

CMHS Block Grant – Connecticut FFY 2008 State Plan & Application

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FFY 2008

Mental Health Block Grant Application

Please find attached a draft of the FFY 2008 Mental Health Block Grant Application (PART C). You are welcome to direct any comments or questions regarding this document to: marilyn.cloud@ct.gov. Deadline for comments/questions is close of business on August 10, 2007.

SECTION 1: DESCRIPTION OF STATE SERVICE SYSTEM

A. DESCRIPTION OF CONNECTICUT’S BEHAVIORAL HEALTH SERVICE SYSTEM FOR CHILDREN, ADOLESCENTS AND FAMILIES

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. The legislation 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 clinics for children, extended day treatment services, foster homes, group homes, emergency shelters and residential treatment centers. These legislative mandates reflect 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.

The Department’s mission is “to protect children, improve child and family well-being and support and preserve families.” These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with families, advocacy groups, public and private service providers, local education authorities, other state agencies, and the federal government. Working collaboratively with stakeholders to improve child safety, to ensure that more children have permanent families, and to advance the overall physical, mental, and social well-being of children is the central focus of the agency.

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

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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 – Work Force 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 referrals from various sources. The goal is to foster resiliency to enable the child to function successfully at home, at school and in the community. The family is considered a partner in all aspects of the planning, treatment, and discharge processes. To achieve this goal DCF works with families, other caregivers, and the broader stakeholder community to ensure the availability of an array of clinically effective services for any Connecticut child or adolescent with serious emotional, behavioral and addictive disorders. DCF also provides specialized behavioral health services for those involved with the child protection and/or juvenile justice systems, particularly for those youth with Serious Emotional Disturbance (SED) who are at placement risk, and for those youth with special mental health or developmental needs who are transitioning out of DCF's service system. For the latter population, DCF has Memorandums of Agreement with the CT Department of Mental Health and Addiction Services (DMHAS) and the CT Department of Mental Retardation (DMR) that require timely identification of youth with either major mental illnesses or developmental disabilities, who need to be referred to DMHAS or DMR for ongoing services at the time of transition from DCF. There are established protocols that include standardized Department-wide clinical criteria to determine if referrals are needed, timeliness standards for referral prior to age-out and/or transition, and written discharge plans.

The agency's primary source of revenue for operating expenses and funding for community 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 resource initiatives. 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.

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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.

Core Values within the system of care framework include the following.

- Services are child-centered, with the needs of the child and family dictating the types and mix of services provided.
- Services are community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.
- The Systems of Care/Community Collaboratives deliver culturally competent care through agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles include the following.

- Children with emotional disturbance should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
- Children with emotional disturbance should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
- Children with emotional disturbance should receive services within the least restrictive, most normative environment that is clinically appropriate.
- The families, surrogate families and legal guardians of children with emotional disturbance should be full participants in all aspects of the planning and delivery of services.
- Children with emotional disturbance should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

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- Children with emotional disturbance should be provided with Care Coordination or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
- Early identification and intervention for children with emotional problems is critical in order to enhance the likelihood of positive outcomes.
- Children with emotional disturbance should be ensured smooth transitions to the adult service system as they reach maturity.
- The rights of children with emotional disturbance should be protected and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
- Children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

A wide range of clinical and non-traditional services are available at the regional or local levels to help children with behavioral challenges experience success in their home, school and community environments. DCF, as a direct provider of services operates a children's psychiatric hospital, a residential treatment program, an emergency shelter and diagnostic center, a facility for male adjudicated juvenile offenders, and an experiential wilderness challenge course. Additionally, DCF funds community-based providers to deliver a diverse range of inpatient and outpatient services. Children with complex behavioral health needs may qualify for an enhanced set of services such as emergency mobile psychiatric services, crisis stabilization services, partial hospitalization, individualized support services, respite services, intensive home-based services, extended day treatment services, enhanced care coordination, and therapeutic support staff. Most youth who fall into this latter category are 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,

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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. Each collaborative has developed a Local Area Development Plan to identify service utilization patterns, service capacity, system/infrastructure barriers, and performance indicators for measuring progress and system improvements. Although each collaborative works in a slightly different fashion, they all remain committed to helping children with serious emotional disturbance succeed in their homes and communities.

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

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

The Managed Service System structure was added in 2004. This represents a consortium of DCF staff and DCF-funded provider agencies convened under the authority of the 15 DCF local area offices to assure that a comprehensive and coordinated array of services are available at the local level to meet the needs of the DCF target population, especially those clients with the most complex behavioral health needs. The goal is to reduce the number of children in residential care and manage access to appropriate levels of 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 a 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.

To comply with a legislative mandate, on January 1, 2006 the CT BHP was formed by DCF and DSS 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

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families. Value Options was selected as the administrative services organization to manage Medicaid mental health and substance abuse services. The CT BHP covers 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.

Value Options employs 8 system managers to provide local leadership and direction for the 15 local area offices and 25 community collaboratives. They also 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. These system managers 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. An intensive care manager has also been assigned to each area office to assist with clinical treatment planning for complex cases. Other Value Options' staff that work at the local levels include peer support specialists who are adults that have had personal experiences with the mental health and/or substance abuse services system, and Family Support Specialists who are trained parents of children with behavioral health needs. These specialists provide education and outreach to families, help families identify resources including natural support networks, engage in treatment, and navigate the service system. They provide information, identify individual barriers to care, and work closely with the intensive care coordinators and care coordinators to address barriers.

Medicaid behavioral health services that are available through the CT BHP include the following:

- Inpatient psychiatric hospitalization;
- Partial hospitalization;
- Substance abuse/detoxification services;
- Residential treatment services;
- Intensive outpatient services such as home-based programs;
- Outpatient mental health or substance abuse services;
- Emergency mobile psychiatric services;
- Medication evaluation and management;
- Extended day treatment services; and
- Psychological/neuropsychological testing.

Staff works closely with family members, providers and other local social service programs to promote a treatment plan that addresses cultural needs, strengths, and preferences of the family.

To determine the need for behavioral health services and the allocation of resources, DCF works in partnership with the Office of the Governor, the state legislature, consumers and family members, advisory groups, advocacy groups, service providers, other state agencies

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who serve children and families, academic institutions, and others. These diverse stakeholders represent the communities and provide valuable knowledge and insights.

One of the most critical bodies that oversees the Community Mental Health Services (CMHS) Block Grant and the overall system design and functioning is the Children's Behavioral Health Advisory Committee (CBHAC), established by Public Act 00-188, whose charge is identical to DCF, specifically to promote and enhance the provision of behavioral health services for all children in the state of Connecticut. This group 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. Several CBHAC members also actively participate in the CT Joint Mental Health Block Grant Planning Council, which is co-chaired by Children's Representatives.

DCF also solicits 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" participate.

Another planning group is The Connecticut Community Providers Association, a member-based organization representing 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. The Connecticut Association of Non-Profits is a collaborative of 500 organizations that 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 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.

DCF, in partnership with DMHAS, 14 other state agencies, the Judicial Branch and the broader stakeholder community continues to focus on transforming the behavioral health system under the aegis of the Mental Health Transformation - State Incentive Grant (MHT – SIG). 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 and the community-based system of care. DCF staff, families, advocacy groups, and service providers are well-represented on 8 workgroups as well as the Oversight Committee and its sub committees. Progress to date is outlined in various sections of this report.

**B. SUMMARY OF AREAS IDENTIFIED AS NEEDING ATTENTION IN FFY 2007
STATE PLAN AND MOST SIGNIFICANT ACHIEVEMENTS IN FFY 2007**

Service Gridlock

Connecticut's behavioral health system, like state systems around the country, is overextended. Community-based services as well as various levels of inpatient care are often insufficient to meet the ever-increasing needs. The lack of accessibility is multi-layered and includes a shortage of existing services, wait lists, over reliance on emergency departments at local hospitals, and barriers to obtaining flexible financing for services.

With the introduction of the Ct BHP in January 2006, Connecticut now has a single organization, Value Options, Inc. with expertise in behavioral health services management to authorize and monitor various types and levels of care for Husky Part A and Part B children as well as DCF involved children who are not Medicaid eligible. Although the work of the CT BHP will not cure "gridlock," it will enable us to better utilize our existing resources, identify service gaps, and track performance. DCF and the broader stakeholder community have joined the CT BHP and worked aggressively on several fronts during the past year. Progress has been achieved in the following areas.

- Increased understanding of the Medicaid target population that requires various levels of care, where they originate, and why, based on an analysis by the CT BHP and a report entitled, *Use of Emergency Departments For Mental Health Care For Connecticut's Children A Rising Tide*, by the Child Health and Development Institute of Connecticut, Inc., 2007.
- Implementation of an authorization process that more closely assesses the need for all levels of care against the approved CT BHP Level of Care Guidelines.
- Implementation of the Residential Care Team (RCT) staffed by CT BHP, DCF and the Judicial Branch's Court Support Services Division to review all referrals for residential or group home care against the CT BHP Level of Care Guidelines and recommend placement matches at clinically appropriate facilities. Alternative plans are recommended for children who do not meet the criteria or for whom there is no immediate vacancy.
- Implementation of the Child and Adolescent Needs and Strengths (CANS) inventory to match the clinical needs of the child to an appropriate clinical program at the "right" level of care.
- Continuation of bi-weekly clinical rounds to oversee and manage the placement of children into available residential and group home treatment facilities.
- Implementation of a tracking system for children in "delayed discharge status" at inpatient facilities to identify alternative services and to facilitate discharge planning when delays are unacceptable. Approximately 30% of the children/youth in these facilities are awaiting step-down services. To expedite access to lower levels of care, some gate-keeping processes have been eliminated.

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- Enhanced oversight of use of emergency departments at local hospitals
 - Intensive inpatient bed tracking system on a daily basis; and
 - Implementation of an automated web-tracking system to identify bed availability across the state, effective 7/01/07.
- Assignment of Intensive Case Managers to proactively call emergency departments statewide to identify any children who may have presented for care and are experiencing difficulties with dispositions, and to assist in securing community resources to mitigate the need for out-of-home placement to the maximum extent possible.
- Assignment of Intensive Case Managers to the most challenging, complex cases, as appropriate.
- Increased access to outpatient psychiatric services for children through the CT BHP's designation of 18 providers as Enhanced Care Clinics. These providers must eliminate wait lists and meet triage protocols that include timeliness standards for access, based on level of acuity, effective 9/01/07.
- Implementation of a child-specific review process for all children ages 12 and under who are in congregate care settings, and over time, serving this age group predominantly through care provided in family-like settings, thus averting congregate care placements.
- Development of a budget option for State Fiscal Year 2008 to increase funding and redesign Emergency Mobile Psychiatric Services (EMPS).
- Development of Memorandums of Understanding between EMPS providers and the local hospitals to increase diversion from emergency departments and to allow for follow-up clinical services by EMPS staff.
- Expansion of community-based therapeutic group homes as an alternative to more restrictive placements. To date 39 homes have been opened with a bed capacity of 180. An additional 15 homes are planned to serve 75 more children and adolescents before the end of the calendar year.
- Expansion of intensive home-based clinical services designed to enable children and adolescents to remain at home with their families, both to avoid the need for hospitalization/residential treatment, or to successfully transition home when out-of-home clinical treatment has been completed.

Service Gaps/Unmet Needs

Several unmet service needs were identified in the FFY 2007 State Plan. These included limited access to: outpatient psychiatric clinics for children; psychiatric medications and medication management; intensive in-home services; care coordination services; mentoring

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and therapeutic support services; and respite services. During the past year there has been an extensive expansion of community-based services, with a current annual expenditure of over 250 million dollars. Areas of expanded service capacity include outpatient psychiatric clinics for both clinical treatment and psychiatric medication evaluation and management through the Enhanced Care Clinic initiative, intensive in-home services, and therapeutic group homes, as described in the preceding section, Service Gridlock. Further, there was a conversion of Intensive In-Home Child And Adolescent Psychiatric Service For Children (IICAPS) to a fee-for-service model to allow for service expansion.

Further, plans are underway to issue a Request for Proposals for the development of a new model for mentoring and therapeutic supports, referred to as Life Coaching (LC). LC is the delivery of behavioral guidance, advocacy and education interventions by trained adults to support habilitation and skill-building in children and adolescents with SED, in partnership with youth, family and other key caregivers, and in furtherance of the therapeutic goals and objectives of the child's individualized service plan. LC will be delivered by community agencies certified as providers, following rules established by DCF and DSS.

Flex funds have been significantly increased to address service gaps and unmet needs. These funds may be used for a variety of needs including behavioral health services. Expenditures are tailored to the unique needs of the child and family, as defined in the individualized treatment plan. Enhanced funding occurred in the following areas.

- Addition of 1.4 million dollars for flex funds that is available for those youth who have psychiatric disorders and are involved in the juvenile services system. These resources are designed to enable access for all types of services, both traditional and non-traditional.
- Addition of 1.5 million dollars of flex funds for children and youth with psychiatric disorders who are served through the local systems of care/community collaboratives.
- Establishment of service definitions, standardized rates and a credentialing system to achieve more effective and efficient use of the flex funds for child welfare services, in the amount of 20 million dollars.
- Selection of a provider, Advanced Behavioral Health to serve as a fiduciary for flex funds and to track disbursements.

Development of Systems of Care/Community Collaboratives

The FFY 2007 state plan cited significant variance in the development of the community collaboratives. To build stronger, more effectively functioning collaboratives across the state, advances have been made in the following areas.

- Re-institution of pre-service training, in-service training and follow-up coaching for care coordinators, family advocates, and key system of care participants utilizing block grant funds. Statewide training was delivered in February 2007 by Mary Jo Meyers from Wrap Around Milwaukee and consisted of the following components:

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- Basic Care Coordination Training – 2 days; and
 - Coaching and Mentoring - 4 Sessions.
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- Initiation of planning for a pilot project to focus on intensive implementation of wrap-around services at four sites throughout the state, to be funded by the MHT- SIG grant and the Ct Health Care Foundation. This includes infrastructure support such as data collection, evaluation, and training.
 - Initiation of planning for a Family Leadership Training to be provided under the Workforce Development Committee, funded by the MHT - SIG. Parents are considered part of the workforce for wrap-around services and delivery of care.
 - Establishment of a multidisciplinary committee to update and enhance the Practice Standards for Systems of Care/Community Collaboratives to improve consistency and quality of care.
 - Development/implementation of 15 Local Area Development Plans (LADP) that identify goals and action steps designed to support local area system development and service expansion.

System Coordination and Accountability Across Agencies

The current system is multi-faceted and complex involving many parties and sectors including public-private, specialty-general health, and health-social welfare. The system is also financed from many funding streams, adding complexity. Families often struggle to understand the system and professionals often fail to integrate their treatment plans and support services with other involved stakeholders. To achieve enhanced collaboration and coordination, advances have been made in several arenas.

- The CT BHP is working to ensure active membership from other state agencies, private foundations, schools, and diverse stakeholder groups.
- Value Options' system managers work within community collaboratives, Managed Service Systems, and area office advisory committees to develop linkages between providers, identify and engage new providers to join the CT BHP, and initiate outreach to schools, police, faith-based organizations, and others to solicit support and integration of service activities.
- Care coordinators have developed collaborative approaches with other state agencies, schools, and service providers. This model includes a unitary (i.e. cross-agency) care management/coordination approach.
- At the local level, the CT BHP staff encourages a review of each child's Individualized Education Plan (IEP) by the appropriate area office staff and the community collaboratives in order to coordinate care and leverage resources.

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- The CT BHP is actively advancing relationship-building and shared treatment planning between outpatient psychiatric clinics for children and primary care physicians through a newly established requirement under the Enhanced Care Clinic option, to become effective in early 2008.
- To assure accountability for the delivery of service supports such as wrap-arounds, DCF developed a certification regulation that grants authority to certify and monitor non-traditional services that are financed by flex funds.

Integration of Resources, Knowledge and Strategies across Advisory Groups

- Efforts have been made to strengthen the relationship between the Joint MH Planning Council and CBHAC as evidenced by routine shared reporting and the establishment of a Joint Council Subcommittee to work collaboratively to address the issue of transitioning youth that cuts across both service systems.
- The Joint Planning Council has made a resolution, based on a recommendation resulting from the NAMHPAC training to develop strategies to link with other advisory groups.
- The CT BHP has completed an inventory of the state's advisory groups and is assessing the mandates, roles, and responsibilities of each entity as well as developing strategies for achieving an integrated approach to system review and reform.
- The MHT – SIG has resulted in bringing together members representing diverse advisory groups in addition to the broader stakeholder community to share information, strategies and knowledge.
- The Behavioral Health Oversight Council, created under recent legislation brings together legislators, providers and families, many of whom serve on various advisory boards. These members are sharing their knowledge and expertise, and working together to improve the statewide service system.

Organizational Redesign – Central Office/Area Offices

The Department's transition from decentralized operations at each area office to centralized core functions such as fiscal services, contract management, program development and program management at central office created significant challenges for many staff. The familiar ways of doing business were no longer acceptable and necessitated adjusting to multiple changes. To address some of these issues, several activities have occurred.

- The Office of the Commissioner established an internal Provider Relations Strategy Workgroup in early 2007, comprised of central office and area office managers. The goal is to improve partnerships with providers through enhanced internal central/area office communications to ensure consistency of messages and enhanced provider relationships.

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- The area offices have gradually achieved increased autonomy that supports decision-making at the local levels through collaborative relationships with the larger stakeholder community.
- The Bureau of Behavioral Health and Medicine’s clinical managers were recently hired and play a key role in serving as adjunct support staff for the area offices for the array of community-based behavioral health programs and services. Primary functions include program development, program management, and clinical oversight.

C. NEW DEVELOPMENTS AND ISSUES AFFECTING MENTAL HEALTH SERVICE DELIVERY IN CONNECTICUT

Emergency Mobile Psychiatric Services (EMPS) - Redesign. Planning is underway to further evaluate and redesign these services. Feedback is being solicited from the broad base of stakeholders and will be utilized to influence the model of care design. The goals are to increase utilization, enhance relationships with hospital emergency departments, police departments, schools, and other initial responders, and increase community mobility. The intent is to assess and divert children and youth from hospital emergency departments and inpatient behavioral health services. Examples of tasks will entail an examination of the current hours of operation to ensure appropriate and sufficient coverage, especially during evenings and weekends.

Enhanced Care Clinics - Expansion. A subclass of mental health and substance abuse clinics, referred to as Enhanced Care Clinics have been established by the CT BHP for the purposes of improving timelines of access to behavioral health care and improving the quality of care. These clinics will receive fees that are, on average, 25 percent higher than the standard Husky A and B Medicaid fees for routine outpatient mental health and substance abuse services. Following the release of a Request for Proposals, twenty-nine providers were designated as Enhanced Care Clinics in April 2007. Eighteen of these clinics deliver psychiatric services for children and families. These clinics must meet the following access requirements by September 2007.

Access Requirements	Timeframes
Centralized Point of Access - All clients are screened, triaged and designated as either emergent, urgent or routine.	Clinics must accept telephonic and walk-in referrals during business hours. Referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine.
Emergency screening and crisis assessments of walk-in or telephonic crisis clients	Clients who present telephonically and are designated as emergent should be directed to come to the clinic immediately. Whether telephonic or walk-in, client should be seen within 2 hours of presentation to clinic.
Urgent outpatient evaluation visit	Client should be scheduled to be seen for initial evaluation within 2 calendar days of presentation at clinic.
Routine outpatient evaluation visit	Client should be scheduled to be seen for initial evaluation within 14 calendar days of presentation at clinic.

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Emergent, Urgent, Routine outpatient follow-up visit	Client should be scheduled for follow-up visit, if appropriate, within 14 calendar days of initial evaluation.
Extended Hours of Operation	Clinics must add 9 hours to regular business hours of 8:00 to 5:00 (evenings, early mornings, weekends)
After Hours Coverage	Clinics must have an answering service or a clinician on-call to respond to calls outside normal business hours. Clinics must provide telephonic access to the on-call clinician for clients in crisis. The on-call clinician must have access to a schedule of urgent visit appointment slots available the next 2 calendar days.

There will be a second opportunity for providers to apply to become an Enhanced Care Clinic during the summer of 2007. Additional requirements will be phased in over the next two years and will include: coordination with primary care providers; member services and supports; evidence-based practices; co-occurring treatment capabilities; clinical specialty areas; and cultural competence.

Extended Day Treatment – Model Development. DCF has contracted with the CT Center for Effective Practice and The Yale Consultation Center to conduct research and develop recommendations for a standardized model of care for the statewide Extended Day Treatment (EDT) program. The intent is to define the range of behavioral health treatments and rehabilitative support services for children and adolescents who have multiple, complex psychiatric disorders, and the types of services and supports for their parents and other caregivers. This will be accomplished through building on the strengths of the existing EDT programs, addressing the collective feedback that was received from the broad base of stakeholders last summer through focus groups and surveys, and incorporating research-based evidence regarding the most effective treatments and interventions. The goals are to: 1) reduce variability regarding the menu of clinical services, the service delivery structure, and the application of policies and practices; 2) improve the quality of care through increased clinical effectiveness; and 3) identify, track and evaluate outcomes that support recovery and strengthen families. Simultaneously, the Department is working closely with the Ct BHP to: a) discuss the role of EDT within the System of Care's continuum of services; b) review the Level of Care Guidelines for EDT; and c) explore strategies for creative, flexible Medicaid funding to support a clinically robust program.

Shelter to Short-Term Assessment and Respite (STAR) Homes - Conversion. During the past year DCF succeeded in redesigning the emergency shelter level of care. The new model of care, Short Term Assessment and Respite (STAR) Homes offers children and youth many advantages over the previous system. There are now 10 shelters that provide smaller, home-like settings. Each shelter has a six-bed maximum capacity and is located in geographic proximity to where the children live and/or the DCF Area Office that supports them. An array of on-site clinical services are provided, which are gender-specific and trauma-informed. For the upcoming year DCF will add 4 STAR homes.

Preparing Adolescents For Self-Sufficiency (PASS) Group Homes. Level 1.5 – Conversion. During the past year the Department issued a Request for Proposals to convert

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the Level 1.5 Group Homes to a newly designed model of care, known as PASS Group Homes. These are community-based residences, serving 6 to 10 youth, ages 14 to 21 who present with mild to moderate emotional problems including, but not limited to trauma histories. Programming focuses primarily on the acquisition of independent living skills such as interpersonal awareness, community awareness and engagement, knowledge and management of medical conditions, maximization of educational, vocational and employability/employment skills, and community reintegration. Staff includes transitional living coordinators, educational/vocational specialists, transitional coaches, and registered nurses.

SAFE Homes – Transfer of Program Management. The programmatic oversight of SAFE Homes was transferred from the Bureau of Behavioral Health and Medicine to the Office of Foster Care Services, effective January 2007. Established over six years ago, these homes provide assessment, stabilization and effective discharge planning over a 45-day period to mixed gender children primarily ages 3 to 12, including sibling groups. The purposes of the SAFE Homes are to place more siblings together, keep children within their communities, return children whenever possible to parents or relatives, and when placement is necessary, ensure an appropriate permanent plan as quickly as possible to avoid multiple placements. These services require closer integration with the foster care services system, thus necessitating the transfer of responsibilities. The Area Office Safe Home Liaisons will work closely with the Behavioral Health Program Directors, Area Resource Groups, and Child Protective Services staff to monitor and move children appropriately from Safe Homes.

Therapeutic Group Homes - Expansion. As of May 1, 2007, 39 therapeutic group homes have been opened with the capacity to serve 180 youth. Approximately 15 additional homes are being developed for specific children or adolescents during the remainder of the calendar year. These homes will serve an additional 75 children and adolescents, for a total capacity of 255. These youth are of both genders, various age cohorts, and present with a broad range of challenges including multiple psychiatric diagnoses, behavioral difficulties, developmental delays, relationship issues, and trauma histories.

These are small (4-6 bed) programs located throughout the state in residential neighborhoods that are indistinguishable from private residences. The goal is to facilitate community integration through public education, recreation, volunteer activities, vocational opportunities, and social activities. In addition, the homes provide a living setting that is far closer to a “normal” family existence than is possible to provide in larger campus residential settings. A youth’s ability to live in a manner that is closer to normal allows greater possibility for successful transition back to a family setting or to some form of independent living as young adults.

Providers deliver an array of clinical and related services within the home including: therapy (individual, group, and family—whenever possible); nursing supports; ongoing psychiatric assessment and intervention (by a psychiatrist); recreational activities; integration with community resources (social, vocational, etc.); life skills taught within the context of the home. Since close to 100% of the youth being served have some history of trauma (including the trauma of disrupted attachments), all homes have some focus on addressing

the history of trauma that these youth bring with them. The model being used in the homes is relational, geared toward repairing and improving relationships that these youth have with those around them.

Provider Training – Dialectical Behavior Therapy and Trauma-Focused Cognitive Behavioral Therapy.

DCF has secured two vendors to deliver extensive training and consultation on these two well-established evidence-based practices during 2007 and continuing into 2008. The training will be offered to providers across diverse practice settings, both outpatient and inpatient. The purpose of the initiative is to increase access to and availability of trauma-specific, evidence-based treatments. Many clients who are served at outpatient clinics, group homes, and residential treatment centers have experienced significant trauma and will benefit from these treatment modalities.

D. LEGISLATIVE INITIATIVES AND CHANGES

The following bills received much scrutiny and study during this year’s legislative session. These bills were incorporated into a budget implementation bill that received final approval on June 28, 2007.

SB 1196 – An Act Concerning The Age Of A Child For Purposes Of Jurisdiction In Delinquency Matters And Proceedings

This bill permits offenses involving 16- and 17-year olds to be adjudicated in juvenile court. Current law requires that these cases be handled in adult criminal court. Existing law, unchanged by the bill, (1) requires juvenile cases involving serious felonies to automatically be transferred to adult court and (2) allows prosecutors to ask juvenile court judges to transfer any other case to adult court.

The bill also eliminates the Youth In Crisis program which currently provides services and limited court order enforcement for 16- and 17-year olds who are truant, run away from home, or are beyond their parents' control (i. e. status offenders). It instead makes these youngsters eligible for the Family With Service Needs (FWSN) program. This program currently serves status offenders under age 16 and generally offers a wider range of services. The law forbids courts from placing FWSN children in juvenile detention facilities or finding them delinquent solely on the basis of a FWSN order violation. The same is true for youth in crisis under current law.

The bill also amends the definition of “youth.” Current law defines a youth as any person 16 or 17 years of age. Under the bill, a youth is any person 16 or 17 years old who (1) has, without just cause, run away from the parental home or other properly authorized and lawful place of abode, (2) is beyond the control of the youth's parents, guardian; or other custodian; or (3) has four unexcused absences from school in any one month or 10 unexcused absences in any school year. This is the current definition of “youth in crisis” that the bill repeals.

HB 5676 – An Act Concerning Children Of Families With Service Needs

The bill expands diversion services and court options for families with service needs (FWSN). Generally, these are families with children under age 16 who have committed status offenses such as running away or truancy.

The bill mandates that children who are the subject of court FWSN complaints be referred for services before any further court action is taken. These youth can no longer be detained for violating a court order. Of the 4,000 referrals per year, it is estimated that 900 are at high risk to be detained, and on average 300 are detained. Although the state budget includes funds for the establishment and evaluation of a network of family support centers, expanded respite beds, and expanded alternative detention beds, there are too few resources to manage the needs of the population. Primary responsibility rests with the Judicial Department's CSSD, however, there are likely to be increased court orders for temporary custody and emergency placements vested with DCF. This will require additional resources including behavioral health services and increased liaison work with involved parties.

The bill also lengthens the time that courts can suspend formal FWSN proceedings and refer a child and family for further services. But it limits the circumstances under which courts can order a FWSN child's commitment to the DCF's custody.

E. DESCRIPTION OF REGIONAL/SUB-STATE PROGRAMS, COMMUNITY MENTAL HEALTH CENTERS AND RESOURCES OF COUNTIES AND CITIES TO THE PROVISION OF MENTAL HEALTH SERVICES WITHIN CONNECTICUT

Connecticut has developed a broad range of comprehensive clinical treatment, related support services and rehabilitative interventions designed to assist and support children with SED and related psychiatric disabilities and their families. DCF either directly operates or provides grant funds and oversight for these services that are delivered by providers at the regional and local levels in accordance with the system of care philosophy.

Inpatient Clinical Services (These facilities are operated and managed by DCF.)

- Riverview Hospital. The agency operates a 98 bed psychiatric hospital for children, ages 5 to 17. Intensive 24-hour care and treatment is provided for children who demonstrate an emotional disturbance, mental illness, personality disorder, or a high risk of danger to self or others.
- High Meadows. This is a 42 bed residential treatment program for severely emotionally disturbed adolescents, ages 12 to 17 that require intensive, structured and comprehensive services 24 hours per day.
- The Connecticut Children's Place. DCF operates a 54 bed residential center that provides diagnostics, brief treatment, and educational services for children, ages 10 to 18 who are in need of protection due to child abuse and/or neglect, unmanageable behavior or sudden disruption in a current placement or residence, until such time as permanent placements can be secured. Length of stay is typically 3 months.
- The Connecticut Juvenile Training School. This is the only state facility for adjudicated youth, ages 11 to 16. The length of stay is determined by the seriousness of the delinquency classification, the behavioral adjustment of the child, the level of risk and special needs, and the availability of a less restrictive placement.

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- DCF also licenses and/or contracts with in-state and out-of-state residential treatment facilities. Reducing reliance on this level of care remains a priority for DCF.

Outpatient Clinical Services (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 11 to 17 with behavioral health needs. These grant-funded providers conduct evaluations and assessments, provide short-term residential treatment, and offer a cluster of services including clinical support, medication management, and aftercare to children and youth to avert out-of-home placement.
- 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. There are 16 grant-funded providers.
- Extended Day Treatment (EDT) Services. DCF contracts with 16 providers to administer 23 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.
- 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.
- Intensive In-Home Services. These services are designed to enable children and adolescents to remain in their own homes, with the goals 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 approximately 2,150 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

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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 280 children/adolescents and their families (biological or foster families).

- Intensive In-home Child and Adolescent Psychiatric Services (IICAPS). For children/youth, ages 3 to 18 with complex psychiatric disorders (DSM-IV Axis 1 diagnosis) who are at imminent risk of hospitalization or who are being discharged from psychiatric hospitalization, the treatment focuses on psychiatric symptoms within an eco-systemic model for a period of less than six months. DCF involvement is not required. Currently, there are 14 IICAPS providers statewide that deliver services to approximately 500 children and families on an annual basis. During the July 2005 – June 2006 fiscal year, 598 children/adolescents and their families received IICAPS services.
- Intensive Community Family Support Service Programs (ICFSS). Clinical support services are provided to children, residing in the city of Hartford, who have serious emotional, behavioral, and psychiatric and/or substance abuse difficulties and are at risk of requiring out-of-home clinical care or returning home from out-of-home care. These clients are either DCF committed or transitioning from residential care to the community. Services are provided by a multi-disciplinary team and integrate mental health and substance use treatment, medical concerns, social and educational goals. Current annual service capacity for this program is approximately 24 children and families. During July 2005 – June 2006 fiscal year, 30 clients received ICFSS services.
- Multisystemic 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 10 MST Teams, with the capacity to serve approximately 319 adolescents and their families per year. During the July 2005 – June 2006 fiscal year, 313 adolescents and their families received MST services.
- 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. Services are available in New Britain. This program has the capacity to serve

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16 youth and families on an annual basis. During the July 2005 – June 2006 fiscal year, 16 youth and families received this service.

- Multisystemic Therapy – Building Stronger Families (MST-BSF). For children/youth, ages 11 to 18 with delinquent behavior and/or substance abuse problems, the primary work addresses child maltreatment 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. Annual program capacity is 15 youth and families. During July 2005 – June 2006, 15 clients were served.
- 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 available in Hartford, New Britain, New Haven, Manchester, and Norwalk-Stamford. Between July 2006 and June 2007, 143 adolescents and their families were served.

DCF has also partnered with MDFT to develop new MDFT programs which pair traditional MDFT services with parental substance abuse treatment components. Five new programs have been identified and contracts negotiated, with a statewide capacity to serve approximately 125 adolescents and their families on an annual basis.

- 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. Currently, there are 9 MDFT teams, with a capacity to serve approximately 270 adolescents and their families on an annual. During the July 2005 – June 2006 fiscal year, 143 clients received MDFT services. (The number of cases served was lower than current capacity due to the fact that expansion was implemented during the fiscal year.)
- 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. During 2006 DCF expanded this service statewide. Currently there are 4 FST programs, with a capacity to treat approximately 350 children and their families on an annual basis. During the July 2005 – June 2006 fiscal year,

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108 children and their families received FFT services. (The number of cases served was lower than current capacity due to the fact that expansion was implemented during the fiscal year.)

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. An additional FFT program is planned for serving youth on parole from Bridgeport, Norwalk and Stamford areas. These expansions will add capacity to serve approximately 185 youth and their families per year.

- 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 does not require DCF involvement and is offered in New Haven, New Britain, Bridgeport, Waterbury, and Norwich. Six FBR programs have been identified and contracts negotiated, with a statewide capacity to serve approximately 72 infants and their families per year. Initial FBR services became available in January 2007, with increased capacity planned throughout the remainder of the year.
- Substance-Abusing Families at Risk (SAFAR). This program provides case management and support services to families with young children, about half of whom are involved with DCF.
- Outpatient Psychiatric Clinics for Children (Child Guidance Clinics). DCF maintains grant-funded contracts with 25 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.
 - Enhanced Care Clinics. Through the CT BHP a subclass of mental health clinics, referred to as Enhanced Care Clinics has been established to enhance access and improve the quality of care. To date 18 clinics have received approval status. These clinics will be required to meet specific access requirements, effective September 1, 2007.
 - Specialty Clinics. Some clinics offer specialized services to treat Problem Sexual Behaviors, Obsessive-Compulsive Disorders, Pervasive

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Developmental Disorders, Traumatic Stress Disorders, and Tourette's Disorder.

- Substance Abuse Clinics. Several clinics also provide outpatient substance abuse evaluation and treatment services.

Community Support Services

- Care Coordination Services. These services are provided to children and youth enrolled in Husky Part A and Part B and DCF's Voluntary Services Program who have complex service needs and require Level III Care Coordination. Services include assessment, service planning via the Child Specific Team, and service brokering.
- Family Advocacy Services. FAVOR is a statewide organization that has been created to educate and support families in their advocacy efforts. Emphasis is placed on empowerment, cultural competency, family strengths, parent/consumer leadership and self-determination. Paid and volunteer family advocates work in tandem with care coordinators to aid in producing positive outcomes for children with SED and their families. Member agencies include: African Caribbean American Parents of Children with Disabilities; Families United for Children's Mental Health, National Alliance for the Mentally Ill of Connecticut (NAMI-CT), and Padres Abriendo Puerta (PAP).
- Respite Services. Respite service providers offer temporary care in the home or community to children and adolescents, under age 18, who have emotional and/or behavioral needs that require constant attention from their caregivers. This is intended to prevent family disruption by reducing stress and burnout by caregivers and to provide age appropriate social and recreational activities. Respite care is intended for DCF involved children and non-DCF involved children from the local systems of care.
- 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 Foster Care Services. For DCF-involved children and youth who need specialized foster care, this is a family-based service delivery approach providing individualized treatment. The treatment focus is on emotional and behavioral issues that prevent the child/youth from participating fully in family and community life. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by treatment foster parents who are trained, supervised and supported by qualified contractor staff.

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- 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.
- Therapeutic Mentoring. Through a one-to-one relationship between a trained, supervised, caring adult mentor and a child with significant mental health issues, usually ages 5 to 17 who is involved in the local System of Care, interventions are developed and tailored as part of an individualized treatment plan. The adult serves as a role model and offers support and guidance, and assists the youth to identify career options and evaluate educational alternatives. This service is primarily for youth who have returned or are returning from out-of-home care. There are several mentoring initiatives for various target populations including youth at the Connecticut Juvenile Training School, gay/lesbian/bi-sexual/trans gender youth, and children in out-of-home placement through the child welfare bureau.
- Wilderness School (DCF-Funded and Operated). This is a therapeutic wilderness challenge program for troubled male and female youth from Connecticut. The program is designed to teach self-reliance and responsibility as well as to improve self-esteem

Other Specialized Resources

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 the following specialized services that have clinical components: two 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; and staffed apartments with supported work, education and transition programs for committed adolescents who are exiting care.

Staff from the Adolescent and Transitional Services Bureau focuses activities on preparing adolescents for successful adulthood. Some examples of services and programs include: life skills classes; post high school education program that provides financial assistance for post-secondary education and/or vocational training; provision of laptops for every child who enters a post-secondary academic program; semi-supervised subsidized housing; and the Jim Casey Initiative that assists youth aging out of foster care in the areas of youth leadership, youth engagement, employment, housing and physical/mental health.

- 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.
- Medical/Health Services. DCF is responsible for assuring that children in its care and custody receive optimal health care. The administration of health care is overseen centrally and carried out at the area office level. Health care standards, policies, procedures and programs are developed and implemented in accordance with the criteria established by the American Academy of Pediatrics, federal mandates, state statutes and guidelines.
- 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: supportive, subsidized housing and case management; suicide prevention and education activities; supported local Youth Advisory Boards and a Statewide Youth Advisory Board; and mental health consultation to child care agencies.
- 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.

F. **DESCRIPTION OF HOW DCF PROVIDES LEADERSHIP IN COORDINATING MENTAL HEALTH SERVICES WITHIN THE BROADER SYSTEM**

DCF continues to lead statewide efforts to transform the behavioral health service delivery system in Connecticut. Through partnering with the entire stakeholder community, DCF seeks to ensure an integrated behavioral health system that offers a full continuum of accessible, high quality, effective services. DCF acts as a catalyst for systemic change at multiple levels.

DCF continues to consistently promote the expansion of the system of care model across the state. Significant DCF behavioral health resources are dedicated to this mission. A commitment has been made at the state level to update the curriculum and provide enhanced training for the network of providers during the next year.

DCF serves as a leader in promoting the dissemination and adoption of evidence-based practices. This includes the development of an evidence-based culture and large-scale organizational and systemic changes. The goals are to: a) raise awareness about evidence-based practices; b) identify and support adoption and implementation of evidence-based and best practices across the service types; c) assure that fidelity monitoring, evaluation and quality assurance activities are included; and d) support the development of infrastructure and related mechanisms for adoption and sustainability. Commencing in 2007 and

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continuing into 2008 DCF will sponsor provider training to advance the dissemination of two trauma-sensitive treatments, Dialectical Behavior Therapy and Trauma-Focused Cognitive Behavioral Therapy.

An evidence-based model of care is being developed for the Extended Day Treatment programs throughout the state. DCF has led the way by conducting stakeholder surveys and focus groups during 2006 to assess the current status of EDT programs and during 2007 by engaging the providers and other stakeholders in extensive dialogue for planning an improved model of service. The Child Health And Development Institute/Connecticut Center for Effective Practice has been selected to conduct further research and develop recommendations.

DCF continues to work in partnership with the CT BHP to advance access to services and the quality of care through an integrated approach. A key behavioral health executive and management position is dedicated to this task. Staff participate on the Oversight Council as well as the four subcommittees. Staff jointly share responsibilities for planning, implementing and evaluating services and programs.

Strong partnerships exist with several state agencies. For example, DCF and the Judicial Branch's CSSD work collaboratively to develop programs, train and create a stronger nexus between juvenile justice and behavioral health services. We continue to work together to assure that all provisions of the settlement agreement for the Emily J. lawsuit are developed and achieved in a timely, meaningful manner. DCF continues to partner with DMHAS and DMR to assure smooth transitions for those youth who are aging out of the DCF service system and entering these adult systems, as described earlier. Another example is the strong linkages with the CT Department of Labor to plan employment and related support initiatives for older youth.

For the past year, DCF staff has partnered with DMHAS, 14 other state agencies and community stakeholders including consumers and families to plan and implement activities under the MHT SIG, which are aimed at a true transformation of the statewide mental health system. Further details of the progress to date may be found under Section III.

DCF staff serves on numerous interagency work groups, committees and other decision-making bodies. Examples include: Children's Behavioral Health Advisory Committee (CBHAC); Joint State Mental Health Planning Council; CT BHP Oversight Committee and Subcommittees including Quality Management and Access to Care; Operations; Provider Advisory; DCF Advisory; and Coordination of Care; Medicaid Managed Care Council; Psychotropic Medication Advisory Committee; Northeast Telemental Health Advisory Committee; CT Workforce Investment Boards (Department of Labor); Governor's Prevention Partnership; CT Coalition to End Homelessness; and Ad Hoc Committee To Improve Health Care Access Through School-Based Health Centers (convened by Senate Bill 317, S51) to examine and evaluate statutory and regulatory changes to improve health care through access to school-based health centers.

SECTION II

A. DISCUSSION OF THE STRENGTHS AND WEAKNESSES OF THE BEHAVIORAL HEALTH SERVICE SYSTEM

The behavioral health service system has been expanded and enhanced in numerous ways during the past few years. There are many strong features that contribute to a more complete and effective service delivery system, yet there are continued opportunities to address challenges. These are summarized below.

Major Strengths

There is a steadfast commitment that children and families should receive services in their homes and communities, whenever possible and that parents and families must be an integral part of the planning, treatment and decision-making process. These are the core values of the Connecticut Kid Care philosophy and are carried out in practice through the systems of care/community collaboratives.

- There are 25 community collaboratives that serve children with SED and their families. They play a critical role in their local communities through the coordination and delivery of behavioral health services.
- The 15 Managed Service Systems, affiliated with the DCF local area offices, serve a lead role in assessing and coordinating services for those DCF-involved children and youth who have complex behavioral health issues and are at risk of entering out-of-home care.
- There are additional local resources available that support maintaining children in their own communities. These include but are not limited to: care coordinators, intensive care coordinators, family advocates, family and peer specialists, system managers, intensive case managers, DCF behavioral health program managers, and DCF Area Resource Group (ARG) specialists.
- Community collaboratives have access to flex funds to meet the multiple, non-categorical needs of children and families.
- The state supports a broad array of community-based services, with a total allocation in excess of 250 million dollars.
- There has been a significant expansion of community-based services including therapeutic group homes, intensive in-home services and other service types.
- Connecticut has an impressive array of evidence-based practices, as outlined in Section 1.
- DCF has embarked on a multi-year training initiative to support the expansion of trauma-sensitive evidence-based practices, specifically Dialectical Behavior Therapy for congregate care and residential treatment providers and Trauma-

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Focused Cognitive Behavioral Therapy for providers of outpatient psychiatric clinics for children.

- The newly created statewide family advocacy network, FAVOR, Inc. continues to gain recognition and has successfully represented the voice of families, their perspectives and priorities, and their presence at local and statewide meetings that focus on system development and improvements.
- The CT BHP has focused the system's attention on increasing access to quality behavioral health services and identifying system needs. The following initiatives have resulted in expanded access: funding of Intensive In-Home Child And Adolescent Services (IICAPS) under Fee-For-Service Medicaid; implementation of the Enhanced Care Clinic Option; and use of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) option to expand the range of services covered under Medicaid.
- The CT BHP Oversight Council, which is a collaborative, legislatively mandated body that includes legislators, behavioral health consumers and advocates, medical and mental health practitioners, state agencies and insurers, continues to assess the development and ongoing implementation of the CT BHP. There are five working subcommittees that include: Coordination of Care; DCF Advisory; Provider Advisory; Quality Management and Access to Care; and Operations.
- Through the leadership of the CT BHP, 15 Local Area Development Plans have been approved. These identify system of care issues as well as recommendations for improvements. These plans provide a road map for working collaboratively at the local levels to improve the system.
- There are strong and sustained collaborations among service sector members including providers, state agencies, school personnel, juvenile justice staff, CSSD personnel, child welfare staff, and other stakeholders.

Major Weaknesses

- There continues to be a lack of service capacity to meet the needs. The availability of services varies statewide. Not every community has access to all services, and many communities have limited availability for specific service types.
- Service gridlock across the traditional levels of care continues to exist. Critical areas include emergency departments at local hospitals, inpatient psychiatric facilities, psychiatric residential treatment facilities, group homes, partial hospitalization programs, outpatient services, in-home services, and extended day treatment programs.

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- We continue to be over-reliant on providing care in institutional settings, due to a failure to develop sufficient foster care resources and adequate, sufficient or appropriate early intervention services to mitigate these needs.
- There is continued fragmentation across service systems. These include but are not limited to: prevention/early intervention; child welfare; juvenile justice; behavioral health; primary care; CSSD; DMHAS; and DMR.
- There are too few qualified, trained behavioral health professionals.
- Workforce issues contribute to barriers to timely, appropriate and quality care. These include high caseloads, recruitment and retention issues related to low wages and limited benefits, and insufficient funds to support robust training initiatives.
- The quality of care is variable across service types and providers. There are limited providers who have developed an evidence-based culture within their organizations, and there are a small number of providers who are implementing evidence-based practices.
- There is a need to promote trauma-sensitive, trauma-informed care and to train providers accordingly.
- The promotion of family-oriented care is a critical need. Effective strategies must be identified and implemented to increase family involvement in all aspects of care for their child/youth.
- Enhanced efforts are necessary to increase the involvement of families in the conceptualization, design, implementation and evaluation of the service system and related supports.
- There are too few performance indicators and outcome measures to monitor and evaluate the effectiveness of the service delivery system for children and families.
- Enhancements are needed for the Behavioral Health Data System (BHDS) to capture value-laden information that is creditable and can be utilized for informing the system.
- Quality assurance activities are weak across the provider network.

B. ANALYSIS OF THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM, AND IDENTIFICATION OF THE SOURCE OF DATA USED TO IDENTIFY THESE

A comprehensive Mental Health Needs Assessment and Resource Inventory across 14 state agencies and the Judicial Branch was conducted under the direction of the MHT SIG during the past year. This initiative consisted of the following sources of

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information and represents a major source of data to inform the analysis of unmet needs/service gaps for the children’s behavioral health system:

- An extensive review of more than 165 existing reports from state agencies, commissions and interagency task forces, compiled since 2000 related to Connecticut’s mental health system;
- Surveys, interviews and document reviews of 14 state agencies and the Judicial Branch that were signatories to the MHT SIG Memorandum of Agreement;
- Interviews with a sample of Connecticut households to query the prevalence of mental health symptoms, the impact on functioning, efforts or barriers to seeking assistance, and recommendations for system transformation;
- An assessment of provider and consumer perspectives on the current service system;
- A survey of parents and providers related to MHT SIG recommendations;
- A Probabilistic Population Estimation (PPE) to identify areas of overlap between state agency service recipients;
- An inventory of resources of all state agency partners that included mental health related revenue, expenditures and numbers of persons served; and
- An assessment of workforce development needs.

Other sources of data used to identify service needs and gaps included the following:

- CT BHP Reports. Identification of numbers of children served, levels of care, types and amounts of services, and provider types;
- Behavioral Health Data System (BHDS) Reports. Identification of number of clients served, by service type, wait times for services, ages, race, ethnicity, and other demographic variables;
- Stakeholders’ Perspectives: A Report on Extended Day Treatment. Feedback from approximately 200 families and more than 400 stakeholders, through surveys and focus groups to assess the overall status of services across the state; and
- Various Stakeholder Meetings/Forums including Children’s Behavioral Health Advisory Council (CBHAC) monthly meetings, service-specific provider meetings including but not limited to extended day treatment, therapeutic group homes, intensive in-home services, and care coordination.

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The findings are summarized below in relationship to the six major goals of the New Freedom Commission.

NEW FREEDOM COMMISSION GOALS	FINDINGS
Goal 1: Mental Health Is Essential To Overall Health	<ul style="list-style-type: none"> • Too few individuals seek help • Stigma prevents help-seeking behaviors • Minimal understanding of a recovery and resilience-oriented mental health framework • Fragmented data systems • Insufficient funding
Goal 2: Mental Health Care Is Consumer And Family Driven	<ul style="list-style-type: none"> • Too few policies that support consumer and family involvement • Too few youth-oriented, community-based supports • Too few family-centered practices • Limited transportation options
Goal 3: Disparities In Mental Health Care Are Eliminated	<ul style="list-style-type: none"> • Too few gender-specific services • Lack of trauma-informed care/treatments • Insufficient culturally and linguistically appropriate services
Goal 4: Early Mental Health Screening, Assessment, And Referral Are Common Practices	<ul style="list-style-type: none"> • Insufficient supportive policies • Limited coordination with school staff • Few integrated treatments for those with co-occurring disorders • Limited access to and coordination with primary health care providers • Limited resources for young adults transitioning into the adult system
Goal 5: Excellent Mental Health Care Is Delivered And Research Is Accelerated	<ul style="list-style-type: none"> • Heavy use of “high end” services such as hospitalization and residential treatment • Insufficient community-based resources and natural supports • Limited service coordination • Too few evidence-based practices, limited outcome measures and insufficient data collection/analysis
Goal 6: Technology Is Used To Access Mental Health Care And Information	<ul style="list-style-type: none"> • Too many large, unrelated data systems • No single electronic health record

B. PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS

Connecticut plans to continue to develop and implement multiple initiatives to address the unmet service needs and system gaps. DCF's strategic plan focuses on expanding service capacity for core clinical and related support services, while simultaneously aggressively promoting family-oriented care, promoting and supporting evidence-based and best clinical practices across service settings, continuing the development and strengthening of the system of care infrastructure, and supporting workforce development through statewide training initiatives. These priorities are aligned with the activities to be undertaken by the CT MHT SIG and the interests and priorities of the CBHAC.

Expansion of Core Clinical Services

- Emergency Mobile Psychiatric Services. Increased state funding during 2008 and 2009 to expand mobile crisis intervention services on a statewide basis.
- Outpatient Services. Release of second Request for Applications to expand the number of agencies that are approved as Enhanced Care Clinics. This will result in increased services statewide, reduced wait lists and expedited, timely care based on level of acuity.
- Psychiatry Services. The expansion of the network of Enhanced Care Clinics, as described above will support additional psychiatry services through enhanced rates. These services include both medication evaluation and medication management.
- Intensive In-Home Services. Increased state funding during 2008 and 2009 for service expansion. Continued expansion of conversion to Medicaid fee-for-service models to allow for service growth and expansion.
- Mentoring Services. To be renamed Life Coaching Services. Plans are underway to design a fee-for-service model, under the Medicaid Rehabilitation Option to deliver behavioral guidance, advocacy and education interventions by trained adults to support habilitation and skill-building for children and adolescents with serious emotional disturbances, in partnership with youth, family and other key caregivers, and in furtherance of the therapeutic goals and objectives of the child's individualized service plan.

Related Priorities To Support Service Expansion

- Family-Centered Care. DCF plans to intensify its efforts to more fully and actively involve families and consumers in planning and designing the service delivery system, and to provide enhanced outreach and advocacy on a case-specific basis. Further, through the MHT SIG there will be a series of ongoing surveys to solicit the voice of individuals and families regarding mental health care, there will be educational activities relative to consumer rights, and a comprehensive mental health website will be developed to improve access to mental health information and resources.

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- Provider Training - Evidence-Based Practices. DCF plans to sponsor statewide training and technical assistance to advance trauma-sensitive evidence-based practices, specifically Dialectical Behavior Therapy (DBT) and Trauma-Focused Cognitive Behavior Therapy (TF-CBT) in the next two years. We also plan to adopt an evidence-based model of care for the extended day treatment program.
- System of Care Infrastructure. Training for care coordinators, supervisors, family advocates and other key system of care/community collaborative staff will continue.
- MHT SIG Initiative Relating To Juvenile Services. Wraparound services will be provided, through pilot sites to prevent youth from becoming involved or having repeated involvement in the juvenile justice system. Training, coaching, fidelity assessment, administrative support, quality assurance, and outcome data will be included in the evidence-based initiative.
- MHT SIG Initiative Relating to Workforce Development. The intent is to establish a CT Mental Health Workforce Collaborative to expand and enhance mental health training throughout the state.

C. SUMMARY OF SIGNIFICANT ACHIEVEMENTS THAT REFLECT PROGRESS TOWARDS DEVELOPMENT OF A COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM OF CARE

DCF continues to make significant progress in several areas to improve the delivery of behavioral health services to children and their families. Below is a summary of the major recent achievements.

- Development and implementation of the CT BHP and within this Administrative Services Organization, new data collection and reporting capacities.
- Development of a plan for the improvement of Riverview Hospital along with corresponding initiatives and actions.
- Re-design of the process by which residential and group home placements are made, resulting in the elimination of the Central Placement Team and the development of a data-informed process for matching children to the appropriate level of care and service.
- Significant reduction in the number of children placed in residential care. (For the third consecutive quarter DCF met the Juan F. federal requirement that no more than 11 percent of children in DCF care are residing in a residential placement. As of January 2007, there were 201 fewer children in residential care than in April 2004, a reduction of 22.6 percent.)
- Development of a budget option for 2008 to enhance and expand emergency mobile psychiatric services.

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- Elimination of shelters and replacement with smaller, clinically-informed, gender-specific short-term assessment programs.
- Development of more than 50 new therapeutic group homes.
- Continuation of Strengthening Communities for Youth, fourth year of a five year federal project for engaging and treating adolescent substance abusers in the city of Hartford through case management services and in-home family-based models.
- Implementation of the Connecticut Adolescent Treatment Effectiveness Project, a state incentive grant that includes DCF, DMHAS, CSSD, DSS, Department of Corrections, Department of Education, and Department of Public Health, aimed at improving the quality of Connecticut's adolescent substance abuse treatment system and integrating with child welfare and juvenile justice best practice models.
- Development and implementation of a trauma-informed model of behavioral health care for those programs and systems used by DCF-involved children and youth.
- Promulgation of a statewide training initiative for Dialectical Behavior Therapy for staff working in congregate care settings.
- Promulgation of a statewide training initiative for Trauma-Focused Cognitive Behavioral Therapy for clinicians at outpatient psychiatric clinics for children.
- Designation of 18 outpatient psychiatric clinics for children as Enhanced Care Clinics.
- Procurement of a vendor to develop recommendations for an evidence-based model of care for the statewide extended day treatment program, in partnership with providers, parents and other stakeholders.
- Development of a statewide system of enhanced care coordinators and enhanced care coordinating agencies.
- Development, expansion and fee-for-service conversion of Intensive In-Home Child And Adolescent Psychiatric Services (IICAPS) and expansion of other in-home services.
- Increased timeliness of provision of multi-disciplinary evaluations for children entering the foster care system.

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- Development of a statewide system for medication tracking and permission processes.
- Development of a statewide medical services infrastructure with Regional Medical Directors, Regional Pediatricians, and the initiation of planning for a medical home model.
- Promulgation of a statewide array of Local Area Development Plans
- Significant increase in the number of “aging out” children referred to DMHAS and DMR.
- Provision of training for care coordinators and other key staff from the local systems of care/community collaboratives.
- Continued support for the statewide Managed Service Systems.
- Enhanced behavioral health training for DCF social workers through the pre-service requirements, DCF Training Academy.
- Development of logic models for all behavioral health services funded or operated by DCF.
- Development of a statewide plan for the MHT SIG, in partnership with other state and community stakeholders.

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

DCF envisions a transformed community-based behavioral health service system that will make a real difference in the lives of children and their families. The vision requires a commitment to promote the emotional well-being of children and ensure that children with serious emotional disorders have access to a full range of effective treatment and supports that are essential for living, learning, playing, working, and thriving in their communities.

The comprehensive and coordinated children’s behavioral health system includes the following components.

- Prevention and early intervention programs and services, beginning prenatally and at birth are widespread. Primary care providers and systems often serve as the first point of contact. There are routine and systematic screenings and assessments in multiple settings where young children and youth are seen.
- There is an array of home and community-based treatment services and supports to enable children and their families to function optimally at home, school, work, and in the community.

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- There is full participation of, and partnership with families and other caregivers in all aspects of promoting their child's optimal social and emotional development, and overall mental health. Families have the necessary information, resources and supports to manage their responsibilities, and families are partners with state agencies and provider organizations in establishing policies, evaluating programs, and determining resource allocation at the state, regional and community levels.
- Quality services and programs are available to all. These are individualized, family-centered, strengths-based, culturally competent, developmentally appropriate, grounded in evidence-based research and best practices, coordinated and integrated across service systems, and delivered in and across natural settings.
- There is a transformed workforce that operates within a system of care framework. There are no isolated or separate spheres of work between service sectors or within agencies. Further, all professionals who come into contact with children are adequately prepared and trained to promote, identify, refer and/or address children's mental health.
- A range of financing sources is available to support all elements of the comprehensive system.
- An effective, efficient information system exists to produce meaningful, creditable reports that support client-specific, programs/services, and system evaluation.
- Accountability for results includes specific child/family, system and provider outcomes and related performance indicators that are monitored, evaluated, and used for determining continuous quality improvement initiatives.

Overall, children and youth receive the services and supports they need to become independent and productive adults. The goals of The President's New Freedom Commission are realized.

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STATE OF CONNECTICUT

PART C SECTION III FFY 2008 State Plan



Performance Goals and Actions Plans to Improve the Service
System

CHILDREN SERVICES SECTION

September 1, 2008

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A. INTRODUCTION

Connecticut's one-year plan responds to the requirements of PL 102-321 that provides block grant funds to states to establish or expand an organized community-based system for improving mental health services for children with serious emotional disturbance (SED). The plan includes a description of the State of Connecticut's behavioral health system for children, addresses the consolidated five criterion including transformation activities, identifies goals and fiscal year targets for the National Outcome Measures (NOMS), and specifies the proposed expenditure of block grant funds for FFY 2008.

Connecticut's plan is consistent with the Department's mandate to ensure the well-being of all children and adolescents through the provision of child protection, juvenile justice, prevention, substance abuse and mental health services. For the past few years, the Department has been reforming its behavioral health system by working collaboratively with the broad array of stakeholders, especially consumers and families to assure the availability of effective, appropriate and integrated community-based services and programs. This reform, *Connecticut Community Kid Care* is operationalized through a system of care framework. Services are family-centered, individualized, culturally competent, strengths-based, and cost-effective. Services are coordinated through a network of twenty-five community collaboratives, under the direction of care coordinators who serve children with SED and their families, and the Managed Service Systems (MSS), that are located in each of DCF's area offices. The MSS teams target children involved in the child welfare and voluntary services systems by providing a forum for key stakeholders to review the clinical needs of all children in residential care and plan for and develop community-based alternatives.

The CT BHP has adopted the vision, values and principles of Kid Care. The goals are to increase access to community services and deliver quality services to prevent unnecessary care in more restrictive settings. Within the past year there has been an increased focus on clinical treatment and discharge planning, especially for children leaving emergency departments and state/private hospitals and residential treatment facilities. Children are tracked across service types and treatment outcomes are monitored. Family outreach, engagement and support has been intensified through the work of peer/family specialists. Further, each area office has an assigned system manager and intensive case manager. Also, Local Area Development Plans (LADP) with specific goals and objectives to enhance service delivery have been developed for each area office.

DCF continues to expand its service array. During the past year significant growth has occurred in the following arenas: therapeutic group homes; intensive in-home services; outpatient psychiatric services through the recently approved Enhanced Care Clinics; flexible funding to purchase both traditional and non-traditional services; and family advocacy services. Reducing the number of children in residential and hospital level care is a key challenge at this time. To achieve this goal multiple efforts are underway that include enhanced tracking, monitoring and treatment/discharge planning for children who use this level of care.

DCF continues to promote and support the adoption of evidence-based prevention and treatment programs to improve the lives of children and families. A comprehensive approach has been adopted and includes the following components: agency readiness assessments; full consumer/family/community involvement; development of organizational infrastructure; change management protocols; coordinated training, coaching and frequent performance assessments; supervision and coaching; fidelity monitoring, quality assurance activities; and routine process and outcome evaluation. During 2008 and 2009 DCF intends to expand the array of empirically supported practices by supporting training for Trauma-Focused Cognitive Behavior Therapy for outpatient psychiatric clinic providers and Dialectical Behavior Therapy for congregate and residential treatment facility providers.

Through the Behavioral Health Data System (BHDS), DCF continues to collect uniquely identifiable client and provider service information for DCF-funded community-based mental health and substance abuse programs. This year DCF developed a new reporting paradigm. This report is created on a quarterly and ad hoc basis by

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the BHDS vendor. BHDS enables DCF to comply with the Uniform Reporting Standards (URS) requirements, but more importantly, supports DCF's program planning, service development and monitoring activities.

One of the most exciting initiatives is the federally sponsored Mental Health Transformation State Incentive Grant (MHT-SIG) that has been awarded to CT. DCF staff has joined forces with all of the state's stakeholders to design a plan for transforming the behavioral health system. During the past year members of seven workgroups have developed detailed plans and recommendations that focus on advancing the understanding of mental health and wellness, eliminating stigma, increasing prevention efforts to reduce youth suicide, enhancing direct services for high-risk target populations, enhancing technology, and transforming the workforce. These initiatives are described under the applicable criterion.

Throughout FFY 2008 DCF will continue to focus on reforming its system. All initiatives are critical to supporting effective care and creating sustainable positive outcomes for Connecticut's children and families.

B. CURRENT ACTIVITIES

Criterion I- Comprehensive Community-Based Mental Health Services System

The current system of care includes a comprehensive array of diverse community-based services and programs that are supported by federal, state, community, and private funds. As described in Section 1 DCF is legislatively mandated to provide a spectrum of prevention services, behavioral health services, child protection and family services, juvenile justice services, substance-abuse related services and education services. The service delivery approach utilizes the federally endorsed system of care model that joins consumers, families, advocates, state and local agencies, and community providers/organizations in planning, delivering and evaluating services. Within the local communities and their respective Community Collaboratives and Managed Service Systems, services are coordinated and delivered by a cadre of multidisciplinary staff including but not limited to care coordinators, intensive case managers, family advocates, peer/family specialists, DCF social workers and Area Resource Group (ARF) specialists, behavioral health professionals, medical providers, educators, and other stakeholders.

Health, Mental Health, Substance Abuse and Rehabilitation Services

(Includes Services For Persons With Co-Occurring Disorders)

The CT BHP continues to focus on expanding the array of individualized, family-centered, community-based services. Please refer to Section 1 for a list of these services. There are ongoing efforts to expand the provider community through rate enhancements and increased provider enrollment. Another area of continued concentration includes the refinement of targeted performance measures including reducing emergency department lengths of stay and discharge delays, reducing prolonged inpatient stays due to placement delays, and a new study to examine the correlation between disruptions in foster care placements and behavioral health disorders for DCF-involved children.

Connecticut continues to provide state-funded grants to enable 25 community-based providers of outpatient psychiatric clinics for children to promote mental health awareness, healthy lifestyles, and to deliver a variety of clinical treatment and rehabilitative support services including but not limited to: assessment (psycho-social, 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. Some clinic providers also treat specialized needs such as eating disorders, problem sexual behaviors, pervasive developmental disorders, and traumatic stress disorders. Eighteen of these outpatient clinics were recently approved and designated as Enhanced Care Clinics. These providers will be required to meet access requirements as of September 1, 2007. These include the establishment of a centralized point of access as well as screening and triage protocols that specify timeliness standards for services based on level of acuity. The goals are to improve timeliness and quality of services. A second Request for Applications will be released during the summer of 2007 to continue to expand the service capacity across the state. Higher rates are the incentives for providers to apply.

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Many of these clinics also serve as providers of emergency mobile psychiatric services. These services will continue to be available across child welfare, juvenile justice, prevention and behavioral health systems. These services include mobile response, psychiatric assessment, medication consultation, assessment, short-term medication management, behavioral management services, substance abuse screening and referral to traditional and non-traditional services for any family in crisis.

Respite services will continue to be funded through mental health block grant funds. These services are available for DCF and non-DCF involved children/youth who exhibit emotional or behavioral problems that require constant care from their families. Temporary respite services may be provided in the home or community to prevent family disruption or out-of-home placement and to reduce family stress and burnout. Services may include screening and referral, family intake and assessment, case coordination, the development of a respite treatment plan including goals, therapeutic recreation and cultural activities, and socialization opportunities.

DCF plans to re-design and strengthen the statewide Extended Day Treatment (EDT) program. There are 22 licensed EDT providers, with 16 of these providers having DCF-funded grants to deliver programs at 23 sites across the state. Service capacity is 864 clients. Throughout 2007 stakeholders met regularly to discuss needs and share ideas for developing a standardized, evidence-based model of care. DCF has contracted with the CT Health and Development Institute, Inc./Ct Center For Effective Practice to conduct research and develop recommendations. Following delivery of this report, there will be continued dialogue with community stakeholders to determine model priorities, identify costs and develop an implementation plan. This initiative is being conducted in partnership with the CT BHP. Further, the EDT Practice Standards Committee, comprised of all stakeholders including families continues to meet regularly to review these standards and incorporate any changes necessary to meet the model description. Additionally, the first statewide EDT Practitioners' Forum was held on May 4, 2007, to be followed by ongoing seminars in the upcoming year. All members of the statewide EDT Teams are invited to share knowledge, experiences, and insights, and to participate in mini trainings.

DCF continues to support and grow an array of intensive in-home services. Please refer to Section 1 for a description of these services. These clinical services are provided in the child's home and community. Services are provided to children and youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community-based services, or are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse. The intent of this service is to provide the clinical intervention and support necessary to successfully maintain each child in his or her home or community. The goal is to provide a degree of clinical care and supervision in the home and community setting that is appropriate to children discharged from a more restrictive setting (e.g., residential, psychiatric hospitalization), or as an alternative to a more restrictive setting. It is expected that more than 2,150 children and families will be served during the FFY 2008.

Improving service delivery to youth with a co-occurring disorder of mental health and substance abuse continues to be a priority for the Department. Two family-based models of treatment will continue, specifically Multi-Systemic Therapy (MST) and Multi-Dimensional Family Therapy (MDFT). DCF and the Judicial Branch, Court Support Services Division (CSSD) have a Memorandum of Agreement that endorses a single entity to manage quality assurance and fidelity monitoring for MST. CSSD funds 15 additional MST teams for a total capacity of over 1,000 youth statewide. Further, DCF contracts for outpatient and residential substance abuse treatment services. The outpatient and residential levels of care are implementing standardized assessments called the Global Appraisal for Individual Needs (GAIN). The GAIN is used nationally by the Center of Substance Abuse Treatment for all adolescent substance abuse programs to monitor performance. The Hartford Youth Project uses the GAIN to monitor performance. The GAIN provides assessment for co-occurring disorders and flags mental health issues needing further assessment and treatment. The GAIN provides quantitative clinical data in multiple domains to improve client and program level effectiveness and to provide follow-up level of care. A plan

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has been developed to implement the GAIN in all DCF funded adolescent substance abuse treatment programs and for use in child welfare services for primary care givers. It will also be piloted in some outpatient mental health clinics for children. Finally, the Department is also implementing the Connecticut State Adolescent Substance Abuse Treatment Coordination (CASAC) project. The intent is to develop and improve state policies, regulations, funding and program development functions of the state system to ensure that culturally competent, gender-specific, evidenced-based and cost-effective treatment and support services are provided to adolescents with substance abuse and co-occurring disorders. The Department intends to create family advocacy and a provider association within Connecticut specifically focused on adolescent substance abuse and co-occurring disorders.

The Hartford Youth Project that was initially funded through federal resources to enhance the alcohol and drug abuse treatment delivery system for youth in Hartford continues and will be 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).

The Partnership For Kids (PARK) Project, a unique school-based system of care model in Bridgeport, CT will continue to serve children with SED and their families, through newly appropriated state funds that partially replace expiring federal funds. Six care coordinators will assist approximately 75 – 100 children and families in accessing clinical and non-traditional community-based services to maintain children in their communities and to return children with SED from out-of-district placements. The partnership involves the Bridgeport Board of Education, the United Way of Eastern Fairfield County, the Child Guidance Center of Greater Bridgeport, Families United for Mental Health, Action for Bridgeport Community Development, Yale University and DCF. The specialized care coordinators will work with Bridgeport teachers, guidance and social work staff, and administrative professionals to ensure that children's individualized System of Care Service Plans are coordinated with educational and other needs.

For those youth with mental illness who will age-out of the DCF system, referrals will be made to the DMHAS Young Adult Services System for ongoing psychiatric services and other significant supports. It is estimated that approximately 300 - 350 youth will be referred during SFY 2008.

Therapeutic Support Services

DCF continues to support and expand the network of contracted community-mentoring providers to work with youth through a one-to-one relationship. Mentor activities focus on increasing self-esteem, habilitation, resiliency, the development and/or improvement of social skills and peer relations, and promoting age appropriate behaviors in a normative, non-clinical setting.

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. The Department has consistently met the federally mandated Juan F. Exit Plan measure for multi-disciplinary exams for the past three quarters by providing timely exams to more than 94 % of 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 an APRN Supervisor, under the direction of the Department's

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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. It is anticipated that this goal will continue to be reached and exceeded in 2008.

The Bureau of Behavioral Health and Medicine plans to implement regional medical teams across the state. The recently hired statewide Director of Pediatrics and the Director of Psychiatry Services are in the process of recruiting three regional medical directors, three pediatricians, three APRNs and three nurses. These medical teams will oversee medical/psychiatric services in the area offices to improve the timeliness and quality of care for DCF-involved children and youth.

Housing Services

The Department will continue to provide a continuum of living options for children and youth. There are plans to expand the array of foster homes including therapeutic foster homes through increased recruitment activities. Further, DCF continues to enhance and expand the network of community-based group homes. There are three levels of care: Level 1 (Preparing Adolescents for Self-Sufficiency); Level II (Therapeutic); Level III (Therapeutic—Medically Fragile). The Level II homes, which are for youth with significant behavioral health issues, are conceptualized as being a higher level of care than the traditional residential treatment centers. These are small homes (e.g. 5-6 beds) in the community where youth can experience a far more normalized existence than is possible in a residential setting. A strong point of emphasis continues to be that these community-based homes are integrated into residential neighborhoods. Further, these providers are expected to integrate normative community, family and peer activities and interaction into the day-to-day care of the children and youth served.

Connecticut will maintain two crisis stabilization programs that provide 24 hour, short term residential care for children/youth, ages 7 to 18 who need a temporary “cooling off” period after experiencing a crisis. Crisis staff 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.

Short-Term Assessment and Respite (STAR) Homes are now replacing the emergency shelter system across Connecticut. STAR centers will offer treatment and support planning for a more effective course of care. The new system will have the capacity to serve 84 children through fourteen program sites. Ten of these sites have been secured and the remaining four are in process.

There are several supported independent living options for youth, ages 14 to 23 who are moving towards independent living. The goal is to offer the least restrictive, most community-based resource. The Bureau of Adolescent and Transitional Services maintains responsibility for these services, as described below.

- Supported Work, Education and Transition (SWET) Program

These programs are designed to work with youth, ages 16 and older who are ready to be involved in a supervised, independent living program. These 8-bed programs are located throughout the

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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.

Education, Skills Training And Employment Programs

DCF continues to provide education, skills training and employment programs for older youth, as described below.

- 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 thirteen 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 2008 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.

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- New Haven Work To Learn Project. Individual service plans will be developed for 62 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.

Family Advocacy Services

DCF will continue to make significant investments to assure parent/family involvement and family advocacy services. FAVOR, Inc., described in Section 1 continues to be supported through block grant funds to provide leadership and support for families. Local grass roots family support groups will continue to receive funding, a statewide parent bank of talented volunteers will be maintained to review state proposals, attend meetings and provide testimony, an upgraded website is available to families to access mental health information, and statewide training will continue. FAVOR, Inc. is also in the process of completing a comprehensive strategic plan.

Prevention And Early Intervention Services

The Department supports prevention and early intervention activities. For example, funding for the statewide Early Childhood Consultation Partnership (ECCP) will continue during FFY 2008. 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. There are 20 early childhood mental health consultants, serving more than 6,000 children.

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 2008, 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.

The state's SAMHSA grant through DMHAS, the CT Youth Suicide Prevention Initiative (CYSPI) specifically targets youth suicide and continues through 2009. The grant supports the following activities: implementation of the Signs of Suicide (SOS) Program, an evidence-based practice, in CT middle/high schools and in selected CT universities; expansion of the DCF-sponsored training program to recognize 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; 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 clinics. These activities will be supplemented through the efforts of one of the MHTSIG workgroups that is focusing on preventing suicide and increasing mental health awareness through health education in schools. Further, in the upcoming year the Department plans to disseminate training to first responders.

The Department will continue to fund the Positive Youth Development/Family Strengthening Initiative. Selected agencies must incorporate several components in their activities: 1) Evidence-based or promising practices; 2) Support for parents in their role as parents; and 3) Provision of recreational and enrichment opportunities for children participating in the program and their families. The targeted population is children at risk for substance abuse and/or violence. Six contract providers have been funded. From the period of July 1, 2006 through March 31, 2007 (most recent data available) 984 individuals, 99 families and 871 children under the age of 18 have been served. The Department has contracted with a local research firm to engage in an evaluation of the initiative to ascertain its effectiveness.

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Multiculturalism Initiatives

The Multiculturalism Subcommittee, convened under the Children's Behavioral Health Advisory Council (CBHAC) will continue to work with the community collaboratives to offer technical assistance and educational activities, and to identify and develop locally informed opportunities to enhance cultural competence throughout the service system. During the past year two events were funded through mental health block grant funds. The Valley Shore Collaborative sponsored a fun-filled family evening that focused on parenting issues of respect and power, using a professional parent coach as the guest speaker. The Greater Bristol/Farmington Valley Collaborative sponsored a two day Train the Trainer seminar, titled "Taking a Personal Journey towards Multicultural Competence." Areas of focus included cultural competence, wrap-around, interagency collaboration, and systems change. The committee is planning to sponsor a statewide cultural competency conference in the upcoming year, to be coordinated with the activities of the related workgroup under the MHT SIG.

On May 9, 2007 the DCF Task Force on Deaf and Hard of Hearing Persons hosted the fifth Keeping Families Together conference with \$ 10,000. in funding provided by the CBHAC Multiculturalism Subcommittee. The focus of the conference was assessing and supporting the mental health needs of the 169 deaf and hard of hearing children and families who have cases with DCF. Approximately 100 foster parents, social workers, supervisors, managers, and Area Resource Group (ARG) specialists attended.

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 plans to apply technological resources to design a comprehensive website to improve access to mental health information, programs, services and other resources. Key features will 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.

Activities Leading To Reduction Of Hospitalization

DCF continues to meet the performance goal of having no more than 11 percent of children in DCF care in residential placement, per the Juan F. Exit Plan (Child Welfare). Several critical activities support this sustained level of success and include, but are not limited to: the Managed Service System's process for review and coordination of discharge plans for all children in residential care and the identification of community resources that enable children to live in their own communities; use of the Residential Care Team to review all referrals for out-of-home placement against the CT BHP's Level of Care Guidelines and the Child and Adolescent Needs and Strengths (CANS) inventory to match the clinical needs of the child to the "right" clinical program; more aggressive attempts to salvage community-based placements before a disruption occurs by DCF Area Resource Group specialists, enhanced care coordinators, psychologists, and licensed social workers; and expanded intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid residential placement; and the significant expansion of group homes.

Further, DCF has undertaken a number of initiatives during the past year to increase its understanding of the users of hospital emergency departments (ED) and to identify and implement solutions. In January 2007 the Child Health and Development Institute of Connecticut, Inc. released a report that focused on the use of hospital emergency departments for children with psychiatric conditions who are enrolled in HUSKY Part A. The study confirmed that usage had increased over time. More than half of the ED visits were made by children who had some connection to the service system both prior to and following the visit. Visits by older children were more likely to be characterized by lack of consistent ties to the service system both before and after the ED visit. Those children who use the emergency departments on multiple occasions also appear to be heavier utilizers of mental health services both before and after the ED visit, suggesting the need for more effective and comprehensive crisis planning that includes alternatives to the use of the ED when problems escalate.

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Currently DCF is designing a pilot project, Child and Adolescent Rapid Emergency System (CARES) to address these needs. A specialized child and adolescent emergency department will be established at The Connecticut Children's Medical Center. The unit will have a bed capacity of 6 and employ trained personnel who have the ability to process psychiatric emergencies in a timely fashion. The goals are assessment and stabilization. Medicaid funds will be utilized.

Further, a tracking system has been implemented. The CT BHP has assigned Intensive Case Managers to proactively contact EDs to identify any Medicaid eligible children who are need assistance in securing more appropriate, community-based psychiatric resources.

CRITERION II- Mental Health System Data Epidemiology

The Department's methodology for estimating child SED epidemiology and quantitative targets is intrinsically tied to its current data collection and reporting activities. Presently, the Department's estimates are extrapolated from and based upon the upper and lower limits set forth in the Volume 62, Number 193, Federal Register of October 6, 1997, and its intersection with Connecticut census data. While the Department will continue to utilize those federally defined ranges for its determination, the availability of unduplicated client level data will be helpful in validating the estimation and/or informing the meaning of the estimates and determining access and potential need.

The Department collects and analyzes data using its Behavioral Health Data System (BHDS). The number of programs included within the BHDS has steadily increased and currently includes twelve service categories. This has supported the presentation of a more accurate accounting of the number of children who are served through and by Connecticut's publicly funded behavioral health system. Advanced Behavioral Health, Inc. (ABH) retains a contract with DCF to serve as the data submission portal and repository for the BHDS. During the most recent contract negotiations, the Department shifted emphasis from adding new services, to expanding quality improvement and quality assurance efforts.

Commencing with the first quarter 2007 data (July 1, 2006 – September 30, 2006), DCF released a new reporting paradigm. The modified quarterly report format uses an "accounting" flow method and establishes broader data episodes (e.g. admission, in-care, discharge, and remaining in care) than previously, and presents such data for the current and past quarters within the fiscal year. These improvements provide enhanced data integrity and data analyses.

The Department has continued its contract with the University of Connecticut to support the implementation of the Youth Services Survey for Families. The contractor is responsible for engaging in a telephonic administration of this survey. During the fall of 2006 ten provider agencies participated, enabling the contractor to conduct 454 telephone interviews with the caregivers of children who are consumers of the behavioral health services system.

CRITERION III- Children Services (See Also CRITERION I)

Department 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 operate 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 process. Further, the Department continues to cultivate partnerships with families, federal and state agencies, advocacy groups, local community service providers, educators and other stakeholders.

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The Department continues to maintain a Memorandum of Understanding (MOU) with both DMHAS and DMR. The MOU with DMR is to facilitate the coordination of services for clients who may be eligible for Voluntary Services through DCF and are eligible for services through DMR, 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, the Department provides funding to facilitate supported community-based living and behavioral health care for youth and young adults with very complex mental health needs.

The Department is also working collaboratively with the State's Judicial Branch-Court Support Services Division (CSSD) and other stakeholders including parents to implement the statewide Emily J. plan to improve treatment options for detainees with behavioral health issues, particularly to maintain these youth in their own communities. Newly developed services for the target population include: therapeutic mentors; multi-dimensional treatment foster care; PASS group homes; wrap-around home-based behavioral health treatment services; post multi-systemic therapy support; outpatient substance abuse treatment; and flexible funding.

The Connecticut State Adolescent Substance Abuse Treatment Coordination Project focuses 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.

The Department 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.

In addition, the Department engages in joint planning, program development, training and funding initiatives with other state agencies. As noted above, the Department continues to work collaboratively with the Judicial Branch. The Department and CSSD have entered into a variety of joint Memorandum of Agreements (MOAs) over the years. Some of the MOAs include a Juvenile Review Board program and a trauma initiative for assessing and addressing the trauma needs of juvenile justice involved children. The Department also works in collaboration with the Department of Labor's Office of Workforce Competitiveness and the Workforce Investment Boards, which assist youth and community stakeholders in the planning and creating of employment opportunities for youth across Connecticut. DCF's Bureau of Adolescent and Transition Services has become a strong partner with the Department of Labor.

A newly planned pilot project under the MHT SIG, Workgroup 5 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 will build 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.

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CRITERION IV- Targeted Service to Homeless and Rural Populations

The Department of Children and Families has a network of options to assist with supporting the various housing needs of the children, youth and families who are under its care. These resources were identified in detail under Section 1 and 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 Foster 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).

Assistance for DCF families in need of housing is addressed through the DCF Supportive Housing Program. The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF. Housing is funded through a combination of DCF funds, DSS Rental Assistance Program Certificates, and federal Section 8 housing vouchers. During the past year 100 new Rental Assistance Program Certificates were received. These were distributed to 100 families who had graduated from case management services. During 2006 378 families were served. It is estimated that 500 families will be served in SFY 2007 and 2008 due to expansion plans. The CT legislature has granted an additional 135 housing vouchers and case management funding.

Also, through the Supportive Housing for Recovering Families program, parents receive substance abuse treatment, stable housing and case coordination. The Department has also been working closely with the Governor's Interagency Council on Supportive Housing and Homelessness, which has proposed to establish additional units of supportive housing for families, adults and young adults.

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

CRITERION V-Management System

Connecticut has continued to work hard to increase resources including funding, service types, training and staffing to meet the comprehensive needs of children and their families. For SFY 2008, state-funding appropriations for DCF exceed \$ 865 million. Annually, over \$250 million is expended by DCF on behavioral health services.

During the past two years the Department has expanded the staffing and expertise of the personnel in the Bureau of Behavioral Health and Medicine. A Director of Pediatrics and a Medical Director (Psychiatry) were hired. Three clinical manager positions were added to oversee the majority of community-based services. A Best Practices Unit was created, which is comprised of psychologists who possess specialized knowledge in forensics, behavioral health assessment and treatment, and trauma. To support the functioning of the CT BHP a Program Supervisor was recruited.

Training activities will be expanded in 2008. The Department is planning to provide intensive training and consultation regarding trauma issues as well as techniques to promote affect regulation. This trauma training initiative is planned to occur over the course of the next three years. The Department will also support workforce development training for the local Systems of Care during the next state fiscal year. The targeted

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audience includes care coordinators, intensive care coordinators, supervisors, family advocates and other key stakeholders.

Specialized training regarding serving diverse populations will continue to occur. During this past fiscal year, three local community-based training events were held, including one that focused on meeting the unique cultural and linguistic needs of deaf and hearing-impaired persons. In addition, the Department continues its collaboration with True Colors, Inc. through the Safe Harbors initiative. The Safe Harbor Project is designed to address the unique needs of lesbian, gay, bi-sexual and transgender (LGBT) youth and families across the spectrum of child welfare. Components of the program include foster parent recruitment, an LGBT youth mentoring program, and comprehensive training.

Additionally, suicide prevention training and information to assist families, youth, DCF staff, providers, and other stakeholders such as emergency service personnel will continue. As described earlier in this section, the Positive Youth Development/Family Strengthening Initiative will be funded.

C. GOALS, TARGETS AND ACTION PLANS

FFY 2008 goals, targets and action plans for children's mental health services focus on the continued development and enhancement of a community-based comprehensive behavioral health services system that meets the diverse needs of children and families.

Consolidated Criterion 1: Comprehensive Community-Based Mental Health Services Systems

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

During SFY 2008 the Department staff and its partners will focus on strengthening and improving the system of care through multiple initiatives. Efforts will be made to achieve a full implementation of the CT BHP. This includes but is not limited to the following areas of work: training on the goals of the CT BHP; program and policy development; outreach and technical assistance to providers regarding best practices; review of utilization data to improve outcomes; increase the number of service providers; develop new services; and enhance existing services. To achieve greater integration of care across service systems, training and technical assistance will be offered to providers. CT BHP policies for integration with CSSD, DMR, DMHAS, and State Department of Education (SDE) will be finalized. Further, plans are underway to strengthen and expand local systems of care and the wrap-around service delivery model through training, technical assistance, and consultations with the System of Care/Community Collaboratives.

Within the Department, a multi-disciplinary group is currently studying the Area Resource Group (ARG) specialists' model. Recommendations will focus on improving the quality and utility of the ARG staff, and their capacity to better integrate and support behavioral health services in the area offices. Further, Department staff is in the process of finalizing logic models for each of the community-based service types. These documents will clearly articulate the goals and intended outcomes for each service.

Workforce development and transformation is another critical area of focus. Department 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. In addition to examining staff development and training needs from the larger system of care perspective, the Department 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.

The Department 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. Efforts to ensure timely access to comprehensive data, such as through the Behavioral Health Data System (BHDS) and the Administrative Service Organization, to aid decision-making, support program monitoring and continuous quality improvement will occur.

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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 extend of their capabilities.

The state will maintain, and within available resources, increase and enhance the capacity and array of the following services to children and their families within local communities as part of its developing service continuum.

- Emergency Mobile Psychiatric Services
- Crisis Stabilization
- Respite Services
- Care Coordination/Case Management
- Intensive In-home Services
- Outpatient Psychiatric Services (Child Guidance Clinics/Enhanced Care Clinics)
- Extended Day Treatment
- Family Support Teams
- Short Term Assessment and Respite (STAR) Homes
- Therapeutic Group Homes
- Family Advocacy
- Flexible Funding

As described in previous sections, the Department plans to increase capacity for emergency mobile psychiatric services, intensive in-home services, outpatient psychiatric services through the Enhanced Care Clinics, STAR homes, and therapeutic group homes.

To support the continuation of the system of care, the Department 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, the Department will continue to fund family advocate positions to enhance effective consumer and family participation in the overall system.

In order to maintain and/or expand services and supports, DCF-funded care coordinators will continue to have access to flexible funding during FFY 2008. These flexible funds are an integral resource to ensure that children and their families have the services, supports and other resources needed to successfully remain in their homes and communities, and/or facilitate children's return from inpatient and residential levels of care. Care Coordinators are able to distribute these funds to assist with security deposits, outstanding utility bills, delinquent rent, furniture and other needs to support safe and stable housing for children and families who are served through the Systems of Care. As in years past, the Department includes as one of its outcome measures the impact of Care Coordination on placement stability. DCF expects that at least 75% of children, while receiving Care Coordination, will maintain stable placements and/or be stepped down to a less restrictive setting of care.

To meet the specialized education, employment and housing needs of adolescents and young adults, the Department 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. Please refer to Part C, Section III B for a description of these services.

The Department 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, as described earlier in this section. Further, through the activities of the MHT SIG Workgroup 1, a comprehensive set of strategies will be developed and implemented to promote mental health

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awareness and prevent youth suicide within local communities. Although many of these activities will occur in school environments, children/youth, family members, other caregivers, providers and the community-at-large will be critical partners. Examples of activities include surveys of appropriate school personnel to identify and catalogue current resources and outcomes, education and training across communities, dissemination of evidence-based suicide prevention programs, and further dissemination of the State Department of Education Suicide Prevention Guidelines.

Consolidated Criterion 2: Mental Health System Data Epidemiology

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 12,900 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 estimates that such services are provided to approximately 2+ % of the children ages 0 to 17.

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, and within available resources, increase service capacity during FFY 2008 as follows.

Care Coordination	1,300
Emergency Mobile Psychiatric Services	5,800
Extended Day Treatment	900
Family Advocacy	4,300
Child Guidance Clinics	11,000
Family Support Teams	360
Respite	180
Crisis Stabilization	272
Intensive In-home	1,900

Consolidated Criterion 3: Children's Services

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

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

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has created two Pupil Services positions to assist youth enrolled in two- and four-year colleges as well as vocational, technical and certification programs. The person in this position will coordinate activities and collect and manage data on youth involved in post secondary services.

Through the PARK Project, a school-based System of Care initiative, Positive Behavioral Intervention and Support (PBIS) activities will be occurring within targeted cluster schools in the Bridgeport community. A Project Leadership Team (PLT) and an Executive Committee oversee the PARK Project. The PLT, which meets monthly, will continue to include participation from the Bridgeport School System (the Assistant Superintendent and the Director of Social Work), families, the child guidance clinic, DCF, Families United, Yale University and other local community service providers. Through the PLT and Executive Committee, strategies are developed to continue to support the schools and communities to effectively serve children with SED, including those who need special education and related services under Individual with Disabilities Education Act (IDEA), through a System of Care approach. The services and related supports provided to aid in compliance with IDEA include: after-school programming; extended day treatment; psychiatric and masters' level therapists through the school-based health center; behavior specialists; mentoring; care coordination; family advocacy, and flexible funding.

Another goal of the Department is to improve the array, coordination and integration of services for children and youth who are court-involved. The Department will continue to collaborate with the Judicial Branch (Court Support Services Division). Activities such as joint planning, program development, training and funding will occur. Gender-specific programming for girls will also be maintained or expanded to serve girls who are committed to the Department as delinquent. The Department will further continue to seek to serve children who are court involved through the System of Care and other wraparound processes. At least 20 % of court-involved youth will receive care coordination services through the System of Care/ Community Collaboratives.

The Department 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 2008. There are six providers who have capacity to service 670 adolescents, annually.

The Department 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. MST will serve approximately 350 youth during FFY 2008. In addition, Multi Dimensional Family Therapy (MDFT) will be funded. There are ten MDFT teams that provide clinical services that target interventions with the adolescent, parents, family interactions & relationships, and extra-familial systems. MDFT works through 3 phases to build alliances and motivation, request changes, and seal the changes before discharging the family. This services targets children who have a mental health and/or substance abuse diagnosis, exhibit complex behavioral health service needs, and are either returning from or approved for a residential placement, or are at imminent risk for an out-of-home placement. Two sites (a total of 4 teams) provide services to girls in a juvenile diversion program in New Haven and Waterbury. These girls are court-involved clients and on probation. One provider in Hartford serves youth who have been in detention (*Emily J* class) and their families.

Finally, the Department will continue implementation of the Connecticut Adolescent Substance Abuse Coordination (CASAC) Project. Evidence-based practices such as MST, MDFT, and CBT/MET will be provided.

The Department 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.

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The Department 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.

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

The Managed Service Systems (MSS) and the System of Care/Community Collaboratives will be maintained to provide access to children with complex behavioral health care needs and their families across the state. The MSS are to include participation from DCF Area Office staff, providers, families and the Administrative Services Organization. Similarly, the System of Care/Community Collaboratives include membership from a variety of service sectors such as mental health, families, insurance, education, juvenile justice, health, substance abuse, recreation, advocacy, and faith-based organizations for the purpose of ensuring an integrated and holistic service approach to serving children with SED and their families, and increasing children's access to community-based care. Enhanced Care Coordination positions through the Managed Service Systems will be available during FY 2008. These positions will assist in increasing the number of children who access community-based treatment options by identifying appropriate treatment, social services and supports to successfully transition and/or maintain a child in their community.

An integrated system of services can not be successfully achieved unless the voices of the consumers and their families/caregivers are heard and addressed. For these reasons, the MHT SIG Workgroup 2 plans to initiate a survey process to stimulate a dialogue between children/youth, families and providers. This may include a forum on consumer rights, possibly a Consumer Rights Summit. Another collaborative initiative proposed by the MHT SIG Workgroup 4 is the expansion of multi-disciplinary treatment teams across service types and providers, and multi-disciplinary teams to conduct audits and performance monitoring.

Criterion 4: Targeted Services To Rural And Homeless Populations

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

Connecticut's community-based services system provides for outreach and services for children and adolescents with serious emotional disturbance who are homeless. As described in Criterion 1, the Department 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. The Department 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.

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During the past fiscal year the Department began a re-design of its emergency shelter system. Slated to be completed during FFY 2008 the temporary shelter placements are being transformed into Short Term Assessment and Respite (STAR) Homes, as previously described.

Ensuring that homeless children receive appropriate education is also a priority for the Department. 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.”

Pursuant to a memorandum issued by DCF’s Commissioner in February 2005, children who are placed on an emergency basis in a transitional foster home with the plan of being moved within 30 days to a more permanent foster or adoptive home may be considered covered by McKinney-Vento on a case-by-case basis. Similarly, the CT Department of Education and DCF will also consider applying McKinney-Vento on a case-by-case basis to children who have experienced more than three placements in a 12-month period.

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

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

The Department will also continue to monitor access, utilization and needs of families in rural communities through the existence of variables within the Department’s Behavioral Health Data System that capture key demographic information and elements such as residence, DCF status, juvenile justice involvement, services provided, services needed and reasons for discharge.

During 2008 the Department will maintain and/or enhance the following core services within the rural areas of Litchfield and Windham County:

Core Services For Rural Communities

- Care Coordination
- Child Guidance Clinics
- Emergency Shelters & Group Homes
- Emergency Mobile Psychiatric Services
- Family Support Teams
- Therapeutic Foster Homes

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

Criterion 5: Management Systems

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

The Department will maintain or expand its current allocation of more than \$ 250 million for behavioral health services. The Department will maintain sufficient staff to plan, develop and monitor the behavioral health system. Please refer to Part C Section III B Criterion 5 – Management System for staffing details. Further, DCF is partnering with the MHT SIG Workgroup 3 to support the pilot development and evaluation of an online integrated information system across all service types and providers. This will address the shared issues of

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resources, staffing and strategic planning to create a creditable information system that provides value-laden data, outcomes and performance measures as well as the capacity for online analytical processing.

The Department 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 and service delivery.

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. The Training Academy currently has 19 full time staff assigned to the division. The staffing consists of a Director and Assistant Director, 1 Program Supervisor, 2 Curriculum Managers, 2 Clinical Education Specialists, 8 Child Welfare Trainers, 1 Video Media Designer, and 3 Clerical Staff. Staff from the Bureau of Behavioral Health and Medicine serve 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, through the use of mental health block grant funds, DCF has contracted with Behavioral Tech to deliver extensive training in 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. Most, if not all, of the children who are under the care of the Department would benefit from this treatment modality.

The Department 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 will establish a Coordinating Center for the purposes of planning, managing, overseeing and evaluating the activities and tasks necessary to integrate TF-CBT as a primary treatment at up to eighteen clinics. The contractor will execute 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 will be utilized.

Also, mental health block grant funds will be applied to increase training for the System of Care/Community Collaboratives. This initiative will support the infrastructure and workforce development needs of those local Systems of Care. There will be three components to this initiative. Pre-service Training, In-service Training, and Consultation will be offered to the community collaboratives to establish/enhance basic competencies for care coordinators and other stakeholders. Training will include: the wrap-around model and individualized planning process including building teams and locating natural supports; crisis and safety planning; developing and implementing individualized plans of care; transition and discharge planning; and incorporation of CT-specific practices and standards such as the BERS and 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. This initiative will complement the efforts of the CT BHP and the Local Area Development Plans. It is estimated that 160 to 200 individuals will be trained.

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At the statewide level, the Department continues to work with the MHT SIG Workgroup 7 to establish the Connecticut Mental Health Workforce Collaborative as a permanent infrastructure charged with planning, coordinating, and implementing interventions to strengthen the behavioral health workforce. The Collaborative will leverage existing resources, link Connecticut's mental health and higher education systems, routinely assess the mental health workforce needs, develop a strategic workforce development plan, implement interventions to strengthen the workforce, promote cultural diversity, disseminate best practices, and advise the executive, legislative and judicial branches relative to workforce issues and policy. Particular areas of focus for children's services will include building a skilled workforce to deliver both intensive home-based services and wrap-around services and strengthening the role of parents in the workforce,

Criterion 5B: Training Of Providers For Emergency Health Services

During 2008 the Department will engage in training activities relating to youth suicide prevention and crisis response to support emergency health care and first responders in improving services to children with mental health needs. Discussions are now occurring with the Center for Trauma, Response and Preparedness (CTRP) to determine the feasibility of expanding the existing curriculum for first responders to include a segment on children's mental health. The CTRP is a collaborative initiative of four partner agencies: The University of Connecticut Health Center, Department of Psychiatry and Yale University, School of Medicine, Department of Psychiatry and Yale Child Study Center in partnership with DMHAS and DCF. One of CTRP's goals is to prepare behavioral health providers to safely and effectively meet the needs of people affected by critical incident trauma in the immediate and long-term aftermath through training and technical assistance.

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 2008, the Department proposes to expend the CMHS Block Grant funds for the following types of services:

Service Type	Total by Service Type
Statewide Total	

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

State Identifier: Connecticut DCF				
Agency Name	Address	Name of Director	Phone #	Amount CMHS BG

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Report Year: FFY 2008				

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 1-1: State Indicator

- Goal: Serve children within family and other less restrictive community settings.
- Target: Maintain placement level of approximately 80 % for children served through the System of Care
- Objective: Increase or maintain stable placements for children/youth who receive intensive Care Coordination through the System of Care Community Collaboratives
- Name: Placement Stability
- Population: Children/youth receiving intensive Care Coordination through the Systems of Care
- Criterion: Criterion 1 – Comprehensive Community-Based Mental Health System

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(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
% of children/youth who remained in a stable placement or who were stepped-down to a family or less-restrictive settings	82.2 %	83 %	85 %
Numerator	337		
Denominator	410		

Sources of Information: DCF behavioral health data system

Measure: Percent of children/youth who remained in a stable placement or were stepped-down to a family or less restrictive setting

Numerator: Number of children/youth who remained in a stable placement or were stepped down to a less restrictive living setting

Denominator: Total number of children/youth discharged from Level III Care Coordination through the System of Care Community Collaboratives.

Significance: Creating safe, permanent environments for children/youth within the context of a family or within a more normative, home-like setting is critical to supporting children's development and transition into healthy, happy and productive adults.

Special Issues: None

Action Plan:

The Department will maintain the current capacity of its Care Coordination service through the Systems of Care. In addition, the Department will maintain Enhanced Care Coordinators who focus on those children who are currently in out of home-settings. Further, flexible funding will be made available to Care Coordinators and DCF Social Workers.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 1-2: NOM: Use of Evidence Based Practices

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

Target: Expand the number of evidence-based practices to 8 and serve approximately 2000 children/youth and their families

Objective: Increase the number of children and youth that receive evidence-based treatment approaches

Name: Evidence-Based Treatment

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

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

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(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
# ¹ of Evidenced-Based Practices Provided (FFT; MST; MST-PSB; MST-BSF; FBR; MDFT; IICAPS)	7	7	8
# of children/youth receiving care from evidence-based treatment approaches	2505 *	1852	2000
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A

Sources of Information: DCF behavioral health data system

Measure: Number of evidence-based practices and number of children receiving these during the state fiscal year

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

Special Issues: None

Action Plan:

The Department will continue the Hartford Youth Project in FFY 2008, through the allocation of state funds at the expiration of the federal grant, in order to continue to deliver Multi-Dimensional Family Therapy (MDFT) for high risk, substance abusing youth residing in the city of Hartford. Further, 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.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 1-3: NOM- 30 Days Readmission

Goal: Reduce use of psychiatric inpatient services

Target: Reduce the percentage of readmissions by .02 %

Objective: Expand breadth of community-services to support care within normative, less restrictive settings

Name: Readmission Rates within 30 days of discharge from inpatient care

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

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

* This number includes therapeutic foster care services, which is not a “true” evidence-based treatment. FY 2007 and 2008 numbers exclude therapeutic foster care services.

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(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
Re admissions to Riverview within 30 days	2.5 %	2.3 %	2.3 %
Numerator	7		
Denominator	285		

Sources of Information: Riverview Hospital data system

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 re-admitted within 30 days

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

Special Issues: None

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

Action Plan:

The Department will provide multiple, diverse activities to support the reduction in use of inpatient psychiatric care. These include, but are not limited to: continued expansion 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; enhanced targeted utilization management activities by the Ct BHP to identify high-end service users and facilitate service planning that supports community-based care.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 1-4: NOM- 180 Days Readmission

Goal: Reduce use of psychiatric inpatient services

Target: Reduce percentage of readmissions by .02 %

Objective: Expand breadth of community services to support care within normative, less restrictive settings

Name: Readmission Rates within 180 days of discharge from inpatient care

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

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

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
Re admissions to Riverview Hospital within 180 days	1.75 %	1.73 %	1.73 %
Numerator	5		
Denominator	285		

Sources of Information: Riverview Hospital data system

Measure: Percentage of clients who are re-admitted to the 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

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

Action Plan:

The Department will provide multiple, diverse activities to support the reduction in use of inpatient psychiatric care. These include, but are not limited to: continued expansion 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; enhanced targeted utilization management activities by the Ct BHP to identify high-end service users and facilitate service planning that supports community-based care.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 1-5: State Indicator: Transformation

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 4300 families, including at least 450 families who receive direct family advocate support

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Objective: Support transformation of Connecticut’s behavioral health system for children by supporting activities that are family informed and driven

Name: Ensuring that mental health services are family driven consonant with New Freedom Commission Goal 2

Population: Families caring for children with mental health needs, particularly those with SED

Criterion 1: Comprehensive, community-based mental health system

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
Increase or maintain # families who receive family advocacy services	376	454	500*
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A

*These numbers do not include families that receive a 2 to 8 hour “consulting” commitment regarding issues that do not require an intake or long-term services.

Sources of Information: FAVOR, INC. records

Measure: Number of families that receive family advocacy services

Numerator: N/A

Denominator: N/A

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. will maintain 10 family advocates and 1 advocacy supervisor as well as increase operational efficiencies. It is estimated that these planned efficiencies will result in a caseload increase of 10 percent in the upcoming year.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 2-1- NOM: Increased Access to Services

Goal: Ensure access to publicly funded behavioral health services

Targets: Maintain the level of access to publicly funded behavioral health services

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Objective: Increase or maintain the number of Connecticut children who receive DCF behavioral health services

Name: Receipt of publicly funded behavioral health services

Population: Children and youth with complex behavioral health care needs

Criterion: Criterion 2 – Estimates of Prevalence and Treated Prevalence of Mental Illness

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
Increase or maintain # of children/youth who receive publicly funded behavioral health services	28,151	28,200	28,200
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A

Sources of Information: DCF behavioral health data system

Measure: Estimated number of children served through DCF funded behavioral health services during the state fiscal year.

Numerator: N/A

Denominator: N/A

Special Issues: None

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

Action Plan:

The Department continues to expand the array of community-based behavioral health services available to children with complex behavioral health care needs. In addition, family advocacy services provide support for children, youth and their caregivers' in order to increase access to necessary behavioral health services.

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**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 3-1-State Indicator

Goal: Facilitate community-based care for children/youth who are court involved

Target: Increase the number of children who receive Care Coordination to include at least 18% of total served who are juvenile justice involved at admission.

Objective: Increase or maintain the number of court involved children and youth receiving Care Coordination through the Systems of Care Community Collaboratives

Name: Juvenile Justice

Population: Children with SED who are involved with the juvenile justice system

Criterion: Criterion 3 – Provision of Children's Services

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
% of children/youth receiving Care Coordination who are court involved	17 %	17 %	18 %
Numerator	225		
Denominator	1323		

Sources of Information: DCF behavioral health data system

Measure: Percent of children/youth who Care Coordination and are court-involved

Numerator: Number of children/youth receiving Care Coordination through the Systems of Care who are court involved

Denominator: Total Number of children who received Care Coordination through the Systems of Care

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: The Department in partnership with the Connecticut Judicial Branch-Court Support Services Division has recently settled a federal lawsuit, *Emily J.* The terms of the settlement require DCF and CSSD to add a variety of community-base services including therapeutic mentoring, flexible funding, outpatient substance abuse treatment, and wraparound home-based behavioral health treatment services. Currently, DCF and CSSD are engaged in the implementation of a statewide plan to effectuate the terms of this settlement. The Systems of

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Care Community Collaboratives, through the functions of the Care Coordinators play a critical role in achieving this outcome.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 3-2- NOM: Increased School Attendance

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

Target: Maintain or increase school attendance level of 80% for children receiving Care Coordination

Objective: At least 80% of children and youth who receive Care Coordination from the Systems of Care will maintain or increase their school attendance

Name: School Attendance

Population: Children with SED who received care coordination through the Systems of Care

Criterion: Criterion 3 – Provision of Children’s Services

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
% of children/youth who receive Care Coordination and whose school attendance has been maintained or increased	100 %	100 %	100 %
Numerator	410		
Denominator	410		

Sources of Information: DCF behavioral health data system

Measure: Percent of children with SED who received Care Coordination and whose school attendance has been maintained or increased

Numerator: Number of children/youth receiving Care Coordination whose school attendance was maintained or increased

Denominator: Total number of children who were discharged from Care Coordination

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 fund Enhanced Care Coordinator positions to assist children and families in maintaining or improving stability in their lives including overall functioning at home, with peers, in the school environment and the broader community. The Enhanced Care Coordinators will ensure that families are linked with appropriate community resources and that any issues arising in the school environment are successfully addressed. Their work will be supported by the tasks performed by Family Support Teams, local family

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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 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 3-3- NOM: Clients Reporting Positively About Outcomes

Goal: Measure client perception of care

Target: Achieve positive client perception of care responses from 63 % of survey participants

Objective: Assess client perception of and satisfaction of care

Name: Perception of Care

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

Criterion: Criterion 3 – Provision of Children’s Services

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target
Clients reporting positively about outcomes	61%	62 %	63 %
Numerator	118	279	
Denominator	191	450	

Sources of Information: University of Connecticut Department of Public Policy

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.

Special Issues: None

Sources of Information: Youth Services Survey for Families – SFY 2007

Special Issues: None

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

Action Plan:

The Department is expanding the use of the YSS-F to additional community services providers. DCF is contracting with the University of Connecticut and working with the selected providers to finalize the components

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of the sampling frame. It is expected that in late September and through-out October 2006, surveying of consumers will be occurring.

**CONNECTICUT STATE MENTAL HEALTH PLAN FY 2008
PERFORMANCE INDICATORS-CHILD**

Indicator 4-1- State Indicator

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

Target: Provide suicide prevention training to at least 1250 persons annually

Objective: Decrease the incidences of youth suicide and other trauma in Connecticut by increasing stakeholders' competency through training on suicide prevention and crisis response

Name: Suicide Prevention and Crisis Response Training

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

Criterion: Criterion 5– Management Systems

(1)	(2)	(3)	(4)
Fiscal Year	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
Number individuals receiving suicide prevention and/or Crisis Response training	1000	1200	1250
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A

Sources of Information: Quarterly reports from funded providers

Measure: Number of persons who are trained in DCF funded youth suicide prevention during the state fiscal year.

Numerator: N/A

Denominator: N/A

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:

Youth suicide prevention training will continue. These efforts are supplemented by various funding resources and activities. For example, the Department will maintain a contract with the Connecticut Clearinghouse to

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provide DCF staff and members of the Youth Suicide Advisory Board with a membership to a resource library that contains information on suicide prevention, abuse and neglect, and behavioral health issues. In addition, through the DCF Training Academy, a training session that addresses suicide prevention and provides continuing education credits will be offered 15 times 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, through a consortium between Yale University and the University of Connecticut will continue to provide training, technical assistance and consultation to behavioral health providers and primary care responders.

Through consultation with the Center for Trauma, Response and Preparedness (CTRP), the Department is currently exploring the feasibility of infusing the existing mental health training for first responders with elements specifically focused on children's mental health. We plan to enter a contract with CTRP to develop and disseminate this specialized training during 2007 and 2008.