

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
999 ASYLUM AVENUE, HARTFORD, CONNECTICUT 06105



Sarah Healy Eagan
Acting Child Advocate

January 31, 2014

Dear Drs. Ryan and Connor,

The Office of the Child Advocate (OCA) wishes to express sincere appreciation for your leadership presiding as co-chairs over the past 6 months of the Task Force to Study the Provision of Behavioral Health Services for Young Adults created by Public Act 13-3 sec.66. The draft offers compelling information regarding the critical importance of paying attention to children's mental health, as well as describes in detail how ensuring access to timely, high quality prevention, early intervention and specialized behavioral health services for children, youth and young adults is a critically important investment in CT's future. We write these comments to emphasize and highlight what we consider to be some of the most urgent recommendations. Thank you for your review and consideration.

Children's Population Health: The work of this Task Forces offers an opportunity to provide policy makers with a clear and concise roadmap to further the important work of ensuring Connecticut has the appropriate infrastructure to meet the behavioral health needs of children, youth and young adults

I. PREVENTION AND EARLY INTERVENTION

Health care dollars are most effectively and efficiently invested in prevention and early intervention efforts. Accordingly, OCA recommends the following:

- Universal screening for behavioral health and developmental impairments for children ages 0 to 21 with financial reimbursement strategy to incentivize compliance with screening requirements. See data from Masshealth regarding implementation and value of universal EPSDT screening. [Behavioral Health Screening Report, December 31, 2007 - September 30, 2012](#)
- Coordinated collaboration between pediatric providers, Department of Social Services, Office of Early Childhood, Help Me Grow, and the Department of Children and Families to ensure that high need families are offered and receive the benefit of regular behavioral health and developmental screenings, particularly for children ages zero to five.
- Development of a data collection strategy to annual report regarding compliance with screening and referral mandates.
- Expansion of the state Birth to Three program to serve children who are less severely developmentally delayed (current eligibility criteria is 2 standard deviations away from the mean)

in one domain or 1.5 standard deviations away from the mean in multiple domains), or who are at risk of impairment. See Massachusetts Part C program, heralded as a national leader in maximizing interventions for at risk or developmentally delayed infants and toddlers.

- Maximization of home visiting services, including dyadic clinical models such as Child FIRST, to ensure that such services are scaled up to meet the needs of all eligible families. Expansion of service delivery capacity for these services will necessitate examination of funding streams, such as inclusion of these services in commercial carrier plans, state Medicaid plan, or braiding insurance and state funding with federal grant dollars. Increasing capacity in these programs is essential given the efficacy of early intervention and the convincing body of evidence that home visitation programs improve developmental outcomes, increase caregiver capacity, and reduce incidents of abuse and neglect.
- Maximize capacity and opportunity for replication of community-based services that provide a bridge between families, schools and pediatric health care providers. These programs often work with schools, Juvenile Review Boards, or Youth Service Boards, to identify at-risk children, facilitate assessment of their needs, connect them with services or pro-social community activities. These programs must be understood as prevention and early intervention programs that have the ancillary benefit of reducing child abuse or neglect and closing the achievement gap for at-risk youth. As Connecticut re-imagines its health care delivery and payment system, it is essential that these services be contemplated, potentially with a plan for certification or licensing and a path for insurance reimbursement. Increasing cost-sharing between insurers, HUSKY and the state for crisis services such as EMPS would allow for recoupment by the state and additional dollars that could be reinvested in these community services.

II. SUBSISTENCE AND THE SOCIAL SAFETY NET

- Nutrition Support for children and youth of all ages.
- Supportive housing for families and/or young adults.
- Peer Support for young adults involved in the mental health system.

III. WORKFORCE DEVELOPMENT

- Need to dramatically increase workforce that is able to identify and meet the developmental and social-emotional needs of young children in a culturally competent manner.
- Examination of development of work force incentives to increase number of child psychiatrists, clinicians trained to work with youth and young adults using evidence-based and promising interventions; all disciplines must be delivered in culturally and linguistically-competent manner.
- Increase care coordinators who are highly trained and able to work with high-need or public-system involved children and youth.
- Modification of reimbursement regulations to ensure funding streams for licensed providers filling essential health-care roles;
- Inventory of essential services, with consideration of developmental continuum.

AVAILABILITY OF EVALUATION AND TREATMENT: MANDATING ACCESS TO NECESSARY SERVICES

- Funding incentives to reward outcomes and quality care coordination (see below).

- Development of rigorous data collection and evaluation/oversight of services delivered and health care outcomes. See e.g., Masshealth’s requirement that all providers utilize and report regarding the CANS on a 90 day basis—used for individual treatment planning and aggregate health care need identification.
- Development and adherence to a menu of necessary services including:
 - Universal Screening;
 - Mental Health Evaluation;
 - Intensive Care Coordination that can assist families and children with locating, accessing, coordinating and monitoring mental health, social services and educational and other services. (see e.g., <http://www.rosied.org/Default.aspx?pagelid=84577>)
 - Home-based assessments, care planning teams and wrap-around services;
 - Family training and support services;
 - Mobile crisis intervention
 - Short-term crisis stabilization;
 - In-home health and mental health care services, with an emphasis (though not exclusively) on research-based models;
 - Therapeutic mentoring.

Integration of Schools into the Health Care Continuum

- Pre-certification and in-service requirements that are general and discipline-specific regarding mental health, trauma, child development, and classroom management.
- Allocation of social work services in according with NASW guidelines.
- Increased access to services which support planning and service delivery for children with neurodevelopmental challenges including behaviorists, child psychologists, neuropsychologists and other developmental specialists.
- Availability of child psychiatry (and consideration of developmental expertise) consultation hubs to school district personnel;
- Health care funding streams for school-based health clinics;
- Modification of health care and HUSKY reimbursement rules where necessary to permit reimbursement for mental and behavioral health services that are delivered in school settings;
- Consideration of the role of schools and school-based health clinics in the state’s planning for advanced primary care, including potential for school-based clinics to be licensed as pediatric care providers or as community health entities that connect families and pediatric homes.
- Health care funding streams for community-based programs that link with schools to identify at-risk children and youth, assess needs and coordinate service delivery. Such programs could be licensed and funded as community health entities, community health workers, or intensive care coordinators.

Again, thank you for your hard work and leadership. The OCA looks forward to working with you and others in advocating for the implementation of these recommendations.

Sincerely,

Sarah Eagan, JD
Acting Child Advocate