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WORKGROUP 4 RECOMMENDATIONS

GOAL: Early Mental Health Screening, Assessment and Referral to Services are Common Practice.

RATIONALE

Studies show that approximately 20% of adults and children experience psychiatric difficulties that interfere with their daily functioning. These difficulties often remain unaddressed and may be exacerbated by inconsistent standards used to refer for suitable screening and treatment, and contribute to various mental healthcare inequities. For example, an individual's receipt of mental health services varies based on:

1) age- with a paucity of such programs for the elderly and very young; 2) race – minorities face more barriers to mental health care and are underserved in the current system; 3) poverty – there are very limited mental health resources, especially psychiatric services, for those of low income or uninsured; 4) geographic location – rural and inner city residents have limited access to mental health services; 5) co-occurring difficulties – existing mental health services typically fail to meet the treatment needs of individuals with co-occurring psychiatric and/or drug use disorders. For example, it is thought that 20-33% of individuals with an intellectual disability have a co-occurring psychiatric diagnosis;¹ and, 6) parents/caregivers beliefs and attitudes – they may not see the consumer as having a problem because of stigma and/or lack of knowledge.

The early identification of and referral for mental health concerns is one of the most critical factors in improving outcomes and reducing the strain on the treatment system for children and adults with mental health problems and may help redress inconsistent mental healthcare standards and inequities in treatment delivery.

Mental health screening and assessment also provides practitioners, from frontline staff to education, transition, and mental health professionals, with a “common language” that can help target needs, provide benchmarks through re-testing and accountability for decision-making. Such commonalities may also facilitate inter-departmental collaboration between mental health, substance abuse, health care, education, child protection, child advocacy, and juvenile justice systems by streamlining healthcare practice and providing uniform synthesized information.

Connecticut's investment in an infrastructure to promote behavioral health and wellness and early intervention across the lifespan through linkages between systems, coordination of care, and co-location in early care and education, schools, and primary health care settings, represents a transformative approach to improving the system of screening, referral and treatment of individuals who have traditionally met with pronounced

¹ The term includes people who have a diagnosis of mental retardation and others who may not fall into that category.

healthcare inequities, such as those with co-occurring disorders. This transformation in healthcare infrastructure will support early identification, assessment and access to services and natural supports. Consumers and families will assume an active role in clients' efforts to sustain health, resilience and recovery.

PROCESS FOR SELECTING AND PRIORITIZING RECOMMENDATIONS

Workgroup 4 consisted of 41 members representing state agencies, consumers, advocates, family members, and representatives from primary and behavioral health care agencies representing children and adults. At the initial meeting of the workgroup, an affinity process was used to brainstorm issues and recommendations around the workgroup's goal. These issues and recommendations were later categorized by themes. At subsequent meetings, participants broke into four sub-groups to clarify and consolidate themes related to the focus of each subgroup. The sub-groups focused on the following topics:

- 1) Fostering the mental health of young children
- 2) Improving/expanding school mental health programming
- 3) Screening for co-occurring disorders
- 4) Screening for mental disorders in primary health care across the lifespan

Themes that did not fit well into consolidated areas were placed in a "parking lot," for further consideration at a later time or submission to the advisory committee. To facilitate the identification and prioritization of recommendations within each subgroup, members were asked to apply certain filters. These included elements such as readiness, allowable activities, level of analyses, domain, lifecycle focus, etc. Consolidated recommendations from each sub-group were discussed and prioritized in the larger group and final recommendations were made.

RECOMMENDATIONS

The following are specific recommendations that support transformed practices in the early identification and intervention for individuals in need of mental health services:

Recommendation 1

Develop screening, assessment, and intervention protocols for use with children and adults including the elderly and those individuals with co-occurring problems.

Strategies

- Survey primary care practitioners on what they need to routinely screen for mental health disorders and connect to treatment across the lifespan.
- Identify screening and assessment protocols that have been used successfully with populations across the lifespan (young children, adults, the elderly, etc.), including those used for individuals with co-occurring disorders.

- Coordinate the protocol development training with relevant state and provider networks and the Workforce Transformation Work Group.
- Identify standards for the routine use of screening and assessment protocols.
- Provide education and training in the use of the protocols to relevant staff in home and community-based, education (including early care), primary care settings, protective services, adult mental health and substance abuse treatment settings, shelters, as well as ongoing support and assistance.
- Train staffs in intervention approaches and evidence-based practices to better engage individuals and identify mental healthcare difficulties.
- Provide financial incentives to primary care providers to pilot protocols.

Population(s) Addressed

- Individuals across the lifespan in need of mental health screening and referral services

State Agencies, Organizations or Current Efforts Impacted by Recommendation

- DCF, DSS, SDE, CTF, DPH, DMR, DMHAS, DHE, Academy of Pediatrics, Academy of Family Physicians, American College of Physicians, Primary Care Physician, Association American Geriatric Society, CT Medical Association, CT Hospital Association

Infrastructure Funding

- To be determined

Timeframe

- To be determined

Recommendation 2

Improve access to mental health screening, referral, consultation, and intervention services (prevention & treatment) within: early care and education settings (schools, centers and home-based), pediatric primary care, home-based services settings (e.g., parent aides, DCF, Birth-to-Three, etc), adult mental health, substance abuse, domestic violence treatment settings (to identify high risk young children), senior centers, senior housing, congregate living centers and congregate meal sites.

Strategies

- Co-locate developmentally-informed, child mental health experts in these settings to provide screening, referral, consultation, and intervention services (prevention & treatment). Include screening for both mental health and environmental risk (especially maternal depression, substance use, and domestic violence.)
- Co-locate resource coordinators (care coordinators/case managers) in these settings to facilitate the identification of families living in conditions that present a risk to child development and enrollment in programs and coordination of services, e.g., vocational supports, adult mental health and substance related services, adult

education, food stamps, WIC, HUSKY, Care-4-Kids, energy assistance, housing subsidies, transportation and other economic support programs.

Population Addressed: Young Children

- Convene, parents, families, significant others and other natural supports (e.g. peers, clergy, community members) as equal partners with professionals to effectively screen and refer individuals across the lifespan at risk for mental health problems.

Population Addressed: Consumers, family members, natural supports

- Fund consultation-liaison arrangements between primary care, early care and education, public education, home visitation, and behavioral health practitioners to provide/increase formal linkages between behavioral health practitioners and community providers.

Population Addressed: Primary and Behavioral Care Providers, Senior Center Directors and Resident Care Coordinators

State Agencies, Organizations or Current Efforts Impacted by Recommendation

- DCF, DSS, SDE, CTF, DPH, DMR, DMHAS, Behavioral Health Providers, Primary Care Physicians, Senior Center Directors and Resident Care Coordinators

Infrastructure Funding

- To be determined

Timeframe

- To be determined

Recommendation 3

Establish a model of coordinated interagency collaboration, building upon existing systems of care that is comprehensive, coordinated, flexible, culturally-competent, and family-driven for individuals with mental health problems to ensure early screening and service access.

Strategies

- Develop and implement a strategic planning process with necessary system partners to create pathways for implementation. Such a process should take into account: 1) the factors unique to the emotional development of young children, youth adults and elders, and 2) pre-existing coordinating entities
- Create a “hub” responsible for coordination of screening, assessment, consultation, and referral services that allows for multiple points of entry for consumers to enter the service system.
- Develop MOAs among providers from various state agencies for sharing and pooling of resources and sharing of data.
- Institutionalize contracting procedures and fee/reimbursement structures for eligible services.
- Formalize ongoing communication with the higher education community and other relevant educational networks to ensure a sufficient workforce of developmentally-

informed, early childhood mental health experts available for co-location in settings for young children.

- Disseminate information to parents and providers through public information campaigns about the availability of a coordinated network of early childhood mental health services with multiple points of entry.

Population(s) Targeted by Strategies

- State agencies, Primary and behavioral health care providers, educational institutions

State Agencies, Organizations or Current Efforts Impacted by Recommendation

- DCF, DSS, SDE, CTF, DPH, DMR, DMHAS, Behavioral Health Providers, Primary Care Physicians, Access to Recovery initiative, System of Care Community Collaboratives.

Infrastructure Funding

- To be determined

Timeframe

- To be determined
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Recommendation 4

Develop a reimbursement mechanism for prevention, screening, assessment, consultation, early intervention, and treatment.

Strategies

- Establish a workgroup of state agencies to leverage federal matching reimbursement dollars and coordinate and align funding streams.
- Maximize Medicaid funding (including utilization of EPSDT).
- Identify and address regulatory changes and waivers necessary to overcome policy barriers.
- Identify and address challenges to sustainability by institutionalizing contracting procedures and fee/reimbursement structures for eligible services.
- Disseminate information to providers, referral networks, natural supports and parents through public information campaigns about the availability of reimbursable services for mental health consumers.

Population(s) Targeted by Strategies

- State agencies, Primary and behavioral health care providers, educational institutions

State Agencies, Organizations or Current Efforts Impacted by Recommendation

- DCF, DSS, SDE, CTF, DPH, DMR, DMHAS, Behavioral Health Providers, Primary Care Physicians, Access to Recovery initiative.

Infrastructure Funding

- To be determined

Timeframe

- To be determined
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Recommendation 5

Develop broad-based educational initiatives for use in educational, natural community, and primary care settings on the topic of mental health, discrimination and stigmatizing of persons with psychiatric and/or substance use disorders, and the availability of suitable referrals.

Strategies

- Educate all professional school personnel on when to initiate referrals for mental health screenings and related case management
- Educate students about mental illness/wellness/recovery in the schools across content areas & school life cycle in order foster appropriate self and peer identification and referral.
- Implement innovative public awareness and outreach strategies for natural supports such as consumer-designed conferences, media-based campaigns, providing participants with guidance and resources, to increase their capacity to recognize and refer individuals with mental health issues.
- Conduct information forums for primary health care providers as part of employment orientation.

Population(s) Targeted by Strategies

- School personnel; professionals in primary care settings; community providers and natural supports.

State Agencies, Organizations or Current Efforts Impacted by Recommendation

- SDE, DSS, CTF, DCF, DPH, DMR, DMHAS, Behavioral Health Providers.

Infrastructure Funding

- To be determined

Timeframe

- To be determined
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EXISTING INITIATIVES WITH CONNECTIONS TO RECOMMENDATIONS

1) The Governor has developed an Early Childhood Education Cabinet, charged with developing an Early Childhood Investment Framework. Within this Framework there is a focus on “Ready Communities” (Part III), which specifies “the development of a community-specific strategic plan that ensures effective collaborations, coordination of services, systems of identification of needs and access to preventative and intervention resources.” (p.24) This includes early screening, ensuring that children receive mental

health services, and review of various “hub” models “to determine their effectiveness in information dissemination to families, making referrals that result in service provision, interagency case coordination, and program monitoring.” The priorities within this framework will then inform state budgetary allocations.

2) CT Early Childhood Partners (State Early Childhood Comprehensive Services Initiative funded federally by Maternal and Child Health and administered through DPH), is developing a plan for comprehensive, integrated services for young children. Screening, assessment, referral and inclusion of a hub or “early childhood system of care” was included in the plan.

3) The CT General Assembly has just passed a bill, “2020 Prevention,” which will increase funding for prevention from 2.8% to 10% by 2020. All state agencies must, therefore, move toward integrating prevention activities.

4) Mental health consultation in early care and education settings is being funded through the Early Childhood Consultation Partnership Initiative, funded through DCF and administered by ABH. DSS is interested in exploring reimbursement for consultation through Medicaid.

5) DSS is working on reimbursement through EPSDT (Early Periodic Screening, Diagnosis, and Treatment – part of Medicaid) for those children who have medical necessity but no diagnosis. This is a critical aspect of early screening, prevention, and early intervention.

6) CT’s KidCare system (through DCF) provides wrap-around services for children with severe emotional disturbance.

7) A model “early childhood system of care” (focusing on social-emotional development/mental health) in Greater Bridgeport, called Child FIRST, is a “hub” which provides community based screening and consultation (to early care and education sites, pediatric primary care, domestic violence shelter, family resource centers, home visiting programs), comprehensive assessment of the child and family, family-driven plan of supports and services, and referral with care coordination with multiple points of entry for families to enter the service system. Randomized trial funded by SAMHSA has documented strong evidence based outcomes (based on preliminary 6 month data analysis). New London is now working on developing an early childhood system of care as well, with SAMHSA funding.

8) The Commissioner of DSS is very interested in ensuring that young children (especially 0-3 years) with social-emotional and developmental problems are identified as early as possible. She is interested in using the DSS funded child care settings as information, consultation, and resource centers for both families who attend the centers and for those in the neighborhood. She is also extremely interested in the challenges and risks experienced by parents and accessing supportive services for them as a way to prevent later developmental and social-emotional problems.

9) CT has a statewide telephone information and referral system through Child Development Infoline called Help Me Grow.

10) Children's Fund of CT and Child Health and Development Institute have special interest in integrating behavioral health into primary health care sites. They have funded an Innovation grant at the Primary Care Center at Bridgeport Hospital (through Child FIRST) and Yale New-Haven Hospital focused on screening for emotional and behavioral problems and environmental risk in young children and early intervention.

11) DPH has a Medical Home Initiative throughout CT funded by Title V, focused on children with special health care needs. However, mental health is **not** given parity with physical health needs. (Opportunity for system change.)

12) Birth to Three (DMR) provides early intervention services for children with developmental delays throughout CT. However, they rarely (depending on the provider and the geographic location) provide mental health services, in spite of the federal law which requires intervention around social-emotional delays and problems, as one of five domains of function. (Opportunity for system change.)

13) CAPTA is a federal law which requires that all children substantiated by DCF have evaluations by Birth to Three for delay or problems in their development. This is especially critical given the frequency of social-emotional and language delays in this population. CT's response to this law needs to be evaluated. (Opportunity for system change.)

14) CT Suicide Prevention Initiative (DMHAS) is a 3-year federal initiative that will build on the existing youth suicide infrastructure, including the Youth Suicide Advisory Board (YSAB) to 1) implement the Signs of Suicide (SOS) Program, an evidence-based practice, in CT middle/high schools and in selected CT universities; 2) expand the DCF-sponsored training program in recognizing the signs and symptoms of suicidality and depression targeting foster and adoptive parents, school nurses, parent/teacher organizations, youth service bureaus, and juvenile justice personnel; and 3) design and pilot implementation of a model program to increase the availability, accessibility, and linkages to mental health treatment by embedding services in school-based health and community-based hospital clinics.

15) The **Access to Recovery Program (ATR)** is a \$22.8 million/3 year federal grant from the federal Substance Abuse and Mental Health Service (SAMHSA) awarded to DMHAS to develop, implement and manage services that increase treatment capacity while ensuring informed choice by participants who self select from a compliment of clinical interventions and recovery supports that have been established by the 5 Regional Networks.

16) The Co-Occurring State Incentive Grant (COSIG) was awarded to DMHAS by SAMHSA in 2005. The \$4 million dollars over five years is designed to implement

integrated care for people with co-occurring mental health and substance abuse disorders statewide. The goals of the grant are to implement standardized screening and assessment, service coordination and network building, integrated models of treatment, and data-based decision making at the pilot sites and then throughout the system. The two pilot sites are the Hispanic Clinic at the Connecticut Mental Health Center in New Haven and the Morris Foundation in Waterbury.