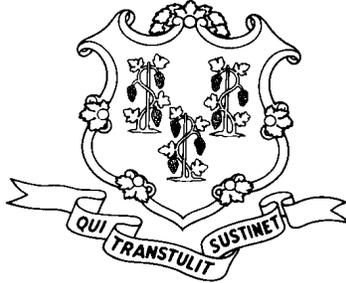


# STATE OF CONNECTICUT



## Community Mental Health Services Block Grant for FY 2011

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

Including

### The Community Mental Health Plan For Children & Adults

September 1, 2010

Submitted By

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

OCTOBER 1, 2010 to SEPTEMBER 30, 2011

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

### **A. OVERVIEW OF THE STATE'S MENTAL HEALTH SYSTEM**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Since January 1, 2006 the CT Behavioral Health Partnership (CTBHP), which is administered by Value Options, Inc. under contract with 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 complete and effective system of community-based behavioral health services and supports for children and families. The CT BHP offers specific services for children and families who are eligible for the HUSKY Part A or HUSKY Part B programs or the Limited Benefit Program through DCF. For the latter program, children who do not qualify for HUSKY Part A or HUSKY Part B may be eligible to apply for services if they have complex behavioral health needs and are involved with DCF.

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

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

These established goals are accomplished through the execution of the following functions/activities:

- Utilization Management: the authorization, tracking and monitoring of selected services;
- Clinical Management: the application and coordination of best practice as applied to members with complex behavioral health needs;
- Quality Management: the collection, analysis and reporting of data and data-driven trends and reports to support service enhancement or improvement.

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 or substance abuse services;
- Emergency mobile psychiatric services;
- Medication evaluation and management;
- Extended day treatment services; and
- Psychological/neuropsychological testing.

Staff at Value Options, Inc. works closely with family members, providers and other local social service providers to support the goals of the behavioral health system. There are 6 Regional Network Managers (RNM) who, in the past year, have focused on provider-specific targets for increasing access to care by reducing lengths of stay and delayed discharges at local hospital emergency and inpatient departments. During 2007 and 2008 the RNM's role moved to a more focused approach to service capacity/access, quality and outcomes. The RNMs may participate in the Managed Service System meetings to review the status of DCF involved children with complex needs and those presented by the local system of care representatives. The RNMs provide information and expertise on CT BHP policies, procedures and resources. They provide local and statewide data and reports to guide service system planning, implementation and monitoring. During 2009 the RNMs also worked closely with hospital Emergency Departments to solicit MOUs with local Children's Emergency Mobile Crisis teams. The goal of this activity has been to ensure that the mobile teams are notified when a child in psychiatric crisis enters the ED and to assist hospital personnel with diversion plans when necessary. RNMs have also worked closely with the Psychiatric Residential Treatment Facilities to help shorten average lengths of stays by monitoring and tracking data on admissions and discharge delays while prompting early discharge planning.

In addition to focusing on the provider system, the ASO contract also allows for the hiring of licensed clinical staff to address individual needs of the CT BHP membership. Specifically, Care Managers are responsible for 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 (ICM) 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. The ICMs have been assigned to each DCF area office to assist with clinical treatment planning for complex cases. 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 to effectuate timely discharges. Other Value Options' staff members that work at the individual member levels include peer support specialists who are adults that have had personal experiences with the mental health and/or substance abuse services system, and family support specialists who are trained parents of children with behavioral health needs. They provide information, identify individual barriers to care, and work closely with the intensive care

coordinators and care coordinators to address barriers. Each of the described staff members are organized into "geo teams" that cover a specific area within the state. These teams meet weekly to share information and to develop provider-specific or community-specific interventions that support the goals of the CT BHP.

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

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

### **B. ROLE OF THE STATE MENTAL HEALTH AGENCY**

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

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

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

- a) State Advisory Council. This seventeen-member council was established through legislation to assist the Department through input into each of the Department's mandated areas of responsibility, including children's behavioral health. The Council recommends, to the Commissioner, programs, legislation or other matters which will improve services for children, youth and their families served by the Department. The State Advisory Council (SAC) assists in the development of, review and comment on the strategic plan for the Department. The SAC

reviews quarterly status reports on the plan, independently monitors progress and offers an outside perspective to the Agency.

- b) Children's Behavioral Health Advisory Committee (CBHAC). Established by Public Act 00-188, CBHAC's charge is to promote and enhance the provision of behavioral health services for all children in the state of Connecticut. The committee oversees the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. The committee evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the State Advisory Council on Children and Families. CBHAC members also actively participate in the CT Joint Mental Health Block Grant Planning Council, which is co-chaired by a Children's Representative.
- c) Youth Advisory Boards. DCF staffs also work in partnership with and solicit input from the Youth Advisory Boards from each of the local area offices and a statewide Youth Advisory Board. Approximately 50 youth in "out-of-home care" participates.
- d) Connecticut Community Providers Association (CCPA). This member-based organization represents providers of services for children with mental illness, substance abuse disorders and other disabilities and special needs. The mission is to achieve service system change, represent the voices of its members at the state and local levels, and support the delivery of high quality, efficient and effective services.
- e) Connecticut Association of Non-Profits. A collaborative of 500 organizations, the association is dedicated to building and sustaining healthy communities. This group also focuses on identifying needs, service priorities, coordination of service systems, and advocacy for effective behavioral health services.

DCF has recently developed a five-year strategic plan to guide agency practice from July 1, 2009 through June 30, 2014. The integrated plan includes goals and activities for each of the Department mandates including child welfare, behavioral health, juvenile justice, substance abuse, and prevention. DCF staff as well as the broader stakeholder community influenced the development of the plan. The strategic planning document includes action steps and time frames for implementation to fulfill the vision, mission, and goals of the agency. Some key behavioral health activities include: establishing a needs assessment methodology to project needs for community-based behavioral health services to guide provider network development and expansion; providing training for targeted providers promoting the utilization of evidence-based practices; and developing and overseeing the implementation of valid, reliable assessment instruments to screen for behavioral health and developmental factors for child welfare cases.

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

DCF also works in partnership with the University of Connecticut, the University of Connecticut Health Center, Yale University School of Medicine/ Department of Psychiatry, The Consultation Center at Yale

University School of Medicine, and the Child Health Development Institute/Connecticut Center for Effective Practice. These academic and research facilities often provide critical support for system-wide planning, policy development, and program development.

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

**C. LEGISLATIVE INITIATIVES AND CHANGES** - Below is a summary of legislation passed during the 2010 Regular Session of the General Assembly that impacts behavioral health services for children and families.

<p><b>PUBLIC ACT 10-160 - SB 31 AN ACT IMPLEMENTING THE BUDGET RECOMMENDATIONS OF THE GOVERNOR CONCERNING THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE CARE AND CUSTODY OF THE DEPARTMENT OF CHILDREN AND FAMILIES.</b></p>
---

This act creates a presumption that it is in the best interest of a child the Department of Children and Families places in out-of-home care under an emergency, temporary custody, or commitment order to continue to attend the school he or she attended before the placement. The act applies to (1) all school-age children, (2) three- to five-year olds determined eligible for special education, and (3) children age 27 months through age five referred for special education determination. It provides mechanisms for parents to challenge DCF decisions. And it makes DCF responsible for some costs of transporting a child from a placement to school and makes a school ineligible to receive state special education excess cost grants for a child placed in another community who continues to attend his or her original school.

**EFFECTIVE DATE:** July 1, 2010

### **SCHOOL PLACEMENT FOR CHILDREN PLACED OUT OF HOME**

#### ***Determining School Placement***

The act requires DCF, when it places a child in out-of-home care, such as a relative's or foster parent's home, or changes such a placement, to determine immediately whether it is in the child's best interest to remain in the school he or she had been attending (the "school of origin"). DCF must notify all parties (i.e., the child or child's attorney and the parents or their attorney) of its decision and the reasons for it, in writing, within three business days after making the decision.

Any party can object to the decision within three business days of receiving this notice. The act requires disagreements to be resolved "expeditiously" and requires DCF to prove that its decision is in the child's best interest. The child must be transported to the school of origin until the three days have passed or the disagreement is resolved.

The act permits the school placement decision to be revisited at any time while the child is in out-of-home care, if circumstances change, to ensure the placement remains in his or her best interest. It does not specify who initiates such a review or how. Notice of a decision in such a review must be given as described above. A party may challenge such a decision by using the dispute resolution process for a DCF treatment plan. DCF policy permits a parent or child aggrieved by a treatment plan provision to ask for an administrative hearing and, if still aggrieved after the hearing decision, to appeal to Superior Court.

If DCF determines it is not in the child's best interest to remain in his or her school of origin, the act requires the agency to work with that school's board of education and the board of the school that DCF decides the child should attend (the "receiving school"). This collaboration must ensure the child's immediate and appropriate enrollment in the receiving school. (For a child requiring special education,

the law requires DCF to notify orally the school board responsible for the child's education (in most cases, the board where the child lived before being removed from home) within one day of the removal and in writing within two days. )

The act requires the school of origin to provide the receiving school with the child's educational records in accordance with federal law. It requires the school of origin, within one day of receiving notice from DCF, to send all essential educational records, including any individualized education or behavioral intervention plan, and all documents the receiving school needs to determine an appropriate class placement and provide educational services. It must transfer nonessential records within 10 days.

***Removing a Child from School Placement***

The act permits DCF to immediately remove the child from the school of origin if it determines that remaining there jeopardizes his or her immediate physical safety. If it does so, it must notify the child's parents, attorney, guardian ad litem, and surrogate parent (if the child has one) by phone or fax on the day it removes the child. Any party (it is not clear whether this includes the guardian ad litem or surrogate parent or just those parties to the original removal from home) may object to the change in placement. It must do so within three business days of receiving the notice, and DCF must hold an administrative hearing within three business days of receiving the objection.

***Paying for School Placement***

The act specifies that any child placed in another town who continues in his or her school of origin remains that district's educational and fiscal responsibility. The act makes the district of origin ineligible for state excess cost grants for special education for such a child's education, including tuition and transportation costs.

By law, when DCF places a child receiving regular education in another town and the child attends school there, the receiving town must provide and pay for the child's education. When DCF places a child requiring special education in another town and the child attends school there, the town of origin retains educational and fiscal responsibility for the child.

The act requires DCF, if it determines a child should remain in his or her original school, to collaborate with that school board on a transportation plan for the student. They must consider cost-effective, reliable, and safe transportation options.

The act makes DCF responsible for any additional or extraordinary cost of transportation beyond that to which the child would otherwise have access. It does not specify what costs are additional or extraordinary. The act requires DCF to maximize any reimbursements for the transportation costs available for eligible foster children under the Social Security Act.

**EFFECTIVE DATE:** July 1, 2010

**PUBLIC ACT 10-170 - HB 5244 AN ACT CONCERNING THE ISSUANCE OF EMERGENCY CERTIFICATES BY CERTAIN STAFF OF THE EMERGENCY MOBILE PSYCHIATRIC SERVICES PROGRAM.**

This act permits certain licensed clinical social workers, professional counselors, and advanced practice registered nurses (APRNs) to issue an emergency certificate, under certain conditions, to hospitalize a child for medical and psychiatric evaluation. Under current law, only physicians can issue such certificates.

The act permits social workers, counselors, and APRNs to issue an emergency certificate if they:

- (1) have received at least eight hours of specialized training in conducting direct evaluations as a member of a Department of Children and Families emergency mobile psychiatric services team and
- (2) reasonably believe, based on their direct evaluation, that the child (a) has a psychiatric disability; (b) is a danger to himself, herself, or others or is gravely disabled; and (c) needs immediate care and treatment.

The act requires the child to be evaluated within 24 hours after the emergency certificate is issued. The law requires a psychiatrist to conduct the evaluation. The act prohibits a hospital from holding a child hospitalized by a social worker, counselor, or APRN for more than 72 hours unless a court orders the child's commitment.

When a physician issues an emergency certificate, the law permits the child to be hospitalized for up to 15 days. And, if a commitment proceeding is begun during those 15 days, hospitalization can continue for 15 days longer (25 if the proceeding is transferred from probate to Superior Court) or until the proceeding is finished, whichever occurs first.

The act gives children hospitalized by social workers, counselors, and APRNs the same rights as existing law gives those hospitalized by physicians. These include the right to consult with and be represented by an attorney and the right to a hearing.

Finally, the act requires DCF to collect data pertaining to certificates social workers, counselors, and APRNs issue.

**EFFECTIVE DATE:** October 10, 2010

<b>PUBLIC ACT 10-179 - SECTIONS 28 - 30 HOMELESS YOUTH.</b>
---

The act requires the Department of Children and Families, within available appropriations, to establish a program for homeless youth and youth at risk of becoming homeless. The program may include one or more of the following services: (1) public outreach, (2) respite housing, and (3) transitional living services. DCF can contract with nonprofit organizations or towns to implement its program. The sum of \$1 million has been provided within Section 1 of this act to support this programming. Following implementation, the department will issue a report which shall include key outcome indicators and measures and shall set benchmarks for evaluating progress in accomplishing the purposes of said section.

***Definitions***

Under the act, a homeless youth is a person under age 21 without shelter where appropriate care and supervision are available and who lacks a fixed, regular, and adequate nighttime residence, including youth under the age of 18 whose parent or legal guardian is unable or unwilling to provide shelter and appropriate care.

The act defines “fixed, regular, and adequate nighttime residence” as a dwelling where a person resides on a regular basis that adequately provides safe shelter, but does not include (1) a publicly or privately operated institutional shelter designed to provide temporary living accommodations; (2) transitional housing; (3) temporarily living with a peer, friend, or family member who has not offered a permanent residence, residential lease, or temporary lodging for more than 30 days; or (4) a public or private place not designed for or ordinarily used as a regular sleeping place by human beings.

“Aftercare services” are continued counseling, guidance, or support up to six months following the provision of services.

### ***Public Outreach***

Under the act, a public outreach and drop-in component is one that provides youth drop-in centers with walk-in access to crisis intervention and ongoing support services. Services include one-to-one case management services on a self-referral basis and public outreach that locates, contacts, and provides information, referrals, and services to homeless youth and youth at risk of homelessness. This component may include information, referrals, and services for:

- (1) family reunification, conflict resolution, or mediation counseling;
- (2) respite housing; case management aimed at obtaining food clothing, and medical care or mental health counseling; counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, HIV, and pregnancy; and referrals to agencies for support services;
- (3) improving education, employment, and independent living skills;
- (4) aftercare; and
- (5) specialized services for highly vulnerable homeless youth, including teen parents and those who have been sexually-exploited or have mental illness or developmental disabilities.

### ***Respite Housing***

The program must also include an emergency shelter component providing homeless youth referrals and walk-in access to short-term residential care on an emergency basis. This includes voluntary housing with private shower facilities, beds, and at least one meal a day, and assistance with reunification with family or a legal guardian when required or appropriate.

Services provided at emergency homeless shelters may include:

- (1) family reunification services or referral to safe housing;
- (2) individual, family, and group counseling;
- (3) assistance in obtaining clothing;
- (4) access to medical and dental care and mental health counseling;
- (5) access to education and employment services;
- (6) recreational activities;
- (7) case management, advocacy, and referrals;
- (8) independent living skills training; and
- (9) aftercare services and transportation

### ***Transitional Living***

The program must also have a transitional living component that assists homeless youth in finding and maintaining safe housing and includes rental assistance and related support services. It may include:

- (1) educational assessment and referrals to educational programs;
- (2) career planning, employment, job and independent living skills training;
- (3) job placement;
- (4) budgeting and money management;
- (5) assistance in getting housing appropriate to needs and income;
- (6) counseling about violence, prostitution, substance abuse, sexually transmitted diseases and pregnancy or referrals for medical services or drug or chemical dependence;
- (7) parenting skills, self-sufficiency support services, or life skills training; and
- (8) aftercare.

### ***Parental Notification***

The act allows agencies to provide services to homeless children and youth unless a parent or guardian refuses to give or rescinds permission. Agencies must make all reasonable efforts to contact a parent or guardian for consent and presumably must stop providing services when the parent objects. But since the age of majority is 18 (or 16 if the child is legally emancipated) parental permission for this group cannot be required.

If the agency acts in good faith and without negligence, under the act they are immune from liability.

***Annual Reports***

Under the act, by February 1, 2012, the DCF commissioner must submit annual reports on the program to the Children's Committee. The report must include key outcome measures and set benchmarks for evaluating the program's progress in achieving its purposes.

It must also include recommendations for any changes to the program to ensure that the best available services are being delivered to homeless youth and youth at risk of homelessness.

Effective Date: October 1, 2010

**PUBLIC ACT 10-119 - SB 402 AN ACT CONCERNING THE BEHAVIORAL HEALTH PARTNERSHIP.**

This act makes a number of changes, primarily technical, to add the Department of Mental Health and Addiction Services (DHMAS) to the Connecticut Behavioral Health Partnership. The partnership is an integrated behavioral health system currently operated by the departments of Children and Families and Social Services (DSS).

By adding DHMAS to the partnership, the act requires the department to assume all partnership responsibilities such as (1) designating a partnership director to coordinate its agency responsibilities, (2) developing clinical management policies and procedures, (3) completing annual evaluation and reporting requirements, (4) developing consumer appeal procedures, and (5) monitoring administrative services organizations with whom it contracts to provide behavioral health services.

It also allows the partnership, at the departments' discretion, to expand coverage to include (1) Medicaid recipients not enrolled in HUSKY Plan Part A and (2) Charter Oak Health Plan members. Currently, the partnership serves only (1) children and families receiving services under the HUSKY program; (2) children enrolled in DCF's voluntary services program; and (3) at the DCF and DSS commissioners' discretion, other children and families DCF serves.

Finally, the act makes changes to the partnership's (1) responsibilities, (2) rate setting, (3) clinical management committee, (4) coordinated benefit policies, and (5) oversight council.

It also makes technical and conforming changes.

**EFFECTIVE DATE:** Upon passage

**PUBLIC ACT 10-91 - HB 5315 AN ACT CONCERNING EDUCATION AND THE REDUCTION OF DOMESTIC VIOLENCE.**

This act requires local and regional school boards, as part of the in-service training they must offer to certified employees, to include information on teen dating violence and domestic violence in the health and mental health risk reduction education information they must provide to those employees.

It also requires the State Board of Education to help and encourage the boards to include domestic violence and teen dating violence as a separate topic in their in-service training programs for certified professional employees. The State Board of Education must provide the assistance within available appropriations and using available material.

Finally, the act expressly allows boards to permit paraprofessionals and noncertified employees to participate voluntarily in the in-service training programs for certified personnel.

**EFFECTIVE DATE:** July 1, 2010

**PUBLIC ACT 10-133 - HB 5360 AN ACT CONCERNING CHILDREN IN THE RECESSION.**

This act creates new state agency responsibilities, and reporting requirements intended to provide an emergency response to children affected by the recession. The Department of Social Services (DSS) is the agency most affected, but the other state agencies that the act gives new responsibilities are: the departments of Children and Families, Education (SDE), Labor (DOL), and Public Health (DPH). The added responsibilities are all to be achieved within available appropriations.

Among other things, the act:

- (1) designates the state's Child Poverty and Prevention Council as the children in the recession leadership team to make recommendations for the state's emergency response to children affected by the recession;
- (2) requires DSS to develop a plan for comprehensive state services;
- (3) specifies how DSS can spend emergency funds received through the federal American Recovery and Reimbursement Act (ARRA);
- (4) makes attending a two- or four-year degree program an acceptable work activity for Temporary Assistance For Needy Families (TANF) participants when the unemployment rate is high;
- (5) prohibits DSS from changing eligibility criteria for the child care assistance program (Care4Kids) without 30 days advance notice;
- (6) increases state agency responsibilities for administering programs for the homeless and those at risk of homelessness;
- (7) calls for greater focus on reducing (a) the number of low birth-weight babies, (b) homeless children and families, and (c) food insecurity;
- (8) requires DSS, SDE, and DPH to submit reports to the Appropriations Committee that includes information on their progress in implementing the provisions of the act they have been assigned; and
- (9) immunizes state agencies and officials from civil liability for actions undertaken in complying with the act's requirements.

**EFFECTIVE DATE:** Upon passage, except the provisions on food outreach which take effect July 1, 2010

**PUBLIC ACT 10-43 - HB 5539 AN ACT CONCERNING JUDICIAL BRANCH POWERS AND PROCEDURES.**

This act makes numerous changes in court operations and powers, including:

- (1) allows the (a) Social Services (DSS) and Children and Families departments to include children, adolescents, and families served by the Judicial Branch's Court Support Services Division (CSSD) in the Behavioral Health Partnership and (b) chief court administrator to appoint someone to represent CSSD as a non-voting, ex-officio member of the Behavioral Health Partnership Oversight Council (§§ 10-11);
- (2) makes family relations counselors, family counselor trainees, and family services supervisors employed by the Judicial Branch mandated reporters of child abuse and neglect (§§ 12-13);
- (3) authorizes the court in certain hearings on temporary custody or a neglected, uncared for, or dependent child or youth to ask the mother under oath about the identity and address of anyone who might be the father and makes the mother's statement admissible in the proceeding (§§ 38-40); and
- (4) extends to certain children accused in a delinquency proceeding, the court's authority to order testing for venereal disease, AIDS, and HIV (§§ 41-42).

**EFFECTIVE DATE:** October 1, 2010, except the Behavioral Health Partnership provisions and a technical change (§ 23) are effective upon passage, and a change regarding admissibility of statements made by a mother under oath is effective July 1, 2012 (an identical provision in the act takes effect October 1, 2010 and the July 1, 2012 change is a conforming change).

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

### **D. OTHER NEW DEVELOPMENTS AND ISSUES**

The Department experienced a significant reduction in staff as a result of the Retirement Incentive Program with a loss of 169 staff across our organization during CY 2009. Due to this reduction in staffing, and in an effort to better position the Department to meet its strategic planning goals, it was necessary to reorganize our structure and reallocate our existing resources. In Central Office, many bureaus were integrated including the Bureau of Adoption and Interstate Compact Services with the Bureau of Child Welfare and the Office of Foster Care and Adoption Services as well as the Bureau of Adolescent and Transitional Services with the Bureau of Child Welfare. The Division of Education, along with all program Bureaus, now reports to the Chief of Staff to better reflect our interest in integrating our educational services and supports across all program areas. All four Bureaus (Child Welfare, Behavioral Health, Juvenile Services and Prevention) have specific responsibility for overseeing the quality assurance and quality improvement activities related to that Bureau's work.

In an effort to continue our focus on prevention, the Family with Service Needs (FWSN) program and FWSN liaisons transitioned from the Bureau of Juvenile Services to our Bureau of Prevention. The goal is to prevent youth who may be the subject of a FWSN petition from escalating further into the system. In order to promote a more seamless process for accessing the various levels of placement services that are available to children in care, the Division of Foster Care and Adoption Services now oversees access not only to foster and adoptive homes, SAFE Homes and Permanency Diagnostic Centers, but also to PASS group homes and STAR programs. Lastly, the Licensing Division and Policy Unit has transferred to the Legal Division to ensure continued adherence to statutory and regulatory requirements.

We retained all existing 15 Area Offices with a local manager in each office. Depending on the size of the office, the lead manager is either an Area Director or a Program Director, and the Area Offices are now organized into 5 distinct Service Areas under the management of a Service Area Director. Each Service Area has a Program Director for Quality Assurance and Administration and a Program Director for Behavioral Health who reports to the Service Area Director and is responsible for overseeing and managing those consultative services and supports across that Service Area.

There has been a \$ 28,000,000. reduction in state appropriations for the FY 10 and FY 11 budgets. This includes \$ 15,000,000. in personnel services (staff), of which almost all has been covered already through Retirement Incentive Program at the end of the last state fiscal year, without refill option. An additional \$ 5,000,000 has been cut in general operating expenses. For behavioral health programs and services, the enhanced care coordination program was eliminated (staff to work with those clients leaving residential care and reintegrating into the community, which is now managed by other resources through the CT BHP and the local Systems of Care) as well as some small, stand-alone miscellaneous programs that were not proven to be effective. Additionally, there has been an \$ 11,000,000. reduction for residential board and care, due to the projected continued decrease in residential utilization, coupled with an almost \$ 2,000,000. increase in the foster board and care account and an additional \$ 1,000,000 added to a new homeless youth account.

High Meadows, a specialized state-operated residential setting for male, developmentally disabled older youth was closed during this past state fiscal year. The decision was driven, in part, by the reduced

demand for residential treatment services, the excess capacity in other existing private residential treatment programs, and the Department's ability to serve many more children and families at home and in their communities. These youth were placed in less restrictive, more community-based settings.

The Department's first-ever agency-wide Strategic Plan that incorporates our four mandate areas has been developed, through input and feedback from internal staff and external stakeholders and partners. The first phases of implementation have begun. The plan builds upon the Department's mission and guiding principles and provides a clear set of action steps as well as a mechanism for monitoring and improving success along the way. There are specific, measurable indicators and nearly 50 important activities - and timeframes for implementation - designed to influence the outcome measures. These activities are organized into four broad areas of focus across all bureaus and divisions: (1) continuum of care; (2) internal practice improvements; (3) external relations; and (4) administrative practice. Examples of behavioral health areas of focus include straining for providers regarding evidence-based practices and undertaking a needs assessment to understand the behavioral health needs, populations, and trends.

Each year the CT BHP, through ValueOptions (the Administrative Service Organization) works to improve behavioral health services for children and their families. One of the major initiatives launched in 2008, focused on reducing the length of stay on inpatient psychiatric settings. For the past 2+ years DCF, DSS, ValueOptions and eight of Connecticut's private general and psychiatric hospitals have worked together to support the reduction of unnecessary inpatient days(Discharge Delay days). Efforts included the following:

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

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

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

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

A continuation of this collective performance target was initiated for Calendar Year (CY) '09 with an additional expectation that further reductions in discharge delay days would be noted across the inpatient system. A 50% decrease in discharge delay days was achieved with no subsequent increase in acute length of stay or 7 day readmissions (7,429 Discharge Delay Days for CY'08 to 5,043 Discharge Delay Days for CY'09)

In addition to the effort to reduce discharge delay on inpatient units, in CY 2009 the CT BHP also supported efforts to divert youth from inpatient care when appropriate by incentivizing local hospital emergency departments to begin to work collaboratively with their assigned children's emergency mobile crisis teams. The goal was to begin the relationship building process such that staff from the mobile teams could lend consultation around community-based alternatives and crisis planning. Memorandums of Understanding were developed to define roles and responsibilities for each entity and to track the number of calls made to the EMPS team to solicit help for a client in the ED.

Efforts to improve access and quality of care within the outpatient system has been effectuated through the initiation of Enhanced Care Clinics (ECC); outpatient mental health and substance abuse clinics that receive a 25% enhanced Medicaid rate in exchange for meeting several strategically staggered performance indicators. In 2008, ECCs were required to increase hours of operation during evenings and weekends in order to achieve and maintain emergent, urgent and routine access standards (2 hours, 2 days, 2 weeks respectively). To date 93% of the 29 clinics have met the established targets. Additional requirements for CY '09 have focused on supporting access to psychotropic medication.

While maintaining the 2008 targets, in 2009 the ECCs were required to develop Memoranda of Understanding with local Primary Care Providers (PCP) and develop a consultation program that would allow for the transfer of medication management for children with non-complex psychiatric issues and medication regimes to pediatricians for routine follow-up in an effort to expand access to medication management resources. Training on psychotropics for PCPs is scheduled to begin in the summer of 2010 to augment the consultation practices in place.

A performance initiative that was made available in 2009 to licensed freestanding clinics and hospitals that are currently active and participating with the CT BHP in the provision of Extended Day Treatment services, was continued in SFY '10. The initiative is intended to promote family engagement, enhance quality of care, and improve child and family outcomes. A total of \$ 120,000 is available each state fiscal year to those programs that meet the specified performance targets that include: established attendance rates by parents/caregivers at initial assessment interviews, treatment plan development meetings, treatment plan review meetings, individual therapy sessions, family therapy sessions, and multiple family group sessions; targeted rates for completion of Risking Connection Basic Training by new hires; and administration of the Ohio Scales as well as targeted increases in overall functioning scores and targeted decreases in problem severity scores. For SFY '10 all program sites participated and progress was made. For example, 95% of the 22 programs met at least 2 of the 4 domains involving family/caregiver attendance/participation in initial assessment interviews, initial treatment plan development meetings, treatment plan reviews, and/or family therapy sessions.

Another development under the direction of Value Options focused on fostering change in foster care. In 2007 The CT BHP conducted a retrospective analysis of data on children and adolescents placed in foster care to identify any relationship between use of behavioral health services and disruption from a first or second foster home placement. Data analysis and focus groups with foster families indicated that a relationship between disruption of foster care placement and authorization of behavioral health care services does exist. One of the findings was that a large number of children who had disrupted from their placements had previously received behavioral health services. Disruptions tended to occur within the first 45 days of placement.

In December 2008 DCF and the CT BHP initiated pilot programs in Norwich and Waterbury areas that were expanded to include Hartford and New Britain in 2009. The focus of the pilot was to support foster children with behavioral health needs and their foster families. Targeting children ages 3 to 18 who are experiencing their first removal from home, receive HUSKY benefits, and have already been identified as having behavioral health issues, the programs' goal has been to reduce the likelihood of disruption within 45 days of placement. If a child was identified as meeting criteria for participation in the pilot project, both the children and their foster families received outreach calls from the CT BHP's peer specialists (employees of the CT BHP who have either experienced behavioral health issues personally or have family members with behavioral health needs). The peer specialists help the foster parents to understand, predict and plan for the challenges and special behavioral health service needs. The CT BHP's intensive care managers also played a role in assuring that every case was authorized for services and linked with providers in a seamless manner.

While plans had been made to identify variables within the foster families that contributed to either stability or disruption for the children placed in their care, further research efforts were necessarily aborted due to the complexities associated with obtaining permission from each identified foster family and the reduction in resources made available within the Value Options contract due to statewide budget cuts.

Perhaps the most significant set of accomplishments within the CT BHP for CY'09 have involved a targeted and staged set of activities designed to reduce the number of CT youth entering residential care (RTC), reduce the average length of stay for youth in residential care, and improve the quality of care provided within that level of care. Significant effort was directed toward lessening the length of stay through a concerted effort to promote early discharge planning. The result was a 9% reduction in LOS from 321 days to 291 days.

Simultaneously, working with in-state residential providers, DCF and the Value Options staff identified a set of 24 mutually agreed upon outcome measures designed to track the efficacy of residential care within the system and within individual providers. In 2009 the logic and programming was developed for 7 of these measure using utilization data within the ASO system that tracks admissions and monitors continued stays. The remaining reports were well under development at the close of 2009 and will be available in 2010. The information and trends embedded within these reports will be analyzed and shared with residential providers. Areas for performance improvement will be identified and if possible a Performance Incentive program, similar to those described above for other levels of care will be developed for In-state RTCs to enhance quality of care for youth who require treatment within this restrictive setting.

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

**A. STRENGTHS AND WEAKNESSES OF THE SERVICE SYSTEM**

The behavioral health services system is complex and multi-faceted. A summary of the strengths and weaknesses (challenges) are included under seven core domains as described in the chart below.

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
<p>1. Access and Service Capacity</p>	<p>Broad range of clinical and non-traditional services available across the state</p> <p>Steady growth in community-based services including Outpatient Care, Extended Day Treatment, Care Coordination, Emergency Mobile Psychiatric Services, Intensive In-Home Services, Therapeutic Group Homes, and Family Advocacy Services</p> <p>28 Enhanced Care Clinics located across the state that meet timeliness standards for access to care covering emergent (within 2 hours), urgent (within 2 days), and routine care (within 2 weeks)</p> <p>DCF/DSS collaboration through the CT BHP to significantly expand Medicaid enrollment and services to children and families</p> <p>Provision of prevention activities through state agencies, universities, public and private providers, and DCF Prevention Division (Examples: Suicide prevention training for first responders, DCF staff, community providers, school children/college students, parents, foster parents)</p> <p>Partnerships between state agencies and the broader stakeholder community to address the needs of young children, birth to five for the purpose of early identification and intervention</p>	<p>Service capacity remains below estimated need</p> <p>Uneven distribution of services across communities. (Some communities have limited service types or wait lists for selective services)</p> <p>Fewer services available in rural areas</p> <p>"Right" type" of service may not be available at the time of need (Example: Need to develop more in-state capacity to provide specialized residential treatment services, specialized living and outpatient treatment programs for youth with problem sexual behavior, and creation of specialized outpatient programs for youth with significant behavioral dyscontrol and aggression, autism spectrum disorders, substance abuse)</p> <p>psychological testing services do not meet the needs</p> <p>Limited transportation resources in certain areas</p> <p>Insufficient specialty services such as traumatized treatments for children/youth</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>Partnerships between state agencies (DCF/DDS/DMHAS) and the broader stakeholder community to address the needs of youth with behavioral health and/or developmental issues who are transitioning to the adult system</p> <p>A network of 25 community collaboratives with specially trained service brokers to assist families in navigating the service system</p> <p>Managed Service Systems within the 15 DCF Area Offices to coordinate care for the DCF target population</p> <p>Strong statewide family advocacy organization, FAVOR to link families with services and organize family support groups</p> <p>Network of Care for Behavior Health website to assist families in locating services and to educate consumers on behavioral health disorders</p>	<p>Insufficient treatments for consumers with co-occurring disorders</p> <p>Insufficient early access options for young children and families for prevention and/or early intervention</p> <p>Need for ongoing monitoring and continued reduction of overstays and unnecessary utilization of hospital emergency departments, inpatient, and residential resources</p> <p>Continued challenges to meet the need for transitional services for those with behavioral health and/or developmental issues who are "aging out" of the child welfare system</p> <p>Need to expand school-based mental health care</p> <p>Continued coordination &amp; integration of child-serving systems needed to address fragmentation</p> <p>Shortage of child and adolescent psychiatrists who will serve publically funded consumers</p> <p>Few behavioral health services designed for child welfare population</p> <p>Shortage of non-therapeutic, natural supports and services in communities (i.e. school and community-based recreational activities;</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
		housing; legal services; and financial services)
2. Service Effectiveness & Quality	<p>Numerous behavioral health workforce activities to increase knowledge, skills and competencies</p> <p>Practice standards adopted for most service types</p> <p>Broad cross-system collaboration and partnering</p> <p>Extensive array of evidence-based treatments that includes 10 intensive in-home models of care</p> <p>Multiple prevention and early intervention initiatives</p> <p>Trauma screening and treatment (TF-CBT) available across the state at selective outpatient clinics</p> <p>Use of learning collaborative methodology to disseminate and sustain evidence-based practices such as TF-CBT, Child FIRST, and family engagement protocols</p> <p>Educational/collaboration forums held for pediatric and behavioral health providers to promote integrating care, i.e. improving reciprocal communication; co-location; transferring appropriate cases; and co-management of psychotropic medications</p> <p>Collaboration with academic institutions and researchers to identify and support practice improvements</p> <p>Increased use of quality improvement, data and outcome assessment methodologies</p>	<p>Increased client complexity makes it challenging to provide what is needed (Children often present with co-morbid conditions; families experience significant poverty; and some parents have a mental health diagnosis)</p> <p>Need for more case management services to assist with complex client needs</p> <p>Few evidence-based practices available at outpatient psychiatric clinics for children, and implementation barriers exist at the individual, agency and system levels</p> <p>Services designed for adolescents/young adults are insufficient in quantity and quality</p> <p>Need to promote mental health of young children</p> <p>Quality of care varies across providers</p> <p>Weak Continuous Quality Improvement (CQI) process for the system as a whole and for provider agencies</p> <p>Continued need to enhance cross-system collaboration to serve "multiple needs" consumers</p> <p>Need to increase the use of standardized</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>Decreased utilization of high end institutional care including inpatient and residential care due to improved case management and enhanced tracking and monitoring initiatives</p>	<p>screening and assessment instruments and to incorporate findings into treatment and discharge planning</p> <p>Too few performance indicators and standardized child/family and system outcome measures for evaluation of the effectiveness of the system of care including all programs and services</p>
<p>3. Child &amp; Family Involvement</p>	<p>CT Kid Care and the wrap-around model of care supports a child-focused, family-centered model</p> <p>Extensive training within local systems of care, DCF area offices, and the broader community on family-centered practice</p> <p>Expanded use of peer support through CT BHP</p> <p>Inclusion of family partners as team members in the TF-CBT Learning Collaborative and other initiatives</p> <p>Implementation of an Engaging Families in Services Learning Collaborative for Extended Day Treatment (EDT) providers, with inclusion of family partners on Quality Improvement Teams</p> <p>Parent training and leadership initiatives provided to prepare and support family and caregiver involvement at all levels of the system</p> <p>Funding and other support to sustain the statewide family organization - FAVOR, Inc.</p> <p>Continued support of youth and family advocacy</p>	<p>Too often families are not fully involved in their own service planning and treatment - outreach and treatment engagement need improvement</p> <p>Too few youth and families are involved in system design, planning, evaluation and system oversight</p> <p>Need to enhance use of Peer Specialists for case management activities, family engagement, and community outreach</p> <p>Limited resources dedicated to family outreach and engagement training for DCF staff and providers</p> <p>Few employment opportunities within the system for family members</p> <p>Limited use of family as faculty in training agency personnel</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>advisory bodies</p> <p>A Consumer, Youth and Family Quality Improvement Collaborative established</p>	<p>Need for longitudinal outcome/impact data on family leadership training</p>
<p>4. Management of Services and Systems</p>	<p>Diverse, dedicated workforce at state/local levels</p> <p>1/3 of DCF budget allocated to behavioral health</p> <p>Creation of positions, policies and programs to improve integration across mandates</p> <p>Creation of CT BHP and carve-out of behavioral health services within Medicaid</p> <p>Use of the CT BHP to facilitate improved access to behavioral health services for children and families served in the child welfare system and voluntary services programs</p> <p>Expansion of clinical case conference methodology to better integrate child welfare</p> <p>Substantial cross-agency collaboration with DMHAS, DDS, Court Support Services Division, Education, Public Health and other state agencies</p> <p>Workforce development initiatives including training and technical assistance for DCF staff through the Training Academy, various training programs for community-based providers, and new CT Infant Mental Health Association's endorsement in infant</p>	<p>Insufficient resources dedicated to training and professional development opportunities for treatment providers and other stakeholders</p> <p>More resources are needed for fidelity monitoring, and quality assurance activities</p> <p>Need to promote clinician credentialing for specialty treatment areas</p> <p>Need to further define and implement performance indicators and outcome measures across service types</p> <p>Further integration of child welfare/behavioral health needed; i.e. cross training; processes for joint decision-making; and addressing overlapping mandates without overlapping jurisdictions</p> <p>New PSDCRS includes only community-based services, no inpatient service providers and lacks integration with other databases</p> <p>Lack of resources to support providers' enhancements of their information systems</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>mental health.</p> <p>Data systems to support state/federal reporting including URS tables for monitoring purposes</p> <p>Development &amp; implementation of a new enhanced behavioral health information system - Programs and Services Data Collection and Reporting System (PSDCRS)</p>	<p>Lack of specially trained staff to aggregate, analyze, and interpret data and to conduct research projects</p> <p>Need to develop a culture where data is viewed as part of the service, not a separate activity</p>
<p>5. Cultural Competence</p>	<p>Promotion of cultural competence through personnel practices</p> <p>DCF Division of Multicultural Affairs develops and sustains initiatives and policies to support diversity needs of clients and staff</p> <p>DCF staff development and training activities support a culturally informed, culturally competent workforce</p> <p>Support of culturally specific projects such as True Colors, Quinceanara, and Black History</p> <p>Improvement of data collection processes to support culturally competent care</p> <p>Use of Mental Health Block Grant funds to support culturally competent initiatives</p>	<p>Need for culturally and linguistically competent services exceeds available resources</p> <p>Growth of non-English speaking families throughout the state strains existing resources</p> <p>Rapid shifts in racial, ethnic, linguistic and other areas present complex challenges for the system</p> <p>Lack of a comprehensive, integrated cultural competency plan to assess, measure and promote cultural competence within the agency and with its contracted providers</p>
<p>6. Public Awareness &amp; Policy</p>	<p>Extensive multi-media public awareness campaign (Opening Doors, Opening Minds) developed and implemented to address mental health myths and facts</p> <p>Delivery of suicide prevention/education training</p>	<p>Need for comprehensive statewide campaign to address stigma and discrimination</p> <p>Need to further educate the public about children's' behavioral health disorders and the availability of effective treatments</p>

DOMAINS	STRENGTHS	WEAKNESSES (CHALLENGES)
	<p>Ongoing statewide promotion of recovery and resiliency in behavioral health services</p> <p>Ongoing education in basic behavioral health needs and services</p> <p>Support of grassroots advocacy</p>	<p>Need to review and address policies that are discriminatory against those with mental illnesses</p>
<p>7. Funding &amp; Revenue Maximization</p>	<p>Increased enrollment in Medicaid Husky A and B</p> <p>Shifting of selected services such as Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) from Grants to Fee-for-Service</p> <p>Blending of DCF Grant Funds and Medicaid through the CT BHP</p> <p>Shared contracting with Partner Agencies</p> <p>Aligning Medicaid to support best practice</p> <p>Revision of clinic option by the CT BHP and DSS to allow reimbursement for school-based clinics</p> <p>Pending DCF/DSS certification regulation to allow the departments to selectively certify evidence-based programs and promising practices for Medicaid reimbursement</p> <p>Public-private partnership with the Robert Wood Johnson Foundation bringing \$3.2 million to support replication of the Child FIRST model, providing home-based early childhood mental health intervention and wrap-around services.</p>	<p>Need to take further actions to align funding sources such as converting grants to fee-for-service, increasing utilization of joint contracting mechanisms, reducing categorical barriers to access, and removing regulatory barriers to evidence-based and promising practices</p> <p>Need to consider additional Medicaid waivers to take full advantage of federal funds</p> <p>Need to creatively explore ways to fund evidence-based practices and assure sustainability</p> <p>Need to explore special incentives or enhanced reimbursement rates for agencies that implement evidence-based practices and achieve improved outcomes</p>

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

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

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

These reports include:

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

More recently, between 2009 and 2010 the following documents addressed the challenges that remain today and a blueprint for continuing improvement:

- A Framework for Child Health Services Supporting the Healthy Development and School readiness of Connecticut's Children (Child Health and Development Institute of Connecticut) March 2009
- Behavioral Health Services for Children & Families A Framework for Planning, Management & Evaluation (Connecticut Department of Children and Families) March 2009
- Strengthening The Foundation: 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
- Department of Children and Families Strategic Plan SFY 2010 - 2014

All of the reports referenced above are fairly consistent in their recognition of the unmet service needs and critical gaps within the current behavioral health service system, as summarized below.

#### **Service Capacity**

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

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

### **Service Needs And Gaps**

There are multiple challenges to address in order to meet the service needs of Connecticut's children and families. The most critical needs are listed below.

- Insufficient funding and too few community-based services to meet the needs of the population. Historically, Connecticut's system has been heavily skewed towards inpatient and residential services, with "70% of all behavioral health dollars spent for inpatient psychiatric hospitals and residential care."
- Limited access to assessment and treatment for children with substance abuse, mental retardation and developmental disorders, and autism spectrum disorders, and limited availability of treatment specializations in outpatient clinics.
- Although there has been recent improvement in the past few years, system gridlock continues to occur. In 2007 two reports were released that described service utilization issues for local hospital emergency departments and residential treatment facilities: Use of Emergency Departments For Mental Health Care For Connecticut's Children A Rising Tide: Statewide Utilization 2001 - 2005 by the Child Health and Development Institute of Connecticut, Inc. and Residential Utilization A Report to the CT BHP Oversight Council by the CT Behavioral Health Partnership. A major finding in both studies was the inability to access the appropriate level of service in a timely manner to meet the level of acuity of the children and youth. There were significant discharge delays for those children and adolescents who were residing in inpatient psychiatric hospitals and residential treatment facilities. The lack of availability of community-based treatment options contributed to prolonged and unnecessary lengths of stay as well as unnecessary utilization of these higher level services.
- Lack of comprehensive, standardized screening and assessment tools, and a need for more efficient sharing of assessment data within and across programs and services, within the boundaries of confidentiality laws and regulations. The sharing of assessment data would minimize the redundancies experienced by children and families, while providing consistent assessment of child and family functioning, ongoing treatment need, treatment response, and treatment decision-making.
- Limited availability of evidence-based practices across the continuum of care. Connecticut's first forays into evidence-based practice focused on intensive community-based treatments that could divert youth from residential care. Although this focus was strategic and appropriate, it has resulted in less availability of these practices in less intensive outpatient settings and more intensive residential and hospital level care. There is a need to have evidence-based practices readily available at all levels of care in the continuum of services. Only a small percentage of children are receiving these treatments. There is a need for ongoing funding and infrastructure to fully implement and sustain these practices.
- Lack of sufficient trauma-specific services to insure that all children requiring care can access effective trauma treatments.
- Limited specialty services for children and families that are involved in the child welfare system.

- Limited specialty services for young adults. Young adults often do not respond well to the services and supports designed for the adult population and the existing services to address their needs are insufficient in both quantity and breadth.
- Shortage of child and adolescent psychiatrists to meet the needs of the population. Many psychiatrists are employed in multiple settings due to the high demand.
- Other unmet needs include housing and related support services such as case management, vocational assistance, financial planning and budgeting.
- Transportation resources to access services are not available in all communities, especially the rural areas of the state.
- Lack of capacity to support the diverse needs of clients regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social or economic status, or language. At present the Department lacks a comprehensive and integrated plan to assess, measure and promote cultural competence within the agency and with its contracted providers.
- Insufficient availability of early intervention services. It has been well-documented that early intervention strategies and services positively impact human and economic outcomes, yet these continue to be limited in scope. .
- Lack of a medical home model to promote both physical and mental health of parents and their children. In order for parents to support their children, both parents and children must be physically and emotionally healthy.
- Incomplete integration of child welfare and behavioral health service systems. There are overlapping mandates without overlapping jurisdictions. There is a need for cross-training of behavioral health and child welfare staff. There are a lack of structures to support joint decision-making and the establishment of priorities for program development.
- Too few youth and families actively involved in their own plans of care. Family involvement is one of the core values of the CT Kid Care system. Research has shown that family involvement makes a difference in many ways including improved outcomes (i.e. reduces emotional and behavioral symptoms; promotes competence; prevents placement in more restrictive settings); maximizes treatment effectiveness, and facilitates generalization of skill acquisition and treatment gains to home, school and community settings. Yet across the spectrum of services few families are involved in the initial assessment process, treatment services, and discharge planning. Too many children and youth are treated in isolation of their family system, and thus it is difficult to sustain treatment gains once services terminate. This was one of the major findings of the Mental Health Needs Assessment and Resource Inventory Summary Report (June 2007) funded by the Mental Health Transformation State Incentive Grant.
- Limited use of evidence-based family engagement models to support the active involvement of families in their children's plan of care. These practices are currently limited largely to the Extended Day Treatment program.
- Too few opportunities for involvement of individuals with lived experience with mental illness or being the family member of an individual with mental illness

- Too few youth and families with leadership roles and active involvement in system planning and oversight of the behavioral health services system.
- Too few employment opportunities for consumers and family members in state and private non-profit agencies.
- Too few program improvement and resource allocation decisions are informed by quality improvement data and processes. Although many programs now include a quality improvement component, many do not and the level of quality improvement is not uniform across programs.
- Insufficient funding to raise public awareness and educate the general public. Many children and families lack knowledge of behavioral health disorders and/or avoid help due to discrimination and stigma. Many in the general public and in the child-serving system lack sufficient understanding of mental health disorders to be of assistance.
- Failure to fully align funding sources to improve access to care and support best practices. Further steps are necessary to maximize the available revenue. These include conversion of grants to fee-for-service, reducing categorical barriers to access, increasing utilization of joint contracting mechanisms, and further removal of regulatory barriers to evidence-based and best practices.

#### **Coordination Across Services and Systems**

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

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

#### **Data Collection, Analysis and Application**

All stakeholders will benefit from efforts to develop a culture in which data is viewed as part of the service, not as a separate activity. Currently, this is a significant limitation. There has been limited capacity for data collection and reporting, both at the state and provider levels. There is a need for further investment in infrastructure development and technical support.

DCF, CT BHP, providers, families, and other stakeholders need to work together to identify a set of performance and outcome indicators that can be collected, analyzed, and reported on a regular basis, in addition to measuring and reporting on case flow indicators. Performance and outcome results need to be analyzed at the aggregate level and for each individual provider. There is a need to incorporate benchmarking, control chart methodology, and continuous quality improvement methodologies.

### **Behavioral Health Workforce Development**

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

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

In light of the shortages of physicians and clinicians outlined above, an expanded role for paraprofessionals has been recommended. However, the way in which the current workforce is organized includes relatively few opportunities for paraprofessional staff. Even with assertive recruitment efforts, the demand is likely to continue to outstrip supply.

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

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

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

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

### **1. Service Capacity**

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

- Support for the local Systems of Care/Community Collaboratives including Care Coordination Services to provide wrap-around services;
- Support for the Managed Service System to find community-based solutions for DCF-involved youth with complex behavioral health needs;
- Partner with the CT BHP to assure access to, and coordination of, a more effective system of community-based care;
- Continue improved utilization and management of Emergency Mobile Psychiatric Services (EMPS) through: oversight of service delivery; data analysis, reporting, and quality assurance through a contracted vendor; standardized training and practice; enhanced outreach and marketing; and provision of incentives for EMPS/Emergency Department (EDs) collaboration to reduce the number of youth seeking behavioral health services at EDs;
- Continued support for intensive in-home services including MST, MDFT, FFT, IICAPS, FST and hybrid variants of these programs;
- In partnership with stakeholders, explore strategies to support Child FIRST;
- Continued operation and management of Therapeutic Group Homes;
- Continued support for the Child and Adolescent Rapid Emergency Services (CARES) program that provides six short-term crisis stabilization beds to reduce emergency department overstay for Hartford and surrounding communities;
- Continued roll-out of performance measures and ongoing monitoring and related performance improvement plans for Enhanced Care Clinics;
- Sustainability planning for Extended Day Treatment Model of Care initiatives including family engagement protocols, multi-family groups, Ohio Scales implementation/assessment, application of Risking Connection trauma framework within the milieu setting, and continuation of Project Joy including training for new hires and refresher training for seasoned playmakers;
- Support for the statewide and other family advocacy organizations;
- Continued collaboration between DCF/DMHAS and DCF/DDS to address the needs of children/youth with mental health and/or developmental disabilities, including those youth who are transitioning to the adult systems; and
- Continued commitment to deliver early intervention and prevention activities such as suicide prevention training and consultations for child care providers working with young children.

### **2. Service Needs and Gaps**

- Explore opportunities to re-allocate resources allotted to residential care to community-based treatment alternatives;
- Continue to align authorization procedures and processes with the goals of increasing outpatient and community-based utilization and reducing residential and inpatient utilization;
- Continue to utilize and strengthen additional CT BHP strategies to reduce inpatient overstay through a combination of provider profiling, incentives/penalties, consultative services, development of alternative services, and other management processes such as data and case review of "stuck children;"
- Continue to explore the feasibility of blending DCF/CT BHP funds to convert the Extended Day Treatment Program from a grant-funded to a fee-for-service program;

- Establish an ongoing outpatient system and treatment improvement learning community, within the context of the broader behavioral health services system, through collaboration with clients, families, advocates, state agencies, providers, and other community stakeholders
- Include a feasible sustainability plan in each funding application and require periodic reviews of sustainability throughout the funding period;
- Work towards designing an integrated system of comprehensive screening and assessment that includes an infrastructure for the dissemination of data to key users and integration of data reports into daily practice;
- Continue to fund evidence-based treatments including the intensive in-home services such as MST, MDFT, and IICAPS to assure the delivery of the most effective services;
- Continue to support the dissemination of evidence-based practices such as the Trauma-Focused Cognitive Behavior Therapy Learning Collaborative that trains clinical teams from outpatient psychiatric clinics for children to address the treatment needs of traumatized children, adolescents and their families;
- In partnership with stakeholders, explore further development and replication of the evidence-based early childhood in-home intervention, Child FIRST, through the Learning Collaborative methodology.
- Support the implementation of research-based family engagement protocols within the Extended Day Treatment Program and find ways to expand to other services;
- Cultivate a "data and information culture" through education and training of DCF staff and key stakeholders, establish data-driven processes at all levels of practice, and review and identify improvements of existing data reports; and
- Continue to explore strategies such as requirements within contract documents to support the delivery of culturally competent services.

### **3. Coordination Across Systems and Services**

- Continue exploration of strategies to further integrate Child Welfare (CW), Prevention and Behavioral Health (BH) Services as well as Juvenile Justice (JJ) and BH Services within DCF that includes co-leadership strategies at the Area Office level, support for the cross-training of CW, JJ and BH staff, and development of methods, such as formal local service system reviews that require joint decision-making and establishment of priorities for program development;
- Continue efforts to generate ways to seamlessly transition individuals with serious mental health needs from one system to another and for ongoing collaboration among agencies, including Department of Education, Judicial Branch - Court Support Services Division, Department of Corrections, Department of Mental Health and Addiction Services, Department of Developmental Services, and Department of Social Services; and
- Advance the integration of behavioral health and primary care by finding ways to strengthen communication and relationships, co-manage psychotropic medications for certain children, and co-locate services, to the extent feasible.

### **4. Data Collection, Analysis and Application**

- Continue to provide education, training and consultative support to the provider network relating to data collection and submittal for the newly implemented Programs and Services Data Collection and Reporting System (PSDCRS) to assure the integrity of the data;
- Through collaboration with consumers, families, advocates, providers, and other key stakeholders, begin the process of developing a set of performance and outcome

indicators and benchmarks to measure levels and types of improvement at the child/family, provider, and system levels; and

- Develop strategies to create a results-based accountability framework and a data-driven culture that informs policy and practice.

**5. Behavioral Health Workforce Development**

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

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

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

Connecticut has made important strides in the past year to strengthen the comprehensive community-based behavioral health system of care. Examples of significant accomplishments are outlined below.

➤ **Emergency Mobile Psychiatric Services (EMPS)**

Enhanced EMPS services are now delivered through six Service Areas located across the state. Teams of trained mental health professionals can respond immediately on-site, or by phone when a child is in crisis. Anyone may contact a central call center - 24 hours per day, 365 days per year. Service is provided regardless of insurance status or ability to pay.

Key accomplishments during the past year include the following.

- Call volume suggests a pace of nearly 9,000 calls annually.
- The statewide mobility rate is 83.6% (Teams are mobile until 10 PM and available by phone during other hours).
- The statewide median mobile response time is 36 minutes. Almost 60% of calls are responded to in less than 45 minutes.
- All full-time EMPS staff has been trained in core modules including: Crisis Wraparound Principles; Crisis Assessment Planning and Intervention; Suicide Risk Assessment; Violence Risk Assessment; Traumatic Stress and Trauma-Informed Care. Other training modules are being planned and developed.
- A Performance Improvement Center has been established and provides data collection, analysis and reporting. Recently, they announced financial incentives to enhance mobility rates and completion of outcome measures.
- Preliminary results of satisfaction surveys by families and referral sources show high levels of satisfaction with mean ratings of 4.73 and 4.58 for families and referrers respectively (1-5 scale, with 5 representing high satisfaction).
- On the Ohio Scales Youth Functioning subscale, both parent and worker ratings show statistically significant improvement from case opening to discharge.
- On average, EMPS is penetrating the population of those who live in poverty at a rate of 11.8 per thousand.
- Outreach and marketing is underway and includes: bus posters on all major bus lines in the four major cities; 700 radio PSA's; press releases, a 5-minute EMPS video; and a presentation "tool-kit."

These findings have been presented at the Children's Mental Health Research and Policy conference in Tampa, Florida this year. We have been accepted to present two symposia at the Georgetown Training Institutes in Washington, D.C.. The program is emerging as a national model for crisis service delivery.

➤ **Extended Day Treatment Services (EDT)**

During the past year DCF, in partnership with the statewide network of EDT providers, continued to develop and strengthen an enhanced, standardized model of care through the following initiatives.

1. In partnership with CT BHP and DSS, DCF and the provider community worked to migrate EDT from the Medicaid Clinic Regulation to the Medicaid Rehabilitation

- Regulation to allow for off-site services and establish staff qualifications and criteria to allow direct care staff to deliver selective psycho-educational therapeutic groups.
2. We established a statewide schedule with EDT " Trained" Trainers for delivering Risking Connection Basic Training for new hires to ensure sustainability;
  3. The final phase of research for determining the impact of Risking Connection Basic Training on employees and the statewide program is in the process of completion.
  4. We trained remaining half of EDT teams in Project Joy - therapeutic recreation training.
  5. We completed a Needs Assessment to determine Project Joy training needs for new and seasoned staff.
  6. Project Joy Booster Sessions for new and seasoned staff were delivered on a quarterly basis by the Project Joy Boston-based staff.
  7. Ohio Scales Training EDT statewide clinicians was offered in 2010.
  8. The EDT Performance Incentive for SFY 2010 was completed, and we developed a new agreement with outcome measures for SFY 2011.
  9. EDT-specific training relating to the newly implemented behavioral health data collection and reporting system was provided.

➤ **Outpatient Psychiatric Services for Children and Adolescents**

○ **Enhanced Care Clinics**

There are 29 Enhanced Care Clinics (ECCs) that provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other services for children, adolescents and their families. Each clinic must meet special requirements such as timeliness standards for access based on level of acuity to receive enhanced rates that are approximately 25% higher than average CT BHP rates. During the past year progress in the following areas was made.

- As of the third quarter of SFY 2010, 98.61% of HUSKY clients who sought treatment at any ECC for routine outpatient needs were offered an initial evaluation within 14 days of their first contact with the clinics.
- 86% of all ECCs met the standard of offering 95% of their clients a routine appointment within 14 days of first contact.
- As of September 1, 2009 all ECCs completed Memorandums of Understanding with two primary care providers.
- Measurement will commence in the next fiscal year of the ECCs and the requirement to provide one behavioral health training per year with their primary care provider partners.
- As of April 1, 2010 the State issued requirements for ECCs for the screening, evaluation and treatment of co-occurring mental health and substance abuse disorders. ECCs will be required to have all infrastructures in place to meet this requirement within one year from the date of issuance.
- At the statewide ECC meeting in March 2010, the goal was set to begin work groups that will meet regularly to address compliance issues with the ECC requirements. These work groups are tentatively scheduled to begin in June 2010.
- Plans for SFY 2010 include use of claims data to review timeliness of follow-up treatment as well as timeliness of evaluations by psychiatric medication prescribers.

Additionally, the ECCs implemented the Global Appraisal of Individual Needs - Short Screener (GAIN-SS) pursuant to a policy directive requiring standardized screening for problems related to substance use and behavioral health. The GAIN-SS is designed to serve as a screener in general populations to quickly and accurately identify clients who need referral to, or treatment from, some part of the substance use and/or behavioral health treatment system, as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision, and as a periodic measure of change over time in behavioral health. Initial training for ECC's on the GAIN-SS began in April 2010. Training and consultation continue to be provided to support implementation and sustainability.

- **Trauma-Focused Cognitive Behavior Therapy (TF-CBT) Learning Collaboratives**  
DCF sponsored a third TF-CBT Learning Collaborative during SFY 2010 for teams of senior leaders, clinical supervisors, clinicians, and family partners from six outpatient psychiatric clinics for children. These three 12-month intensive collaboratives have focused on adoption, implementation and sustainability of TF-CBT within outpatient clinics.

To date we have trained teams from 16 outpatient clinics across the state. All clients at these clinics are assessed for trauma histories at the time of intake, and more than 850 children have been offered this evidence-based treatment. Of the first 85 children who completed treatment, there was a 43% decrease in PTSD symptoms and a 26% decrease in depression symptoms.

Additionally, the second annual TF-CBT Conference was held this spring. Participants included both current and former TF-CBT Learning Collaborative members and DCF staff. There were sessions for those new to TF-CBT and for experienced TF-CBT clinicians, with CEUs offered. Sessions were led by our faculty TF-CBT Trainers, TF-CBT fellows, and seasoned TF-CBT team members. The keynote speaker was Dr. Robin Goodman, an expert on child traumatic grief.

- **Enhancing Children's Behavioral Health and Pediatric Primary Care Integration**  
Two critical initiatives occurred in 2010 to further integration between pediatric and behavioral health providers, as follows.
- **"Train the Trainer" Program for Behavioral Health Providers (March 2010)**  
A one-day intensive training was developed and delivered to Enhanced Care Clinics and other behavioral health settings providing services to children and families. The purpose was to explore specific strategies to increase opportunities for collaborative care with pediatric primary care providers. Training included:
  - Overview of the continuum of collaborative practice from improved reciprocal communication in single-case treatment planning to integrated, collaborative co-location;
  - Review of the current challenges for pediatricians and the resources enhanced care clinics/behavioral health providers can offer to enhance patient care and minimize barriers for physicians assisting their patients in accessing behavioral health care;
  - Suggestions for getting started, selecting a primary care provider to approach;
  - Training toolkit with in-service training modules to offer pediatric practices;
  - Follow-up consultation;
  - Financial assistance to support staff time and costs associated with offering the training modules within primary care settings; and

- 6.5 CEUs for LCSWs, LMFTs and LPCs.

- **Promoting Integrated Care: A Session for Pediatric and Behavioral Health Providers (April 2010)**

The Child Health and Development Institute and Value Options co-sponsored a session for pediatric and behavioral health providers on promoting integrated care. The keynote speaker was Michael Jellinek, Developer of the Pediatric Symptom Checklist for use in primary care settings. Topics included: connecting children with public and private insurance to behavioral health services; strengthening relationships between pediatric and behavioral health providers; and co-management of psychotropic medications.

➤ **Intensive In-Home Services**

- **Intensive In-Home Child And Adolescent Psychiatric Services (IICAPS)**

Service capacity has continued to expand. There are now 107 IICAPS teams located across the state, which represents an increase of 7 teams since the end of the last state fiscal year. For SFY 2009 1595 clients were served. As of March 31, 2010 a total of 1783 clients have been served.

These services continue to be effective in improving the mental health of children and adolescents. Results show reductions in both inpatient psychiatric hospitalizations and usage of emergency departments for behavioral health crises during the course of treatment and at the time of discharge. Those families who complete treatment report significant improvement in level of child functioning and problem severity, which matches the ratings by their respective workers.

IICAPS services continue to be available for juvenile justice-involved youth through the Juvenile Branch - Court Support Services Division.

- **Functional Family Therapy**

The Department has continued to fund evidence-based Functional Family Therapy (FFT) services for youth at risk for juvenile justice involvement or involved with the juvenile justice system. Most recently, this service has been successfully utilized as a resource for the Families with Service Needs (FWSN) - Juvenile Justice population. These youth exhibit misbehavior considered unlawful only if committed by children younger than sixteen (16) years of age. Behaviors include running away, truancy, defiance of school rules, being beyond the control of the parent/guardian, engaging in immoral or indecent conduct, and engaging in certain sexual activities. A FWSN adjudication is not a delinquency adjudication, however, the court does retain authority over children who exhibit non-criminal behaviors. Although these children cannot be detained in a detention or correctional facility, they can be committed to the Department. FWSN cases are predicated upon the principle that the family as well as the child must be involved in services in order to effectively deal with the child's problematic behavior. The law provides for the coordinated utilization of a wide range of public and private social, education, and court services at a local, regional and statewide level including those provided by the Department. FFT has been successful in addressing the needs of children/adolescents, and their families, experiencing emotional, behavioral, and/or psychiatric difficulties.

- **Family Support Teams**  
These teams provide clinical support for children and youth involved with DCF protective services who are at risk for out-of-home care or who are returning from out-of-home care and require intensive services to effectively transition to the community. In partnership with child welfare colleagues and providers, the Department is in the process of re-designing the service to increase responsiveness to the target population. The intent is to seek an evidence-based, standardized model of care with built-in training and quality assurance components.
  - **Multi-Systemic Therapy-Problem Sexual Behavior (MST-PSB)**  
The MST-PSB Team annually serves 13 adolescents involved with parole in the New Britain and Hartford areas. The MST-PSB team has now expanded to serve the same number of adolescents in the Waterbury, Torrington and Danbury areas.
  - **Multi-Dimensional Family Therapy-Family Substance Abuse Treatment Services (MDFT-FSATS)**  
Two new MDFT-FSATS teams are now fully functional and serving court-involved adolescents in Hartford and in the Manchester, Willimantic and Norwich areas.
  - **Child and Family Interagency Resource Support and Training (Child FIRST)**  
This is a new, evidence-based, early childhood, in-home, parent-child intervention, which targets very high risk, young children (0-5 years) and their families. The goal is to prevent serious emotional disturbance and abuse and neglect. This model combines an early childhood system of care with intensive, parent-child psychotherapy, provided by a therapeutic team of a licensed mental health clinician and care coordinator. It was developed in the greater Bridgeport region, where a randomized controlled trial was conducted, funded by SAMHSA. Outcomes at 12 month follow-up showed decreased behavioral problems in young children; decreased maternal depression, stress, and other mental health problems; decreased DCF involvement, and marked increase in utilization of community-based services. Robert Wood Johnson Foundation has provided \$3.2 million in a public-private partnership with CT government and philanthropy to support replication in Hartford, New Haven, Norwalk, Waterbury, and New London County. Training has been conducted through a Learning Collaborative, facilitated by the Connecticut Center for Effective Practice (CCEP). Current capacity in the six sites is approximately 500 children and families/year.
- **Connecticut Family and Community Partnership Wraparound Initiative:** A project of the Mental Health Transformation - State Incentive Grant the Wraparound approach to service delivery is strengths-based and emphasizes that the family, the community and the service system must work together to meet the needs of the child. The Connecticut Family and Community Partnership Wraparound Initiative seeks to demonstrate high-fidelity Wraparound through comprehensive training, consultation, and evaluation. This project will prevent or minimize criminal justice system involvement by implementing community wraparound in two selected communities in Connecticut and ensure consistency of various court-based assessments to wraparound.
- From September 2008 to September 2010, the Wraparound initiative will focus on one urban (Bridgeport) and one non-urban community (Bristol/Farmington) rather than on the entire state. The project crosses service systems including parole, probation, child welfare, education, behavioral health and other systems working with at-risk children and youth. Training offered to stakeholders—including families, advocates, providers and state workers—in each of these systems includes an overview of the Wraparound approach; smaller training sessions will instruct project participants in

core competencies of wraparound practice as well as system of care and infrastructure enhancement. In addition to a full-time training coordinator, funding is available to support a self-sustaining train-the-trainer model, which will involve identifying trainers from among the project participant pool. Expert trainers will also provide feedback and help during the process.

Coaches, trainers, and the training coordinator use a tool to measure wraparound process fidelity in order to provide corrective feedback. Court-based assessments and the measures are being modified to include strengths-based, culturally competent, least restrictive principles and are consistent with and show fidelity to the Wraparound approach. Finally, a quality assurance and outcome data system is being established and key process and outcome data collected periodically throughout the project to assess project effectiveness in reducing juvenile justice involvement, reducing recidivism, and improving educational and vocational attainment.

To date, 454 community stakeholders have participated in coaching and/or training activities which include: 80 agencies; over 66 families. Additionally, over 38 training sessions and 28 coaching sessions have been provided and we continue to enroll families in the intensive quality assurance process for the wraparound initiative.

As the T-SIG grant ends this September 30<sup>th</sup>, 2010, we hope to receive a small no-cost extension to partially fund a part-time youth coordinator in each of the two communities. We will be preparing a report and presentation to be brought to the other 23 community collaboratives (and related stakeholders) about "Lessons Learned" from this initiative.

- **Care Coordination Services:** Staff finalized the development of the new statewide "Care Coordination Family Record" (CCFR) form that all care coordinators throughout the state will use when facilitating the wraparound process. It is in both English and Spanish and is posted on the DCF website for all to access and use. It includes a proactive crisis safety planning document to be developed for all families. The new CCFR is more consistent and aligned with the Wraparound process. Additionally, they (the care coordinators and their supervisors) completed a practice manual to support the use of the CCFR. Finally, we are just beginning to update the Care Coordination Practice Standards.
- **Respite Care Services:** Staff implemented the use of two stress indexes: the Parenting Stress Index (PSI) for caregivers of children up to age 13 and the Stress Index for Parenting Adolescents (SIPA). We will be monitoring the scores as it relates to the short term, 12 week Respite Care intervention. Also, we will be looking into changing this from following adult only outcomes to possibly measuring both adult and child outcomes.
- **Therapeutic Group Homes:** Therapeutic group homes are small, 4 to 6 bed congregate care facilities with integrated clinical services designed to serve children and youth with moderate to severe behavioral health disorders. Established in homes in the community, these programs represent the least restrictive treatment option for many youth who do not require residential care but who are not yet appropriate for reunification with their family or placement in a foster care setting. This community-based alternative to residential treatment allows youth to attend school in the community and to maximize community living while receiving intensive clinical services and supports. There are three age groups served: 5 to 9 years; 10 to 14 years; and 14 to 21 years.  
  
Currently these 54 homes serve 283 children/youth, at approximately an 85% capacity rate. A recent evaluation by Public Consulting Group found that 55% of treatment plan goals were realized, i.e. transition to independent living or foster care, etc.
- **Treatment Outcome Package (TOP) - Residential Facilities:** In 2010 Connecticut adopted the Treatment Outcome Package (TOP) screening and assessment tool for use at state-operated and

private residential treatment programs across the state and within the statewide network of therapeutic group homes. The TOP serves as a core outcome battery to screen for all major behavioral health and substance abuse conditions at the time of admission/intake. Additionally, treatment progress is tracked. Follow-up assessments are conducted at 30 and 90 days. The contractor, Behavioral Health Laboratories, Inc. trained all staff in March 2010 and provides customized monthly reports to the facilities/users.

- **Connecticut Workforce Collaborative on Behavioral Health:** Connecticut Workforce Collaborative on Behavioral Health was established under the federal Mental Health Transformation State Incentive Grant and is staffed by the Yale Group on Workforce Development. The Collaborative promotes the health, resilience, and recovery of persons with mental health and substance use conditions by strengthening the behavioral health workforce.

- **Behavioral Health Career Pathways Initiative**

This recently launched initiative involves mapping career pathways in the fields of mental health and addiction prevention, treatment, rehabilitation and recovery across the lifespan. Increased knowledge about these pathways is necessary to ensure that more individuals access them and make their way into the workforce. The Central Connecticut State University (CCSU), Department of Counseling and Family Therapy is undertaking the project. In partnership with other educational institutions and accreditation bodies, CCSU staff members are mapping existing career pathways, which are comprised of educational programs, certificates and degrees, and certifications and licenses. CCSU staff will also assemble data on the numbers of individuals who traverse these pathways to become qualified for behavioral health jobs and careers. A final report will be used to inform workforce planning in Connecticut and to increase collaboration between Workforce Investment Boards and behavioral health educators and employers. CCSU is also exploring ways to make the information easily accessible to individuals who are searching for career options in behavioral health.

- **Parent Leadership Development**

The best advocates for children and youth affected by serious emotional difficulties are their parents. The Parent Leadership Development initiative is intended to increase participation of parents in the behavioral health workforce (traditional and broadly defined) by helping them to develop the skills necessary to become more effective advocates. This advocacy will take place on multiple levels, including:

- Participating in the broadly-defined behavioral health workforce as participants in their child's treatment team and as advocates for their child's needs;
- Advocacy on behalf of other families and their children involved in the behavioral health system;
- Participating in shaping state policy, thereby moving the state closer to a family-driven system of care.

Families United for Children's Mental Health was awarded a contract to implement this initiative. The initiative incorporates two key elements: parent leadership training; and local parent networking and advocacy.

To accomplish the training component of the initiative, the Agents of Transformation (AOT) curriculum developed by the Rhode Island Parent Support Network was identified as the curriculum to be used for training, and it was adapted for use in Connecticut. A Spanish translation has also been developed to make the training more accessible to families across the state. During the first year of the initiative, nearly 200 Connecticut parents participated in CT-AOT.

The networking and advocacy component of the initiative is underway. The goal of this component is to establish and support local networks of parents who provide mutual support and participate in advocacy opportunities. Examples of current opportunities for advocacy involvement include participation in the Children's Behavioral Health Advisory Council, participation in subcommittees of the Connecticut Behavioral Health Partnership Oversight Council, and participation as members of Request for Proposal review teams evaluating proposals to determine award of clinical service contracts.

- **Supervisor Competency Development Initiative**

The State of Connecticut contracted with the Yale Group on Workforce Development to help increase the capacity of front-line supervisors to train, manage and mentor direct care staff with the support of web-based learning resources. Called the Supervision Competency Development Initiative (SCDI), it was divided into two phases. The first phase (May-December 2008) was focused on core skill development for four domains of supervision: quality of care, administration, professional development and support. Throughout the training, supervisors learned about "contracting" with supervisees, identifying a supervisee's learning needs, building an education plan, and working with "supervision resistant" supervisees. The second phase (January - September 30, 2009) focused on developing an agency-specific plan for the sustainability of these skills. This effort included strategies to develop formal supervision standards for each participating agency, such as frequency and duration of supervision. The web-based learning modules continue to be available during 2010 and beyond with the goal of reducing the need for didactic in-service training and increasing the use of workplace-based learning guided by the supervisor and supported through e-learning modules.

An evaluation conducted by The Consultation Center at Yale University showed that supervision training focused on managing supervisory relationships, managing job performance, and promoting professional development is likely to affect improvement in each competency. A total of 123 supervisors and 186 supervisees from one state-operated facility and three private non-profit agencies completed evaluation surveys.

- **Higher Education Partnership on Intensive Home-Based Services**

Delivering intensive home-based services to children, youth and their families who need mental health and co-occurring treatment is a much-needed alternative to psychiatric hospitalization, residential treatment, and detention for children and youth. The State of Connecticut provides funding for such home-based services, along with the training, consultation and quality assurance necessary to support their practice, however, the lack of therapists with adequate training and skills is an ongoing barrier to effective care. The Higher Education Partnership on Intensive Home-Based Services focuses on expanding the workforce of therapists trained in leading-edge practices.

To meet the demand for more fully-trained therapists, the Collaborative contracted with

Wheeler Clinic to develop a graduate training curriculum used to educate selected faculty of six university graduate programs in social work, marriage and family therapy, counseling and psychology. This curriculum prepares faculty to offer an overview course that introduces students to several evidence-based and promising practice models of home-based treatment. The trained faculty members subsequently deliver the course in their respective graduate programs, using the new curriculum.

Providers with rigorous, research-supported treatment programs have opportunities as Provider Guest Educators to share their knowledge from the field with faculty and graduate students in the university setting while therapists in training have exposure to the feedback of family members who have received these services and who serve as Guest Educators in the university setting. At present, the faculty fellows are offering the course to more than 70 graduate students as part of the program's course selection. The project also strengthens partnerships of provider agencies with participating graduate training programs to enhance the knowledge and skill-set of therapists entering the public sector behavioral health workforce.

The Higher Education Partnership promotes the recruitment of a more informed and skilled workforce prepared to deliver services that are proven by the evidence to be most effective with youth and families.

- **Implementing Best Practices Successfully**

In November 2009 Dr. Dean Fixson, co-director and Founding Member of the National Implementation Research Network led a discussion with 35 participants representing 18 state and private non-profit agencies involved in the federally-funded five year Connecticut Mental Health Transformation State Incentive Grant. The interactive consultation included an overview of the research on strategies for implementing best practices effectively, presentation and discussion of a Connecticut implementation experience on co-occurring services, and consultation on three workforce initiative implemented through the Connecticut Workforce Collaborative.

- **CT Infant Mental Health Association Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health**

The CT IMHA has recognized the need for workforce development in infant and early childhood mental health. They therefore purchased the competencies and the process for providing a four level Endorsement in Infant Mental Health (0-3 years) for those individuals working with young children and families, from paraprofessional through experienced therapist, supervisor, and mentor. This has been supported by the Mental Health Transformation Grant (SAMHSA) and CT philanthropy.

- **Programs and Services Data Collection and Reporting System (PSDCRS)**

On July 1<sup>st</sup>, 2009 a new statewide behavioral health data and reporting system for community-based services and programs was implemented. This is a web-based system that provides "real time" information or data snapshots of clients and programs, through our vendor - Corporation for Standards and Outcomes. We can track care over time across multiple programs and services. This is a client-level database that records episodes of care, following a client's journey from intake/admission, through treatment, and discharge.

This first year of implementation has focused on training all providers and assuring that all cases are entered into the system. Data quality and outcomes reporting will be critical areas of focus as we move into the next year. **et members of this workforce**

➤ **Connecticut Behavioral Health Partnership (CT BHP)**

Please refer to **PART C SECTION 1: D Other New Developments and Issues** for details regarding the areas of focus and notable achievements by the Ct BHP.

➤ **Juan F. (Federal Lawsuit) Exit Plan**

On April 13, 2010 the Department filed a motion with the federal court in the *Juan F.* Consent Decree to end the two-decade long child welfare litigation. The motion is based on the fact that fundamental improvements have transformed the Department since the Consent Decree was established in 1991. A number of these major reforms directly relate to the behavioral health services system and are described below.

- Due primarily to increased in-home services, the number of intact families (where children are living at home) receiving services grew 43 percent over the last eight years. In State Fiscal Year (SFY) 2009, roughly 86 percent of all children served were served at home with their families.
- Intensive in-home clinical services for children with behavioral health needs have doubled since 2006. In home services assisted 3,000 children and families in SFY09 compared to 1,500 in SFY06.
- Due in large measure to this increase in in-home services, the number of children in residential treatment centers declined by 46 percent since 2004 and the number of children in congregate care settings overall has declined by one-third since 2004.

➤ **Global Appraisal of Individual Needs (GAIN)**

The GAIN is a progressive and integrated series of measures and computer applications designed to support a number of treatment practices, including initial screenings; brief interventions; referrals; standardized clinical assessments for diagnosis, placement, and treatment planning; monitoring of changes in clinical status, service utilization, and costs to society; and subgroup- and program-level needs assessment and evaluation. It is an evidence-based assessment used with both adolescents and adults and in a variety of service settings including outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community, and correctional programs. Within CT DCF, the GAIN has been implemented by social workers as a screen for substance use and behavioral health needs among caregivers during child welfare investigations and ongoing services. The GAIN also is a contractual requirement for DCF funded providers of adolescent substance abuse treatment services, a specialty substance abuse program for caregivers who are at risk of having their child(ren) removed due to problems related to substance use, Family Based Recovery and Enhanced Care Clinics (ECCs). DCF holds two multi-agency licenses, one for substance abuse providers and one for ECCs, to implement the GAIN. Standardized training, computer applications, data management, and consultation are provided to support implementation and sustainability.

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

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

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

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

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

### **Part C Section III: State Mental Health Plan**

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

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

- Outpatient Psychiatric Services (Child Guidance Clinics/Enhanced Care Clinics)
- Extended Day Treatment
- Intensive In-home Behavioral Health Services
  - Multi-Systemic Therapy (MST)
  - Multi-Systemic Therapy - Building Stronger Families (MST-BSF)
  - Multi-Systemic Therapy - Problem Sexual Behavior (MST-PSB)
  - Multi-Dimensional Family Therapy (MDFT)
  - Functional Family Therapy (FFT)
  - Family Support Teams (FST)
  - Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
  - Child FIRST (Through Robert Wood Johnson Foundation support)
  - Family-Based Recovery
- Emergency Mobile Psychiatric Services (EMPS)
- Mentoring Services
- Respite Services
- Care Coordination
- Adolescent Outpatient Substance Abuse Clinics
- Family Advocacy
- Therapeutic Foster Care Services
- Therapeutic Group Homes
- Early Childhood Consultation Partnership

Please refer to Section II D for further details.

DCF will focus on strengthening the system of care including Care Coordination and the wrap-around service delivery model through training, technical assistance, and pilot projects. DCF will lead and support the Managed Service Systems in the local area offices and continue to fund the care coordinator positions through the Systems of Care/Community Collaboratives. Further, DCF will continue to fund family advocate positions to enhance effective consumer and family participation in the overall system. As described in previous sections, DCF plans to continue to provide enhanced funding, support and monitoring of outcomes for the newly designed statewide Emergency Mobile Psychiatric Services. A family engagement model of practice will be a critical focus of intervention and care, with continued support of this initiative with Extended Day Treatment providers and planning to advance family outreach and engagement with outpatient psychiatric clinic providers. Quality assurance including fidelity measures and monitoring will continue for the array of Intensive In-home Services.

In order to maintain services and supports, DCF-funded care coordinators will continue to have access to flexible funding during FFY 2011. These flexible funds are an integral resource to ensure that children and their families have the services, supports and other resources needed to successfully remain in their homes and communities, and/or facilitate children's return from inpatient and residential levels of care. Care coordinators are able to distribute these funds to assist with security deposits, outstanding utility bills, delinquent rent, furniture and other needs to support safe and stable housing for children and families who are served through the system of care.

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

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

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

Further, DCF will continue to support the expansion of evidence-based and/or promising practices. For example, DCF will continue to support the Trauma-Focused Cognitive Behavior Therapy (TF-CBT) Teams at the outpatient clinics, through continued data collection and reporting as well as ongoing training and education. Evidence-based family outreach and engagement protocols will be supported and expanded across service types, to the extent that resources are available. In partnership with stakeholders, opportunities to expand Child FIRST will be explored.

DCF will continue to utilize technology to support an integrated, coordinated and effective system of care for children and families obtaining services through the publicly funded behavioral health system. Intensive efforts to improve the behavioral health data system will continue, with a focus on data quality and outcomes-based reporting in FY 2011.

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

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

- **Crisis Stabilization Services.** There are two crisis stabilization programs in the state that offer 24-hour, short-term residential care for children, ages 7 to 18 with behavioral health needs who require a temporary "cooling off" period after experiencing a crisis. These grant-funded providers conduct assessments and deliver short-term interventions aimed at stabilizing the child and family. The assessment integrates medical, psychosocial, educational and previous treatment history and addresses the needs of the child/youth within the context of their ecosystem. Clinical

services include screening and referral, individual, group and family treatment, consultation, parent education and instructional modeling, and linkage to family substance abuse screening. Medication management includes consultation and assessment from a psychiatrist or an APRN under the direction of a psychiatrist.

- Child and Adolescent Rapid Emergency Services (CARES)  
The CARES program is a short-term (3-day) stabilization inpatient service supporting the Connecticut Children's Center Medical Center in Hartford. The six-beds serve those children for whom additional evaluation is required in order to determine a disposition or who are expected to be able to avoid lengthy hospitalization and return to the community following a brief stabilization and intervention period within CARES. Those served in the past year avoided extended stays in the hospital's emergency department.
- Emergency Mobile Psychiatric Services (EMPS). These community-based crisis intervention and assessment services include mobile response, psychiatric assessment, medication assessment/short-term medication management, behavioral management services, substance abuse screenings and referral to traditional and non-traditional services for any child or youth in crisis. These services will continue to be available across child welfare, juvenile justice, prevention and behavioral health systems.
- Intensive In-Home Services. These services are designed to enable children and adolescents to remain in their own homes, with the goal of preventing hospitalization or residential placement and/or assuring a successful transition to their own communities following out-of-home clinical treatment. These programs have the capacity to serve more than 2,000 children and their families annually.
  - Family Support Teams (FST). For children/youth, ages 3 to 19 with complex psychiatric and family difficulties who are at imminent risk of out-of-home care, returning to the community from out-of-home care, or entering treatment foster care, these services are provided by an integrated team of licensed professional staff who offer a range of therapeutic services in the home environment. These include psychiatric, medical, educational, vocational, and rehabilitative services for a period of 9 to 15 months. Children must be DCF involved or receive voluntary services. Currently, there are 9 providers throughout the state, with a capacity to serve approximately 460 children/adolescents and their families (biological or foster families). (Note: The Department is in the process of re-designing the service to seek an evidence-based, standardized model of care with built-in training and quality assurance.)
  - Intensive In-home Child and Adolescent Psychiatric Services (IICAPS). For children/youth, ages 3 to 18 with complex psychiatric disorders (DSM-IV Axis 1 diagnosis) who are at imminent risk of hospitalization or who are being discharged from psychiatric hospitalization, the treatment focuses on psychiatric symptoms within an eco-systemic model for a period of less than six months. DCF involvement is not required.  
  
Currently there are 107 IICAPS teams delivering these services, with an estimated statewide service capacity of more than 1500 cases.
  - Multi-Systemic Therapy (MST). For children/youth, ages 11 to 18 with delinquent behavior and/or substance abuse problems, living at home with or returning to a primary caregiver, the treatment focuses on adolescent development, substance abuse, peer

influences and parenting for a period of 4 to 6 months. DCF involvement is not required. Currently there are 27 MST teams funded by DCF and CSSD with a capacity of serving more than 1000 families annually.

- Multisystemic Therapy – Problem Sexual Behavior (MST-PSB). These services are available for children/youth, ages 11 to 17 with problem sexual behaviors and/or substance abuse who are either living at home or returning home to a primary caregiver. Treatment focuses on problem sexual behaviors, substance abuse, peer influences, and parenting for a period of 9 to 12 months. The youth are usually involved with DCF Parole Services during their treatment. This is a small, yet effective program.
- Multisystemic Therapy – Building Stronger Families (MST-BSF). For children/youth, ages 6 to 18 who are involved with DCF for child abuse/neglect at risk of out-of-home placement and who have parents with an alcohol/drug problem. The primary work addresses safety, permanency, and well-being of the children and parental substance abuse for a period of 9 to 12 months. There must be DCF child protective services involvement. The services are offered in New Britain and New Haven. The latter site works with children who have been in detention to prevent a residential placement. The two BSF teams serve about 40 families annually.
- Multidimensional Family Therapy (MDFT). For youth, ages 11 to 17 who are substance abusing or at risk for substance abuse, at imminent risk of removal from their home or returning home from residential care. The treatment focuses on adolescent development, family systems issues and extra-familial systems for a period of 4 to 6 months. DCF involvement is not required. These services are located in Hartford, New Britain, Waterbury, New Haven, Manchester, and Norwalk-Stamford. The fourteen MDFT teams serve about 350 families annually.
- Family Substance Abuse Treatment Services (FSATS). For children/youth, ages 11 to 17 in detention where there is evidence of parental substance abuse, treatment focuses on substance abuse, family systems issues and extra-familial systems for a period of one year. DCF involvement is not required. These services are available in Hartford, New Britain, New Haven, Manchester, and Norwalk-Stamford.
- Functional Family Therapy (FFT). For children/youth, ages 11 to 18 with problems ranging from mood to conduct disorders, the primary treatment focus is on the function of maladaptive behavior within the family structure, problem solving, encouraging/supporting positive relationships, family support and empowerment, access to medication evaluation and management, crisis intervention and case management for a period of 10 to 20 weeks.

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

There are currently five provider agencies delivering FFT services. For SFY 2009 more than 500 families were served.

- Family-Based Recovery (FBR). The target population is infants/toddlers, ages birth to 2 who have been exposed to parental substance abuse in utero and/or environmentally, their

parents and siblings. Adult substance abuse treatment is integrated with family treatment designed to enhance parenting and parent/child attachment for a period of one year. This initially requires DCF involvement and is offered in six locations throughout the state. FBR serves about 120 families annually.

- Child FIRST. The target population is young children, ages birth through five years, who are already demonstrating serious emotional or behavioral problems or who come from homes with very significant environmental risk, like maternal depression, substance abuse, domestic violence, homelessness, or abuse/neglect. In-home parent-child psychotherapy and wrap-around services are provided by a clinical team (licensed clinician and care coordinator). Services are offered for 4 to 12 months, driven by individual family needs. DCF involvement is not required. Child FIRST is currently in six cities or regions, with an annual capacity of serving 500 children and their families.
- Outpatient Psychiatric Clinics for Children (Child Guidance Clinics). DCF maintains grant-funded contracts with child guidance clinics to provide behavioral health services for children, under age 18 and their families. A multidisciplinary team of psychiatrists, psychologists, masters' level clinicians and other behavioral health professionals provide diagnostic and treatment services. The goals are to promote mental health and improve functioning, and to decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. These providers deliver a variety of clinical treatment and rehabilitative support services that include but are not limited to: assessment (psychosocial, psychiatric and psychological); medication evaluation/management; crisis intervention services; individual, group and family therapies; play therapy; home-based interventions; substance abuse treatment; parenting skills development and parent training.
  - Enhanced Care Clinics. Through the CT BHP specially designated mental health clinics, referred to as Enhanced Care Clinics have been established to enhance access and improve the quality of care. To date 37 clinics (adult and child) have received approval status. These clinics are required to meet specific access requirements in order to receive enhanced Medicaid rates.
  - Specialty Clinics. Some clinics offer specialized services to treat those with trauma histories, problem sexual behaviors, obsessive-compulsive disorders, pervasive developmental disorders, traumatic stress disorders, and tourette's disorder.
  - Substance Abuse Clinics. Several clinics also provide outpatient substance abuse evaluation and treatment services for adolescents and adults.
- Extended Day Treatment (EDT) Services. DCF contracts with providers to administer 22 community-based programs that offer a structured, intensive, therapeutic milieu with integrated clinical treatment and rehabilitative support services for children, ages 5 to 17 who experience behavioral and emotional disturbances. A team of multi-disciplinary staff deliver a broad range of treatment services and psycho-social interventions through after school and summertime programming. The target population includes children who have returned from out-of-home care or are at imminent risk of placement due to mental health issues or serious emotional disturbance.
- Extended Day Treatment (EDT) Services – Juveniles Opting For Treatment To Learn Appropriate Behaviors (JOTLAB) Program. This is an extended day treatment program for children with problem sexual behavior who can safely reside in the community. Both adjudicated and non-adjudicated youth, ages 8 to 17 that may or may not be involved with DCF are eligible for services. This program is available only in New Haven.

- Short-Term Assessment and Respite (STAR) Homes. DCF awards grant-funded contracts for congregate-care programs that provide temporary, short-term care, evaluation and a range of clinical and nursing services to children who are removed from their homes due to abuse, neglect or other high-risk circumstances. Services include a structured milieu with clinical supports, assessments and evaluations, and other behavioral health and medical services.
- Therapeutic Group Homes. DCF provides grant-funded contracts for congregate-care behavioral health treatment settings for children and youth. A combination of treatment and intervention approaches may include, but are not limited to: clinical services (individual, group and family therapy); milieu therapy; empowerment and family support services; case management; and aftercare services.

Two group homes were developed specifically for youth transitioning to DMHAS who have cognitive and/or other neuropsychological deficits.

### Community Support Services

- Care Coordination Services. Connecticut continues to fund 66 care coordinators through out the state. The Care Coordinators provide support to children and their families through the wraparound process. The wraparound process is used to identify the unique needs of each child and family and then create the Child and Family Team to assist and support the family in meeting their unique needs. The average length of stay in care coordination has been reduced by a month in the past two years. We attribute that to better fidelity to the wraparound process and the ongoing coaching and training that the care coordinators receive.
- Care Coordination is available to any SED child and their family who is not already "system-involved in child welfare or juvenile justice. Families who do not have an active child welfare worker or juvenile justice probation or parole officer often have no assistance in getting their behavioral health needs met. Therefore efforts are made to secure care coordination for those families.

The 66 total statewide care coordinators includes the 5.5 care coordinator positions and .5 supervisor position to serve children with SED and their families, through a unique school-based system of care model in Bridgeport. This model was originally established through a SAMHSA funded school-based System of Care cooperative agreement.

- Respite Care Services. This service offers temporary care in the home or community to children and adolescents, under age 18, who have emotional and/or behavioral needs that require constant attention from their caregivers. This is intended to prevent family disruption by reducing stress and burnout by caregivers and to provide age appropriate social and recreational activities. Respite Care has undergone some slight modification in this past year by changing the outcome measures to be caregiver-based rather than child-based and to serve primarily the caregivers who are not-DCF involved and who are identified by the local systems of care. The Parenting Stress Index (PSI) and the Stress Index for Parenting Adolescents (SIPA) are use to measure the stress reduction that occurs over the 12 week respite intervention.

Family Advocacy Services. FAVOR is a statewide organization that has been created to educate and support families in their advocacy efforts. Emphasis is placed on empowerment, cultural competency, family strengths, parent/consumer leadership and self-determination. Paid and volunteer family advocates work in tandem with care coordinators to aid in producing positive outcomes for children with SED and their families. Additionally, family advocates provide support to caregivers under a Brief Intervention model, where they offer support between 1 to 4

hours a week for up to 12 weeks. Member agencies include: African Caribbean American Parents of Children with Disabilities; Families United for Children’s Mental Health; National Alliance for the Mentally Ill of Connecticut (NAMI-CT); and Padres Abriendo Puerta (PAP).

▪ Community Services Funded under Flexible Funding

The primary purpose of the Flex Funding account is to make small amounts of money available for families to be quickly and flexibly accessed to pay for informal activities, supports or services that assist the families in meeting their needs. DCF has two primary Flexible Funding accounts servicing families involved in Child Welfare, Juvenile Justice and Behavioral Health. Last year the total amount of dollars spent in the Flexible Funding accounts was \$26 million dollars. Some examples of what is funded include: child care, job coach, transportation, utilities, housing deposits, therapeutic camps, specialized evaluations and assessments, parenting skills training, seed money to start parent or child/adolescent support groups, academic tutoring and recreational/social activities that support treatment interventions, (i.e. karate, music or art lessons, riding lessons, dance lessons, etc.). Additionally, DCF identified the more popular and/or more expensive services that were being provided through Flexible Funding and developed a credentialing process to be sure there was adequate expertise being provided in those areas. Those services identified that require participation in a credentialing process include:

- Behavior Management Service
- Temporary Care Services
- Supervised Visitation
- Therapeutic Support Staff
- Support Staff
- Community Housing Assistance Program (CHAP) Case Management
- Assessment
- Assessment: Perpetrator of Domestic Violence

Behavior Management Service

A Behavior Management Service includes the design and support of a therapeutic plan that will assist parents, caretakers, teachers and/or other service providers responsible for the care, teaching or supervision of a child or youth to decrease self-injurious, dangerous, or disruptive behaviors and to increase adaptive behaviors. This service includes the observation of the child at home, at a caretakers home and/or in natural community settings; the preparation of a written therapeutic plan designed to guide and improve a teacher or caretaker’s ability to successfully manage the child’s or youth’s behavior and to teach and reinforce the development of social skills, adaptive skills, life skills and self-management strategies.

Temporary Care Services

Temporary Care Services provide a short term break or intervention, separating the child/youth from caregivers for a few hours, or other relatively short period of time in order to assist family members with the practicalities of living and their attending to the needs of all family members. This service is provided in the home of the parent or caretaker.

Supervised Visitation

Supervised Visitation is primarily a site-based service provided in order to facilitate contact between children in out of home care and their biological parents, relatives or significant others, to monitor this contact and to report on the contact to DCF social workers. All sites must be approved by the local DCF Area Office. Supervised visitation can also be provided in alternative, more normalized community settings as part of a unification plan and as approved by the DCF Area Office.

#### Therapeutic Support Staff

Therapeutic Support Staff is a service designed to address the individualized needs of a child or youth with complex behavioral health needs. These children or youth have a current diagnosable behavioral health condition that results in moderate to acute functional impairment which substantially interferes with, or limits the child's or youth's role or functioning in family, school, or community activities. This service is intended for children or youth whose level of functioning puts them at risk of entering a residential level of care, disrupting from their home or foster placement, or for children or youth who are being discharged from residential treatment or a more acute level of care. These individualized supports are provided by paid, trained and supervised individuals. This service is provided for up to eight (8) hours per week per child or youth and includes a combination of structured and enrichment activities consistent with identified treatment plan objectives. For children or youth discharging from residential treatment/congregate care, the service is provided for up to two (2) visits for no more than one (1) hour per visit prior to discharge.

In order to emphasize consistency and relationship building, it is expected that the same staff person will continually provide this service during the course of care.

This service is intended as a component of a comprehensive treatment plan. As such, the individual providing this service is expected to collaborate with other service providers toward the implementation of the child's individual treatment plan.

#### Support Staff

Support Staff is a service designed to address the individualized needs of a child or youth in the community who may be exhibiting mild to moderately challenging behaviors in the home, in school or in the community. This service provides a range of life supports focused on making positive decisions and behavioral choices; assisting with attaining social and emotional gains; connecting with positive peer and other community supports and reinforcing success in school. These individualized supports are provided by paid, trained and supervised individuals. This service is provided for up to five (5) hours per week per child or youth and includes a combination of structured and enrichment activities consistent with identified treatment plan objectives. In order to emphasize consistency and relationship building, it is expected that the same staff person will continually provide this service during the course of care. This service is intended as a component of a comprehensive treatment plan. As such, the individual providing this service is expected to collaborate with other service providers toward the implementation of the child's or youth's individual treatment plan.

#### Community Housing Assistance Program (CHAP) Case Management

CHAP Case Management is a community-based program that provides case management, supervision, educational/vocational support or career development support, and life skills development services, utilizing the DCF approved Life Skills Program - Ansell Casey Life Skills, to youth living in a community housing environment. This case management service is intended as a component of a comprehensive treatment plan. As such, the individual providing this service is expected to collaborate with other service providers toward the implementation of the child's individual treatment plan.

#### Assessment (Diagnostic/Functional)

Individuals access a diagnostic/functional assessment when there is a concern that the individual has a mental health and/or a substance abuse issue that requires further evaluation. The assessment includes an initial face-to-face screening, additional face to face contacts with the individual and collateral contacts with

family members, caretakers and other treatment providers to determine the individual's strengths and limitations, to determine functional capacity, to identify natural supports and to develop or review an individualized service plan.

Assessment: Perpetrator of Domestic Violence

Assessment: Perpetrator of Domestic Violence is an assessment of an adult member of a current active DCF case. The assessment will include a face-to-face interview(s) with the perpetrator and may include collateral contacts with family members, DCF, the police, court staff, victim advocates, and other involved providers as required.

Other Specialized Resources

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

Funding for the statewide Early Childhood Consultation Partnership (ECCP) will continue during FFY 2011. The ECCP is a mental health consultation program designed to meet the social/emotional needs of children birth to five by offering support, education and consultation to those who care for them. A primary goal of ECCP is to reduce/eliminate the incidence of suspension/expulsion of young children from their care and education setting. Consultation is provided in homes, early care and education centers and home day care centers. Current funding of \$ 2.6 million supports 20 early childhood mental health consultants, serving all areas of the state. Each major urban city has a dedicated consultant, in addition to a second consultant serving the surrounding communities. All towns and cities have access to consultation.

Activities to prevent youth suicide will also be continuing. In compliance with Public Act 89-191, the Department convenes and staffs the Youth Suicide Advisory Board. During FFY 2011, the DCF Prevention Unit will be overseeing suicide prevention activities that include training and education for parents, youth, providers and DCF staff; development and distribution of suicide prevention brochures and information packets, and purchasing of a membership to the Connecticut Clearinghouse and its library of resources pertaining to suicide, child abuse/ neglect, mental health and substance abuse.

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

Child FIRST offers in-home parent-child psychotherapy and wrap-around services and supports, through an early childhood system of care. It targets very young children (birth through age five years) with emotional/behavioral problems or those coming from families with multiple challenges. Currently, Child FIRST is in six cities/regions, with a total of 21 early childhood mental health clinicians. The goal is to have Child FIRST in each of the 15 DCF area offices.

- DCF Head Start Collaborative. The partnership began as an effort of the DCF Bureau of Prevention and the Connecticut Head Start State Collaboration Office working with all fourteen Department of Children and Families (DCF) area offices to establish and strengthen a working partnership with the Head Start and Early Head Start programs in each of their

areas. This has been a win for the children served by the DCF area offices, the Head Start programs, and DCF.

The primary win is more young children in DCF placement receiving a high quality preschool experience. Besides benefitting from the comprehensive educational and health services (vision, dental, hearing, home visiting, etc.) offered by Head Start, the children's families also receive additional support and resources that help reduce the level of stress in the families.

From a systems perspective, this partnership has resulted in benefits to Department of Children and Families and Head Start staff members. In addition, the Partnership has expanded to include ECCP and Child FIRST making for better connections between early childhood programs and services at the local level and statewide.

The goal of the partnership is to ensure very young children's access to high quality early care and education, enhancing stability and supports for young children and their families, and preventing family disruptions and foster care placements.

- Positive Youth Development/Strengthening Families. Seven programs around the state (West Haven, Torrington, Enfield, Hartford, Willimantic, New Haven and Bridgeport) focus on high-risk families with children age 6 to 13 to support parents in their role as parents. Based on local need, community providers under DCF contract have selected their program models from available evidence-based programs. Parents learn how to become more effective in their role and how to build stronger relationships with their children and stronger families overall.
- Parents with Cognitive Limitations Workgroup. The Parents with Cognitive Limitations Workgroup (PWCL) consists of state agencies, community-based service providers, and other stakeholders. The group is working to raise awareness regarding the existence of this population and the needs of their families. Major accomplishments include the development of an assessment guide and a day-long training on identifying and working with parents with cognitive limitations (with CEUs for social workers). The Workgroup developed a website as well as recommendations regarding use of plain language. The Department's Training Academy is now offering courses on parents with cognitive limitations through their pre-service programming.
- DCF staff from the Bureau of Prevention will work with a planning group in New Haven to bring Circle of Security training to New Haven. The planning group includes: New Haven Public Schools - Early Childhood Services; Coordinating Council for Children in Crisis; The Connection - Supportive Housing Program; r Kids; Yale Child Study Center; and DSS - New Haven, and DCF. Circle of Security Parenting is designed to help parents and other early childhood caregivers build specific relationship capabilities rather than acquiring specific behavior management skills. Circle of Security parenting helps them acquire a simple template (The Circle) for viewing their children's behavior. The Circle has two hands - one representing a secure base from which children explore and the other representing a safe haven to which children return when distressed. Parents and other caregivers, through the extensive use of videotaped parent-child interactions, learn to identify whether a child's behavior is at the top of the circle or the bottom of the circle. Then parents and other caregivers learn to identify the child's specific need. Circle of Security parenting also helps parents build self-reflection, and thus explore their own parenting struggles.

- Voluntary Services. Numerous behavioral health services and programs are offered on a voluntary basis to families who have children with complex behavioral health needs who are unable to access care for their children. These children are not committed to DCF and do not require protective services intervention.

Children with behavioral health needs and mental retardation continue to be served by the Department of Developmental Services (DDS) Voluntary Services Program.

- Flexible Funding. Children with SED who are at risk of out-of-home placements, have limited resources or have exhausted resources including commercial insurance, and have complex needs that require multi-agency involvement are eligible to receive flex funds for a range of clinical and non-clinical services.
- Child Welfare Services. Staff from the Bureau of Child Welfare Services including foster/adoption services and adolescent and transitional services develop and support the provision of numerous specialized services that have clinical components. Some examples include: specialized in-home services to strengthen families and reduce the risk of abuse/neglect; safe homes that provide short-term care with a range of clinical and nursing services; foster and adoptive support teams; specialized sexual abuse evaluations; therapeutic child care; therapeutic foster care services; and staffed apartments with supported work, education and transition programs for committed adolescents who are exiting care. Details regarding some of these services are outline below.
  - Foster Care Clinics. There are 16 DCF-funded clinics that serve DCF-involved children and youth, ages birth to 21 who are placed in foster care for the first time. The purpose is to provide a comprehensive multi-disciplinary evaluation including comprehensive mental health, medical and dental evaluations.
  - Therapeutic Foster Care Services. The new Therapeutic Foster Care (TFC) contracts were launched effective April 15, 2010. The redesigned service, for 840 slots, is intended to better support timely access to high quality, well resourced and standardized TFC programming for children with complex mental and behavioral health needs. The new system is expected to support greater accountability, enhanced communication, and improved collaboration.

The TFC service system includes, but is not limited to, the following changes and new components:

- Collapsed Levels. A reduction from multiple levels to only two (e.g., Therapeutic Foster Care and Therapeutic Foster Care Enhanced) clinical levels of care;
- Increased training for TFC staff and foster parents
- Five Service Area Lead Agencies (SALA will aid in ensuring that each of the partnering TFC agencies for a given area office and catchment are performing efficiently and effectively (e.g., timely matches and placements);
- Ansell Casey Life Skills (ACLS) provision to the youth in TFC. The Department is providing training to all the TFC care managers on the ACLS curriculum;
- Uniform, Objective Assessment Tool. The TFC Eligibility Instrument (TEI) has been developed to support a more objective admission of children into TFC. This is an Excel document that has embedded scoring to allow for immediate determination of a child's eligibility. It is based upon the Child and Adolescent Needs and Strengths (CAN) used in other jurisdictions to assess eligibility for TFC;

- Family Profile Form. This is a document that provides CPS staff with core information about a family to support the most effective match and successful placement;
  - Pre-placement and Planned Placement Transition Form. This document provides a schedule and plan to support children's transition to their TFC family;
  - Wraparound dollars of an average of \$3650 per child to allow for the purchase of individualized clinical supports and services;
  - Progress updates are sent to DCF social workers regarding the children on their caseload to ensure the regular sharing of information;
  - There is an emphasis on permanency so that the work within and through TFC supports children returning back to their family of origin, being adopted, or transitioning to independence.;
  - Aftercare services are expected to be provided. Children will receive aftercare for at least 2 months and up to 6 months; and
  - All TFC agencies are funded to provide at least a .5 FTE recruiter. This is expected to aid with maintaining a sufficient pool of licensed TFC homes and respite resources.
- We are working with John Lyons, Ph.D., author of the CAN tool, to support a refinement of the TEI. Dr. Lyons will be offering any recommendations to hone, as needed, the domains, weighting and score tiers.
  - Through a Request For Qualifications (RFQ), Community Care Services, Inc. (CCS) was awarded the right to negotiate for the provision of Statewide TFC. This new contract will provide an additional 100 slots dedicated to ensuring timely TFC placements for children in Safe Homes, PDCs and STARs. The team's recommendation has been submitted to the DCF Contract's Unit and OFAS will begin negotiations with the awarded provider. CCS is currently finalizing its licensing. They are expected to be running by the first of June.
    - Transitioning Youth. For those youth with mental illness who will age-out of the DCF system, referrals are made to the DMHAS Young Adult Services System for ongoing psychiatric services and other significant supports.
    - Supported Work, Education and Transition (SWET) Program  
These programs are designed to work with youth, ages 16 and older that are ready to be involved in a supervised, independent living program. These 8-bed programs are located throughout the state and offer youth an opportunity to remain in fairly close proximity to their home community. The goal is to support youth as they move towards vocational and college aspirations.
    - Community Housing Assistance Program (CHAP)  
This is a semi-supervised, subsidized housing component for youth ready for less supervision and more independence. Youth, ages 18 to 23 who have graduated from high school or received their GED can reside in a semi-supervised setting, with a minimum of 5 hours of case management services per week. This enables youth to gradually transition to their own living arrangement with community ties, supports and living skills.
    - Foster Parent Community Housing Assistance Program (Foster Parent CHAP)  
Youth, ages 17 and older who are ready to assume some of the responsibilities of their own care with the support of a trained, caring foster parent are eligible to participate in this pilot program.
    - Life Skills Training

DCF-involved youth, ages 15 to 21 may participate in a community-based life skills training program to enhance their knowledge of essential life skills, to increase self-reliance and to prepare for successful adulthood. There is a core life skills curriculum that includes employment, housing, financial management, health and other critical topics. The standardized curriculum, the Ansell-Casey Life Skills Model is utilized by all contracted service providers.

- Post-Secondary Education  
Youth may be assisted, as appropriate and based on eligibility, to enroll in two- and four-year colleges, as well as vocational, technical and certification programs. Additionally, DCF has hired two Pupil Personnel Specialists to work with all youth in care to make appropriate plans for their post-secondary educational or vocational programming. The specialists meet regularly with DCF social workers and providers, offer college and vocational fairs, college tours, tutoring resources and other related services.
- Community, Housing, Educational and Enrichment Resources (CHEER) Program  
Financial assistance is provided to youth, 18 years of age and older, who have graduated from high school or obtained a General Equivalency Diploma (GED) and demonstrated an interest in pursuing post-high school employment services and apprenticeship programs.
- Jim Casey Initiative  
Youth who are aging out of the foster care system have increased opportunities for a successful transition to adulthood in the following areas: youth leadership; youth engagement; employment; housing; and physical/mental health. Three programs that will operate in 2011 include the following.
  - Our Piece of Pie (OPP) Program. This is a comprehensive work/learn model that helps youth to access and attain a mix of educational, employment and personal development opportunities that lead to their success.
  - Family Services of Woodfield. Youth work with technical experts and role models in a youth-centered small business. They develop transferable skills, identify goals and reinforce the personal skills needed for successful employment.
  - New Haven Work To Learn Project. Individual service plans will be developed for DCF-involved youth in New Haven, ages 14 to 21 to enhance their financial literacy, life skills, educational, vocational, and employment assets. This involves a collaboration of many public agencies including CT Department of Labor, Governor's Prevention Partnership, State Board of Education, CT Court Support Services Division, and the New Haven Board of Education.
- Juvenile Justice Services. The Bureau provides and funds residential and community-based services to over 1,000 delinquent children and youth on an annual basis. These include specialized evaluations, counseling and outreach services for families with high risk adolescents and for those families experiencing substance abuse and/or domestic violence.
- Substance Abuse Services  
DCF contracts for outpatient substance abuse treatment services. The six outpatient providers offer evaluation, outpatient and intensive outpatient services to about 600 adolescents annually.

In 2006, through federal support from CSAT's State Adolescent Coordination (SAC) grant, DCF implemented standardized screening and assessment using the GAIN among providers of adolescent substance abuse treatment services, and a specialty substance abuse program for caregivers who are at risk of having their child(ren) removed due to problems related to substance use, Family-Based Recovery. In addition, DCF contracted with Chestnut Health Systems to implement the GAIN ABS computer application and for data management and reporting services. Requirements to use the GAIN in the contracts of these DCF-funded providers support sustainability of the tool.

Through this initiative, the child welfare system implemented the GAIN-SS across all of DCF's 15 Area Offices to screen primary caregivers for problems related to substance use and behavioral health, and to initiate referrals for services. Since then, Area Offices have expanded use of the GAIN-SS to identify problems among adolescents. Previously the Bureau of Juvenile Justice recommended use of the GAIN among its funded providers, but more recently included the GAIN-I as a requirement in its Request for Proposals (RFP) for the Juvenile Justice Intermediate Evaluation programs that will be funded in July 2010.

As noted in an earlier section of this report, Enhanced Care Clinics also are required to use the GAIN Short Screener pursuant to an April Policy Directive requiring this tool specifically to comply with the standardized screening requirement. While implementation of the GAIN was supported initially through federal funding, all GAIN activities currently are supported with state funds.

A significant barrier to sustainability of the comprehensive GAIN-I in particular is the cost of training and certification especially for those provider agencies that do not have a local GAIN trainer. DCF's GAIN Coordinator, in collaboration with other states using the GAIN-I, implemented a regional training model that reduces the length and costs associated with training. DCF continues to work with the tool developer to implement training practices that will reduce costs including web-based training materials and the development and use of local trainers. DCF provides training at no cost for the other GAIN tools that do not require more formal training and certification to use them.

The Hartford Youth Project (HYP) that was initially funded through federal resources to enhance the alcohol and drug abuse treatment delivery system for youth in Hartford continues and is partially supported by state funds. A community-based outreach, education and treatment initiative, the continuum of services includes early identification, screening, family-focused treatments, models appropriate to dual diagnosed clients, case management, and after care services for approximately 100 youth. These include: GAIN screening and assessment; intensive in-home treatment models; Motivational Enhancement Therapy (MET); and Cognitive Behavior Therapy (CBT). HYP serves about 100 youth and their families annually.

- Medical And Dental Services

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

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

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

The Centralized Medication Consent Unit was established in 2007 and is responsible for reviewing issues regarding the use of psychotropic medications in the treatment of DCF-committed children. The unit is staffed by two Psychiatric Advance Practice Registered Nurses who are supervised by a psychiatrist.

Within the Bureau of Behavioral Health and Medicine, a registered nurse clinical instructor is part of the Congregate Care Team. She provides nursing related instructional programs for staff and supports the advancement of the health services provided to congregate care settings.

- Housing Services

DCF continues to provide a continuum of living options for children and youth. These include therapeutic foster care. Please refer to: *Other Specialized Resources Child Welfare Services - Therapeutic Foster Care Service.*

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

DCF and DDS have collaborated on the development of specialized residential and therapeutic group homes for children and youth with co-occurring developmental and psychiatric disorders.

Justice Resources Incorporated (JRI) and Ability Beyond Disability have recently contracted with DCF for the development of specialized treatment programs. Several group homes are already in operation and a new continuum of residential and group home services is under development in northwest Connecticut. JRI has developed a residential program which is utilized by both DCF and DDS and is in the process of developing several group homes as part of this continuum.

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

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

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

- Multiculturalism Initiatives

The Multiculturalism Subcommittee, convened under the Children’s Behavioral Health Advisory Council (CBHAC) will continue to work with the community collaboratives to assess community needs and recommend strategies to improve service delivery to diverse groups.

- Network of Care Website (MHT SIG Initiative)

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

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

It is estimated that the Connecticut Kid Care behavioral health services system will serve at least 32,000 children who meet the functional and diagnostic criteria for Serious Emotional Disturbance (SED) or who are at high risk for emotional disturbance. Connecticut’s methodology for estimating prevalence is based on definitions published in the federal register in 1998. No less than 6 % of the 841,175 children ages 0 to 17 would meet the SED criteria. The defined population, the methodology for determining a count of children with SED receiving public sector services is based upon an evaluation of the state’s behavioral health system for children that estimate that such services are provided to approximately 3+ % of the children ages 0 to 17.

DCF, in partnership with stakeholders, launched a newly designed, enhanced data collection and reporting system for DCF funded programs in SFY 2010. The purpose of this initiative, Programs and Services Data Collection and Reporting System (PSDCRS), is to create an effective, efficient, and value-laden information system for describing the populations served and identifying client and program level outcomes. It is expected that this system will improve the data pertaining to children with SED.

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

The Department will seek to maintain services at the following levels during FFY 2011.

Care Coordination	1,100
Emergency Mobile Psychiatric Services	7,500
Extended Day Treatment	1,200
Family Advocacy	325
Child Guidance Clinics	20,000
Respite Services	160
Intensive In-home Services	3,500
Therapeutic Group Homes	280

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

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

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

Further, DCF continues to cultivate partnerships with other state agencies. DCF continues to maintain a Memorandum of Understanding (MOU) with both DMHAS and DDS. The MOU with DDS is to facilitate the coordination of services for clients who may be eligible for Voluntary Services through DCF and are eligible for services through DDS, as well as the coordination of services for protective services cases. The MOU with DMHAS supports activities to transition young adults requiring on-going behavioral health care to the adult service system. In partnership with DMHAS' Young Adult Services program, DCF provides funding to facilitate supported community-based living and behavioral health care for youth and young adults with very complex mental health needs. In addition, DCF continues to

work collaboratively with the Judicial Branch. DCF and CSSD have entered into a variety of joint Memorandum of Agreements (MOAs) over the years. Examples of ongoing, strong collaborative work include: MST, MDFT, and IICAPS Service Networks; shared flexible funding for court-involved children; Joint Juvenile Justice Strategic Plan that includes an inter-agency workgroup to develop a Results-Based Accountability framework; Raise the Age legislation that expands juvenile court jurisdiction to 16 and 17 year olds; MacArthur Foundation MH and JJ Action Network Project; and various Mental Health Transformation - State Incentive Grant initiatives. The Department also works in collaboration with the Department of Labor's Office of Workforce Competitiveness and the Workforce Investment Boards, which assist youth and community stakeholders in the planning and creating of employment opportunities for youth across Connecticut.

One of the Department's goals is to ensure that children and youth's educational needs are met in an integrated, supported manner. Multiple educational services, including services provided to those with disabilities under the Individuals with Disabilities Education Act (IDEA) are available and include the following:

- Family advocates and care coordinators receive training regarding special education laws to enable them to inform and link families with appropriate resources;
- Family advocates, care coordinators and DCF social workers often attend Pupil Placement Team Meetings and assist families in obtaining appropriate Individual Education Plans (IEPs);
- Case-specific Managed Services System (MSS) meetings and Child-Specific Team Meetings at the local System of Care/Community Collaborative level are attended by key inter-agency staff including but not limited to DCF staff, school personnel, mental health providers, families and advocates.
- Education consultants continue to be employed within each of the DCF Local Area Office's. These professional consultants are experienced in assessing children's educational needs and progress, including the child's eligibility for special education services. Activities include, but are not limited to: review of client educational records to evaluate the appropriateness of the present education program, assess progress and make recommendations for educational programming; observation of the child and consultation with foster parents and other involved professionals, as appropriate; participation in special education planning when children are referred to Pupil Placement Teams and consultation with assigned social workers and/or surrogate parents, when requested; and work with the education community to improve access, coordinate services and facilitate problem resolution, as needed.
- DCF supports two Pupil Services positions to assist youth enrolled in two- and four-year colleges as well as vocational, technical and certification programs. Staff coordinates activities and collects and manages data on youth involved in post secondary services.
- DCF funds and collaborates with the Department of Education in the Early Childhood Consultation Project to provide mental health consultations to early care and education centers and for children at disruption from these centers.
- DCF serves in the capacity of a school district for committed children.
- DCF works with Birth to Three to evaluate those children under age three years who are substantiated for abuse or neglect, as per CAPTA legislation.

Another goal of DCF is to improve the array, coordination and integration of services for children and youth who are court-involved. Gender-specific programming for girls will be maintained or expanded to serve girls who are committed to the Department as delinquent. DCF will further continue to seek to serve children who are court involved through the System of Care and other wraparound processes. A newly planned pilot project under the MHT SIG focuses on the implementation of the Community-Based Wrap-Around Model in two communities to divert children and youth from the juvenile and criminal

justice systems. This collaborative project builds on existing resources in the community including local community collaboratives, local family support organizations, DCF-funded care coordinators, DCF and CSSD flexible funding, parole, probation and protective services workers, local mental health service providers, local juvenile review boards, court-based assessment programs, and other complementary initiatives. Infrastructure support will consist of training, in-vivo coaching, fidelity monitoring, administrative supports, clinical quality reviews, and a quality assurance and outcome assessment. This initiative emphasizes community-based service delivery by a diverse blend of practitioners, family voice and choice, culturally competent services, and a strengths-based approach.

DCF will continue to integrate youth's substance abuse treatment needs within the context of their broader, holistic service plans. Adolescent Substance Abuse Treatment Outpatient Programs will continue to be funded during SFY 2011. There are six providers who have capacity to service 670 adolescents, annually.

DCF will provide intensive in-home, evidenced based treatment programs for youth with substance use issues, including providing multi-systemic therapy (MST) for youth who are court involved. In addition, Multi Dimensional Family Therapy (MDFT) will be funded. The MDFT teams provide clinical services that target interventions with the adolescent, parents, family interactions & relationships, and extra-familial systems. MDFT works through 3 phases to build alliances and motivation, request changes, and seal the changes before discharging the family. This services targets children who have a mental health and/or substance abuse diagnosis, exhibit complex behavioral health service needs, and are either returning from or approved for a residential placement, or are at imminent risk for an out-of-home placement.

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

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

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

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

The Managed Service Systems (MSS) and the System of Care/Community Collaboratives will be maintained to provide access to children with complex behavioral health care needs and their families across the state. The MSS are to include participation from DCF Area Office staff, providers, families and the Administrative Services Organization. Similarly, the System of Care/Community Collaboratives include membership from a variety of service sectors such as mental health, families, insurance, education, juvenile justice, health, substance abuse, recreation, advocacy, and faith-based organizations for the purpose of ensuring an integrated and holistic service approach to serving children with SED and their families, and increasing children's access to community-based care.

**Criterion 3B: Establishes defined geographic area for the provision of the services of such system.**

Services are delivered statewide unless otherwise noted in the narrative under Criterion 1 B.

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

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

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

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

Assistance for DCF families in need of housing is addressed through the DCF Supportive Housing Program. The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management and other services are funded through DCF. Over 500 families are served annually.

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

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

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

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

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

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

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

DCF has signed a Personal Service Agreement with the Child Health and Development Institute of Connecticut, Inc./Connecticut Center for Effective Practice to administer three Learning Collaboratives focused on the adoption of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at licensed outpatient psychiatric clinics for children during SFY 2007 through 2010. The contractor has established a Coordinating Center for the purposes of planning, managing, overseeing and evaluating the activities and tasks necessary to integrate TF-CBT as a primary treatment at sixteen clinics. The contractor

executes a critical leadership role to advance evidence-based culture and continuous quality improvement to achieve sustained organizational and practice changes that will result in an enhanced quality of care. Consultants from the National Center for Child Traumatic Stress and Yale University are being utilized. Upon completion of the third Learning Collaborative in 2010, DCF will continue to support the dissemination of this treatment through ongoing data collection and reporting, training for new clinicians, and an annual conference for new and seasoned clinical staff.

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

Another major training initiative, supported by mental health block grant funds is the continued enhancement of the standardized model of care for the Extended Day Treatment program. Clinical components include ongoing training and support for Risking Connection (a trauma-based, relational philosophy of care), Project Joy (a therapeutic recreation program), the Ohio Scales, and evidence-based family engagement protocols.

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

#### **Criterion 5B: Training Of Providers For Emergency Health Services**

First responders to youth suicide in CT are the Department's Emergency Mobile Psychiatric Services (EMPS) staff. The EMPS staff has been trained in Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals. AMSR was produced by the Suicide Prevention Resource Center (SPRC) and the American Association of Suicidology (AAS) and funding to develop the curriculum was provided by the Substance Abuse and Mental Health Services Administration. DCF and DMHAS staffs worked in partnership to coordinate the training.

#### **Criterion 5C: Mental Health Block Grant Fund Expenditures**

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

During FFY 2011, the Department proposes to expend the CMHS Block Grant funds for the following types of services:

Service Type	Total by Service Type
Respite Services	\$ 425,995
Family Advocacy Services	\$ 467,300
Youth Suicide Prevention & Mental Health Promotion	\$ 50,000
CT Community Kid Care (System of Care) <ul style="list-style-type: none"> <li>o Workforce Development &amp; Training</li> <li>o Multiculturalism Initiatives</li> </ul>	\$ 70,000
Trauma-Focused Cognitive Behavior Therapy - Sustainability	\$ 53,198
Extended Day Treatment – Model Development & Training	\$ 60,000
Outpatient Care: System Treatment and Improvement Initiative	\$ 284,890
Co-Occurring Screening and Assessment	\$ 40,000
Best Practices Promotion & Program Evaluation	\$ 62,794
Other Ct Community Kid Care Activities	\$ 20,000
Statewide Total	\$ 1,534,177

**Transformation Expenditure: Family Advocacy Services**

Consonant with Goal 2 of the New Freedom Commission Report, DCF will expend funds to support activities that are child-centered and family-driven. During FFY 2011, DCF has allocated \$ 467,300. from its MHBG to fund family advocacy services.

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

<b>State Identifier: Connecticut DCF</b>				
Agency Name	Address	Name of Director	Phone #	Amount CMHS BG
FAVOR, Inc. FAMILY ADVOCACY SERVICES	2138 Silas Deane Hwy, Suite 103 Rocky, Hill CT 06067	Director, Hal Gibber	(860) 563-3232	\$467,300
Family and Children’s Agency, Inc. RESPITE SERVICES	9 Mott Ave. Norwalk, CT 06850	Chief Executive Officer, Rob Cashel	(203) 855-8765	\$ 81,484
Family and Children’s Aid, Inc. RESPITE SERVICES	75 West Street Danbury, CT 06810	Director, Irvin Jennings, MD	(203) 748-5689	\$61,048
Agency Name	Address	Name of Director	Phone #	Amount CMHS BG
Jewish Family Service, Inc. RESPITE SERVICES	1440 Whalley New Haven, CT 06515	Executive Director, Jonathan Garfinkle	(203) 389-5599	\$53,459
Klingberg Comprehensive Family	370 Linwood St.	Director, Rosemarie	(860) 224-	\$115,497

CMHS BG – Connecticut FFY 2011 State Plan and Application

Services, Inc. RESPITE SERVICES	New Britain, CT 06052	Burton	9113	
United Community & Family Services, Inc. RESPITE SERVICES	77 East Town Street Norwich, CT 06360	CEO/ President, Charles Seeman	(860) 889- 2375	\$61,048
YMCA of No. Middlesex Co. Inc. RESPITE SERVICES	99 Union Street Middletown, CT 06457	President, Frank Sumpter	(860) 347- 6907	\$46,133
United Way of Connecticut SUICIDE PREVENTION	1344 Silas Deane Highway Rocky Hill, CT 06067	President, Richard Porth	(860) 571- 7500	\$21,500
Wheeler Clinic, Inc. SUICIDE PREVENTION	91 Northwest Drive Plainville, Connecticut 06062	President, Susan Walkama	(860)	\$28,500
Child Health and Development Institute/Connecticut Center for Effective Practice	170 Farmington Ave Suite 367 Farmington, CT 06032	President, Judith Meyers	(860) 679- 1519	\$53,198
Report Year: FFY 2011				

**C. GOALS, TARGETS AND ACTION PLANS**

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

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

<b>Name of Performance Indicator:</b> Increased Access to Services (Service Capacity)				
<b>Population:</b> Children/youth with complex behavioral health needs			<b>Criterion:</b> 2 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (# of clients served)</b>	28,815	29,639	28,250*	28,250
<b>Numerator</b>	NA	NA	NA	NA
<b>Denominator</b>	NA	NA	NA	NA

**Goal:** To ensure access to publicly funded behavioral health services

**Target:** Maintain the number of children, youth and families served at 28,250.

**Population:** Children and youth with complex behavioral health care needs

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

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

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

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

**Special Issues:** \* A new behavioral health data system, Programs and Services Data Collection and Reporting was implemented on July 1, 2009. This required data entry of all cases, including those open prior to July 1<sup>st</sup>, 2009 and those entering care after July 1<sup>st</sup>, since there was no data imported from the old system due to data credibility issues. We anticipated that the transition to a new data system might show lower numbers of clients served during FY 2010 due to the resource demand and other challenges in operationalizing a new system. Additionally, the "old" system did not include an unduplicated case count, which will be achieved with PSDCRS.

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

Action Plan:

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

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

<b>Name of Performance Indicator:</b> Re-admission rates within 30 days of discharge from inpatient care				
<b>Population:</b> Children/youth in need of inpatient care at Riverview Hospital				<b>Criterion:</b> 1 and 3
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator</b> (% of clients re-admitted)	1.27%	3.63%	2.50 %	2.50 %
<b>Numerator</b>	3	7	NA	NA
<b>Denominator</b>	236	193	NA	NA

**Goal:** To reduce use of psychiatric inpatient services

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

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

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

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

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

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

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

**Source of Information:** Riverview Hospital Data System

**Special Issues:** None

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

**Action Plan:**

DCF will provide multiple, diverse activities to support the reduction in use of inpatient psychiatric care. These include, but are not limited to: a recovery-focused model of care at Riverview Hospital; continued

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

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

<b>Name of Performance Indicator:</b> Re-admission rates within 180 days of discharge from inpatient care				
<b>Population:</b> Children/youth in need of inpatient care at Riverview Hospital				<b>Criterion:</b> 1 and 3
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (% of clients re-admitted)</b>	3.39%	11.92%	2.00 %	5.00 %
<b>Numerator</b>	8	23	NA	NA
<b>Denominator</b>	236	193	NA	NA

Goal: To reduce use of psychiatric inpatient services

Target: Maintain the percentage of readmissions at 5.00 % or less

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

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

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

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

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

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

Source of Information: Riverview Hospital Data System

Special Issues: None

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

Action Plan:

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

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 3: NOMS - Use of Evidence Based Practices**

<b>Name of Performance Indicator:</b> Use of Evidence-Based Practices (EBPs)				
<b>Population:</b> Children/youth that receive evidence-based treatments			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008</b> <b>Actual</b>	<b>FY 2009</b> <b>Actual</b>	<b>FY 2010</b> <b>Projected</b>	<b>FY 2011</b> <b>Target</b>
<b>Performance Indicator</b> (Number of Evidence-Based Practices)	11	12	12	13*

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

Evidence-Based Practice	FY 2008 Actual n	FY 2009 Actual n	FY 2010 Projected n	FY 2011 Target n
Therapeutic Foster Care	1,435	1,404 (20.52%)	1,290* (15%)	1,000* (15%)
Multi-Systemic Therapy	365 (2.14%)	385 (2.14%)	325** (1.9%)	220** (1.2%)
Functional Family Therapy	427 (2.50%)	512 (2.85%)	400	500

- \* Therapeutic Foster Care - Connecticut anticipated a lower number of children to be served in FY 2010 due to the major re-design of its Therapeutic Foster Care (TFC) Program. The lowered number does not reflect a decrease in capacity, but a strengthening of the gate-keeping process to better ensure that only children within the TFC target population are admitted into this service. As a new TFC eligibility screening tool has been implemented effective 04/15/2010, it is expected that the number of children served in TFC during SFY 2011 will be lower than that for 2010. Absent the new standard screening process for TFC, children who were outside of the target population were admitted into the service and resulted in the previous years' larger service numbers.
- \*\* Multi-Systemic Therapy - A non-performing MST program was terminated during 2010 and the funds were re-allocated to a more intensive MST program that serves fewer children, thus the decrease in number (n) for projected children served for FY 11.

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

**Target:** Maintain the number of evidence-based practices at 12 and maintain or expand numbers served. (Note: The new TFC service has been contracted to serve up to 940 TFC level children at a time. While the previous contracts for TFC had a slightly higher capacity (N=1033), the system did not

have a solid gate-keeping process and there was drift in the admitted population. The Department thinks that the new design and the uniform eligibility screening process will effectively result in an increased number of children with SED being served, rather than the admission vulnerability that had previously existed and likely thwarted the timely placement of children within the target population into TFC.

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

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

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

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

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

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

Special Issues:

Action Plan:

Contract providers will continue their commitment and investment of resources to deliver the above-listed evidence-based practices. DCF will continue to fund related training and quality assurance activities to support these practices. Also, DCF will continue to support the TF-CBT teams from sixteen outpatient clinics through continued data collection and monitoring, a TF-CBT Google Site, a two-day TF-CBT training for new hires, and a third annual TF-CBT conference for new and seasoned TF-CBT clinicians.

TFC and TFC-Enhanced will be implemented consonant with new contracts that outline the expected training, support, wraparound funding, and performance outcomes. The Department meets with its TFC providers at least once a month (alternating between a bi-monthly general TFC providers' meeting and a Quality Improvement meeting). These meetings are an opportunity for the Department and the TFC agencies to discuss any successes, challenges and best practices to ensure the effective implementation of this level of care.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 4: NOM - Client Perception of Care**

<b>Name of Performance Indicator:</b> Client Perception of Care				
<b>Population:</b> Families caring for children receiving mental health services			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008</b> <b>Actual</b>	<b>FY 2009</b> <b>Actual</b>	<b>FY 2010</b> <b>Projected</b>	<b>FY 2011</b> <b>Target</b>
<b>Performance Indicator (Percent of clients)</b>	64 %	64.9%	64%	64%
<b>Numerator</b>	253	98	NA	NA
<b>Denominator</b>	393	151	NA	NA

**Goal:** To achieve positive responses regarding care outcomes

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

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

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

**Indicator:** Percent of clients reporting positively regarding outcomes

**Measure:** Percent of clients responding positively about outcomes

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

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

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

**Special Issues:** None

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

**Action Plan:**

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

the results until the survey is automated within the newly designed, Programs and Services Data Collection and Reporting System (PSDCRS). The latter is not anticipated to occur until resources can be secured to do so.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 5: NOM - Return to/Stay in School**

<b>Name of Performance Indicator:</b> Return to/Stay in School				
<b>Population:</b> A sample of children with complex behavioral health needs				<b>Criterion:</b> 1
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (Percent of clients)</b>	88.04%	93.6%	90%	90 %
<b>Numerator</b>	162	44	NA	NA
<b>Denominator</b>	184	47	NA	NA

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

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

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

**Criterion:** Criterion 1 – Comprehensive Community-Based Mental Health System

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

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

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

Denominator: Total number of completed YSS-F Surveys

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

**Special Issues:** None

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

**Action Plan:**

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

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 6: NOM - Decreased Criminal Justice Involvement**

<b>Name of Performance Indicator:</b> Decreased Criminal Justice Involvement				
<b>Population:</b> Children with complex behavioral health needs who are involved with juvenile justice			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
	<b>Actual</b>	<b>Actual</b>	<b>Projected</b>	<b>Target</b>
<b>Performance Indicator (% of clients served)</b>	44.12%	52.38%	46%*	45%
<b>Numerator</b>	60	11		
<b>Denominator</b>	136	21		

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

**Target:** Decrease the number of children/youth involved in the criminal justice system by at least 1 %.

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

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

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

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

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

**Denominator:** Total number of completed YSS-F surveys

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

**Special Issues:** None

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

**Action Plan:**

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 7: NOM - Increased Stability in Housing**

<b>Name of Performance Indicator:</b> Increased Stability in Housing				
<b>Population:</b> Children/youth with complex behavioral health needs			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
	<b>Actual</b>	<b>Actual</b>	<b>Projected</b>	<b>Target</b>
<b>Performance Indicator (Percent of clients)</b>	.69%	.45%	.68%*	.68%
<b>Numerator</b>	199	134	NA	NA
<b>Denominator</b>	28,815	29,639	NA	NA

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

**Target:** Less than 1% of children/youth with complex behavioral health needs will be homeless or living in shelters

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

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

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

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

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

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

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

**Special Issues:**  
None

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

**Action Plan:**

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 8: NOM - Increased Social Supports/Social Connectedness**

<b>Name of Performance Indicator:</b> Increased Social Supports/Social Connectedness				
<b>Population:</b> Families caring for children receiving mental health services			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (Value)</b>	89.92%	84.67%	86%	87 %
<b>Numerator</b>	357	127	NA	NA
<b>Denominator</b>	397	150	NA	NA

**Goal:** To support clients' achievement of social supports/social connectedness

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

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

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

**Indicator:** Families with children/youth who have complex behavioral health needs that report increased social supports/social connectedness

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

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

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

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

**Special Issues:** None

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

**Action Plan:**

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

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

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

**Indicator 9: NOM - Improved Level of Functioning**

<b>Name of Performance Indicator:</b> Improved Level of Functioning				
<b>Population:</b> Families caring for children receiving mental health services			<b>Criterion:</b> 1 and 3	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008</b> <b>Actual</b>	<b>FY 2009</b> <b>Actual</b>	<b>FY 2010</b> <b>Projected</b>	<b>FY 2011</b> <b>Target</b>
<b>Performance Indicator (Percent of clients)</b>	65%	69.5%	67.5%	68 %
<b>Numerator</b>	257	105	NA	NA
<b>Denominator</b>	394	151	NA	NA

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

**Target:** Increase the level of positive client responses to 68% of survey participants

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

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

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

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

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

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

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

**Special Issues:** None

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

**Action Plan:**

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

DCF continues to expand the use of the YSS-F with community services providers. DCF will continue to contract with the University of Connecticut and work with selected providers to execute the survey and tabulate the results. DCF plans to incorporate the survey into the newly designed behavioral health information system, once we can obtain sufficient resources to do so. This will allow broader access to survey respondents.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

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

<b>Name of Performance Indicator:</b> Family-Driven Behavioral Health Services				
<b>Population:</b> Families caring for children with mental health needs				<b>Criterion:</b> 1 and 3
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (# of families)</b>	5,390	5,500	5,200	5,200
<b>Numerator</b>	NA		NA	NA
<b>Denominator</b>	NA		NA	NA

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

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

**Population:** Families caring for children with complex mental health needs

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

**Indicator:** Families receiving family advocacy, education and support services

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

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

**Special Issues:** None

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

**Action Plan:**

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

1. Success this year was achieved through increasing and strengthening the development and functioning of adolescent and family support and advocacy groups across the state while serving as fiduciary for Systems of Care unable to find another non-profit to fulfill that responsibility. In FY 2011, FAVOR will serve as fiduciary to or directly support 10 to 15 additional family advocacy and support groups.
2. Continue to utilize newly acquired teleconferencing equipment to hold bi-monthly family organizations and System of Care leadership calls focused on sharing best practices and policy work. This technology has been made available to numerous family groups to assist them in planning and delivering local, community educational, training and support events.
3. Participate fully in the Behavioral Health Oversight Council and its sub-committees while serving as co-chair of the provider advisory sub-committee. FAVOR leadership staff brings to the Connecticut Children's Behavioral Health Advisory Council all of the issues and policy positions discussed at the Oversight Council. By doing so, FAVOR assists families and allied professionals in staying aware on issues of significance with a major focus on health care and behavioral health financing.
4. The Executive Director will continue to play a leadership role in the three funded Transformation grant projects: QUIC, Wraparound and Workforce Development. The Executive Director remains a member of the Executive Committee of the Behavioral Health Oversight Council and continues to co-chair the Consumer Youth and Family Advisory Council of the states Transformation Grant. This direct participation supports strengthening the family voice across Connecticut's mental health system.
5. Manage and lead 2 Citizen Review Panels charged with commenting on DCF performance in Child Welfare. The focus in FY 2011 will be on DCF policy and practice in foster care along with further development of consumer satisfaction surveys.
6. Direct Services will continue. Ten family advocates carry caseloads of 24-30 families. Brief interventions address level 3 families placed on waiting lists while targeting the gaps in the service system. At the beginning and end of each school year, referrals increase by up to 50% with each family advocate working with increased number of families in excess of contractual requirements.
7. FAVOR'S Public Policy Committee currently has 46 parents as members. They work with system partners on the establishment of policy priorities targeting gaps and barriers to needed services. Families are trained and supported in sending emails, writing policy position letters, testifying and meeting with elected officials to tell their story. System partners convened to develop a collaborative and non-duplicative set of policy priorities on behalf of families and youth.
8. FAVOR'S Partner Agencies continue to receive funding from the block grant to provide community based outreach, education and training while working to advocate for families' needs and the utilization of their strengths. FAVOR'S budget for 2011 continues set aside financial resources to support the development of additional local family advocacy organizations. FAVOR has recently increased its training capacity to assist internal staff and community partners. Family engagement and safety training for our staff represent the curriculum currently under development.

9. An expanded multi-member Data Committee has been implemented with leadership and technical assistance provided by a new board member who is an expert researcher and evaluator. We are adding outcome measures to the DCF contract and relating a results-based accountability strategic plan format. This will organize and direct our data collection concerning families receiving our various services.
10. During these challenging and economic times, FAVOR continues to improve collaboration with partners in state government and connect with all the disability groups whose children and youth also may have behavioral health needs. Priority areas of program interest include substance abuse prevention and treatment, youth in transition, early childhood, juvenile justice, and youth on the Autism Spectrum whose only help has come thru DCF Voluntary Services and the public schools. This year we will focus on identifying and establishing an early identification capacity and state wide infrastructure and direct services for children and youth on the Autism Spectrum. Working with two national consultants retained by Yale University and DCF Workforce Development program, FAVOR, with its partners, has successfully completed and will soon implement a sustainable plan for statewide parent leadership. FAVOR is on board to co-manage the project and staff it.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2011  
PERFORMANCE INDICATORS-CHILD**

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

<b>Name of Performance Indicator:</b> Increased Suicide Prevention and Crisis Response Training				
<b>Population:</b> Youth, families, DCF staff, providers and first responders				<b>Criterion:</b> 1, 3 and 5
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Projected</b>	<b>FY 2011 Target</b>
<b>Performance Indicator (# of individuals)</b>	716	911	700	715
<b>Numerator</b>	NA	NA	NA	NA
<b>Denominator</b>	NA	NA	NA	NA

**Goal:** Increase knowledge base of youth, families, DCF staff, providers and first responders with respect to the prevention of youth suicide and promote the health, safety and well being of young children at risk of abuse and/or neglect, including children with open and closed DCF cases and homeless children, as well as promoting their social-emotional development to enable them to be socially and emotionally healthy and ready for success upon entry to school.

**Target:** Provide suicide prevention training to at least 715 persons annually

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

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

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

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

**Source of Information:** Quarterly reports from providers

**Special Issues:** None

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

Action Plan:

DCF will continue funding a contract with the United Way of Connecticut for the provision of youth suicide prevention training. Due to cuts in the state budget, funding has been shifted from state dollars to federal Mental Health Block Grant dollars for Wheeler Clinic's Connecticut Clearinghouse to continue training on para suicidal behaviors, self injurious behaviors, and general information on risk factors for youth suicide to DCF staff; community-based organizations, college students, faculty and staff; and members of the Youth Suicide Advisory Board (YSAB). In addition, a membership to the statewide resource library is open to all DCF staff and YSAB members. Through the DCF Training Academy, training sessions that address suicide prevention and provide continuing education credits will be offered throughout the year to DCF staff. This training is also delivered to schools, community groups and the CT Association of Foster and Adoptive Parents through concentrated outreach by the contractor. DCF, in partnership with DMHAS, was able to provide training, technical assistance and consultation to behavioral health providers and primary care responders until the Federal Garrett Lee Smith Act funds ended in September 2009. However, several community providers were trained as trainers in ASIST and AMSR (nationally recognized, evidence-based curricula in suicide prevention) and a cadre of trainers now have the ability to continue training without state contracts.