NA	NA
Numerator	2093	3134	NA	NA
Denominator	27,330	28,815	NA	NA

* Includes TFC, MST, FFT, Multi-Dimensional Family Therapy (MDFT), Multi-Dimensional Family Therapy - Family Substance Abuse Treatment Services (MDFT-FSATS); Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS); Family Support Teams; MST-Problem Sexual Behavior; MST - Building Safe Families; Family-Based Recovery (FBR); Trauma-Focused Cognitive Behavior Therapy (TF-CBT); and Dialectical Behavior Therapy (DBT).

Evidence-Based Practice	FY 2007 Actual n	FY 2008 Actual n	FY 2009 Projected n	FY 2010 Target n
Therapeutic Foster Care	1,418	1,435	1,000	1,000
Multi-Systemic Therapy	391	365	350	325**
Functional Family Therapy	250	427	300	400

325** - A non-performing MST program will be terminated and the funds will be re-allocated to a more intensive MST program that serves fewer children, thus the decrease in our estimated target.

Goal: To deliver evidence-based treatment models to affect positive outcomes for children and youth

Target: Increase the number of evidence-based practices to 12 and number of children/youth served

Population: Children and youth with complex behavioral health care needs and their families

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services

Indicator: Number of evidence-based practices that are delivered throughout the state and the percent of children/youth that receive these research-based treatments

Measure: Number of evidence-based practices; and
Number of children/youth that receive evidence-based treatments
Numerator: Not Applicable
Denominator: Not Applicable

Source of Information: Programs and Services Data Collection and Reporting System * and other data sources

Significance: Use of scientifically based treatment models is an important means of ensuring that children and youth receive care that is appropriate and effective.

Special Issues: *A new data system, Programs and Services Data Collection and Reporting will begin on July 1, 2009. The existing data system (Behavioral Health Data System) will be terminated. There will be no data import from the current system to the new system, thus we anticipate some data issues in the first year of operation. There may be a decrease in cases due to a lack of diligence by providers in continuously "scrubbing the data in the current system (resulting in higher numbers now versus under the new system) coupled with the difficulties inherent in entering all cases, existing and new into a new database.

Action Plan: The Department will continue to provide state funds for the delivery of Multi-Systemic Therapy and Family Functional Therapy. Additionally, some state funds will support related training and quality assurance activities.

The Department is in the process of redesigning its Therapeutic Foster Care (TFC) system. Under this new system, which is slated to begin during the fall of SFY 2010, a standardized referral process, using the Child and Adolescents Needs and Strengths (CANS), will be implemented. The introduction of the CANS is expected to better ensure that the "right" children have timely access to quality therapeutic level care within a family setting. The Department will be contracting to provide up to 940 TFC slots, with significantly enhanced per diem rates for foster parents and provider agencies, and robust training, care management, data collection, and outcome expectations.

The 940 slots do not include siblings who will be placed with a sibling who requires a TFC placement. The current count (i.e. SFY 2009 Projected) of TFC reflects a comingling of the TFC level children and their siblings who are placed with them. Thus, the previous years' projected and actual were based upon an undifferentiated count (i.e. TFC level children served plus their "non-clinical needing" siblings placed with them in a TFC setting). The SFY 2010 target is a projection of total number of TFC level children only and the total unduplicated count of such children who will have been placed in TFC at any point during the SFY 2010 fiscal year.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 4: NOM - Client Perception of Care

Name of Performance Indicator: Client Perception of Care				
Population: Families caring for children receiving mental health services			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Percent of clients)	62 %	64%	63%	64%
Numerator	279	253	NA	NA
Denominator	450	393	NA	NA

Goal: To achieve positive responses regarding care outcomes

Target: Achieve positive client perception of care responses from 64 % of survey participants

Population: Families caring for children receiving DCF-funded behavioral health services

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 – Provision of Children’s Services

Indicator: Percent of clients reporting positively regarding outcomes

Measure: Percent of clients responding positively about outcomes

Numerator: # of positive responses reported in the outcome domain of the child consumer survey

Denominator: Total responses reported in the outcome domain on the child consumer survey.

Source of Information: Youth Services Survey for Families (YSS-F)

Special Issues: None

Significance: Client input about service and care perception informs quality maintenance and system improvement

Action Plan:

The entire service delivery system is focused on improving the quality of care and child/family outcomes. DCF continues to expand the use of the YSS-F with community services providers. DCF will continue to contract with the University of Connecticut and work with selected providers to execute the survey and

tabulate the results until the survey is automated within the newly designed, Programs and Services Data Collection and Reporting System (PSDCRS). The latter is not anticipated to occur until 2010 or later.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 5: NOM - Return to/Stay in School

Name of Performance Indicator: Return to/Stay in School				
Population: A sample of children with complex behavioral health needs				Criterion: 1
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Percent of clients)	93.04%	88.04%	89%	90 %
Numerator	401	162	NA	NA
Denominator	431	184	NA	NA

Goal: To support children and youth achieving their fullest potential through regular school attendance

Target: Increase school attendance for a sample of children/youth receiving community-based behavioral health services

Population: A sample of children/youth with complex behavioral health needs who receive community-based mental health services

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services

Indicator: Children/youth with complex behavioral health needs and receiving community-based behavioral health services that maintain or increase school attendance

Measure: The percent of children/youth whose school attendance improved or remained the same in a sample of those receiving community-based mental health services

Numerator: Number of YSS-F survey responses that report maintenance or improvement in school attendance

Denominator: Total number of completed YSS-F Surveys

Source of Information: Youth Services Survey for Families (YSS-F)

Special Issues: None

Significance: Children and youth's regular and stable attendance at school is an indicator of functional and behavioral improvement.

Action Plan:

The Department will continue to support children, youth, families, behavioral health providers, other service providers and advocates to advance a collaborative person-in-environment approach in meeting the needs of children/youth with behavioral health issues. Many service contracts require providers to collaborate with school personnel in meeting the needs of the child/youth. The Department will continue to fund Enhanced Care Coordinator positions to assist children and families in maintaining or improving stability in their lives including overall functioning at home, with peers, in the school environment and the broader community. The Enhanced Care Coordinators will ensure that families are linked with appropriate community resources and that any issues arising in the school environment are successfully addressed. Their work will be supported by the tasks performed by Family Support Teams, local family advocates, family/peer specialists provided through the CT BHP, DCF Area Resource Group specialists and social workers, and school personnel.

Flexible funding continues to be available to support activities that are congruent with a child's Individual Service Plan. Dedicated school-related flexible funding is also available for youth who are juvenile justice involved.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 6: NOM - Decreased Criminal Justice Involvement

Name of Performance Indicator: Decreased Criminal Justice Involvement				
Population: Children with complex behavioral health needs who are involved with juvenile justice			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (% of clients served)		44%	45%*	46%
Numerator		60		
Denominator		136		

*Target not set in FFY 09 State Plan due to omission, so this is newly set target.

Goal: To support children and youth with complex behavioral health needs to achieve their fullest potential through normative community-based activities without criminal justice involvement

Target: To decrease the number of children/youth involved in the criminal justice system by 1 %.

Population: A sample of children and youth with complex behavioral health needs who receive community-based services

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 – Provision of Children's Services

Indicator: Children/youth with complex behavioral health needs and receiving community-based behavioral health services that maintain or decrease criminal justice involvement

Measure: Percent of children/youth arrested in Year 1 who are not re-arrested in Year 2

Numerator: Number of responses that report arrests in Year 1 and no arrests in Year 2

Denominator: Total number of completed YSS-F surveys

Source of Information: Youth Services Survey for Families (YSS-F)

Special Issues: None

CMHS BG Connecticut FFY 2010 State Plan and Application

Significance: Children/youth who are court involved may have significant behavioral health care needs. Connecting these children/youth to community-based treatment options better ensures that children receive indicated treatment and may aid in abating future juvenile justice involvement.

Action Plan:

DCF in partnership with the Connecticut Judicial Branch-Court Support Services Division will offer a menu of enhanced services for the juvenile justice population including therapeutic mentoring, flexible funding, outpatient substance abuse treatment, and wraparound home-based behavioral health treatment services. The System of Care Community Collaboratives, through the functions of the Care Coordinators plays a critical role in assuring the delivery of these services.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 7: NOM - Increased Stability in Housing

Name of Performance Indicator: Increased Stability in Housing				
Population: Children/youth with complex behavioral health needs			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Percent of clients)		.69%	.68%*	.68%
Numerator		199	NA	NA
Denominator		28,815	NA	NA

*Target not set in FFY 09 State Plan due to omission, so this is newly set target.

Goal: To assure safe, stable housing for children and youth with complex behavioral health needs

Target: Maintain the level of homelessness at less than 1 % for children/youth served in the publically funded behavioral health service system

Population: Children/youth with complex behavioral health needs who receive publically funded mental health services

Criterion: **Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services**

Indicator: Children/youth with complex behavioral health needs and receiving community-based mental health services that maintain or increase stability in living arrangements

Measure: Percent of children/youth that are homeless or living in shelters

Numerator: Number of children/youth who are homeless or living in shelters

Denominator: Total number of children/youth who are receiving community-based behavioral health services

Source of Information: Programs and Services Data Collection and Reporting System *

Special Issues: * A new data system, Programs and Services Data Collection and Reporting will begin on July 1, 2009. The existing data system (Behavioral Health Data System) will be terminated. There will be no data import from the current system to the new system, thus we anticipate some data issues in the first year of operation. There may be a decrease in cases due to a lack of diligence by providers in continuously "scrubbing the data in the

current system (resulting in higher numbers now versus the new system) coupled with the difficulties inherent in entering all cases, existing and new into a new database.

Significance: Stable housing is an essential basic need and critical to supporting children and youth's improved functioning and achievement of their fullest potential.

Action Plan: DCF will continue to maintain a diverse array of community-based living arrangements including but not limited to: adoptive homes; therapeutic foster homes; therapeutic group homes; transitional group homes; and independent living facilities (supervised/unsupervised apartments, etc.). Also, DCF will continue to operate 14 STAR homes across the state. These are small, family-like homes that provide temporary, short-term care for children/youth that must be removed from their homes due to abuse/neglect. A range of evaluation, clinical treatment and nursing services are available. Services are provided within a structured milieu by trained staff.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 8: NOM - Increased Social Supports/Social Connectedness

Name of Performance Indicator: Increased Social Supports/Social Connectedness				
Population: Families caring for children receiving mental health services			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Value)	83%	89.92%	85%	86 %
Numerator	377	357	NA	NA
Denominator	454	397	NA	NA

Goal: To enhance social supports/social connectedness for children, youth and families served in the community-based behavioral health system

Target: To increase the number of families who report favorably regarding enhancing social supports and social connectedness by 1 %

Population: Families caring for children/youth receiving DCF-funded behavioral health services

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 – Provision of Children’s Services

Indicator: Families with children/youth who have complex behavioral health needs that respond positively regarding social supports/social connectedness

Measure: Percent of families responding positively about social supports/social connectedness

Numerator: # of positive responses reported in the outcome domain of the child consumer survey

Denominator: Total number of responses reported in the outcome domain on the survey

Sources of Information: Youth Services Survey for Families – (YSS-F)

Special Issues: None

Significance: Client input about service and care perception informs quality maintenance and system improvement

Action Plan:

DCF continues to work with providers and the broader stakeholder community including family advocates and natural helping networks to support the inclusion of those with mental illness into the full life of the community, building support networks across multiple domains such as school, arts community, and community recreation services.

Also, DCF continues to expand the use of the YSS-F with community services providers. DCF will continue to contract with the University of Connecticut and work with selected providers to execute the survey and tabulate the results. Future plans include the incorporation of the YSS-F survey into the newly designed, Programs and Services Data Collection and Reporting System.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 9: NOM - Improved Level of Functioning

Name of Performance Indicator: Improved Level of Functioning				
Population: Families caring for children receiving mental health services			Criterion: 1 and 3	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (Percent of clients)	65 %	65%	67%	67.5 %
Numerator	296	257	NA	NA
Denominator	454	394	NA	NA

Goal: To improve the level of functioning for children/youth with complex behavioral health needs

Target: Increase the percent of families that respond positively in the outcome domain regarding level of functioning by .5%

Population: Families caring for children receiving DCF-funded behavioral health services

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 – Provision of Children’s Services

Indicator: Families caring for children with complex behavioral health needs that report positively regarding level of functioning

Measure: Percent of clients responding positively about outcomes relating to level of functioning

Numerator: # of positive responses reported in the outcome domain of the child consumer survey

Denominator: Total responses reported in the outcome domain on the child consumer survey.

Source of Information: Youth Services Survey for Families – (YSS-F)

Special Issues: None

Significance: Client input about service and care perception informs quality maintenance and system improvement

Action Plan:

DCF continues to fund and support an effective system of care that delivers high quality clinical services that work to reduce symptoms of mental illness and promote healthy recovery with a full life in the community. Please refer to previous sections that describe the array of services including evidence-based treatments.

DCF continues to expand the use of the YSS-F with community services providers. DCF will continue to contract with the University of Connecticut and work with selected providers to execute the survey and tabulate the results. In the next one to two years, DCF plans to incorporate the survey into the newly designed behavioral health information system. This will allow broader access to survey respondents.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 10: State Transformation Indicator - Family-Driven Behavioral Health Services

Name of Performance Indicator: Family-Driven Behavioral Health Services				
Population: Families caring for children with mental health needs				Criterion: 1 and 3
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (# of families)	4,450	5,390	4,475	5,200
Numerator	NA	NA	NA	NA
Denominator	NA	NA	NA	NA

Goal: Assure that all families who are part of local systems of care receive culturally responsive advocacy, education and support services

Target: Provide statewide family advocacy services to 5,200 families

Population: Families caring for children with complex mental health needs

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 - Children's Services

Indicator: Families receiving family advocacy, education and support services

Measure: Number of families that receive family advocacy, education and support services
(Numerator and denominator are not applicable.)

Source of Information: Programs and Services Data Collection and Reporting System *

Special Issues: *A new data system, Programs and Services Data Collection and Reporting will begin on July 1, 2009. The existing data system (Behavioral Health Data System) will be terminated. There will be no data import from the current system to the new system, thus we anticipate some data issues in the first year of operation. There may be a decrease in cases due to a lack of diligence by providers in continuously "scrubbing the data in the current system (resulting in higher numbers now versus under the new system) coupled with the difficulties inherent in entering all cases, existing and new into a new database.

Significance: Meaningful family involvement is essential to creating a responsive behavioral health services system. Family participation is key to the development of individualized, culturally competent and strengths-based care that supports children/youth in realizing

their fullest potential.

Action Plan:

The family advocacy organization, FAVOR, Inc. that is funded with block grant resources will continue outreach, education, training and advocacy activities, as follows.

1. Increase and strengthen the development and functioning of adolescent and family support and advocacy groups across the state
2. Utilize newly acquired teleconferencing equipment to hold bi-monthly family organizations and System of Care leadership calls focused on sharing best practices and policy work.
3. Participate fully in the CT BHP Oversight Council and its sub-committees while serving as co-chair of the provider advisory sub-committee.
4. Continue to play a leadership role on the 3 funded Transformation grant projects.
5. Manage and lead 2 Citizen Review Panels charged with commenting on DCF performance in Child Welfare, focusing on family engagement and family-centered practice.
6. Continue to provide direct services to families through 10 family advocates that carry caseloads of 24 to 30 families.
7. Continue to lead FAVOR's public policy committee with 46 parents as members to establish policy priorities targeting gaps and barriers in the service system.
8. Fund partner agency's to provide community-based outreach, education and training.
9. Fund additional start-up family advocacy organizations, to the extent funds are available.
10. Strengthen the newly established multi-member data committee to examine statistics and trends.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2010
PERFORMANCE INDICATORS-CHILD**

Indicator 11: State Indicator - Suicide Prevention and Crisis Response Training

Name of Performance Indicator: Increased Suicide Prevention and Crisis Response Training				
Population: Youth, families, DCF staff, providers and first responders				Criterion: 1, 3 and 5
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
Performance Indicator (# of individuals)	864	716	700	715
Numerator	NA	NA	NA	NA
Denominator	NA	NA	NA	NA

Goal: Increase knowledge base of youth, families, DCF staff, providers and first responders with respect to the prevention of youth suicide

Target: Provide suicide prevention training to 715 persons annually

Population: Youth, families, DCF staff, providers and first responders

Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System
Criterion 3 – Children’s Services
Criterion 5 – Management Systems

Indicator: Youth, families, DCF staff, providers and first responders that receive suicide prevention and crisis response training

Measure: Number of persons who are trained in DCF-funded youth suicide prevention and crisis response during the state fiscal year. (Numerator and denominator are not applicable.)

Source of Information: Quarterly reports from providers

Special Issues: None

Significance: Increasing individual’s knowledge of the issue and signs related to youth suicide, trauma and crisis may assist in abating the number of attempts and/or completed suicides in the state.

Action Plan:

DCF will continue funding a contract with the United Way of Connecticut for the provision of youth suicide prevention training. DCF will maintain a contract, as long as state appropriations allow, with the

Connecticut Clearinghouse to provide DCF staff and members of the Youth Suicide Advisory Board with a membership to a resource library. In addition, through the DCF Training Academy, a training session that addresses suicide prevention and provides continuing education credits will be offered throughout the year to DCF staff. This training is also delivered to schools, community groups and the CT Association of Foster and Adoptive Parents through concentrated outreach by the contractor.

The mental health of young children in the care of the Department and Head Start often exhibit signs of mental distress. Funds will be provided for mental health professional consultants to work with children as needed in Head Start agencies within the Manchester DCF Area Office region.