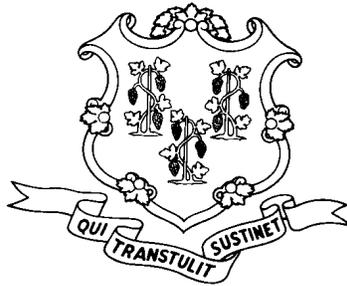


STATE OF CONNECTICUT



Community Mental Health Services Block Grant FY 2012-2013

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

Including

The Community Mental Health Plan For Children & Adults

September 1, 2011

Submitted By

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

OCTOBER 1, 2011 to JUNE 30, 2013

Behavioral Health Assessment And Plan

A. Framework for Planning - Mental Health

Identified Populations That Are The Focus Of The Mental Health Block Grant

Comprehensive community-based behavioral health services will be provided to the following specified populations:

- Children/adolescents with serious emotional disturbance (SED) and their families;
- Children/adolescents with mental, emotional and behavioral disturbances, including those at risk of having behavioral health disorders and their families; and
- Adolescents with behavioral health and substance use disorders.

For the specified populations identified above, targeted services will be provided to the following:

- Children/adolescents involved in the child welfare and/or juvenile justice system (Includes children/youth who have experienced chronic trauma and exhibit depression, PTSD or related symptoms);
- Children/adolescents who are homeless;
- Children/adolescents who are "aging out" of the child welfare system and require ongoing behavioral health and/or developmental services;
- Children/adolescents who are underserved due to racial/ethnic/LGBTQ status;
- Schools and local communities to promote emergency/crisis response services and suicide prevention; and
- Families of children/adolescents with behavioral health service needs, targeting family outreach and engagement through use of evidence-based protocols and a Strengthening Families model of care.

The Department will continue to work closely with the Department of Social Services (CT's Medicaid agency) and the CT Behavioral Health Partnership (CT BHP) to determine who will not be covered by Medicaid in 2014. Currently, HUSKY B (Healthcare for Uninsured Kids and Youth) provides health coverage, including behavioral health services, to children in households that have income up to 300% of the Federal Poverty Level. Coverage level is primarily determined by family income, as follows.

HUSKY Part A provides health services for low income children under age 19, pregnant women and some parents or relative caregivers of covered children with family income at or below 185%.

HUSKY Part B Tier 1 provides health services for families with incomes between 185% and 235% of the Federal Poverty Level.

HUSKY Part B Tier 2 provides health services for children in households with income between 236% and 300% of FPL.

HUSKY Part B Tier 3 provides health services for children in households with income above 300% of FPL.

HUSKY Plus provides additional coverage for children with HUSKY B (Tiers 1 and 2 only) who have intensive physical health care needs.

There is NO asset restriction for any level. Higher income families pay co-pays and sometimes premiums.

Estimates regarding the uninsured population vary by data source. The latest data from the US Census Bureau's Current Population Survey (CPS) indicate that in 2009, an estimated 62,000 Connecticut children under 18 (7.7%) were uninsured for the entire year. The 2-year average uninsured rates for all persons under 65 and for children in Connecticut in 2008-09 were essentially unchanged from recent previous years. An estimated 33,000 Connecticut children under 19 who lived in families with income at or below 200 percent of the federal poverty level (\$43,512 for a two-parent family with 2 children in 2009) were uninsured. Nearly all uninsured children in Connecticut are eligible for coverage in the HUSKY Program. The state's Office of Health Care Advocacy (OHCA) estimates that 2.1 percent of Connecticut children are uninsured—about 17,300. That's considerably lower than the CPS report. It should be noted that OHCA's study reported the number of uninsured children at one specific point in time, while other studies report how many children have been uninsured at any point within a given calendar year.

Connecticut has been quite successful in marketing HUSKY to large numbers of children. The next goal is to refine the approach to reach children in underserved communities.

Any newly designed Medicaid programs will certainly include the integration of primary care. Areas that may be supported by block grant funds in the future include wellness, prevention, and recovery support services. Further assessment and planning is necessary.

B. Planning Steps

Step 1: Assess the strengths/needs of the service system to address specific populations

The Department of Children and Families (DCF) is a consolidated children's service agency. DCF is legislatively mandated to provide behavioral health, child welfare, juvenile justice, substance abuse, prevention, and education services with the latter services provided exclusively for children in out-of-home placement. The legislative mandate reflects Connecticut's historical belief that the wide range of services necessary to meet the needs of children with serious emotional disturbance and their families can best be realized through an integrated, multidisciplinary approach that draws upon family, community and state resources.

(Criterion 1A: Establishment and implementation of an organized community-based system of care for individuals with mental illness) DCF has two different State-level administrative roles in the delivery of its behavioral health services. The Department:

- Provides or Operates Some Behavioral Health Services: DCF directly operates a children's psychiatric hospital for consumers from 5 to 17 years old (Riverview), a residential treatment program (CT Children's Place), a facility for male-adjudicated offenders (CT Juvenile Training Center), and an experimental wilderness challenge program (Wilderness Center).
- Funds and Evaluates Other Behavioral Health Services: DCF administers most of its other behavioral health treatment and rehabilitative services through contracts with community-based providers. Those services include: privately operated residential treatment facilities; therapeutic group homes; therapeutic foster care; therapeutic day care; intensive in-home services; extended day treatment; outpatient mental health and adolescent substance abuse services, emergency mobile psychiatric services; care

coordination services; respite services; early childhood intervention/prevention services; and family advocacy.

At the local level, DCF's services are organized and integrated through a network of 25 statewide community collaboratives that are part of the children's system of care and attached to each of the DCF's 15 local area offices. Each collaborative consists of local service providers, family advocates and family members. They meet regularly to plan, address system of care issues, and implement solutions for keeping children in their homes and strengthening community-based services. Parents and families are an integral part of the planning, treatment and decision-making process.

Each collaborative has care coordinators who are specially trained service brokers. Working in partnership with families, they identify and advocate for appropriate services and ensure that an individual service plan is developed and implemented. Child-specific team meetings may be convened at the request of the family to assure the implementation of a timely, appropriate service plan.

Another component of the local service delivery system is the Managed Service System, which is a consortium of DCF staff and DCF-funded provider agencies convened by local area office staff to assure that a comprehensive and coordinated array of services are available 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 services in a timely manner.

Since January 1, 2006 the Connecticut Behavioral Health Partnership (CT BHP), which is the Administrative Services Organization (ASO) administered by Value Options as the vendor under contract with the DCF and the Department of Social Services (DSS), has managed Medicaid mental health and substance abuse services and selected DCF-funded behavioral health services. The goal is to provide enhanced access to, and coordination of, a more effective system of community-based behavioral health services and supports for children and families. The Department of Mental Health and Addiction Services (DMHAS) was added in 2011 to form a three-way partnership. For Children's Services the benefit design includes children and families who are eligible for Health Insurance for Uninsured Kids and Youth (Husky-Part A and Part B programs), those who are eligible for the Limited Benefit Program through DCF, and those who are ineligible for the previous benefits but who have complex behavioral health needs that have led to their involvement in DCF. Medicaid behavioral health services that are available through the CT BHP include: inpatient psychiatric hospitalization; partial hospitalization; substance abuse/detoxification services; residential treatment services; intensive in-home services; outpatient mental health and substance abuse services; emergency mobile psychiatric services; medication evaluation and management; extended day treatment; and psychological/neuropsychological testing.

Staff at Value Options works closely with family members, providers and other stakeholders to address the needs of members and to improve the provider system. There are 6 regional network managers who focus on provider-specific targets, such as increasing access to care and service capacity by reducing lengths of stay and delayed discharges at local hospital emergency and

inpatient departments. There are licensed care managers that focus on authorizing care for all covered services and working with providers to track a member's progress against goals and objectives developed within the treatment plan. Intensive care managers are assigned to a variety of clinical arenas to assist in the development and implementation of treatment plans for members with complex behavioral health needs. They 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. Other staff includes peer support specialists who are adults that have had personal experiences with mental health and/or substance abuse services, and family support specialists who are trained parents of children with behavioral health needs. Each of these staff is organized into "geo teams" that cover a specific area within the state.

The CT BHP has utilized funding incentive programs to positively impact timely access and service capacity. One example is the implementation of 29 Enhanced Care Clinics (outpatient children's services' clinics) that meet timeliness standards for access based on level of acuity to receive enhanced rates that are approximately 25% higher than average CT BHP rates. Another example is the use of incentive funding for hospitals to decrease inpatient discharge delays and the number of inpatient placements.

(Criterion 3A: Provide for a system of integrated social services, educational services, juvenile justice services, substance abuse services, health and mental health services) The Department plays a key leadership role in coordinating services at all levels of the state system. The Office of the Commissioner works closely with the Office of the Governor, Office of Policy and Management, Connecticut State Legislature, consumers and family members, advisory groups, service providers, and state/federal agencies. The Commissioner has appointments or ex officio memberships to 19 statewide, regional and local boards, councils and committees. DCF staff also serves on several state-level work groups such as the CT BHP Oversight Council, CT BHP State/Provider Committee, Mental Health Transformation State Incentive Grant Oversight Council, Interagency Suicide Prevention Network, Parents with Cognitive Limitations Workgroup, legislatively mandated School-Based Health Clinics Committee, and CT Coalition to End Homelessness. Connecticut has several family advocacy organizations that provide peer support, parent education and advocacy including: FAVOR; Families United for Children; Padres Abriendo Puertas (Parents Opening Doors); African Caribbean American Parents of Children with Disabilities (AFCAMP); and NAMI-CT. Through all of these venues DCF collaborates with a diverse array of stakeholders to obtain multiple perspectives on unmet needs and priorities and to identify short and long term directions for the statewide service delivery system.

Coordination efforts between DCF and DMHAS occur on multiple levels. The Commissioners are members of the Governor's Cabinet and participate in regular collaborative planning and dialogue regarding cross-cutting issues of importance to both agencies. Staff from both Departments is involved in other policy coordination opportunities such as the statewide Alcohol and Drug Policy Council and the Interagency Council on Supportive Housing and Homelessness. A Memorandum of Agreement (MOU) between DCF and DMHAS supports coordinated activities to transition DCF-involved young adults requiring ongoing behavioral health care to

the adult service system. Other joint programs include Project Safe, DMHAS's substance abuse treatment services for child welfare-involved children, and Project Safe RSVP, a Family Court diversion program that provides parents with treatment supports and legal representation. Also, DCF and DMHAS staff has a collaborative planning process, in partnership with the JSMHPC, to develop and evaluate the Block Grant Application and Plan as well as the Implementation Report each year.

DCF has a long-standing history of collaborating with several state agencies. For example, DCF continues to maintain a MOU with the Department of Developmental Services (DDS) to assure timely identification of youth with SED and developmental disabilities, who may need to be referred to DDS for ongoing services at the time of discharge from DCF. Children with SED and physical disabilities may also be referred to Vocational Rehabilitation for services. DCF and the Judicial Branch – Court Support Services Division (CSSD) have several joint MOUs and other initiatives that support: the shared dissemination of evidence-based practices such as Multi-Systemic Therapy (MST), Multi-Dimensional Family Therapy (MDFT), and Intensive In-Home Child and Adolescent Psychiatric Services (IICACPS); shared flex funding for court-involved youth; a Joint Justice Strategic Plan that includes an inter-agency work group to develop a results-based accountability framework; and the MacArthur Foundation MH and JJ Action Network Project. Through a collaboration with DCF, DSS, and two hospitals, the Child and Adolescent Rapid Emergency Service has been established to provide short-term inpatient stabilization and evaluation service to determine if more restrictive care is warranted for consumers. DCF works in partnership with the Department of Public Health to coordinate licensing regulations and policies and to support school-based health clinics. DCF and the Department of Education (DOE) have several formal linkages based on MOUs, practice improvements, reimbursement policies, public policies and other initiatives. Examples include the improvement of emergency mobile psychiatric services and the Park Street/Bridgeport Schools' implementation of Positive Behavior Interventions and Supports (PBIS), Medicaid reimbursement for school-based behavioral health clinics, transportation of foster children residing in Project Safe and STAR homes to their school of origin related to the McKinney-Vento Bill, and co-sponsorship of youth suicide prevention training initiatives. DCF also works in collaboration with the Department of Labor's Office of Workforce Competiveness and the Workforce Investment Boards that assist youth and community stakeholders in the planning and creating of employment opportunities for youth across Connecticut.

The CT BHP and DCF have a joint requirement for Enhanced Care Clinics to develop and implement MOUs with a minimum of two primary care providers in their service areas. These agreements are designed to improve care coordination through the phases of referral, treatment and discharge planning. A "train the trainer" program has been developed and disseminated for use by outpatient clinic staff to assist pediatric primary care providers to increase opportunities for collaborative care. This includes a training toolkit with in-service training modules. The Symptom Checklist is also promoted as a tool for use in primary care settings to promote integrated care.

A critical goal is to ensure that children and youth's educational needs are met in an integrated, supported manner. Multiple educational resources, including services to those with disabilities under the Individuals with Disabilities Act (IDEA) are available and include: family advocates

and care coordinators who have specialized training regarding special education laws to inform and link families with appropriate resources; family advocates, care coordinators and DCF social workers to attend Pupil Placement Team meetings and assist families in obtaining appropriate Individual Education Plans; case-specific Managed Services System meetings attended by DCF staff and Child-Specific team meetings attended by care coordinators; education consultants employed at DCF Area Offices; and two Pupil Services positions at the state level/DCF to assist youth with enrollment in two- and four- year colleges as well as vocational, technical and certification programs.

(Criterion 1B: Description of the available services and resources in a comprehensive system of care) DCF offers a diverse array of behavioral health treatment and support services within the continuum of care to meet the range of needs of children, youth and their families. These include: therapeutic group homes; therapeutic foster homes; Short Term Assessment and Respite (STAR) homes, therapeutic day care; emergency mobile psychiatric services; crisis stabilization services; intensive in-home services (Family Support Teams, IICAPS, MST, MDFT, Family Substance Abuse Treatment Services, Family Functional Therapy, and Family Based Recovery), outpatient psychiatric services including enhanced care clinics; outpatient substance abuse services; and extended day treatment. Other services are especially designed for and available to parents and other caregivers of children with SED. These family support services include: family advocacy; care coordination/wrap-around services; respite services; mentoring services; informal behavioral health-related recreation services; and flex funding for special needs such as family reunification, school success, and prevention of homelessness.

Additionally, the Department supports prevention and early intervention services, particularly in the areas of early childhood behavioral health. Child FIRST provides in-home parent-child psychotherapy and wrap-around services for young children, ages birth through five years, who demonstrate serious emotional or behavioral problems or who experience abuse/neglect, domestic violence, and/or homelessness. Other prevention resources include: Early Childhood Consultation Partnership offering education, consultation and support to child care providers; Building Blocks for Brighter Future offering mental health services for young children in New London, Groton, and Norwich counties; DCF Head Start Collaborative between DCF area offices and Head Start offices; Positive Youth Development/Strengthening Families offering parent education to high risk families; and Circle of Security parent training in the New Haven area.

The Department supports youth suicide prevention initiatives. The statewide Suicide Prevention Initiative targets youth from 10 to 24 years of age and provides training for school staff, first responders, Head Start staff, clinicians, and DCF workers. The Connecticut Youth Suicide Advisory Board assumes responsibility for increasing public awareness and making annual planning recommendations to the Commissioner.

(Criterion 5B: Training of Providers for Emergency Health Services) First responders to youth suicide in Connecticut are the Department's Emergency Mobile Psychiatric Services (EMPS) staff. Staff has been trained in Assessing and Managing Suicide Risk (AMSR) and Core Competencies for Mental Health Professionals. DCF and DMHAS staff works in partnership to

coordinate the training. Also, this training is offered to local police and emergency medical personnel.

(Criterion 3B: Establishes defined geographic area for the provision of the services of such system) Most services described above are available across the state unless otherwise noted in the narrative under Criterion 1B.

(Criterion 4A: Outreach and Community-Based Services for Children/Youth Who Are Homeless) There are significant resources available for homeless children/youth including: crisis stabilization services; 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; and Community Housing Assistance Program (CHAP). Assistance for DCF-involved 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 and other services are funded through DCF. Over 500 families are served annually.

Also, there are inpatient treatment facilities available for those children/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. During FY 2012 the Department will move to consolidate two psychiatric facilities - Riverview and the Connecticut Children's Place. At the state psychiatric hospital - Riverview there will be six inpatient psychiatric units, serving 66-68 youngsters with severe psychiatric needs. In addition, there will be six Brief Treatment Units at Connecticut Children's Place. Two units will serve eight girls each, ages 13 through 16 who have complex psychiatric needs that can be addressed in a brief treatment context. Four units will serve a total of 38 boys, ages 13 through 16 who have complex psychiatric needs that can be addressed in a brief treatment context. The expected length of stay is 120 days across all units.

DCF has systematically disseminated evidence-based treatments with attention to fidelity and quality assurance methods to enhance and strengthen the quality and range of least-restrictive community-based services within the children's system of care. These services emphasize family engagement, family-driven assessment and treatment, individualized services, culturally and linguistically competent services, and the principles of recovery and resiliency. Families are respected and treated as allies. Their involvement and self-determination in the planning and service delivery process are considered essential. It is recognized that all families have strengths to build upon, and these strengths influence the individualized treatment plan. Also, the diversity of families is recognized and appreciated. Children and families are to be understood within the context of their own family rules, traditions, history and culture. Staff receives ongoing training in order to provide culturally and linguistically competent services and to deliver strengths-focused services through a community-based wrap-around approach.

DCF has implemented a broad array of evidence-based treatments that result in improved child/family outcomes. These include: Multidimensional Family Therapy (MDFT), Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Family Based Recovery (FBR), and Multisystemic Therapy (MST) Teams, the latter co-funded through the Judicial Branch – CSSD. There are two specialized MST programs, one for child welfare-involved children and their families (MST – Building Stronger Families) and the other for youth who are discharged

from residential facilities and are on parole for problem sexual behaviors (MST-Problem Sexual Behaviors). DCF has developed a special arrangement with university faculty to train BSW students in these evidence-based MST practices to support the expansion of a skilled workforce. Most recently DCF trained treatment teams from 16 outpatient psychiatric clinics for children as part of three Trauma-Focused Cognitive Behavior Therapy (TF-CBT) Learning Collaboratives. One of Connecticut's promising practices is the enhanced Emergency Mobile Psychiatric Services (EMPS) model of care. Mobile clinicians provide community- and home-based crisis intervention, short-term stabilization and follow-up services and referral/linking services to the system of care.

(Criterion 2B: Identify quantitative targets to be achieved in the implementation of the system of care) The Department will seek to maintain services at the following levels during FY 2012-13: Care Coordination - 1,000 ; Emergency Mobile Psychiatric Services - 3,000: ; Extended Day Treatment - 1200; Family Advocacy - 300; Outpatient Mental Health Services - 20,000; Outpatient Substance Abuse Services - 450; Problem Sexual Behavior - 75; Respite Services - 150; Intensive In-Home Services - 3,500; Therapeutic Group Homes - 280.

(Criterion 5A: Financial Resources, Staffing and Training for Mental Health Service Providers) Although these are difficult economic times, the Department seeks to maintain sufficient funds, staff and other resources to support the behavioral health service system. These resources include almost 200 million dollars in funding of behavioral health services and the following behavioral health staff: health management administrators including pediatricians, child psychiatrists, APRNs; RNs; behavioral health clinical managers; and area office resource staff, behavioral health program managers, supervisors and social workers.

Also, the Department is revamping its DCF Academy for Workforce Development and Knowledge. The training academy's purpose is to provide quality training and opportunities for every staff member to develop the competencies needed to fulfill the mission of the Department and improve the services to children and families. It is anticipated that training offerings will be expanded to include the provider network and families.

Although funding for the Connecticut Workforce Collaborative on Behavioral Health, through the Mental Health Transformation State Incentive Grant (MHT-SIG) terminates in September 2011, the Executive Council will continue to meet periodically to guide a broad range of activities. These include launching the Connecticut Parent Leadership Network; finalizing a report on "Strengthening the Youth and Young Adult Voice," and convening stakeholders to develop a plan of action based on the report; implementing a plan to sustain the higher education initiative focused on Intensive Home-Based Services for children, youth and families; offering the Yale Leadership Program in Behavioral Health to a second cohort of senior middle managers; and finalizing the Career Pathways in Behavioral Health report and engaging Workforce Investment Boards in increasing career opportunities in this field.

The Department utilizes several strategies to address the needs of diverse racial, ethnic, and sexual gender minorities. The Division of Multicultural Affairs (DMCA) facilitates relevant policy changes and oversees many culturally related strategies, including the Commissioner's statewide Multicultural Advisory Council (MCAC). The Council advises the DCF Senior

Management Team about multicultural issues that affect employment and service delivery and develops and implements diversity initiatives to address those issues. The membership includes Co-Chairs of DCF's Diversity Action Teams (DATs), who (along with their team members) identify priority issues and implement the Department's practice initiatives.

Cultural competency training is a standard requirement for the Department's contracted service providers. At the Department interview panels for prospective staff are composed of culturally and linguistically diverse staff, and the Department allows longer periods of time than usual to recruit linguistically and culturally competent staff. Other strategies include basic training in culturally competent services for new staff through the DCF's Training Academy and special training for other staff on selective cultural issues such as gender and transgender issues, the Puerto Rican experience, and trauma-informed care for child welfare staff.

B. Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

A summary of the most critical unmet service needs and critical gaps within Connecticut's system of care is based on the following sources of information, in addition to the sources cited under #1 below for estimate of prevalence of mental illness.

- a. Mental Health Needs Assessment and Resource Inventory - Summary Report
Connecticut Workforce Collaborative on Mental Health June 7, 2007
- b. Behavioral Health Services for Children & Families A Framework for Planning, Management & Evaluation - Connecticut Department of Children and Families
March 2009
- c. Strengthening the Foundation: An Analysis of Connecticut's Outpatient Mental Health System for Children - Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut May 2010
- d. A Framework for Child Health Services Supporting the Healthy Development and School Readiness of Connecticut's Children Paul Dworkin, M.D. and Lisa Honigfeld, Ph.D. and Judith Meyers, Ph.D. Child Health and Development Institute of the Connecticut Center for Effective Practice March 2009
- e. Strengthening Family Advocacy in Connecticut Recommendation Report
Connecticut Workforce Collaborative on Behavioral Health September 2010
- f. DCF's Programs and Services Data Collection and Reporting System (PSDCRS)
SFY 2010-2011
- g. Utilization Analysis, Qtr 4 2010 Connecticut Behavioral Health Partnership

1. Mental Health Needs Surpass Service Capacity

(Criterion 2A): The need for child and adolescent mental health services exceeds the available behavioral health resources, which is a similar trend across the nation. 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 at home, in school, and/or community. Most recent estimates are that up to 20% of children and youth have some form of psychiatric disturbance and almost 70% do not receive treatment for their disorder. Of Connecticut's 807,985 children/youth, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional children with some form of psychiatric disturbance requiring mental health care (Sources: U.S. Census Bureau; US DHHS

Agency for Health Care Research and Quality; Collaborative Psychiatric Epidemiologic Surveys). DCF's Programs and Services Data Collection and Reporting System (PSDCRS) shows that between 18% and 23% of children/youth with SED were served within the publically funded mental health system during SFY 2010. Further, of the total children/youth served in the public mental health system, 46.8% were diagnosed with SED. (Source: PSDCRS FY 2010)

It is well documented that rates of psychiatric disorder are even higher for those children living in poverty. It is estimated that 12% of Connecticut's children live below federal poverty levels (Sources: US Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement; Children's Defense Fund). Although Connecticut has one of the highest state per capita incomes in the country, three of Connecticut's larger cities (Hartford, Waterbury and New Haven) have some of the highest child poverty rates in the nation. Psychiatric disorders are also higher amongst those involved with the child welfare and juvenile justice systems. Some studies (i.e. Farmer et al. (2001) found that SED was present in 78% of the children in foster care. In Connecticut there are 4300 children/youth in state custody on any given day (Source: DCF LINK), which translates into an estimate of 3,354 children/youth with SED. Of those youth served in the DCF juvenile justice system, it is estimated that over half of the adolescents have some type of behavior disorder including mental illness and alcohol/drug dependence.

Access to behavioral health care for eligible children/youth is further challenged due to an uneven distribution of services across large, mid-sized and rural communities. Typically, larger communities deliver substantially more service units per youth and subsequently expend greater sums. Some communities may have a limited menu of service options or there may be wait lists for certain services. Sometimes the "right" type of service may not be available at the time of need. (Sources: DCF Programs/Services Contracts and Assigned Catchment Areas; DCF's PSDCRS SFY 2010).

Transportation continues to be a barrier to accessing services, most particularly in rural areas of the state. There is limited public transportation. Also, there are fixed routes and hours of operation that make it difficult for families to attend support groups or evening appointments.

2. There are limited evidence-based treatments and programs available across the continuum of care.

Connecticut's first foray 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 of 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 services, especially in outpatient care. For example, for FY 2010 37% of children/youth residing in the foster care system (excludes inpatient, residential and congregate care settings) resided in therapeutic homes. Only 160 children/youth received Functional Family Therapy.

(Source: PSDCRS FY 2010). Also, there are too few evidence-based early intervention and prevention services available across the state.

Evidence-based practices tend to be more available where there is the largest concentration of the target population. This tends to be in the larger urban areas. While IICAPS and MST are available across the state, many other services are only located in selected areas. The challenge is to develop a full array of these services in rural and suburban areas as well as urban centers.

Many evidence-based practices are not eligible for reimbursement under private insurance plans and various critical components such as supervision, training, program fidelity, and quality assurance activities are not reimbursable under Medicaid. There is a need to develop policy, promote statute reform and establish partnerships with key stakeholders to promote the alignment of the public and private reimbursement systems with evidence-based and best practices.

3. Evidence-based treatments for traumatized children, youth and families are insufficient to meet the level of need.

The prevalence of trauma is high in the general population, and higher in the foster care population. One of four children experience at least 1 potentially traumatic event before the age of 16, almost 2/3 experience more than one type of violence, and 4 in 10 children report witnessing domestic violence (David Finkelhor et al UNH). High risk populations are those that experience chronic traumatic situations including children who experience abuse/neglect, are in out-of-home placement, have been exposed to domestic violence, or are exposed to violence in their schools and communities. Rates for post-traumatic stress disorder are 21% for foster children versus 4.5% for the general population. Connecticut providers report that 70 to 80% of all children receiving mental health services have a history of traumatic events (CT PSDCRS - SFY 2010). Yet, there are few trauma-specific evidence-based treatments available to address the need. During SFY 2010 only 300 children/youth were offered Trauma-Focused Cognitive Behavior Therapy, which represents 6.9% of those children/youth committed to state custody. (Source: TF-CBT Monthly Metrics Child Health and Development Institute of the Connecticut Center for Effective Practice) This is a critical concern because it is well documented that those who are adversely impacted by traumatic experiences in childhood suffer lifelong consequences. These include poor physical and mental health, school failure, teen pregnancy, unemployment, and unsuccessful relationships.

A first step in assuring that traumatized children and youth receive specialized treatment and care is the development of a trauma-informed system of care, including a well-trained workforce that understands the nature of trauma and its impact, recognizes the signs and symptoms, and has the skilled professionals to deliver the right type of treatment at the right time. The Department has begun the process of educating frontline DCF social workers and supervisors, primarily through the use of the Child Welfare Trauma Training Toolkit and other in-service trainings by trauma specialists. Additionally, the Department has sponsored three Trauma-Focused Cognitive Behavior Therapy Learning Collaboratives to train treatment teams from sixteen outpatient mental health clinics. However, considerable resources and support are necessary to sustain and even expand the work of these TF-CBT Teams, plus there are nine additional DCF grant-funded clinics that do not have treatment teams. Ongoing education and training at the local child welfare offices and assuring linkages between child protection social workers and community providers continues to be a critical need. Another need is the dissemination of trauma-informed treatments to all levels of care including residential and inpatient settings.

4. There is a continued need for transitional services for those youth with behavioral Health and/or developmental needs who are aging out of the child welfare system.

The Department transfers eligible youth, typically at age 21 to the Department of Developmental Services (DDS). (Only voluntary and in-home cases transfer at an earlier age.) Currently there are 131 youth who are DCF-committed, ages 17 and up who have been accepted to DDS and will transition at age 21. The number of these referrals continues to grow. (Source: [DCF LINK](#))

Currently there are 313 youth ages 17 and up, who have been accepted to the Department of Mental Health and Addiction Services (DMHAS) and are waiting to transition, and an additional 161 who are pending with DMHAS (17 and up). (Source: [DCF LINK](#))

5. There are insufficient in-state specialized residential services for children/youth who are: fire setters; exhibit problem sexual behavior; present with mental retardation (MR) or pervasive developmental disorder (PDD) including autism spectrum disorders; and those who present with conduct disorders (CD) and have involvement with the juvenile justice (JJ) system.

Currently, there are no in-state beds for those who are fire starters or those who exhibit problem sexual behavior, and only 69 beds for CD and juvenile justice-involved youth. At this time 100% or 14 children/youth who are fire setters or have sexual problem behavior are placed out-of-state, 60% (12 individuals) with MR or PDD are placed out-of-state, and 20% (9 clients) with CD and JJ involvement are placed out-of-state. Also, there are very few community-based providers to treat these particular populations. Those with MR diagnosis continue to be more than double PDD. The PDD category has more than doubled since Quarter 4 2008 and increased by 29.2% from Quarter 4 2009. The MR category has increased by 30.8% since Quarter 4 2008 and by 7.6% since Quarter 4 2009. These are Medicaid eligible consumers only. (Source: [CT BHP Quarterly Reports](#))

6. There are insufficient early intervention services available across the state.

There is a significant need for prevention and early intervention services. 35.2% of Connecticut parents with children ages birth to five express one or more concerns about their child's learning, development or behavior, and 9.2% of parents with children three to seventeen report moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others. (Source: [National Survey of Children's Health, 2003](#)) Yet, a survey of 48 pediatric and family medicine providers in Connecticut reported that 90% of their patients experience difficulty obtaining mental health services. (Source: [Child Health and Development Institute, 2007](#)) These findings mirror another large scale national study. The 1998 Early Childhood Longitudinal Study of children in kindergarten found that 56% of a sample of 40,000 children were deemed not ready for kindergarten, 30% lagged in socio-emotional developmental and more than 36% had one or more health concerns.

Despite robust research support for the value of early intervention and the long term cost-effectiveness of these interventions, they remain sparsely implemented across the state and their full promise unrealized. For example, Child FIRST that provides in-home parent-child psychotherapy and wrap-around services and supports is available in only six cities/regions of the state; and Building Blocks for a Brighter Future that offers mental health services to children ages birth to six is available in only selected areas of the state.

7. The behavioral health system does not employ standardized screening instruments and assessments at multiple points of access.

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- Short Screen) within DCF offices and substance abuse services, are significant achievements in the Department's efforts to improve screening and assessment. However, it will take several years to develop a mature and integrated system of behavioral health screening and assessment and a method for insuring that results are utilized in care planning and service design. There has been no systematic analysis of the points of contact between youth and families and the various service systems to inform a rational approach to the design of a screening and assessment system. Failure to do so may result in inefficient or duplicative screening and assessment processes. The development of an integrated and systematic strategy for identifying screening and assessment needs is required. Further, there is a need to embed screening data in routine practice. Reporting of screening and assessment data that is timely, well-designed, and easy to use will promote use of this information by all stakeholder groups.

8. There is limited use of technology and data to enhance services.

While a more robust and functional data system has been recently implemented and now undergoing incremental enhancements (PSDCRS), it remains distinct from the Department's primary LINK (child welfare) system and does not currently have the capacity to connect with other systems within the state (including DSS, CSSD, DOC and the CT BHP). This lack of data integration fosters duplicative data entry and limits analysis of outcomes and service utilization across systems. A long-term plan and funding are needed to tackle this need.

A "data and information culture" is not pervasive throughout the system. Many reports do not display data in a manner that promotes its effective use, some stakeholders, especially families never see these reports, few managers are adequately trained in the use of data, and too few decision-making processes are built around data inputs. CHDI's Strengthening the Foundation Report found that: "All stakeholders reported that data has not been extensively utilized to monitor treatment outcomes, inform outpatient treatment practices, or guide treatment decision-making. Clinicians also reported that they are the least likely to have data shared with them which can compromise the ability to use data to inform treatment."

The PSDCRS 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. The new system is in the early stages of development and requires further work by all stakeholders to construct a "data dashboard" that reports child/family, program, and system outcomes, enabling stakeholder groups to measure performance, statewide and by provider over time and to track improvements and needs. This dashboard should be integrated as one component of a comprehensive continuous quality improvement (CQI) approach.

Despite its relatively small geographic size, Connecticut has some isolated rural communities where access to behavioral health services, particularly psychiatry, can be difficult. Currently Connecticut lacks the technology infrastructure, practitioner agreements, and payment systems to support live internet audio and visual "cyber-sessions." Federal grant funds or other resources are necessary to support such a project.

At present no DCF facility utilizes an electronic medical record. There is a need to establish an electronic records task force and a plan to comply with HIPPA requirements and promote the common use of medical records technology.

9. Too few families participate in overall system development and oversight as well as in their own case-specific care planning and treatment

The implementation of Kid Care in 2001 accelerated the Department's progress in increasing consumer and family involvement in planning and oversight of the statewide behavioral health system, and progress has been made in improving consumer, youth and family involvement in their own service planning and care. However, this movement has not yet matured to achieve a statewide family-driven system of care, a key finding of the 2007 Mental Health Needs Assessment and Resource Inventory. Further, CHDI's Strengthening the Foundation Report found "no disagreement among stakeholders about the need for enhanced focus on family engagement."

A primary goal of the New Freedom Commission Report is consumer, youth and family participation in system design, planning, evaluation and oversight. The Department supports many strategies to promote participation including support of advisory bodies and advocacy groups, family participation in procurement of services and development of practice standards, consumer committees to analyze service data, and consumer survey methodologies. However, the progress that has been made falls short of effectuating a true family-driven and youth-guided process.

In 2010 the Connecticut Workforce Collaborative on Behavioral Health engaged the services of a consultation team to examine the strengths and challenges of the state's family advocacy structure and to provide recommendations. A series of interviews and focus groups were held with key Connecticut stakeholders, including family support organizations, families, and youth. Connecticut families consider the staff and activities of the many Connecticut family advocacy organizations to be extremely valuable, however, they report that "the care system as a whole needs to be more invested in family engagement, support, and advocacy." There is "a largely unmet advocacy need for families whose children express emotional or behavioral health challenges and are involved with the juvenile justice, child welfare, substance abuse, and/or education systems." Stakeholders strongly emphasized the necessity for all child and family serving systems to collaborate more effectively in the planning and provision of care for children, adolescents, young adults, and their families. Also, opportunities for parent leadership development were a priority in all focus groups.

One aspect of the Mental Health Needs Assessment and Resource Inventory Summary Report, completed by DMHAS under the Mental Health Transformation Grant in 2007 included a DCF Mental Health Transformation Survey. Through use of a self-reported questionnaire that solicited input from providers and parents, respondents were asked to rate the priority of each of the New Freedom Commission goals using a Likert scale. The highest priority for consumers was Goal 2 - Mental health care is consumer and family- driven, which was rated significantly higher than the providers' rating for this goal. It is clear that an important element of a transformed system of care includes that care is directed by people in recovery and their families.

Through the implementation of many family-based evidence-based practices, the Department has promoted and supported the greater role of the family in the planning and oversight of their own care. However, other services that are not guided by a defined program model or that are not family-based do not always actively involve families in the way that they should. Greater emphasis needs to be placed on insuring that family-based care planning is routinely incorporated into all treatment interventions. For example, the capacity of the Family Advocacy Program and Care Coordination, two services that embody the importance of family-driven service delivery, are limited and serve only a portion of children and families with SED. Two Engaging Families Initiatives exist within only two service types currently - the statewide Extended Day Treatment programs and 22 outpatient clinics. Further, although an ambitious training initiative was launched at the outset of Kid Care to educate stakeholders regarding the system of care principles, the training did not reach all stakeholders and has not been fully sustained. Thus, many portions of the service system remain unaware of the critical importance of giving families voice about their needs, preferences and the design of their own care, and further many service providers have not received evidence-based training regarding family engagement protocols.

10. There is a continuing need to offer education and training in multiple areas to assure a well-trained, diverse and culturally competent workforce.

Connecticut continues to experience a shortage of well-trained, multidisciplinary professionals and paraprofessionals. Once individuals enter the workforce there is often a lack of quality supervision as well as continuing education opportunities to retain existing competencies and learn new skills. Also, families and other caregivers do not receive adequate training and support, and there are few meaningful formal opportunities for family members to participate in the children's behavioral health workforce.

Like every other state in the nation, Connecticut is experiencing a shortage of psychiatrists, in particular board eligible/certified child and adolescent psychiatrists. Much of the medication management provided to children/adolescents could be provided by psychiatrists and APRNs if there were better integration between behavioral health and primary care.

During the last four years, as programs requiring masters' level clinicians have expanded and more students seek degrees in higher paying professions such as business, finance, and technology, there is a shortage of clinicians, especially at outpatient behavioral health clinics where most children/youth are treated. As cited in CHDI's Strengthening the Foundation report, administrators and clinicians cite "low pay, burnout, and limited opportunities for training, professional development, and career advancement as the primary factors" related to staff turnover. Other factors included "poor preparation for service delivery and insufficient supervision."

While the trend in the field of behavioral health is towards implementation of evidence-based practices, higher education has not kept pace and few trained professionals enter the workforce with the knowledge, skills, and competencies to deliver evidence-based practices. The disconnect between existing curricula and the knowledge and competencies required in the field is best addressed through building collaborations with higher education and developing curricular materials, training/supporting instructors within higher education, and coordinating national efforts at curriculum reform.

Supervision 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. It is critical to develop supervision models and support their implementation in the workplace through a variety of methods including pilot projects, implementation of evidence-based practices with embedded supervisory and consultative components, funding and reimbursement support of supervisory practice, and training and support programs.

Rapid shifts in racial, ethnic, linguistic and other areas present complex challenges for the system. The need for culturally and linguistically competent services continues to increase. The workforce for DCF and contract providers must be well-trained and culturally and linguistically competent.

B. Planning Steps

Step 3: Prioritize State Planning Activities

Table 2 Plan Year: 2012-13

State Priorities	
1	Childhood Trauma & Violence
2	Evidence-Based Prevention, Early Intervention and Treatment Services
3	Family/Caregiver Involvement in: <ul style="list-style-type: none"> ▪ Individual care planning and treatment; and ▪ System development, planning, and oversight
4	Workforce Development

B. Planning Steps

Step 4: Develop Objectives, Strategies and Performance Indicators

Table 3 Plan Year: 2012-2013

<u>Priority Area #1: Childhood Trauma & Violence</u>
<u>Goal:</u> Assure that traumatized children, youth and their families receive evidence-based trauma treatments to meet their needs
<u>Strategy #1:</u> Continue trauma screening for all referrals at the 16 outpatient behavioral health clinics that have TF-CBT Teams
<u>Strategy #2:</u> Continue to produce the TF-CBT Metrics Report on a monthly basis and include an analysis with specific areas to be addressed by the teams
<u>Strategy #3:</u> Maintain the TF-CBT Learning Collaborative website and TF-CBT Team Roster
<u>Strategy #4:</u> Continue the strategizing and planning meetings on a quarterly basis with the TF-CBT Senior Leaders
<u>Strategy #5:</u> Deliver a TF-CBT Annual Conference for current TF-CBT teams and DCF staff

<u>Strategy #6:</u> Provide a 2-day Introduction to TF-CBT training for new TF-CBT Team members
<u>Strategy #7:</u> Continue to develop a statewide trauma-informed system of care through training child welfare workers using the NCTSN Child Welfare Trauma Training Toolkit and other targeted trainings, and through further development of the statewide Trauma-Informed Gender-Responsive (TIGR) model.
<u>Performance Indicator #1:</u> Increase the number of children, youth and their families that are offered Trauma-Focused Cognitive Behavior Therapy by __ %.
<u>Performance Indicator #2:</u> Increase the number of children, youth and their families that complete the TF-CBT treatment by __%. (# staff trained?)
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> The TF-CBT Metrics Report will be used to identify the number of children/youth who are offered TF-CBT during the year as well as the number of clients that complete the treatment. This database is maintained by the Child Health and Development Institute (CHDI) of the Connecticut Center for Effective Practice. Contract staff from CHDI oversees the data collection, analysis and reporting. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percentage of change.

<u>Priority Area #2:</u> Evidence-Based Prevention, Early Intervention and Treatment Services
<u>Goal #1:</u> Enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide
<u>Strategy #1:</u> Use evidence-based curricula, ASIST and Safe Talk to train youth, families, Department staff, and first responder agency staff, through contracts with United Way and Wheeler Clinic
<u>Strategy#2:</u> Use evidence-based curricula, Assessing and Managing Suicide Risk (AMSR) to train clinicians who deliver Emergency Mobile Psychiatric Services (EMPS).
<u>Strategy #3:</u> Implement awareness campaigns that include informational e-mails, a Department website, and suicide prevention brochures
<u>Strategy #4:</u> Continue to engage in collaborative partnerships with DMHAS, schools, and first responder agencies to share delivery of the prevention training
<u>Performance Indicator #1:</u> Increase the number of individuals receiving suicide prevention and/or crisis response training by __%
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> Provider Reports (based on attendance records - United Way and Wheeler Clinic). SFY 2012 will serve as the baseline year. SFY 2013 will use the same sources of data to measure a specified percent of change.
<u>Goal #2:</u> Promote the statewide dissemination of evidence-based practices (EBP)
<u>Strategy #1:</u> Continue to provide state funds to support the delivery of the existing 12 EBPs
<u>Strategy#2:</u> Continue to develop state interdepartmental partnerships to blend funding in order to maintain, and to the extent that funding permits expand EBPs (DCF/CSSD - IICAPS and MST)
<u>Strategy #3:</u> Provide targeted technical assistance for providers and communities planning on adopting an EBP including focus on organizational and fiscal challenges as well as barriers
<u>Performance Indicator #1:</u> Increase the number of individuals receiving any type of EBP by __ %
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> DCF's PSDCRS

will be used to identify the number of clients receiving any type of EBP by aggregating types of EBTs received at time of discharge across service providers. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.
<u>Performance Indicator #2:</u> Increase the number of families responding positively about functioning by __%
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> The Youth Services Survey for Families (YSS-F) will be administered to families at the time of discharge, in accordance with the Guidelines for Administering YSS-F. Responses will be entered into DCF's PSDCRS. Numerator: # of families of child/adolescent consumers reporting positively about functioning Denominator: Total # of family responses regarding functioning SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

<u>Priority Area #3:</u> Family/Caregiver Involvement
<u>Goal #1:</u> Behavioral health care is consumer and family-driven.
<u>Strategy #1:</u> Continue to use a community-based system of care approach and promote wraparound services and supports to respond to child and youth consumer and family needs and preferences, as reflected in individualized plans of care <u>Strategy #2:</u> Provide two “Improving Engagement and Retention of Children and Families in Mental Health Care” Learning Collaboratives to train teams from outpatient clinics in the evidence-based family engagement protocols developed by Dr. Mary McKay/Mt. Sinai School of Medicine <u>Strategy #3:</u> Include family partners on each of the clinic’s Family Engagement/Quality Improvement Teams and offer family stipends for participation in the learning collaborative <u>Strategy #4:</u> Develop criteria for the Welcoming and Engaging Families domain for Enhanced Care Clinics through the CT Behavioral Health Partnership
<u>Performance Indicator #1:</u> Increase the # of families that complete treatment/meet treatment goals at outpatient behavioral health clinics by __%
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> DCF's PSDCRS will be used to identify the number of clients that complete treatment/meet treatment goals at grant-funded outpatient psychiatric clinics. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.
<u>Performance Indicator #2:</u> Increase the # of families/caregivers who respond positively about participation in treatment planning by __%
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> The data source is the Youth Services Survey for Families (YSS-F) which will be administered by contract providers. Responses will be entered into the Department’s PSDCRS by the providers and the results and reports will be provided by PSDCRS. Numerator: # of families reporting positively about participation in treatment planning Denominator: Total # of family responses regarding participation in treatment planning SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.
<u>Goal #2:</u> Ensure that the voices, perspectives and input of family members are included in

developing, planning, and overseeing the statewide behavioral health system
<u>Strategy #1:</u> Provide education, training and empowerment through the Parent Leadership Training Network
<u>Strategy #2:</u> Continue to expand family membership in the statewide program and policy advisory committees as well as evaluation committees for procurement of services
<u>Strategy #3:</u> Continue to deliver case-specific family advocacy services and family/peer support services
<u>Performance Indicator:</u> Increase the number of families that receive family advocacy education, training and direct advocacy services by ___ %
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> Provider Reports (Attendance Records) in addition to the PSDCRS family advocacy case-specific numbers served. SFY 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

<u>Priority Area #4:</u> Workforce Development
<u>Goal:</u> Promote the development of a more informed and skilled workforce who have interest and solid preparation to enter positions within evidence-based in-home treatment programs.
<u>Strategy #1:</u> Provide funding and other support to the Higher Education Partnership on Intensive Home-Based Services Workshop Development-Sustainability Initiative through contract with Wheeler Clinic
<u>Strategy #2:</u> Expand the pool of faculty and programs credentialed to teach the Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut curriculum and promote accurate implementation of course content that is current and up-to-date through contract with Wheeler Clinic.
<u>Strategy #3:</u> Maintain and promote teaching partnerships between higher education and providers delivering evidence-based treatments through ongoing coordination and assignment of provider and client/family guest speakers for the curriculum.
<u>Performance Indicator #1:</u> Increase the number of faculty that will be trained in the curriculum by ___.
<u>Performance Indicator #2:</u> Increase the number of students that will receive certificates of completion for the course by ___.
<u>Description of Collecting and Measuring Changes in Performance Indicator:</u> The contract provider, Wheeler Clinic will maintain records regarding number of faculty members trained and number of students completing the course. 2012 will serve as the baseline year. SFY 2013 will use the same database to measure a specified percent of change.

C. Use of Block Grant Dollars For Block Grant Activities

Table 4 Plan Year: FY 2012-2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract based reimbursement	Respite Services; Family Advocacy; Suicide Prevention; CT Community KidCare Workforce Development & Training; Extended Day Treatment Model Development and Training; TF-CBT Sustainability Activities; Outpatient Care: System Treatment and Improvement Initiatives; and Workforce Development -

	Higher Education Partnership on Intensive Home-Based Services
Risk based reimbursement	
Innovative financing strategy	
Other reimbursement strategy (please describe)	

**Table 5 Plan Year 2012
Projected Expenditures for Treatment and Recovery Supports
Estimated Percent of Funds Distributed**

Category	Service/Activity Example					
		<10%	10-25%	26-50%	51-75%	Over 75%
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 					
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	X				
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 					
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 					
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 					
Recovery Supports	<ul style="list-style-type: none"> • Peer Support 					

	<ul style="list-style-type: none"> • Recovery Support Coaching • Recovery Support Center services • Supports for Self Directed Care 					
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted Living services • Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters 			X		
Category	Service/Activity Example	<10%	10-25%	26-50%	51-75%	Over 75%
Intensive Support Services	<ul style="list-style-type: none"> • Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management 					
Out-of-Home Residential Services	<ul style="list-style-type: none"> • Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential Services • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care 					
Acute Intensive Services	<ul style="list-style-type: none"> • Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services 					
Prevention (Including Promotion)	<ul style="list-style-type: none"> • Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention/Wellness Recovery Support • Warm line 			X		
System Improvement Activities			X			

Other		X				
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Table 8

Plan Year: 2012						
State Identifier: Connecticut						
Resource Development Planned Expenditures Checklist						
ACTIVITY	A. Prevention MH	B. Prevention SA	C. Treatment MH	D. Treatment SA	E. Combined	F. Total
1. Planning, coordination, and needs assessment	\$ 19,752.00 *					
2. Quality assurance						
3. Training (post-employment)						
4. Education (pre-employment)						
5. Program development						
6. Research and evaluation						
7. Information systems						
8. Total						

*This funds are used for various administrative and support services such as providing interpreters for the monthly meetings of the Children's Behavioral Health Advisory Council, and providing funds for a parent representative to attend the annual Mental Health Block Grant Conference.

Table 8

Plan Year: 2013						
State Identifier: Connecticut						
Resource Development Planned Expenditures Checklist						
ACTIVITY	A. Prevention MH	B. Prevention SA	C. Treatment MH	D. Treatment SA	E. Combined	F. Total
1. Planning, coordination, and needs assessment	\$ 19,669.00 *					
2. Quality assurance						

3. Training (post-employment)						
4. Education (pre-employment)						
5. Program development						
6. Research and evaluation						
7. Information systems						
8. Total						

These funds are used for various administrative and support services such as providing interpreters for the monthly meetings of the Children's Behavioral Health Advisory Council, and providing funds for a parent representative to attend the annual Mental Health Block Grant Conference.

D. Activities that Support Individuals in Directing the Services

1. Summarize your State's policies on participant-directed services.

Connecticut adopted the federally endorsed System of Care model as the basis for the state mental health plan in 1997 and established a coordinated network of community services and supports to meet the needs of emotionally disturbed children, youth and their families. The system of care is not a program; it is a philosophy of how care should be delivered. The hallmarks of the system of care approach include the following.

- The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective.
- Family involvement is integrated into all aspects of service planning and delivery.
- Services are built on multi-agency collaboration and grounded in a strong community base.
- A broad array of services and supports are provided in an individualized, flexible, coordinated manner and emphasize treatment in the least restrictive, most appropriate setting.

Core values include:

- Child-centered, family focused, and family-driven;
- Community-based; and
- Culturally competent and responsive.

The Department's grant-funded provider contracts as well as the practice standards for each service/program type require that services are delivered in accordance with these principles and core values.

2. What services for individuals and their support systems are self-directed?

Children, youth and families learn about the menu of services and programs at the time of intake and referral. Through a mutually respectful partnership between the child/family and

the treatment provider, a careful assessment process results in a highly individualized treatment plan. The treatment provider seeks to understand the reason(s) for the child/family's referral, their expressed and felt needs, and the outcomes they desire. The child and family's strengths and skills are acknowledged and valued in the planning process. The family is viewed in the context of their culture, ethnicity, religion, and gender. All of these elements are considered in planning the right mix and frequency of services for the child/family, with the child/family serving as the main designer of the care plan through a shared decision-making process.

Treatment providers may recommend particular treatments and a schedule of appointments to address the needs, but the family ultimately decides if these recommendations will meet their unique needs.

3. What participant-directed options do you have in your state?

Children and families have the option of seeking services from any type of service provider within their catchment areas. The broad array of community-based services includes: emergency mobile psychiatric services/crisis stabilization; respite services; intensive in-home services; extended day treatment services; routine outpatient behavioral health services; family advocacy services; and family/peer support services.

4. What percentage of individuals funded through the SAMHA self-direct their care?

As described above, all families have the option of requesting any type of behavioral health service at any time. The referral initiates an initial assessment and pre-planning process to determine the needs, acuity level, and most effective course of treatment. Child, youth and family members are fully involved in this process.

5. What supports does your State offer to assist individuals to self-direct their care?

The Department funds FAVOR, an umbrella statewide family advocacy organization that has been created to educate, support and empower families. One component of this work is the delivery of advocacy services to selected families. The primary goal is to empower these families to advocate for their own needs and services.

The Department also funds 66 care coordinators across the state. Staff provides support to SED children and their families who are not already involved in the child welfare or juvenile justice system. Intensive training and efforts are made to assist these families in getting their needs met.

E. Data and Information Technology

The Department utilizes two primary information systems.

1. The Department is responsible for the Programs and Services Data Collection and Reporting System (PSDCRS). The system is maintained by a private contractor which works closely with DCF staff. PSDCRS is DCF's web-based online data collection and reporting solution for community-based programs. It includes services provided to clients who are not involved with DCF, as well as those who are. Currently, there are 77 providers enrolled in the PSDCRS

database. These providers represent community-based agencies that contract with the Department to provide one or more services to clients.

Providers enter data on episodes of service provided by programs funded by DCF. Data is entered for each episode upon intake and upon discharge, and in some cases at specified periodic intervals or upon the occurrence of specific activities (e.g. a comprehensive assessment or development of a care plan). It sometimes includes data on the type and amount of services provided, but not on individual service providers. PSDCRS does not include data on prescription drug utilization.

PSDCRS produces many on-demand reports, ranging from length of stay and client flow reports to individual client histories.

E. Data and Information Technology		
	Question	PSDCRS
1	For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?	No.
2	Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?	PSDCRS includes a unique provider ID which allows data to be aggregated by provider.
3	Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?	There is no system-wide unique client identifier. The system does assign a client identifier which is unique within that provider, and allows for unduplicated counts and aggregation of services by that provider.
4	Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?	In most cases, no. There are a few instances where encounter-level data is collected which include some of these variables.
5	Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?	No. DSM-4 codes are used in some cases.

E. Data and Information Technology		
	Question	PSDCRS
6	Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?	Strictly speaking the answer is no, since PSDCRS does not contain Medicaid provider identifiers. Provider Medicaid and non-Medicaid information is aggregated in some reports, although not by the method specified in the question.
7	Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?	Not by PSDCRS.
8	Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?	Staffs from the Department and the State Medicaid Agency (Department of Social Services - DSS) address mutual issues through the CT Behavioral Health Partnership.
9	Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?	No.
10	Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards? In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.	DSS redesigned its IT system two years ago through a reprocurement process.

2. The Department utilizes the DSS Data Warehouse (DWH). This system provides direct user access to Connecticut Medical Assistance data for the creation of ad hoc queries and reports as well as for producing regularly scheduled reports. The DSS is responsible for maintaining this system. It is a comprehensive user tool that provides information to facilitate and enhance access to data and program reporting. The DWH system also serves as the Management and Administrative Reporting and Surveillance and Utilization Review subsystems for the Medicaid Management Information System (MMIS).

Husky Encounter data and MMIS fee-for-service data are included in the data warehouse so that previously separate subject areas can be combined and formatted into reports by both novice and power users. The DWH Universe includes: Claims; Provider; Recipient; and Reference.

E. Data and Information Technology		
	Question	PSDCRS
1	For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?	Yes.
2	Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?	Yes. The Provider Universe contains the following data: Provider's type; license number; mailing address; and program
3	Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?	Yes.
4	Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?	Yes.
5	Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?	Yes.
6	Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?	No. A match can occur only through addresses.
7	Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?	Yes.
8	Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?	Staffs from the Department and the State Medicaid Agency (Department of Social Services - DSS) address mutual issues through the CT Behavioral Health Partnership.

E. Data and Information Technology		
	Question	PSDCRS
9	Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?	No.
10	Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards? In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.	DSS redesigned its IT system two years ago through a re procurement process.

Currently, the state has no funds to assist providers with developing and using Electronic Health Records. Many providers have already implemented systems and other providers are in the process of research and development.

F. Quality Improvement Reporting

The Department utilizes a continuous quality improvement process and a results-based accountability model for managing behavioral health services. Providers are required to have a written plan for responding to critical incidents, complaints and grievances, per contract, and the Department utilizes the Office the Ombudsman to address complaints, in addition to utilizing the approaches and tools identified below.

Connecticut Department of Children and Families
Behavioral Health Quality Improvement Plan
Quality Improvement Approaches/Tools by Program

- Tools:
- 1) Standard Data Reports and Review Under PSDCRS.
 - 2) Program Lead meets regularly with providers, reviews data, manages contract, and updates Practice Standards.
 - 3) Evidence Based or Best Practice Program for which there is a standardized model-specific QA process that is overseen by a contracted vendor (*some programs incorporate evidence based components that are externally monitored).
 - 4) Undergoes periodic and for-cause licensure inspections (by DCF).
 - 5) Program Standards written into contracts.
 - 6) Has completed or is in the process of a CT-specific formal program evaluation or research project.
 - 7) Direct consumer feedback following completion of care.
 - 8) Standardized training for all providers.

- 9) Pay for Performance Initiatives incorporated into management.
 10) Youth Services Survey for Families (YSS-F) administered at time of discharge.

BH Program	Acronym	Brief Description	QA/QI Tools Utilized
Care Coordination	CC	Provides community-based wraparound support and case management to children with SED and their families.	1, 2, 5, 6, 8, 10
Extended Day Treatment	EDT	Provides 3 hours of after school milieu- based therapeutic recreation and clinical/rehabilitative services.	1, 2, 3*, 4, 5, 7, 10
Emergency Mobile Psychiatric Service	EMPS	Provides home and community-based mobile crisis services to children and their families including short term stabilization services and linkage to care.	1, 2, 3, 4, 5, 7, 8, 9, 10
Family Advocacy	FAM ADV	Individuals with lived experience provide guidance and support to children and families receiving care coordination or other select services.	1, 2, 5
Family-Based Recovery	FBR	Intensive in-home service that works with mother's with young children who have a history of substance use/abuse and child welfare involvement. Program combines evidence-based treatment of adult substance abuse and best practices in early childhood support of development and promotion of attachment and bonding.	1, 2, 3*, 4, 5, 6, 8
Functional Family Therapy	FFT	Evidence-based intensive in-home service that works with children with moderate to severe externalizing and internalizing disorders and their families.	1, 2, 3, 4, 5, 8, 10
Family Substance Abuse Treatment Service	FSATS	Intensive in-home service that is a variant of evidence-based MDFT that has a special engaging Mother's protocol.	1, 2, 3, 4, 5, 6, 8
Intensive In-Home Child and Adolescent Psychiatric Service	IICAPS	Best practice model for in-home family- based treatment of children with a wide array of psychiatric disorders.	1, 2, 3, 4, 5, 6, 8, 10
Multi-Dimensional	MDFT	Evidence-based intensive in-home	1, 2, 3, 4, 5, 6, 8, 10

BH Program	Acronym	Brief Description	QA/QI Tools Utilized
Family Therapy		service that works with children with moderate to severe externalizing and internalizing disorders and risk for or current substance abuse and their families.	
Mentoring	MENT	Community-based recreational and therapeutic support to children with SED.	1, 2, 5
Multi-Systemic Therapy	MST	Evidence-based intensive in-home service that specializes in working with children with moderate to severe externalizing disorders and risk for or involvement in the JJ system and their families.	1, 2, 3, 4, 5, 7, 8
Multi-Systemic Therapy, Building Stronger Families	MST - BSF	An adaption of MST for child welfare families.	1, 2, 3, 4, 5, 6, 7, 8
Outpatient Behavioral Health Treatment for Children	OPCC	Community clinics that provides mental health evaluation, screening, treatment, and case coordination through individual, family and group therapies.	1, 2, 3*, 4, 10
Outpatient Substance Abuse Treatment	OPSAT	Community clinics that provides co-occurring mental health and substance screening, case coordination in conjunction with individual, family and group therapies.	1, 2, 3*, 4, 5, 10
Multi-System Therapy - Problem Sexual Behavior		An evidence-based adaptation of MST that provides intensive in-home and clinic-based services to children with problem sexual behavior.	1, 2, 3, 4, 5, 7, 8
Respite	RESP	A family support service that pairs a trained behavior support staff with a youth and then engages in therapeutic recreation activities outside the home to give families respite from the demands of a child with SED.	1, 2, 5, 10
Project SAFE	SAFE	A community-based program that provides screening, evaluation and treatment to caregivers engaged in the child welfare system when substance abuse is suspected or been documented.	1, 2, 3*, 5

G. Consultation with Tribes

There are two federally recognized tribes in Connecticut - the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. Both tribes are located in the southeastern (Norwich/New London) area of the state. Both medical and behavioral health care are provided to tribal members, funded largely by their successful gaming enterprises that are maintained in the state.

Historically, local collaboration between tribal leaders and behavioral health administrators has occurred. Discussion has focused on needs and services as well as the culture of the tribal nations, and an identification of areas for mutual collaboration. An example of the latter is the partnership between Clifford Beers Child Guidance Clinic and the Mashantucket Pequot Tribal Nation in sponsoring the annual Family Violence and Child Trauma Conference for the past three years. This event has provided a forum to disseminate information about the tribal nations, their history and current behavioral health agenda.

There is a need to foster consultation and collaboration at the state level. Technical assistance from SAMHSA will be requested.

H. Service Management Strategies

1. Describe the processes the State will employ over the next planning period to identify trends in over/underutilization of MHSBF funded services

Utilization rates will be monitored through use of the statewide behavioral health information system, Programs and Services Data Collection and Reporting System (PSDCRS). All grant-funded contract providers must report client-level data including numbers served on a monthly basis. Each provider has a state contract that specifies the target population and numbers to be served. The PSDCRS produces standard data reports that identify numbers served monthly, quarterly and annually including in-care at period start, admissions, discharges, and in-care at period end for each segment. This is a "real time" online system so case counts are also available on a daily basis for both provider and state-level access.

2. Describe the strategies that your State will deploy to address these utilization issues

DCF employs Program Leads within the behavioral health arena. They are responsible for overseeing specific programs and services. Responsibilities include monitoring service utilization rates and other measures such as program outcomes on a regular basis. Program Leads meet regularly with providers to discuss findings, implement corrective action plans as needed, and monitor results.

Further, Program Leads work in partnership with DCF's contract staff to address utilization issues. For example, when utilization issues can not be resolved within a reasonable time frame and through a corrective action plan with Program Leads, then staff from the Contract Unit may assist with discussion and further action steps.

Additionally, Program Leads coordinate and facilitate statewide "Data Quality Improvement Work Groups," by service/program type. The statewide program/service profile is continuously reviewed and any outstanding statewide trends are identified and addressed.

For Medicaid eligible clients, the CT BHP monitors over/underutilization of services through the Medicaid data system. There is ongoing collaboration with DCF behavioral health staff.

3. Explain the intended results of your State's utilization management strategies

The utilization management strategies are intended to assure contract compliance relative to numbers served. The identified numbers to be served by provider and program/service type are an important component of the larger continuum of care. By achieving the provider-specific utilization targets, this supports timely access to care, applying the most effective treatment modalities and assuring the appropriate length of stay. Each of these factors contributes to effective child/family outcomes.

4. Identify the resources needed to implement utilization management strategies

More detailed data reports will be helpful for further analysis of service use. This will require funds to design and produce new reports, and to support data analysts for evaluating the data. There are no resources to achieve these goals at this time.

5. Identify the proposed timeframes for implementing these strategies.

Regarding questions 1 and 2, the data reporting system (PSDCRS) was implemented on July 1, 2009 and the strategies for monitoring utilization rates have been in effect since the inception of Program Leads in 2005.

I. State Dashboards

Table 9 Plan Year 2012-2013

Priority Area	Performance Indicator
1. Childhood Trauma & Violence	# 1: Increase the number of children, youth and their families that are offered Trauma-Focused Cognitive Behavior Therapy (TF-CBT) by __%. (State Indicator)
	#2: Increase the number of children, youth and families that complete the TF-CBT treatment by __%. (State Indicator)
2. Evidence-Based Prevention, Early Intervention & Treatment Services	#3: Increase the number of families responding positively about functioning by __%. (NOMS Indicator)
3. Family/Caregiver Involvement	#4: Increase the number of families who respond positively about participation in treatment planning by __%. (NOMS Indicator)
4. Workforce Development	#5: Increase the number of faculty that will be trained in the <i>Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut</i> curriculum by __%. (State

	Indicator)
	#6: Increase the number of students annually that will receive certificates of completion in the <i>Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut</i> curriculum by __%. (State Indicator)

The two state-specific indicators were chosen for the following reasons.

1. Focusing on Trauma-Focused Cognitive Behavior Therapy (TF-CBT) was selected to respond to the critical need for treating traumatized children and youth, especially those in the child welfare and juvenile justice systems. Please refer to the Behavioral Health Assessment and Plan, Step 2 for details regarding the unmet service need. The goal is to improve access to evidence-based treatment for children and adolescents suffering from PTSD and other traumatic stress symptoms and to make evidence-based trauma-focused services available to children and families across the state.
2. Connecticut’s need to prepare and recruit a pool of clinicians entering the workforce to deliver evidence-based in-home treatment to families keeps growing. Currently, there are over 350 clinician positions across the state connected to one of the empirically supported in-home models. As Connecticut continues to invest in evidence-based treatments and expand services (through increased capacity and addition of new models to better serve a broad array of treatment needs) there is a need to promote training regarding the fundamental concepts of evidence-based practice, the principles and practices of specific empirically supported in-home treatment models offered throughout Connecticut, and the core competencies that are shared across models.

A graduate-level 3-credit course entitled *Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut* was initially developed and implemented through the Mental Health Transformation State Incentive Grant in January 2009. Five in-home models are covered in the curriculum, as identified below.

Models reviewed in the curriculum	
<ul style="list-style-type: none"> ▪ Multisystemic Therapy ▪ Intensive In-Home Child And Adolescent Psychiatric Services ▪ Multidimensional Family Therapy ▪ Functional Family Therapy ▪ Brief Strategic Family Therapy 	<ul style="list-style-type: none"> ▪ Multisystemic Therapy for Problem Sexual Behavior ▪ Multisystemic Therapy – Building Stronger Families ▪ Family Based Recovery ▪ Family Substance Abuse Treatment

There is a need to expand the number of graduate level faculty and programs prepared to deliver the curriculum. This will be accomplished through use of the Instructor's Toolkit and a Faculty Fellowship training component that includes 30-hours of training and ongoing consultation designed to support the effective implementation of the curriculum.

J. Suicide Prevention

Connecticut's Suicide Prevention Plan is attached. This document was created in 2005 by the Interagency Suicide Prevention Network, in partnership with the CT Youth Suicide Advisory Board and other entities. The Plan serves as the guiding document that is regularly reviewed with annual recommendations for changes/additions made directly to the Commissioner by the Interagency Suicide Prevention Network and the CT Youth Suicide Advisory Board.

K. Technical Assistance Needs

The Department requests technical assistance relative to consultation with federal tribes. To date collaboration has occurred primarily at the local level between tribal nations and community-based service providers, and at the state level we have worked with tribal program leaders and community providers to support an Annual Conference on Violence and Trauma. At the state level there is a need to better understand the organizational structure of tribes and their culture as well as strategies for outreach and engagement of tribal leaders in regular consultation and collaboration.

L. Involvement of Individuals and Family Members

1. How are individuals in recovery and family members utilized in the development and implementation of recovery-oriented services (including therapeutic mentors, recovery coaches and/or peer specialists)?

There are at least three ways that family members and/or caregivers are utilized in the development and implementation of recovery-orientated services. First, for all behavioral health service procurements (this would include therapeutic mentors, recovery coaches and /or peer specialists) DCF includes family members and/or caregivers in the focus and work groups that occur prior to the release of a competitive state award. Family members or caregivers also participate on the review teams that make the final recommendation to the Commissioner for the award.

Second, family members are utilized in one component of the Children's Behavioral Health Advisory Council (CBHAC) - the Behavioral Health Services and Local Systems of Care Review Committee. In January 2010, this single committee was created, combining the roles and responsibilities of what was previously two separate committees. This decision was made because the oversight, monitoring and reviewing of the local system of care or community collaboratives, was strongly connected to the health and well-being of the overall statewide service delivery system. The committee is responsible for developing an annual report (on behalf of CBHAC) to the Commissioner and Legislators on the status of the 25 Community Collaboratives and every two years is responsible for drafting a report to the Commissioner and Legislators making recommendations and commenting on the overall behavioral health service system. CBHAC has 32 voting members, 16 of whom are family members and/or caregivers and all committees strive to include at least 50% family members and/or caregivers. The current

make-up of the Behavioral Health Services and Local Systems of Care Review Committee is 17 members, 10 of whom are family members.

Finally, family members and/or caregivers are utilized in the development and implementation of recovery-orientated services through the input of the ten statewide family advocates who not only support individual families, but who assist in the recruitment and retention of family member's and/or caregiver's participation in the local systems of care/Community Collaboratives. These ten family advocates are family members themselves and are integral to contributing to and supporting the family voice at the local level.

2. Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?

The state of Connecticut conducts ongoing training and technical assistance for child, adult and family mentors as well as others in the behavioral health service system. Although Connecticut has been providing strengths-based, culturally and linguistically competent training for years, recently Connecticut has developed the Wraparound Connecticut Learning Collaborative, or WrapCT. This learning collaborative was an outgrowth of a Mental Health Transformation State Incentive Grant (MHTSIG) activity. WrapCT's mission statement reads: "Our mission as a statewide learning collaborative is to educate, train, and promote the benefits of the values and principles of System of Care and the Wraparound Process."

There are currently over 120 members of WrapCT. As a group, WrapCT is made up of families, advocates, managers, and behavioral health providers who desire to make a difference in the lives of children and families that experience behavioral health issues. WrapCT meets the second Tuesday of each month in Middletown to plan and strategize about the best way to continue to educate families and providers in the Wraparound process and system of care values and principles. The group is currently in the process of developing a statewide culturally competent training and workforce development plan. There are three master trainers, two from Wraparound Milwaukee and one from Westfield State College in Massachusetts. They provide training, coaching and technical assistance in the wraparound process.

The wraparound process is a unique and individualized model of care that creates a Plan of Care using the family vision, identified family strengths and individualized unique needs and then develops short and long term strategies using formal and informal supports, care and services to meet the identified family needs. The wraparound process goes beyond matching the family's goals (i.e. identified needs and family vision) to services, because it is not limited by what is available on the behavioral health service continuum, but rather by the unique identified family needs and meeting those needs by a broader consideration of the use of informal and natural support and care networks.

The wraparound process is formally brought together in monthly (at a minimum) family- driven, Child and Family Team (CFTs) meetings. At each CFT the Plan of Care is reviewed and updated as appropriate. Families are able to share how the support, care and services to their family is

progressing, thereby directly participating in the decision- making process and their Plan of Care (i.e. treatment plan). Concerns are addressed through the CFT meeting process.

3. Does the state sponsor meetings that specifically identify individual and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

When a family member has a concern or grievance about the way a particular service provider is working with them, there are several avenues to address these issues. First, they can begin with the agency providing the service if they are comfortable doing so and they would follow the protocol of speaking to the manager or administrator overseeing the service. If they feel uncomfortable going directly to the agency with their concern or uncomfortable with the agency process or feel like their concerns were not heard, each Community Collaborative has a grievance process for families to bring concerns forward. Most of those grievance procedures involve bringing the concern or complaint to the paid family advocate that is assigned to the Community Collaborative, and the Family advocate then facilitates and supports the family through the grievance procedure.

4. How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?

All individuals and family members who receive any type of behavioral health service are invited to participate fully in the treatment process, beginning at intake and continuing throughout the treatment and discharge phases. Person-centered planning and treatment is the centerpiece of care. Multiple strategies are used to achieve this goal and include the use of evidence-based outreach and engagement protocols, child and family-friendly waiting rooms, child and family friendly documents available in English, Spanish and other languages, and well-trained staff who understand the importance of involving the child and family. The treatment plan or plan of care is a critical clinical tool that is developed in partnership with the child and family and is used as a guide to assessing progress throughout the episode of care. Additionally, all contract providers are required to administer the Ohio Scales at intake and discharge to identify child and family's felt needs and assessments as well as the Youth Services Survey for Families (YSS-F) to evaluate the child/family's level of satisfaction with services.

5. How does the State support and help strengthen and expand recovery organizations, family peer advocates, self-help programs, support networks, and recovery-oriented services?

DCF directly funds FAVOR - the statewide family advocacy organization, who has as one part of their contractual work, to assist and support the ongoing development of other family/peer advocacy organizations and family/peer support networks. They act as the local fiduciary of many of the Community Collaboratives' family member/parent/caregivers Support Groups. Additionally, many of the paid family advocates assist in the facilitation of the support groups attached to the local Community Collaboratives.

There are a number of different service categories in the overall statewide system of care. It is the desire and goal of the state of Connecticut for all of the services to operate within the context of a family driven, strengths-based, culturally competent and least-restrictive approach, but the

reality is that we are continually assessing and improving how well individual provider organizations are able to truly align themselves with those values and principles.

M. Use of Technology

1. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

Department staff, in partnership with community providers explored the use of telemedicine in a rural region of northwestern Connecticut. However, the state Medicaid agency does not approve telehealth as a reimbursable service, and there are no other funds to support this initiative.

2. What specific applications of ICT's does the State plan to promote over the next two years?
The Department is exploring the feasibility of the use of smart boards and webinar capacity. Also, the Department may explore the use of video conferencing. It will be advantageous to join forces with other state agencies for the latter technology. However, at this time there are no funds to promote specific applications of Interactive Communication Technology.

3. What incentives is the State planning to put in place to encourage their use?

See #2 above.

4. What support systems does the State plan to provide to encourage their use?

See # 2 above.

5. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

The most significant barrier is a lack of funding to support Interactive Communication Technology. Another barrier is the Department of Information Technology's stance that security risks are posed by use of certain technology.

6. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

This is not an area of work at this time.

7. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

No.

8. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

See # 2 above.

N. Support of State Partners

State Partner	Role
1. Department of Developmental Services (DDS)	<ul style="list-style-type: none"> Joint planning and coordination of services for clients involved with both DCF and DDS. Activities include: service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice/program evaluation.
2. Judicial Branch – Court Support Services Division (CSSD)	<ul style="list-style-type: none"> Continue to strengthen the shared service network for youth that are involved with child welfare and juvenile justice systems. Activities include: shared blended funding for Multi-Systemic Therapy (MST) and Intensive In-Home Child and Adolescent Psychiatry Services (IICAPS); and continued collaboration on state/federally funded initiatives such as the MacArthur Foundation MH/JJ Action Network and State Wraparound Project.
3. Department of Public Health (DPH)	<ul style="list-style-type: none"> Continued collaboration on the Personal Education Responsibility Program (PREP), the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, and Child FIRST grant application. (See Letter of Support for details.)
4. Department of Education (DOE)	<ul style="list-style-type: none"> Continued collaboration regarding school-based diversion of children involved in both child welfare and juvenile justice systems by intervening around mental health crises that might otherwise lead to arrest. Continued support of DCF’s school-based suicide prevention and mental health promotion activities.
5. Department of Mental Health and Addiction Services (DMHAS)	<ul style="list-style-type: none"> Joint planning and coordination of services for clients who are under the care of DCF and who are eligible for services through DMHAS. Activities include: joint planning for transition cases; regular communication to monitor the referral process, identify and resolve issues; and ongoing strategizing to address funding issues.
6. Department of Social Services (DSS)	<ul style="list-style-type: none"> Continue the jointly managed CT Behavioral Health Partnership to strengthen an integrated behavioral health system for Medicaid eligible children and youth. Work collaboratively to define the criteria for the Welcoming and

	Engaging Families domain for Enhanced Care Clinics; and continue to work jointly to improve access, quality and outcomes.
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O. State Behavioral Health Advisory Council

1. Membership Requirements

Section 1914c of the PHS Act (42 U.S.C. 30x-4) requires that the SMHPC conform to certain membership requirements. This includes representatives of principal state agencies, other public and private entities concerned with the need, planning, operation, funding and use of mental health services and related services, family members of adults and children with serious emotional disturbances, and representatives of organizations of individuals with mental illness and their families, and community groups advocating on their behalf. Specifically, the law stipulates that not less than 50% of the members of the Planning Council shall be individuals who are not state employees, or providers of mental health services. The law also requires that the ratio of parents of children with serious emotional disturbance (SED) to other members of the Council is sufficient to provide adequate representation of children in the deliberations of the Council.

The SMHPC (a.k.a. Joint MHP Council) members are appointed as follows:

- Families of children with SED and primary (adult) consumers of mental health services/ persons in recovery who serve as advocates on citizen advisory councils may be nominated by the State Advisory Council, the legislature, Governor’s office, local advisory boards, statewide organizations such as the National Alliance for the Mentally Ill - Connecticut (NAMI - CT), Advocacy Unlimited, Inc., Consumer Self Help, or volunteer individually;
- In preparation for review of an integrated mental health and addiction services plan in the future, the council is in the process of expanding to include families of children with substance abuse and primary (adult) consumers/persons in recovery of substance abuse services/ persons in recovery who serve as advocates on citizen advisory councils, local advisory boards, statewide organizations such as the Connecticut Communities for Addiction Recovery (CCAR), Consumer Self Help, or individual volunteers.
- Providers of mental health and/ or substance abuse services and members who represent public and private entities concerned with the need, planning, operation, funding and use of mental health services and related support services are recruited by the two departments and/or nominated by professional and trade organizations; and
- The Commissioners of those departments or agencies designate state agency representatives.

- Members of the Joint MHP Council include the Adult State Mental Health Planning Council, plus the Children’s Behavioral Health Advisory Committee, plus state agency representatives.

The policies and procedures for selection of Joint MHP Council members are as follows:

Adult State Mental Health Planning Council (ASMHPC): No formal by-laws have been enacted but the ASMHPC has adopted guidelines and procedures. ASMHPC has established various stakeholder group representations that reflect geographic, stakeholder (advocates, consumers, providers) and planning representation. A nominating committee recommends selections of Council members, within the guidelines established, to the Chair. A simple majority of those present and voting (50% + 1) applies for passage of motions.

Children’s Mental Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children’s Behavioral Health Advisory Committee (CBHAC) to the State Advisory Council on Children and Families (SAC) to “promote and enhance the provision of behavioral health services for all children” in Connecticut. The CBHAC serves as the state’s Children’s Mental Health Planning Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state’s System of Care for children and families.

The 31-member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Protection and Advocacy, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, six members appointed by the leadership of the General Assembly, as well as sixteen members appointed by the chairperson of the SAC. The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. “At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child.” In addition, a parent is to serve as co-chair of the CBHAC/CMHPC.

A standing Nominations Committee is responsible for recruiting, interviewing, and nominating persons to serve as CBHAC/CMHPC officers. The committee also assumes responsibility for ensuring that CBHAC/CMHPC has the full complement of members and the appropriate distribution of members in accordance with applicable laws and statutes. The Nominations Committee also presents a slate of officers (i.e., at least one nominee for each Co-Chairperson position) for approval at a CBHAC/CMHPC meeting. A majority of all present CBHAC members who submit a written ballot is required for a nominee to be elected as an officer.

The bylaws for the CBHAC/CMHPC define a number of standing and ad hoc committees. Many of these committees have a concrete role in shaping the quality monitoring components of behavioral services funded through DCF.

The CMHPC is also responsible for reviewing and forwarding of recommendations to the DCF Commissioner concerning all new and revised Practice Standards that pertain to children’s behavioral health system programs. DCF requires that all its contracted service providers comport with the tenets of the applicable Practice Standard(s) as a term of their contract.

State Agency Representatives: State agency Commissioners are notified of Joint MHP Council meetings held four (4) times a year. Commissioners may assign a person within their agency to be an alternate for him or her. Only one person per agency may be a voting member. State departments and agencies include: DMHAS, DCF, Department of Correction (DOC), Department of Education (SDE), Department of Higher Education (DHE), Department of Economic and Community Development (DECD), Department of Developmental Services (DDS), Office of Protection and Advocacy (OP&A), Department of Public Health (DPH), Department of Social Services (DSS) and Bureau of Rehabilitation Services (under DSS for administrative purposes only).

2. Table 1 State Mental Health Planning Council Membership List Table 1

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Cathleen Adamczyk	Parent of a Child with SED – Children’s BH Council, CBHAC		31 Hill Street Ansonia, CT 06401 T (H): 203-735-6098 T (W): 860-679-1585 E: Adamczyk@uchc.edu
Margaret “Peggy” Ayer	Adult MH Advocate, DMHAS State Board, Adult SMHP Council and Children’s BH Council, CBHAC	Eastern Regional MH Board	151 Pond Road North Franklin, CT 06254-1224 T: 860-642-4318 E: msayer@adelphia.net
Kristie Barber	Adult MH Advocate, RMHB Exec. Dir., Adult SMHP Council	South Central CT Regional MH Board, Inc.	CT Valley Hospital PO Box 351 Middletown, CT 06457 T: 860-262-5027 F: 860-262-5028 E: rmhb2@aol.com
Sincilina Beckett	MH Provider, Children’s BH Council, CBHAC		90 Fowler Street New Haven, CT 06515 T: 203-641-8667 sincilina@aol.com
Joan Cretella	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		225 Beach Street, Unit 2A West Haven, CT 06516 T: 203-933-4272 E: N/A
Robert Davidson	Adult Primary Consumer, RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	Eastern Regional MH Board	401 West Thames Street Campbell Building, Room 105 Norwich, CT 06360 T: 860-886-0030 F: 860-886-4014 E: ERMHB@Downcity.net
Marcia DuFore	RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	North Central Regional MH Board	367 Russell Road, Bldg. 34 Newington, CT 06111 T: 860-667-6388

			F: 860-667-6390 E: mdufore@ncrmhb.org
Robert Franks	MH Provider, Children's BH Council, CBHAC	Connecticut Center for Effective Practice and Child Health (CCEP) & Development Institute (CHDI)	270 Farmington Avenue Suite 367 Farmington, CT 06032 860 679-1531 rfranks@uchc.edu
Hal Gibber	Parent of a Child with SED – Children's BH Council, CBHAC	FAVOR, Inc.	2138 Silas Deane Highway Suite 100 Rocky Hill, CT 06067 T: 860-563-3232, Ext 201 F: 860-563-3961 E: Halgibber@favor-ct.org
Lorna Grivois	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		586 Westchester Road Colchester, CT 06415 T: (860) 267-6083 E: grivois620@comcast.net
Gabrielle Hall	MH Provider, Children's BH Council, CBHAC	Clifford Beers Clinic	370 James Street New Haven, CT 06513 T: 203-777-8648, Ext 207 F: 203-785-0617 E: ghall@cliffordbeers.org
Mary Held	Parent of a Child with SED - Children's BH Council, CBHAC		929 Bank Street Waterbury, CT T: 203-441-1887 E: Heldmary30@aol.com
Irene Herden	Adult MH Advocate, DMHAS State Board, Consumer Advocacy Group, RMHB member, Adult SMHP Council	South Central CT Regional MH Board	49 Bogue Lane East Haddam, CT 06423-1442 T: 860-873-1999 (H) F: 860-873-1999 (H) E: evherd@aol.com
Mui-Mui Hin-McCormick, MS, LMLT	MH Provider, Adult SMHP Council	Community Renewal Team, Asian Family Services	1921 Park Street Hartford, CT 06106 T: 860-951-8770, Ext 222 F: 860-233-2796 E: hinm@crtct.org
Norma Irving	Parent of a Child with SED - Children's BH Council, CBHAC		192 Affleck Street Hartford, CT 06106 T: 860-803-8754 Larry192@comcast.net
Lisa Jameson	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		112 Bell-Aire Circle Windsor, CT 06096 T: (860) 796-9116 Jameson-one@sbcglobal.net
Marcy Kane, Ph.D.	MH Provider, Children's BH Council, CBHAC	Wellpath	36 Sheffield Street Waterbury, CT 06704 T: 203-575-0466 C: 860-217-5276 E: mkane@wellpathct.org
Karen Kangas, D. Ed.	Adult Primary Consumer, Adult MH Advocate, Adult SMHP Council	Advocacy Unlimited, Inc.	300 Russell Road Wethersfield, CT 06109-1346 T: 860-667-0460, Ext 302 F: 860-666-2240 E: karen.kangas@mindlink.org

Darcy Lowell, MD	MH Provider, Children's BH Council, CBHAC	Bridgeport Hospital	267 Grant Street, Bridgeport, CT 06610 T: 860-384-3626 F: 860-454-4472 darcylowell@aol.com
Mary M. Martinez	MH Advocate, Adult SMHP Council; Children's BH Council, CBHAC		7 Mary Shepard Place, Apt 710 Hartford, CT 06120 T: 860-241-1040 & 860-816-0881 E: N/A
Debbie McCusker	Parent of a Child with SED - Children's BH Council, CBHAC		35 Maywood Street Waterbury, CT 06704 T: 203-757-7569 E: jamesmccusker@sbcglobal.net
George McDonald	Parent of a Child with SED - Children's BH Council, CBHAC		P.O Box 2617 Hartford, CT 06146 T: 860-794-6283
John McGann	MH Provider, Children's BH Council, CBHAC	Catholic Charities/ Catholic Family Services	203 High Street Milford, CT 06401 T: 203-735-7481 F: 203-735-5021 E: milford@cccfs.org
Tabor Napiello, MSW	MH Provider, Children's BH Council, CBHAC	Wheeler Clinic	91 Northwest Drive Plainville, CT 06062 T: 860-793-3551 F: 860-793-3371 E: tnapiello@wheelerclinic.org
Kim O'Rielly	Chair: Adult SMHP Council; RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	Southwest Regional Mental Health Board	1 Park Street Norwalk, CT 06851 T: 203-840-1187 (office) F: 203-840-1926 E: swrmhb@optonline.net
Brian Reignier, MS	Adult Primary Consumer, Adult MH Advocate, Adult SMHP Council	River Valley Services, Human Services Advocate	H: 19 Irving Street Naugatuck CT 06457 HT: (203) 720-1048 WT: (860) 262-5362 WF: (860) 262-5356 E: Brian.Reignier@po.state.ct.us
Barbara Roberts	Family of Adult Consumer with SMI, RMHB member, MH Advocate, Adult SMHP Council	Northwest Regional MH Board	42 School Street Woodbury, CT 06798 T: 203-263-3250 E: Barbara114@sbcglobal.net
John F. Sims	Primary Adult Consumer, MH & SA Consumer Advocate, Rep of Minority Group (African Origin), Adult SMHP Council		118 Federal Street West Hartford, CT 06110 T: 860-232-8514 F: N/A E: N/A
Karen Smith	Parent of a Child with SED- Children's BH Council, CBHAC	Helping Hands CT	166 Green Manor Drive East Hartford, CT 06180 T: 860-890-0299 homenterprises@sbcglobal.net
Janine Sullivan-Wiley	Adult MH Advocate, RMHB Exec. Dir., Adult SMHP Council; Member of Family Focus Partnership (Youth System Collaborative)	Northwest Regional MH Board, Inc.	969 West Main Street, Suite 1B Waterbury, CT 06708 T: 203-757-9603 (Office) F: 203-757-9603 E: nwrmhb@snet.net

Dominique S. Thornton, JD	Adult MH Provider, MH Advocate, Adult SMHP Council	Mental Health Association of Connecticut, Inc.	20-30 Beaver Road Wethersfield, CT 06109 T: 860-529-1970, Ext 11 F: 860-529-6833 E: dthornton@mhact.org
Dave Tompkins	Co-Chair, Children's BH Council, CBHAC ; Child MH Provider	The Children's Home	60 Hicksville Road Cromwell, CT 06416 T: 860-635-6010, Ext 391 F: 860-398-0397 E: Dtompkins@childhome.org

\Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Jan VanTassel, Esquire	Adult MH Advocate, Adult SMHP Council	CT Legal Rights Project	CT Valley Hospital, Shew-Beers Hall P. O. Box 351, Silver Street Middletown, CT 06457 T: 860-262-5042 F: 860-262-5035 E: Jvantassel@clrp.org
Doriana Vicedomini	Co-Chair, Children's BH Council, CBHAC ; Parent of a Child with SED-Children's BH Council, CBHAC		317A Thompsonville Road Suffield, CT 06078 T: 860-668-5228 DMV35@aol.com
Cara Westcott	MH Provider, Children's BH Council, CBHAC	United Community and Family Services, UCF Health Center, The Meadows Center	47 Town Street Norwich, CT 06360-2315 T: 860-892-7042, Ext 409 F: 860-886-6124 E: cwestcott@ucfs.org
Curtis Willey	Primary Adult Consumer, MH & SA Consumer Advocate, Adult SMHP Council	Connecticut Behavioral Health Partnership	500 Enterprise Drive, Suite 4-D Rocky Hill, CT 06067 T: (860) 263-2168 F: (860) 263-2166 E: Curtis.Willey@valueoptions.com

List of Planning Council Members (Table 1) (Continued)
Table 1 – Voting Members – Non State Agencies Representatives

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Vacancy	Adult SMHP Council – Substance Abuse Consumer/ Person in Recovery		
Vacancy	Adult SMHP Council – Substance Abuse Consumer/ Person in Recovery		
Vacancy	Substance Abuse Family Member		
Vacancy	Substance Abuse Family Member		
Vacancy	Substance Abuse Provider		
Vacancy	Parent – Children’s BH Council (State Advisory Council)		
Vacancy	Minority Leader of the House Appt.		

The Nominations Committee of the Children’s Planning Council is seeking parents to fill the above-identified vacancy. Activities to recruit parents through existing family advocacy organizations are ongoing. In addition, e-mail announcements and use of the local System of Care Collaborative meetings are used to recruit members. These efforts will continue in order to fill the existing and future vacancies.

The Nominations Committee of the Adult State Mental Health Planning Council is actively outreaching to substance abuse consumers/ persons in recovery and family members and substance abuse providers that have been identified as potential members. As the Adult Council expands its membership to address behavioral health issues, it is anticipated that in the next block grant plan period it will be ready to review and comment on an integrated mental health and addictions block grant state plan and application.

Table 1 – State Agency Voting Members (M) or Alternates (A)

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Leo Arnone Commissioner (M)	State Agency, State Employee, Adult MH Provider	Dept. of Correction (DOC)	24 Wolcott Hill Road Wethersfield, CT 06109 T: 860-692-7482 F: 860-692-7483 E: Leo.Arnone@po.state.ct.us
Roderick Bremby Commissioner (M)	State Agency, State Employee	Dept. of Social Services (DSS) Bureau of Rehabilitation Services (BRS)	25 Sigourney Street Hartford, CT 06106 T: 860-424-5053 F: 860-424-5057 E: Robert.Bremby@ct.gov
Cathy Foley Geib (M)	State Agency, State Employee - Children's BH Council (CBHAC)	Court Support Services (CSSD)	936 Silas Deane Highway Wethersfield, CT 06067 T: 860-721-2190 F: 860-721-2147 E: Cathy.Foley.Geib@jud.state.ct.us
Joette Katz Commissioner (M)	State Agency, State Employee. Children MH Provider (CBHAC)	Dept. of Children & Families (DCF)	505 Hudson Street Hartford, CT 06105 T: 860-550-6300 F: 860-566-7947 E: Commissioner.DCF@ct.gov
Timothy Marshall (A) Represents DCF Commissioner	State Employee (Support Staff/ Children's BH Council (CBAHC))	Dept. of Children and Families (DCF)	505 Hudson Street Hartford, CT 06106 T: 860-550-6531 F: 860-556-8022 E: Tim.Marshall@ct.gov
Joan McDonald , Commissioner (M)	State Agency, State Employee	Dept of Economic and Community Development (DECD) (includes Housing)	505 Hudson Street Hartford, CT 06106 T: 860-270-8010 F: 860-270-8008 E: Joan.Mcdonald@ct.gov
James D. McGaughey Executive Director, (M)	State Agency, State Employee	Office of Protection and Advocacy (OP&A)	60-B Weston Street Hartford, CT 06120-1551 T: 860-297-4320 F: 860-566-8714 E: James.McGaughey@po.state.ct.us
Dr. Mark K. McQuillan Commissioner (M)	State Agency, State Employee - Children's BH Council	Dept. of Education (SDE)	165 Capitol Avenue, Room 305 Hartford, CT 06106 T: 860-713-6500 F: 860-713-7001 E: Mark.McQuillan@po.ct.gov
Jewel Mullen, MD Commissioner (M)	State Agency, State Employee	Dept. of Public Health (DPH)	410 Capitol Avenue Hartford, CT 06106 T: 860-509-7101 F: 860-509-7111 E: Jewel.Mullen@ct.gov
Charles Nathan (A) Represents DPH Commissioner	State Agency, State Employee	Dept. of Public Health (DPH)	410 Capitol Avenue Hartford, CT 06106 T: 860-509-7127 F: 860-509-7160 E: Charles.Nathan@ct.gov

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Lynne Neff, (A) Represents DOC Commissioner Correctional Health Services Manager	State Agency, State Employee & MH Provider – Adult SMHPC	Dept. of Correction (DOC)	24 Wolcott Hill Road Wethersfield, CT 06109 T: 860-692-6958 F: 860-506-6068 E: Lynne.Neff@po.state.ct.doc
Scott R. Newgass (A) Represents SDE Commissioner	State Agency, State Employee - CBHAC	State Dept. of Education (SDE)	25 Industrial Park Road Middletown, CT 06457 T: 860-807-2044 F: 860-807-2127 E: scott.newgass@ct.gov
Terrence Macy, Commissioner (M)	State Agency, State Employee	Dept. of Developmental Services (DDS)	460 Capitol Avenue Hartford, CT 06106 T: 860-418-6011 F: 860-418-6009 E: Terry.Macy@ct.gov
Paul Piccione, Ph.D. (A) Represents DSS Commissioner	State Agency, State Employee	Dept. of Social Services (DSS)	25 Sigourney Street Hartford, CT 06106 T: 860-424-5160 F: 860-424-5206 E: Paul.Piccione@ct.gov
Patricia A. Rehmer, MSN, Commissioner (M)	State Agency, State Employee, Adult MH Provider	Dept. of Mental Health & Addiction Services (DMHAS)	410 Capitol Avenue Hartford, CT 06134 T: 860-418-6969 F: 860-418-6691 E: Pat.Rehmer@po.state.ct.us
Nikki Richer (A) Represents DMHAS Commissioner	State Agency, State Employee, Adult MH Provider (Young Adults) - CBHAC	Dept. of Mental Health & Addiction Services (DMHAS) Young Adult Services (YAS)	YAS, CVH P.O. Box 351 Middletown, CT 06457 T: 860-262-6995 F: 860-262-6980 E: Nikki.Richer@po.state.ct.us
Wiley Rutledge (A) Represents OP&A Director	State Agency, State Employee – Adult State Mental Health Planning Council	Office of Protection & Advocacy (OP&A)	60-B Weston Street Hartford, CT 06120-1551 T: 860-297-4360 F: 860-566-8714 E: Wiley.Rutledge@po.state.ct.us
Rachel Sherman (A) Represents OP&A Director	State Agency, State Employee - Children’s BH Council (CBHAC)	Office of Protection & Advocacy (OP&A)	60-B Weston Street Hartford, CT 06120-1551 T: 860-297-4320 F: 860-566-8714 E: Rachel.Sherman@po.state.ct.us
Maureen Thomas, Ph.D. (A) Represents DDS Commissioner	State Agency, State Employee – Children’s BH Council (CBHAC)	Deputy Commissioner Dept. of Developmental Services (DDS)	370 James Street New Haven, CT 06513 T: (203) 974-4268 F: (203) 974-4211 E: Maureen.Thomas@ct.gov
Barbara Parks-Wolf (M) Represents Secretary of OPM	State Agency, State Employee	Office of Policy & Management (OPM)	450 Capitol Avenue Hartford, CT 06106 T: 860-418-6442 F: 860-418-6495 E: Barbara.Wolf@ct.gov

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Paula Zwally (M)	State Agency, State Employee, Adult MH Provider (Director of Compliance)	Greater Bridgeport Community Mental Health Center	1635 Central Avenue Bridgeport, CT 06610 T: (203) 551-7464 E: Paula.Zwally@po.state.ct.us

List of Planning Council Members (Table 1) (Continued)
Table 1B – NON- Voting Members

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Alfred Bidorini	State Employee (Support Staff/ Adult SMHP Council)	Dept. of Mental Health & Addiction Services (DMHAS)	P. O. Box 341431, MS 14 PAS Hartford, CT 06134 T: 860-418-6838 F: 860-418-6792 E: Alfred.Bidorini@po.state.ct.us
Marilyn Cloud	State Employee (Support Staff/ Children’s Behavioral Health Advisory Council)	Department of Children and Families (DCF)	505 Hudson Street Hartford, CT 06106 T: 860-723-7260 F: 860-566-8022 E: Marilyn.Cloud@ct.gov
Donna Stimpson	State Employee (Support Staff/Adult SMHP Council)	Dept. of Mental Health & Addiction Services (DMHAS)	P. O. Box 341431, MS-14PAS Hartford, CT 06134 T: 860-418-6837 F: 860-418-6792 E: Donna.Stimpson@po.state.ct.us

Planning Council Composition by Type of Member (Table 2)

Table 2: Planning Council Composition by Type of Member		
Types of Council Members	Number	Percentage of Total Membership
TOTAL MEMBERSHIP:		
Consumers/Survivors/Ex-patients (C/S/X)*		
Family Members of Children with SED		
Family Members of Adults with SMI		
Vacancies (C/S/X and Family Members)		
Other: Advocates and Citizen Advisory (Not state employees or providers)		
Other: Vacancies (Advocates and Citizen Advisory -Not state employees or providers)		
TOTAL: C/S/X, Family Members and Others (not include vacancies)		
State Employees Voting Members (M)**		
Mental Health (MH) Providers		
Vacancies		
TOTAL: State Employees Voting Members (M) & Mental Health Providers (not include vacancies)		

Please note that although these membership categories are not mutually exclusive, members are only counted once on the table above. For example, a member who is a primary adult consumer may also be a family member of an adult with SMI.

- * None of the primary consumers are also a family member of an adult with SMI.
- ** Four of the 12 state employees are also mental health providers.

3. Planning Council Charge, Role and Activities

Section 1914(b) of the PHS Act (42 U.S.C 300x-4) requires that the SMHPC (aka Joint MHP Council) perform certain duties. The duties are:

- To review plans provided to the Joint MHP Council pursuant to section 1915(a) by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), and to submit to the Commissioners of those departments any recommendations of the Joint SMHP Council for modifications to those plans;
- To serve as an advocate for adults with serious mental illness, and children with SED and their families, as well as other individuals with mental illness or emotional problems; and
- To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Connecticut.

The Children's Planning Council conducted numerous activities to carry out their role. Some highlights include the following:

- Tracked proposed legislation and provided testimony to oppose legislation that would adversely impact behavioral health services for children and families;
- Submitted recommendations to the State Advisory Committee, per the CBHAC by-laws, regarding the behavioral health needs of youth and their families in Connecticut;
- Convened a Forum at the Legislative Office Building in November 2010 to formally present to the State Advisory Committee two reports:
THE ANNUAL REPORT ON THE STATUS OF CONNECTICUT'S COMMUNITY COLLABORATIVES/SYSTEM OF CARE; and
RECOMMENATIONS TO THE STATE ADVISORY COUNCIL ON CHILDREN AND FAMILIES REGARDING THE BEHAVIORAL HEALTH SYSTEM IN CONNECTICUT;

(Over 100 Parents, Legislators and Providers attended.)

- Continued to review Practice Standards for services and programs

(In addition, the Practice Standard Sub-Committee made a recommendation to the full CBHAC who endorsed the recommendation and passed it along to the SAC. The recommendation was that DCF develop practice standards for all services and that any service that does not yet have practice standards that DCF would make those practice standards a priority. This was the same recommendations as last year.);

- Continued to recruit new members;
- Continued participation on the Mental Health Transformation Workgroups and the CT Behavioral Health Partnership Oversight Council;
- Continued to work collaboratively with the Adult Council to focus on needs and services for transitioning youth;
- Provided the CBHAC members and guests with presentations on new and developing initiatives within Connecticut, data relating to behavioral health services in Connecticut and nationally, and DCF strategic planning and reviews of the Mental Health Block Grant progress report;
- Co-Chair attended the 2010 National Mental Health Block Grant Conference and reported back to CBHAC members;
- Established a stronger relationship with the State Advisory Committee, supporting improved outcomes for both groups;
- Continued to sponsor quarterly meetings of the state's Community Collaboratives (The goal for the year was to establish a free standing statewide Community Collaborative Council. This has been almost accomplished due to the hard work of many CBHAC members. A grant application has been submitted to SAMHSA through the department of Children and Families for funding for a planning grant to implement the structure that has been developed.);
- Participation on Partnering with Parents, a statewide group that brings together entities that focus on parent training; and
- CBHAC Co-Chair served as tri-chair for the Family Engagement Committee, part of the Outpatient Learning Collaborative for improving outpatient behavioral health care.

4. State Mental Health Planning Council Comments and Recommendations
(Section 1915(a))

Connecticut is required to submit a letter from the SMHPC containing any recommendations for modifications to the State Plan received by the state, regardless of

whether the state has accepted the recommendations. The draft FFY 2012 – 2013 CMHS Block Grant State Plan was posted on the state websites, the Adult services on the DMHAS website and the Children’s services on the DCF website. Any comments from the public were shared with the Joint MHP Council. The Council met on August 9, 2011 to provide comments. Prior to the August 9th meeting, components, the adult and children’s portion of the Joint MHP Council met and reviewed their respective parts of the plan, and provided comments and recommendations. Final recommendations, based upon the Council’s review are provided with the joint letter from both Council co-chairs (see letter and comments on Section P. Comment on the State Plan below).

DRAFT