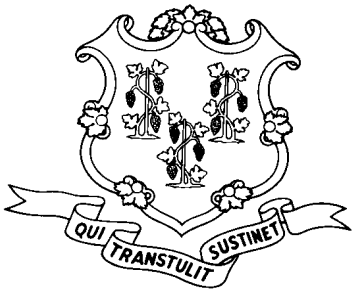
STATE OF CONNECTICUT



Community Mental Health Services Block Grant for FY 2014-2015

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

Including

The Community Mental Health Plan For Children & Adults

April 1, 2013

Submitted By

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

JULY 1, 2013 to JUNE 30, 2015

Behavioral Health Assessment and Plan - Children's Services

B. Planning Steps
Step 1: Assess the strengths and needs of the service system to address specific populations

Overview

Introduction
The Connecticut Department of Children and Families (DCF), established under Section 17a-3 of the Connecticut General Statutes, is one of the nation's few consolidated agencies serving children under age eighteen and their families. The legislation directs DCF to provide a spectrum of prevention, behavioral health, child welfare, juvenile justice, substance abuse and education services, in the latter instance specifically acting in the capacity of a school district for committed children. The legislative mandate reflects Connecticut's historical belief that the wide range of services necessary to meet the needs of children and their families can best be realized through an integrated approach that draws upon family, community and state resources.

Of the state's population of slightly more than 3.5 million, there are 817,015 children under age eighteen. For FY 2012 the child poverty rate was 12.8% (compared to 10.1% for overall state poverty rate), with children under age 5 at 16.5% and children, ages 5 to 17 at 11.4%. However, one in four children (27%) lived at or below 200% of the Federal Poverty Level. The January 2012 Annual Report of the Connecticut Child Poverty and Prevention Council indicates that "Using the most recent data available, the percentage for all low income and poor children in Connecticut increased from the previous year, suggesting that more families fell into poverty." The negative impacts of poverty are well-known, including increased likelihood of child welfare engagement and foster care.

The rate of children living at or below the Federal Poverty Level varies widely in Connecticut, by location, race and household structure. Nearly 45% of all children in Hartford live at this level of poverty compared with 10% in Danbury. While 5% of white children live in poverty, 29% of African American children and 28% of Hispanic children live in poverty. These data are of great importance to DCF because the agency serves disproportionately greater numbers of children of African American and Hispanic heritage, many of whom live in single parent families and all of whom have been referred for services due to abuse, neglect, mental health or juvenile justice problems.

The race groups for Connecticut's child population are:

- 64% White, non-Hispanic
- 18% Hispanic
- 13% Black
- 4% Asian/Pacific Islander
- 3% Two or more races
- .05% American Indian/Alaska Native

Based on the fact that one in five children suffers from a diagnosable mental disorder, there are approximately 163,000 children likely need mental health care. However, national studies affirm that only about 20% of children in the U.S. receive necessary treatment, and it is similar for Connecticut's children. DCF's publically funded behavioral health database shows that 48,095 children and their caregivers received some type of community-based mental health services in SFY 2012. The majority, but not all of these children are diagnosed with a serious emotional disturbance (SED). We do not have statistics regarding the number of children served through the private provider network; however, the data from publically funded sources strongly suggests that the need for behavioral health services is not fully met.

We also know that children involved in the child welfare and juvenile justice systems have a greater prevalence rate of trauma and mental illness than the general population, especially those children in the foster care system. The following statistics illustrate the potential need for behavioral health services for these children who often present with complex behavioral and emotional issues.

- For CY 2012 there were 45,748 reports of child abuse and/or neglect
- Of the total reports, 27,354 were investigated, resulting in 1,387 substantiated physical abuse and or sexual abuse and 16,803 substantiated physical, emotional, educational and/or medical neglect.
- Approximately 4,000 children are in some type of out-of-home placement.
- At any point in time, the Department serves approximately 35,000 children and 15,000 families across its programs and mandated areas of service.
- Approximately 14,000 cases are open on a given day.
- Approximately 2,000 investigations and 1,000 family assessments are underway at a point in time.
- Approximately, 650 children receive voluntary services and are not committed to the Department. About 550 of these children are receiving services at home, with the balance receiving services out of the home.

Connecticut's Community Mental Health Assessment and Plan for Children, in response to the requirements of P.L. 102-321 will enable us to enhance the system of community-based behavioral health services for children and their families, and better meet the needs of children with serious emotional disturbance.

Organizational Structure - State Level (DCF)

The Department employs a workforce of approximately 3,200 and operates with a budget of slightly more than $ 802,000,000. Between January 2011 and June 2012, the department's workforce has declined from 3,456 to about 3,200, and its budget has declined from $ 842,000,000 to about $ 802,000,000.

During the past two years DCF has embarked on an ambitious agenda to transform and improve the service delivery system, under the leadership of newly appointed Commissioner Joette Katz and her leadership team. DCF's mission has been reframed, as follows.

Healthy, Safe, Smart and Strong

In partnership with families and communities, we will advance the health, safety and learning of the children we serve both in and out of school, identify and support their special talents, and provide opportunities for them to give back to their communities and to leave the Department with an enduring connection to a family.

Our mission statement mirrors the Substance Abuse and Mental Health Services Administration's (SAMHSA's) four major dimensions that support a life of recovery - health, home, purpose and community.

A first step in the transformation plan began with a major agency restructuring at both central and field offices. The central office, which is located at 505 Hudson Street in Hartford was re-designed to eliminate siloed program bureaus. These were replaced with an integrated framework that emphasizes collaborative team management.

Commissioner	Deputy Commissioner Operations	Deputy Commissioner Administration	Chief Planning/ Quality Improvement
Deputies **Planning/Development** **Policy &Licensing** **Regional Administrators** **Adolescent & Juvenile Justice Services** **CT Juvenile Training School**	**Unified School District** **Academy for Family & Workforce Knowledge & Development** **Health & Wellness** **Clinical/Community Consultation & Support** **Albert J. Solnit Children's Center, North & South Campuses**	**Fiscal Services** **Information Services** **Human Resources** **Community Based Outcomes Committee** **Strategic Financing** **Unique Services**	**CARELINE** **Liaison - *Juan F.* Court Monitor** **Research and Evaluation** **Program Review and Development** **Change Management** **Ombudsman**

There are several teams, not separate bureaus that manage program operations.

1. The Clinical and Community Consultation and Support Team has subject matter experts across health, nursing, psychiatric consultation, mental health, education, child welfare and substance abuse to support the new comprehensive system of regional services for children and families. The team has responsibility for policy direction, guidance on evidence-based programs, technical support on program fidelity, community and residential services including placement matches, and interagency work related to the transfer of children and youth between DCF and the Department of Mental Health and Addiction Services, Corrections, Developmental Services and the Judicial Branch's Court Support Services Division.

2. The Child and Systems Development and Prevention Team brings together best practices related to child and youth development in a culturally and gender-specific manner. The staff also provide leadership in juvenile justice systems work, foster and adoptive support, new partnerships with local education agencies, and expanded investments in prevention.

3. The Residential and Institutional Facilities Team is responsible for planning related to secure girls' services and performance contracting with our private residential treatment partners.

4. The Health and Wellness Team is led by the Director of Pediatrics and Medical Director of Psychiatry, who report directly to the Deputy Commissioner. This unit reflects a high priority for child health and wellness. The goal is to collaborate with our community providers for services and guidance around children's issues.

5. The Adolescent and Juvenile Services Division, comprised of the Superintendent of CJTS and the Child and Adolescent Development Director and their staff provide the resources and support needed to develop skills in the areas of vocation, education, employment, personal and emotional well-being, individual and cultural identity as well as family and community connectedness.

6. The Academy for Family and Workforce Knowledge and Development integrates the provider academy, advocacy groups, community service providers, professional organizations, state agencies and universities. The academy reflects the belief that collaboration among interdisciplinary professionals: 1) improves services and client outcomes; and 2) ensures that workforce knowledge and development remains a continuous and coordinated process within and across agencies.

In addition, quality assurance and administrative case review staff are now located at central office to improve standardization, efficiency and accountability for service delivery at the regional level.

The Department's field offices were re-designed to create a regional structure of "mini DCF's" with higher levels of regional responsibility, authority and resources. The reorganization emphasizes regionally-focused and clinically advanced services that will allow children and youth to grow up healthy, safe and learning in their communities. The Department operates with six regions and 14 area offices where the delivery of child welfare, mental health and juvenile justice services (including parole) are administered at the local level. The chart below shows the regions and their respective area offices.

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Bridgeport Norwalk/ Stamford	Milford New Haven	Middletown Norwich Willimantic	Hartford Manchester	Danbury Torrington Waterbury	Meriden New Britain

DCF has two distinct state-level administrative roles in the delivery of its behavioral health services.

Operates Three Facilities

- The Albert J. Solnit Children's Center with a South Campus (formerly Riverview Hospital) in Middletown and a North Campus (formerly the Connecticut Children's Place) in East Windsor. The newly consolidated facility has 6 inpatient hospital units and 6 sub-acute/residential treatment units across the North and South Campuses, with a 120 day target for length of stay. Pediatric services are integrated across the new center, and the facility continues as a teaching hospital.
- The Connecticut Juvenile Training School in Middletown, a facility for male-adjudicated offenders.
- The Wilderness Center in East Hartland, which is an experiential wilderness challenge program.

Funds and Evaluates Other Behavioral Health Services:

DCF administers most of its other behavioral health treatment and rehabilitative services through contracts with community-based providers. These services include: privately operated residential treatment facilities; therapeutic group homes; therapeutic foster care; therapeutic day care; intensive in-home services; extended day treatment; outpatient mental health and adolescent substance abuse services, emergency mobile psychiatric services; care coordination services; respite services; early childhood intervention/prevention services; and family advocacy.

DCF has identified ten Principles of the DCF Continuum of Care Partnership.

1. Increase attention to the health, well-being and educational success of all children and youth in the DCF system, based on demonstrable outcomes.

2. Increase attention to meeting the needs of younger children so as to reduce the pipeline of middle childhood and adolescent youngsters needing a long-term engagement with DCF.

3. Assure family-based regional and community services as the presumptive service context.

4. Expand early and proactive use of in-home family and child supports to prevent the need for placement and to promote children's well-being.

5. Expand the use of family foster care, especially relative care, decreasing the use of congregate care settings overall, especially for young children and systematically returning youngsters from out-of-state placements.

6. Increase the direct participation of youth, parents and family members in the case process from entry to exit.

7. Achieve compliance with case planning and service requirements of the Juan F. Consent Decree.

8. Redesign and realignment of agency resources over time to address changes in agency policy and to improve program results, including reinvestment of resources from congregate care to family-based community services and supports.

9. Invest in essential infrastructure, including data systems development and use of strategic planning, communications and accountability, and expanded training partnerships.

To achieve these transformation goals, DCF has adopted six cross-cutting themes:

- A family-centered approach to all service delivery. This represents an agency-wide move to family-centered practices and programs, including implementation of the Strengthening Families Practice Model and the Family Assessment Response System. The Strengthening Families Practice Model includes four components: family engagement; purposeful visits; family assessment; and family teaming. The Family Assessment Response System enables DCF to respond in a less adversarial manner to child maltreatment reports involving low and moderate risk families and helps connect families with services and supports in the community.

- Application of the neuroscience of early childhood, adolescent and young adult development to agency policy, practice and programs. This builds on the rapidly expanding field of brain development with an emphasis on dramatic growth in the very early years as well as key developments in the adolescent and young adult years in executive functioning.

- Trauma-informed practice. The DCF workforce (child welfare and juvenile justice) will receive foundational trauma training, and as a result of a federal trauma grant awarded by ACF universal screening for trauma exposure and child traumatic stress symptoms will occur for all DCF-involved children. Additionally, relevant policies are being reviewed and re-written into practice guides to incorporate the "trauma lens."

- Development of stronger community and agency partnerships. This includes key working relationships with the Departments of Social Services, Education, Developmental Services, Public Health, and Mental Health and Addiction Services. It also includes the work of Early Childhood Collaboratives, Community Mental Health Collaboratives, and Juvenile Justice LIST Collaboratives.

- Improvements in leadership, management, supervision and accountability. This includes development of child outcomes and program performance measures within the context of Results-Based Accountability as well as attention to managerial and supervisory roles, skills and competencies.

- Establishment of a Department culture as a learning organization. This includes attention to a strategic planning and strategic communication as well as expanding opportunities for 24/7 technology-enabled training and learning opportunities. For 2012, it will provide the context for advancing the first five cross-cutting themes as well as addressing issues of racial/ethnic disproportionality and the challenges of undoing racism.

Role of State Mental Health Agency (DCF)

DCF plays a key leadership role in coordinating mental health services across the state. Commissioner Katz and designees work closely with the Office of the Governor, Office of Policy and Management, Connecticut State Legislature, consumers and family members, advisory groups, advocacy groups, service providers, and state/federal agencies. Staff works collaboratively with a diverse array of stakeholders to solicit multiple perspectives on unmet needs and priorities and to identify short and long term directions for the statewide service delivery system.

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

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

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

b) Children's Behavioral Health Advisory Committee (CBHAC). Established by Public Act 00-188, CBHAC's charge is to promote and enhance the provision of behavioral health services for all children in the state of Connecticut. The committee oversees the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. The committee evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the SAC on Children and Families. CBHAC members also actively participate in the CT Joint Behavioral Health Block Grant Planning Council, which is co-chaired by a children's representative.

c) Youth Advisory Boards. DCF staffs also work in partnership with and solicit input from the Youth Advisory Boards from each of the local area offices and a statewide Youth Advisory Board. Approximately 50 youth in "out-of-home care" participates.

d) Connecticut Community Providers Association (CCPA). This member-based organization represents providers of services for children with mental illness, substance abuse disorders and other disabilities and special needs. The mission is to achieve service system change, represent the voices of its members at the state and local levels, and support the delivery of high quality, efficient and effective services.

e) Connecticut Association of Non-Profits. A collaborative of 500 organizations, the association is dedicated to building and sustaining healthy communities. This group also focuses on identifying needs, service priorities, coordination of service systems, and advocacy for effective behavioral health services.

DCF has a long-standing history of collaborating with several state agencies. For example, the Commissioners from DCF and the Department of Mental Health and Addiction Services (DMHAS) are members of the Governor's Cabinet and participate in regular collaborative planning and dialogue regarding cross-cutting issues of importance to both agencies. Staff from both Departments is involved in other policy coordination opportunities such as the statewide Alcohol and Drug Policy Council and the Interagency Council on Supportive Housing and Homelessness. A Memorandum of Understanding (MOU) between DCF and DMHAS supports coordinated activities to transition DCF-involved young adults requiring ongoing behavioral health care to the adult service system. Other joint programs include Project Safe, DMHAS's substance abuse treatment services for child welfare-involved children, and Project Safe RSVP, a Family Court diversion program that provides parents with treatment supports and legal representation. Also, DCF and DMHAS staff has a collaborative planning process, in partnership with the Joint State Behavioral Health Planning Council, to develop and evaluate the Block Grant Application and Plan as well as the Implementation Report each year.

DCF continues to maintain a Memorandum of Understanding (MOU) with the Department of Developmental Services (DDS) to assure timely identification of youth with serious emotional disturbance (SED) and developmental disabilities, who may need to be referred to DDS for ongoing services at the time of discharge from DCF. Children with SED and physical disabilities may also be referred to Vocational Rehabilitation for services.

DCF and the Judicial Branch – Court Support Services Division (CSSD) have several joint MOUs and other initiatives that support: the shared dissemination of evidence-based practices such as Multi-Systemic Therapy (MST), Multi-Dimensional Family Therapy (MDFT), and Intensive In-Home Child and Adolescent Psychiatric Services (IICACPS); shared flex funding for court-involved youth; and a Joint Justice Strategic Plan that includes an inter-agency work group to develop a results-based accountability framework. Through a collaboration with DCF, DSS, and two hospitals, the Child and Adolescent Rapid Emergency Service has been established to provide short-term inpatient stabilization and evaluation service to determine if more restrictive care is warranted for consumers.

DCF works in partnership with the Department of Public Health to coordinate licensing regulations and policies and to support school-based health clinics. DCF and the Department of Education (DOE) have several formal linkages based on MOUs, practice improvements, reimbursement policies, public policies and other initiatives. Examples include the improvement of emergency mobile psychiatric services, Medicaid reimbursement for school-based behavioral health clinics, transportation of foster children residing in Project Safe and STAR homes to their school of origin related to the McKinney-Vento Bill, and co-sponsorship of youth suicide prevention training initiatives. DCF also works in collaboration with the Department of Labor's Office of Workforce Competiveness and the Workforce Investment Boards that assist youth and community stakeholders in the planning and creating of employment opportunities for youth across Connecticut.

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

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

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

Organizational Structure - Community Level

At the local level, behavioral health services are organized and integrated through a network of 25 statewide community collaboratives that are part of the children's system of care and attached to each of the DCF's 14 local area offices. Each collaborative consists of local service providers, family advocates and family members. They meet regularly to plan, address system of care issues, and implement solutions for keeping children in their homes and strengthening community-based services. Parents and families are an integral part of the planning, treatment and decision-making process.

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

Another component of the local service delivery system is the Managed Service System, which is a consortium of DCF staff and DCF-funded provider agencies convened by local area office staff to assure that a comprehensive and coordinated array of services are available to meet the needs of the DCF target population, especially those clients with the most complex behavioral health needs. The goal is to reduce the number of children in residential care and manage access to appropriate levels of community services in a timely manner.

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

Staff at Value Options works closely with family members, providers and other stakeholders to address the needs of members and to improve the provider system. There are 6 regional network managers who focus on provider-specific targets, such as increasing access to care and service capacity by reducing lengths of stay and delayed discharges at local hospital emergency and inpatient departments. There are licensed care managers that focus on authorizing care for all covered services and working with providers to track a member's progress against goals and objectives developed within the treatment plan. Intensive care managers are assigned to a variety of clinical arenas to assist in the development and implementation of treatment plans for members with complex behavioral health needs. They track and monitor the status of children seen throughout the state's emergency departments and assist in identifying appropriate resources when diversion is indicated. They attend discharge planning meetings on inpatient units and work with DCF area office staff and family members. Other staff includes peer support specialists who are adults that have had personal experiences with mental health and/or substance abuse services, and family support specialists who are trained parents of children with behavioral health needs. Each of these staff is organized into "geo teams" that cover a specific area within the state.

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

Description of Behavioral Health Service System

Connecticut's service system is based on the core values and principles of the System of Care.

…. *"all treatment, support and care services are provided in a context that meets the child's psychosocial, developmental, educational, treatment, and care needs. The treatment environment must be safe, nurturing, consistent, supervised, and structured."*

Services should be:

1. Child-centered, family-focused with the needs of the child and family dictating the types and mix of services provided;
2. Community-based, with the focus of services as well as the management and decision-making resting at the community level; and
3. Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

(Practice Standards for the System of Care Community Collaboratives (CT DCF, 2001)

All children and families are affirmed and valued for their unique identifies. DCF policies are aligned with this principle. Additionally, there is a Safe harbors Project Liaison in each area office, Solnit Center and the CT Juvenile Training School. These individuals are subject matter experts in the area of culturally relevant service delivery for children and families who identify as gay, lesbian, bisexual, transgender, intersex and those questioning their sexuality and gender identify. A Safe Harbors Project website contains relevant resources for staff, families, providers and clients.

To assure that the diverse needs of clients regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social- economic status, or language are met, the DCF Division of Multicultural Affairs is charged with developing, implementing, and sustaining diversity initiatives and policies designed to meet these challenges. The shifts in racial, ethnic, linguistic, religious, special needs, disability, and gender orientation diversity in Connecticut have required that the Department discover approaches and skills that will enable us to effectively work with people from diverse backgrounds. Training initiatives and case practices are focused on the following areas:

- Cultural Awareness: This includes a process of self-exploration that results in a clear understanding of the worldview that directs interactions with clients who are different than the DCF worker;
- Knowledge Acquisition: Staff is expected to be thoroughly familiar with the language of multiculturalism and culturally competent practices; and
- Skills Development: Training also focuses on what are, and how to apply multi-culturally competent practices, by attending and participating in trainings, regional training plans, informal activities and ongoing self-assessments.

Additionally, all DCF contracts with service providers require the timely access to and delivery of culturally competent services and supports. Quality assurance mechanisms are in place to review and address issues.

The regional services continuum is characterized by: data-driven planning and decision-making; a balance of promotion, prevention, early intervention and treatment services; attention to the child's development and the developmental appropriateness of interactions and interventions; and collaboration across a broad range of formal and informal systems and sectors to develop comprehensive strategies and effective services, as described below.

Clinical Services and Programs

(These services are available statewide unless otherwise noted).

- Inpatient Psychiatric Services. The Albert J. Solnit Children's Center is a 118- bed psychiatric facility, treating youth ages 13 through 17. On its North Campus, located in East Windsor, current residential beds are being converted to Psychiatric Residential Treatment Facility (PRTF) beds, allocated to adolescent boys, ages 13 through 17, with complex behavioral health care needs that include but are not limited to: aggression, self-harm, substance abuse and low-risk problem sexual behavior. There will be a total of 38 treatment beds on this campus and 2 emergency beds that social workers can access through the Department's Careline. The conversion will be complete by September 1, 2013. Fifty-two inpatient psychiatric beds will remain at the Solnit Center's South Campus in Middletown. These beds will be for both genders, ages 13 through 17. The 16 PRTF beds for adolescent girls, 13 through 17 will also remain in operation. The facility will close two inpatient psychiatric units currently serving very young children and opening them both as PRTFs. One unit will provide care to adolescent girls, 13 - 17, while the other will serve both genders, ages 12 through 15 with complex behavioral health care needs that include but are not limited to: aggression, self-harm, substance abuse and low-risk problem sexual behavior.

- Crisis Stabilization Services. There are two crisis stabilization programs in the state that offer short-term residential treatment (up to 15 days length of stay) for children, ages 7 - 18 who have a rapidly deteriorating psychiatric condition, complex behavioral health needs, and who are at imminent risk of removal from home to a higher level of care. 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. There are 8 beds, with an annual service capacity of 184 children for the Meriden, Middletown, and Milford areas, and 6 beds with an annual service capacity of 145 children for Hartford, Manchester and New Britain areas.

- Emergency Mobile Psychiatric Services (EMPS). The target population includes any child (up to age 18) who may be experiencing a mental or behavioral health crisis. The community-based crisis intervention and assessment service includes mobile response (over 90% of children are seen in their homes, at school, or in the community within 45 minutes of receiving the crisis call), psychiatric assessment, crisis stabilization, 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 from any city or town in Connecticut. The service is available across child welfare, juvenile justice, prevention and behavioral health systems. There are six regional service areas, a statewide call center and a performance improvement center. Last year there were 13,814 calls which developed into 10,560 episodes of care for children, youth and families.

- The Community Bridge Program. Children, ages 11-17 with complex behavioral, emotional and physical needs that would likely necessitate out-of-home care if a successful intervention were not implemented, and their caregivers receive intensive in-home therapeutic support on a 24/7 basis from a clinical team comprised of licensed clinicians and paraprofessional mental health support workers. The Bridge is envisioned as a flexible array of family-based community, residential and aftercare programs that are closely linked and integrated. Youth at this level of care will have access to consultation from a psychiatrist to monitor the effectiveness of medication. Most services will be oriented to an in-home venue and will be rooted in evidence-based practice. The clinical team engages with all family members and provides necessary support to the youth in all aspects of community functioning for a period of up to two years. Youth who do not have adequate family resources are served in foster homes. The community-based service is supplemented by the availability of brief residential placement for purposes of assessment and behavior stabilization. This relatively new program has been in operation as a pilot in one community (Hartford), serving 20 children and families over a period of five months. Expansion to other areas of the state is expected to occur in 2013 and beyond.

- Intensive In-Home Services. These services are designed to enable children and adolescents to remain in their own homes, with the goal of preventing hospitalization or residential placement and/or assuring a successful transition to their own communities following out-of-home treatment. These programs have the capacity to serve more than 4,000 children and their families annually.

    - Intensive In-home Child and Adolescent Psychiatric Services (IICAPS). The target population is children and adolescents, ages 5 to 17 with complex psychiatric disorders who have been hospitalized or at risk for psychiatric hospitalization or residential treatment. IICAPS is a six month home-based intervention designed to address specific psychiatric disorders in the identified children while remediating problematic parenting practices and/or addressing other family challenges that impact the child and family's ability to function. Service is delivered by a team of professionals and averages 4 to 6 hours a week of intervention with the child and caregivers. The goal of treatment is to prevent psychiatric hospitalization and return the child to community-based outpatient care. Approximately 2000 families per year receive services by 130 certified IICAPS teams (14 provider agencies), with coverage across the state.

    - Multisystemic Therapy (MST). For children/youth, ages 12 to 18 (18 year olds accepted on case-by-case basis) with conduct disorder and 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 3 to 5 months. DCF involvement is not required. Annual capacity is 212 children and their caregivers. DCF Area Offices covered are Bridgeport, Hartford, Manchester, Milford, New Britain, New Haven, Norwich, Waterbury, and Willimantic.

    - Multisystemic Therapy - Family Integrated Transitions (MST-FIT). The target population includes youth on parole, ages 12 to 17 ½ with co-occurring mental health and substance use disorders and their caregivers. These youth are currently living in a residential or juvenile justice facility and are scheduled to return home within 2 months. Integrated individual and family services are provided during the period of re-entry into their communities. These youth have received dialectic behavior therapy while in placement. The six-month program is available in Hartford, Manchester, Middletown, New Britain, Torrington and Waterbury. The annual capacity is 60.

    - Multisystemic Therapy - Transition Age Youth (MST-TAY). The target population is youth, ages 17 to 19 with serious mental health conditions and/or substance abuse disorders, and involvement with the juvenile or criminal justice system. Services focus on fostering skills of independent living and addressing problems that impact functioning as an emerging adult. A typical course of treatment is 4 to 8 months, with life coaching available up to 14 months. DCF Area Offices served include: Bridgeport, Meriden, Milford, New Haven, and Waterbury. Annual capacity is 30.

    - Multisystemic Therapy – Problem Sexual Behavior (MST-PSB). This 5 to 7 month evidence-based program provides in-home treatment and services for children, ages 10 to 17.5 with problem sexual behaviors. The model is family and community-based and has demonstrated long-term positive outcomes with minimal recidivism of problem sexual behaviors. The program may be used as an alternative to residential treatment or as a step-down from residential care for the small number of very high risk youth who require the level of supervision and containment provided in residential treatment. Statewide annual capacity is 123 clients and caregivers.

    - Multisystemic Therapy – Building Stronger Families (MST-BSF). The target population is children/youth, ages 6 to 17 who are involved with DCF for child

abuse/neglect allegations and at risk of out-of-home placement, and who have at least one parent with alcohol or drug-related problems. The primary work addresses safety, permanency, and well-being of the children and parental substance abuse for a period of 6 to 8 months. There must be DCF child protective services involvement. The service is available in the Meriden and New Britain DCF Area Offices. Annual capacity is 20.

- Multidimensional Family Therapy (MDFT). The target population includes 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 an average of 6 months. Individual, caregiver and family therapy, and case management services are provided. DCF involvement is not required. These services are located in Bridgeport, Danbury, Hartford, New Haven, Norwalk, Manchester, Milford, Stamford, Torrington, and Waterbury. The MDFT teams serve about 713 families annually.

- Multidimensional Family Therapy (MDFT), Residential. The target population includes males, ages 12 to 18 whose behavioral needs cannot be managed in community, home or educational settings. These children are often at risk or using substances and exhibit complex behavioral needs. Four months of residential MDFT services are followed by 4 to 6 months of community-based MDFT services. The service is available statewide, with an annual capacity of 24.

- Family Substance Abuse Treatment Services (FSATS). The target population covers children/youth, ages 12 to 16 who have been in detention, where there is evidence of either youth and/or parental substance abuse. Treatment focuses on providing substance abuse treatment, addressing family systems issues and extra-familial systems for a period of twelve months. DCF involvement is not required. These services are available in Hartford, New Britain, Willimantic/Manchester, Norwich and Bridgeport. The five FSATS teams serve about 100 families annually.

- Functional Family Therapy (FFT). The target population includes at-risk children/youth, ages 11 to 17 and their caregivers, including youth with problems such as conduct disorder, violent acting out, and substance abuse, many of whom are involved with the juvenile justice system. The primary treatment focuses 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. There are currently four provider agencies with a total of five teams. Last year 519 youth and their caregivers were served.

- Family-Based Recovery (FBR). The target population is infants/young children, ages birth to 3 years who are at risk of an out-of-home placement due to parental substance abuse. Adult substance abuse treatment is integrated with family treatment designed to enhance parenting and parent/child attachment for a period of 7 to 18 months. FBR serves about 120 families annually in Bridgeport, New Britain, Milford, New Haven, Norwich, Waterbury, and Willimantic.

- Child and Family Interagency Response, Support and Training (Child FIRST). This evidence-based, early childhood home visiting program, based on the latest research on early brain development and attachment theory provides services to abused/neglected, or at-risk children from prenatal to age 5. The goals are to decrease SED, developmental and behavioral problems and abuse/neglect by facilitating nurturing child/parent relationships and connecting families to

services and programs. A two-person clinical and paraprofessional team addresses family mental health challenges (including maternal depression) and basic service needs. Six expansion sites began receiving DCF funding in SFY 2012 to ensure continuous operation and are fully funded by DCF for SFY 13 going forward.

- Outpatient Psychiatric Clinics for Children (Child Guidance Clinics). DCF maintains grant-funded contracts with child guidance clinics to provide behavioral health services for children, under age 18 and their families. A multidisciplinary team of psychiatrists, psychologists, masters' level clinicians and other behavioral health professionals provide diagnostic and treatment services. The goals are to promote mental health and improve functioning, and to decrease the prevalence and incidence of mental illness, emotional disturbance and social dysfunction. These providers deliver a variety of clinical treatment and rehabilitative support services that include but are not limited to: assessment (psychosocial, psychiatric and psychological); medication evaluation/management; crisis intervention services; individual, group and family therapies; substance abuse treatment; parenting skills development and training. Last year 22,402 children and their caregivers were served.

    - Enhanced Care Clinics. Through the CT BHP specially designated mental health clinics, referred to as Enhanced Care Clinics have been established to enhance access and improve the quality of care. To date 37 clinics have received approval status. These clinics are required to meet specific access and other requirements in order to receive enhanced Medicaid rates.

    - Specialty Clinics. Some clinics offer specialized services to treat problem sexual behaviors, obsessive-compulsive disorders, pervasive developmental disorders, traumatic stress disorders, and tourette's disorder.

    - Substance Abuse Clinics. Several clinics also provide outpatient substance abuse screening and evaluation, individual, group and family therapeutic interventions for youth, ages 11 to 17 and their caregivers. DCF youth have priority access. 358 adolescents received services last year. DCF Area Offices with these clinics include: Bridgeport, Middletown, Milford, New Haven, Norwich, Waterbury, and Willimantic.

    - Project MATCH-ADTC (Modular Approach to Treatment for Children with Anxiety, Depression, Trauma and Conduct Disorders). This evidence-based 4-year pilot program at 3 outpatient clinics, beginning in February 2013 will serve youth with disruptive behaviors, anxiety, depression and trauma. This approach has been extensively tested in community mental health settings as part of the ChildSTEPs clinical trials. State and federal grant funds will be used to support the clinics. State funds will sustain the effort if proven successful.

- Extended Day Treatment (EDT) Services. The target population includes children and youth, ages 5 to 17 who present with moderate to serious emotional and behavioral disturbances and their caregivers. A multi-disciplinary team of psychiatrists, APRNs, clinicians and direct care staff at 19 program sites (11 providers) deliver an integrated array of behavioral health treatment through individual/family/group therapies, multiple family groups, and therapeutic recreation as well as rehabilitative support services, for a minimum of 3 hours per day/5 days per week through a milieu-based model of care. For SFY 2012, a total of 1,134 children/youth and caregivers were served.

- Extended Day Treatment (EDT) Services – Juveniles Opting to Learn Appropriate Behaviors (JOTLAB) Program. The target population includes a mixed gender, ages 8 to 17 who have engaged in inappropriate and abusive sexual behaviors, and their caregivers. Both adjudicated and non-adjudicated youth who may or may not be involved with DCF are eligible for services. Clinical evaluation, individual psychotherapy, family counseling, psycho-educational therapy

groups, and social skills building groups are provided. These services are primarily delivered in the Milford and New Haven areas of the state. Last year 99 children/youth and their caregivers received services.

- Intensive Family Violence Services (IFVS). For DCF-involved families who have experienced domestic violence, core services include: safety assessments; safety planning for the survivor and child; trauma-focused work with children; dyad-based interventions focused on repairing and healing relationships and on batterer interventions.

- Domestic Violence Consultation. Community domestic violence consultants are available to provide expertise for frontline child welfare workers. The intent is to improve our capacity to identify and respond to domestic violence. The impact of domestic violence on children from a holistic perspective is emphasized. This requires an expansion beyond an incident-based, safety focus to include the chronic behavior patterns of perpetrators and a more meaningful understanding of the behavioral health, substance abuse and mental health needs of children and their caregivers. Staff discusses and responds to the impact of trauma, including whether the child and/or caregiver may be presenting with traumatic stress symptoms and require further trauma-specific assessment and/or treatment.

- Regional Resource Group. Each area office has a multi-disciplinary group that provides a range of support and consultation services to caseworkers. The Group provides expertise in substance abuse, domestic violence, behavioral health, medical issues and skilled clinical social work treatment services involving complex cases.

- Child Psychiatry and Trauma Consultation Services. The target population is community-based mentally ill and/or traumatized children and youth connected to DCF through either voluntary services or an open case. One of the two Central Office Child Psychiatrists or the Central Office Psychologist with expertise in trauma provides case-specific consultation at the request of a community provider, the probate court, or the area office worker or team member who is struggling to meet the needs of the child/adolescent. The child may still be residing with their family, or in a foster home, a group home, a residential treatment center, an out-of-state placement, a shelter, or an acute or long-term hospital. The consultation may be about the use of medication, the diagnosis, or the treatment approach. In SFY 2012 approximately 200 consultations (some brief/some in-depth) were provided.

Community Support Services

(These services are available statewide unless otherwise noted).

- Care Coordination Services. These services are provided to children and youth, ages birth to 17 and their caregivers. These children have serious mental or behavioral health needs that place them at risk for removal from their home and/or community, and who are not formally involved with child protection or juvenile justice services. Care coordinators utilize an evidence-based child and family wraparound team meeting process to develop a plan of care that uses both formal and informal networks of care to meet the unique needs of each child and caregiver. Services include assessment, service planning via the Child Specific Team, and service brokering. Last year 1200 families were served.

- Respite Services. These services are available for children and adolescents, under age 18, who have emotional and/or behavioral needs that require constant attention from their caregivers. Both DCF involved and non-involved children from the local systems of care are eligible. The intent is to prevent family disruption by reducing stress and burnout by caregivers and to provide age appropriate social and recreational activities. This is accomplished by providing community or home-based respite for up to 4 hours per week for a 12 week period. The statewide capacity 250 is clients annually.

- Family Advocacy Services (FAVOR). FAVOR is an umbrella statewide organization that has been created to educate and support families in their advocacy efforts. 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). The target population includes parents or caregivers of children and youth who have a serious mental or behavioral health need that places them at risk for removal from their home and/or community and who are not involved with child protection or juvenile services. FAVOR offers a 12-week brief family intervention or a longer term family advocacy intervention of 6 to 12 months, depending on the needs of the family. The Family Advocate is paired with the Care Coordinator and shares the child and family wraparound team meeting process with the care coordinator, but focuses on providing support to the parent/caregiver throughout the intervention. Annually, FAVOR serves over 400 families.

- Regional Family Engagement System Coordinators. This is a new initiative that will provide leadership in regional system development from the family perspective. Family engagement coordinators will be employed by FAVOR, the statewide umbrella agency for family advocacy. Each family engagement coordinator will work in partnership with the DCF Regional Systems Managers with formal reporting and supervision through FAVOR to promote the core values of the local system of care. These values include family-driven, youth-guided, culturally and linguistically competent, individualized and community-based, and evidence-based programming. These individuals will assist in identifying natural supports, including the faith community, service organizations and recreational agencies, as well as promoting improved coordination with other community-oriented collaboratives. There are 8 regional coordinators for statewide service.

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

- Behavior Management Services. These services for DCF-involved children and youth are intended to develop or support a therapeutic behavior plan to be followed by parents, caregivers, teachers and/or other service providers. This includes preparation of a written therapeutic behavior plan designed to assist in the management of the child's behavior. Duration of services is 40 hours or 60 days whichever comes first.

- Voluntary Services. Children up to age 18 with emotional, behavioral or substance abuse disorders whose needs cannot be met through existing services or for whom services are not available, and their caregivers may receive case management services, community referrals and behavioral health treatment. These are children who are not referred to the Department under an allegation of abuse or neglect and who are not committed. Last year 1,569 children and caregivers were served.

- 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. During SFY 2012 a total of 361 unduplicated clients were served.

- 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. Annual bed capacity is 282 contract slots.

- Family and Community Ties Program. Currently there are 6 providers who operate one family home each, staffed with professional parents and utilizing a wraparound approach to service delivery for some of the Department's most complex youth. This model promotes in-state individualized and comprehensive treatment in a family setting. This resource offers an alternative to residential placement.

- 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.

Prevention Services

- Suicide Prevention. The statewide Suicide Prevention Initiative targets youth from 10 to 24 years of age and provides training for school staff, first responders, Head Start staff, clinicians, and DCF workers. Training includes: Assessing and Managing Suicide Risk (AMSR) and Core Competencies for Mental Health Professionals. DCF and DMHAS staff works in partnership to coordinate the training. The training is offered to local police and emergency medical personnel.

  The Connecticut Youth Suicide Advisory Board assumes responsibility for increasing public awareness and making annual planning recommendations to the Commissioner.

- Connecticut School-Based Diversion Initiative (SBDI). SBDI aims to reduce the number of children who are arrested for relatively minor behavioral incidents that can be addressed through in-school discipline and access to mental health services rather than formal processing through the juvenile justice system. Secondarily, SBDI seeks to reduce the number of youth who are expelled or receive out of school suspension when these students can be held accountable while remaining in school. Funded by the Connecticut Judicial Branch, DCF and Department of Education, the model brings training to school staff for recognizing mental health needs, including trauma exposure, and accessing services and supports in the school and the community.

- Positive Youth Development Initiatives. Afterschool programs are available for youth, ages 8 - 14 to prevent children from entering the DCF system. Services include parenting, recreational and enrichment activities for children, tutoring, social skills building, and parent engagement and support.

- Early Childhood Consultation Partnership. DCF funds statewide mental health consultation services to pre-schools, Head Start, and providers. The service is designed to meet the social/emotional needs of children birth to five by offering support, education and consultation to those who care for them. A primary goal of ECCP is to reduce/eliminate the incidence of suspension/expulsion of young children from their care and education setting. All towns and cities have access to consultation. Each major urban city has a dedicated consultant, in addition to a second consultant serving the surrounding communities. Between 2002 and 2010 there were 12,350 children served at 715 centers.

- DCF-Head Start Partnership. All 14 DCF area offices have established and strengthened a working partnership with Head Start and Early Head Start programs. The goals is to ensure children's access to high-quality early care and education, enhancing stability and supports for young children and families, and preventing family disruptions and foster care placements.

Housing Resources

- Supportive Housing for Families. DCF contracts with a community provider, The Connection, a statewide housing non-profit agency, to provide about $ 12 million in housing services to its clients annually. Services include housing assistance and intensive case management services to DCF families who are homeless or at risk of homelessness. There are 500 families served across the state. A newly awarded $5 million, 5-year grant from ACF will allow the state to expand and enhance services for families experiencing chronic homelessness and high service need. Services include affordable housing, intensive, on-site case management and a variety of vocational, mental health, and educational supports to strengthen the family unit.

- DCF Young Adult Supportive Housing Pilot. Housing assistance and case management services are provided for 36 DCF youth who are homeless or at risk of homelessness.

- Community Housing Assistance Program (CHAP) Case Management**.** This is a community-based program that provides case management, supervision, educational and vocational support or career development support, and life skills development services, utilizing the DCF approved Life Skills Program - Ansell Casey Life Skills, to youth living in a community housing environment. This case management service is for youth who are committed to the Department as abused, neglected and/or uncared for at the time of placement into the program or at youth's eighteenth (18th) birthday and is intended as a component of a comprehensive treatment plan. As such, the individual providing this service is expected to collaborate with other service providers toward the implementation of the child's individual treatment plan. The service is only for referrals approved by DCF for a period of twelve months, with a maximum extension to eighteen months.

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

- **Human Anti-Trafficking Response Team (HART).** The State of Connecticut has increased its efforts to identify and respond to child victims of human trafficking. In 2008 almost 100 victims of sex trafficking were identified and confirmed within our state. With few exceptions, the majority of victims were children in DCF care. The HART team, comprised of various individuals with specific expertise to support the team's efforts will focus on three areas:
  - Awareness and education;
  - Identification, response and restoration; and
  - Recovery of youth impacted by this crime.

STRENGTHS

System of Care Philosophy, Values and Infrastructure

DCF adopted the 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 14 area offices. This statewide integrated system of services and supports, known as Connecticut KidCare continues to operate today. The intent is to promote community-based care planning and local service system development. At the community level, Connecticut KidCare and the wraparound model operates through a child-focused, family-centered approach to service delivery. This is a strengths-based, recovery-oriented, age and culturally appropriate system to serve children and their caregivers. All treatment, support and care are

locally coordinated across various systems and provided in a context that meets the child's psychological, developmental, educational, treatment and care needs.

Health and Wellness Framework

Health and wellness are at the heart of the DCF mission and are fundamental to DCF's cross-cutting themes, 2012-15 Strategic Plan, and Results-Based Accountability (RBA) focus. Refer to Section A - Organizational Structure for details. The purpose of the health/wellness framework is to guide decision-making and action so that all children engaged with DCF achieve optimal health and wellness. Examples of implementation strategies include:

- DCF Health and Wellness Unit to collaborate with community providers for services and guidance around children's health needs, including the education of medical providers about DCF and the needs of children and their families we serve;
- Health Advisory Board, comprised of members of CT Chapter of American Academy of Pediatrics and CT Council of Child and Adolescent Psychiatry, and Departments of Social Services, Public Health, and Developmental Services to guide development and implementation of policy and practice for DCF-involved children; and
- Establishment of regional system of providers who will work with DCF regions to ensure access to services for children in our care.

Diverse Workforce

The behavioral health service system workforce is highly dedicated and diverse. Much emphasis and resources have been directed towards training and skills development in recent years, thus providing the workforce with the competencies and skills necessary to engage, assess and intervene to assist children and families in achieving health and well-being.

Family-Centered Child Welfare Practice

Experience and research indicate that the quality of family participation is the single most important factor in the success of our interventions. Within the state child welfare system, the Strengthening Families Practice Model and Family Assessment Response (FAR) - which is an important component of the practice model - will substantially improve how we support families to take control and responsibility of their own treatment and their own lives. The FAR utilizes a family team meeting to engage the family in the assessment, planning and treatment process in order to assess their own strengths and needs and to identify their natural supports in the family and community.

Child and family teaming is another component of the Strengthening Families Practice model. Applied at the time of considering removal from home and/or at the time of considering a permanency plan, this is an effective way to engage families to achieve better safety, permanency and well-being outcomes.

Fatherhood engagement is also a critical component of family-centered practice. The goal is to promote positive outcomes for children through early and ongoing efforts to identify, locate and engage fathers.

Trauma-Informed Care

Connecticut has focused on building a statewide system of Trauma-Informed Care available to families across the state experiencing sustained traumatic stress reactions. Key components include the following.

- Beginning in 2007, DCF utilized a combination of DCF state funds, mental health block grant funds and a recently awarded federal grant from ACF to partner with a coordinating center, the Child Health and Development Institute (CHDI) to disseminate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in community-based children's outpatient clinics across Connecticut. There are currently 22 clinics with more than 250 clinical staff trained to provide TF-CBT. Since 2007, this network has provided TF-CBT to more than 2, 000 children and their caregivers. In addition, a range of other evidence-based or promising trauma-informed treatments for children are available at selected provider agencies.
- The statewide Emergency Mobile Psychiatric Service (EMPS) has trained staff, as first responders (trained in Psychological First Aid).

- Workforce development and training on identifying and responding to child trauma is available for pediatric primary care providers, school personnel, police and child welfare workers.
- As part of a federal grant from the Administration on Children and Families, the Department is planning a statewide roll-out of trauma training and universal trauma screening in 2013. All child welfare staff will be trained using the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit, and will also be trained to administer a brief, standardized trauma screening tool. All children involved in the child welfare system will be screened for trauma exposure and traumatic stress symptoms, and those deemed at risk will be referred for further assessment by clinicians trained in trauma assessments and trauma-focused treatments. The goal is to identify children suffering from traumatic stress symptoms as early as possible, and to connect them to appropriate services.

Diverse Service Array

A wide range of clinical and non-tradition services, programs and rehabilitative supports are available across the state, including services to address trauma and co-occurring disorders. Please refer to Section 1 for details.

Community-Based versus Congregate Care

During the past two years DCF has undertaken crucial reforms to ensure that children, especially children under 12 grow up in families, rather than in expensive institutional and congregate (group) care and when necessary, receive mental health services within their communities. Historically, Connecticut has had one of the highest rates of use of congregate care for young children in the nation. More than 350 children were placed in residential settings outside of the state, and at the same time, the Department's use of foster families was well below the national average. Sufficient funding was expended at the "back end" of the service continuum, associated with an overreliance on out-of-home residential services rather than on evidence-based, flexible family and community-based services that intervene early, promote development and resilience, and provide timely community treatment services. Within the past year, Connecticut has nearly halved the number of children under 12 in congregate care, and has also decreased the percentage of all children in congregate care. Recognizing the restrictive and costly nature of this treatment modality and its limited documented efficacy, the focus of DCF's behavioral health program development has been to foster and support community-based care and interventions, in tandem with reducing reliance on congregate care. Through mandatory policy and practice changes focused on reducing the age and length of stay for children residing in congregate care settings and implementing a system of performance management as well as review and repurposing of existing resources, the following results were achieved between January 2011 and October 2012.

- 13% reduction in number of children in placement
- 72% reduction in number of children in out-of-state residential placement
- 63% reduction in number of children ages 12 and younger in congregate care
- 81% reduction in number of children ages 6 and younger in congregate care
- 32% increase in number of placements with relative foster families

In order for the shift to family-based care to be successful, DCF has begun to invest a portion of the savings from reducing congregate care to community-based services that will support children returning to the community.

- DCF, in partnership with the Child Health and Development Institute (CHDI), providers and academia has disseminated a range of evidence-based and best practice models (e.g. TF-CBT, community-based Wraparound, Multisystemic Therapy (MST), ChildFIRST) that result in improved outcomes for children and families.
- Quality assurance mechanisms are in place to ensure improved treatment outcomes for children and families.

Family/Caregiver Involvement

Connecticut has long-term, well-organized and effective consumer, family, and advocacy organizations. These include, but are not limited to: Family Advocacy Services (FAVOR), Children's Behavioral Health Advisory Council (CBHAC), State Advisory Council (SAC), Youth Advisory Boards and others. (Please refer to Section 1 for details).

The Mental Health Block Grant (MHBG) state plan is informed by CBAC and its MHBG subcommittee. Families and consumers also participate in reviewing bidder proposals for new or re-procured programs and services, learning collaboratives such as the family engagement and TF-CBT collaboratives for outpatient clinics, and various committees to evaluate programs, develop new services and initiatives, and implement plans.

At the case-specific level, there are care coordinators, family engagement specialists, intensive care managers (CT BHP), child-specific team meetings for non-DCF involved children, child and family team meetings for DCF-involved children, and other resources to assist families in successfully connecting with and effectively utilizing appropriate resources.

Collaboration Within and Across Agencies and Systems

Efforts aimed at coordinating services at the community level occur across child welfare, juvenile justice, adult and children's behavioral health, developmental, and healthcare service systems. The goal is to promote more efficient and integrated service delivery. At the state level several councils and boards exist to assist in the planning and coordination of behavioral health services. Please refer to Section 1 for examples.

Infant and Early Childhood Mental Health Initiatives

The most cost-effective approach to optimal mental health is to start in the earliest years to promote healthy brain development and strong and nurturing attachments. The following are examples of statewide initiatives to advance this agenda and support a child's optimal social-emotional development from birth.

- A public/private partnership supports communities across the state to develop comprehensive plans for early childhood systems to assure that children's full range of developmental needs, including social-emotional, are met at home and in early care and education settings.
- The CT Infant Mental Health Association has an approach for training and endorsing professionals at all levels who interact with children in a competency-based approach to promote infant mental health.
- There are several strong outreach, screening, prevention, and clinical mental health programs for our youngest children including ChildFIRST, Early Childhood Consultation Partnership (ECCP), Early Head Start, Home Visitation programs and Help Me Grow.
- *Educating Practices in the Community* (*EPIC*) trains pediatric providers throughout the state to screen children for a variety of health and mental health issues (developmental and behavior problems, trauma and autism) at well-child visits and connect them to further evaluation and intervention services when needed.
- Mid-Level Assessment fills a gap in the child health system, connecting at-risk children to early therapeutic health and mental health services more efficiently, without having to wait for sometimes unneeded comprehensive evaluations for which there are a dearth of appropriate providers. It was recently piloted at three Connecticut sites with excellent results.
- In June 2012 DCF launched *First 1000 Days: Getting It Right from the Start*, a collaborative public/private initiative with the Governor's Office, six state agencies, pediatricians and other professionals to focus attention on improving the development, health, safety and school readiness outcomes of young children in the state of Connecticut. It is a period of public and private action to support Connecticut's most vulnerable children, prenatal through age 3, served by multiple agencies. Activities over the next three years include forums, specific topic-focused webinars, a public gateway website and public-private sector engagement at both the state and local level. One goal is to expand coordinated access to family-based intervention and prevention services.

Husky A (Medicaid) and Husky B (CHIP - Child Health Insurance Program)

Husky Health is a pillar of Connecticut's health care infrastructure for children, parents, and pregnant women, providing low-cost or free health care coverage for abut 275,000 children and nearly 134,000 parents and pregnant women. One in four children in the state relies on Husky Health for preventive and comprehensive health care services. Under Husky A, children under the age of 19 in families with income under 185% of the Federal Poverty Level (FPL) are eligible for coverage. Under Husky B, all uninsured children under 19 in families with income above 185% of FPL are eligible for coverage.

The state has changed its model for providing care and now pays for medical care, but utilizes a private contractor (CHNCT) instead of a managed care organization to provide administrative support functions, such as assisting families in finding a doctor, conducting outreach to enroll providers, and tracking utilization of services.

Bi-Directional Integration of Behavioral Health and Primary Care Services

Connecticut has become a national leader in promoting the Person Centered Medical Home (PCMH) model of care as the optimal health care delivery system for children. A "medical home" is an accessible and family-centered primary care practice that is well coordinated with medical and community services that children need. In January 2012, Connecticut was the first state to implement a statewide medical home system through Medicaid. Governor Malloy called for a reorganization of Husky from a managed care system to a PCMH model. Medicaid providers who achieve national medical home recognition receive increased Medicaid payments. Private insurers have stated their intention to follow suit. Since the change took effect in January 2012, the Department of Social Services has approved more than 100 practices (including almost 500 providers) as medical home providers. Another 79 practices have applied.

One of our leading partners, The Child Health and Development Institute of Connecticut, Inc. (CHDI) has assisted nearly two-thirds of Connecticut's pediatric practices with change strategies through an initiative known as Educating Practices in the Community (EPIC). They assist providers to access care coordination for their patients, implement family-centered care, incorporate developmental surveillance and screening in their well child services, and address behavioral health concerns. This has contributed to a nearly seven-fold increase in the number of children who are screened for developmental and behavioral health issues in Connecticut since 2008.

DCF recently re-procured the Multi-Disciplinary Examination (MDE) service to include a new requirement that MDE clinics communicate with a child's Primary Care Provider (PCP) before the MDE and that they also provide them with a copy of the MDE report. It is expected that the DCF Area Office nurse will work with the PCP to review the MDE report and develop recommendations for a child's treatment plan.

Federal/State/Community/Family/Consumer/Academic Partnerships

DCF works in collaboration with a broad, diverse network of stakeholders including but not limited to: federal/state agencies, community providers, families, consumers, advocates, and academia. The coordination of care as well as program planning, development and evaluation across providers and service systems is critically important to the overall success of the system.

In September 2011 DCF launched a new level of partnership between the public and private sector, known as The Continuum of Care Partnership. Membership includes DCF Senior Leadership, the Connecticut General Assembly and broad representation from the private sector including non-profit providers, pediatricians, psychiatrists, early childhood, juvenile justice, families, and advocates. Serving as an advisory group to the Commissioner, the tasks include identifying implications for the private sector related to current DCF policy initiatives, identifying additional areas of service needs to achieve DCF goals, and identifying joint training needs/opportunities.

Highlights of current federal/state partnerships include:

- $ 3.2 million, 5-year grant from the Administration for Children and Families to expand trauma training and implement universal trauma screening for the child welfare system, and to further disseminate evidence-based trauma treatments, specifically Trauma-Focused Cognitive Behavioral Therapy and Child and Family Traumatic Stress Intervention;

- 2 National Institute on Drug Abuse (NIDA)-funded research projects on the effectiveness of adaptations of evidence-based models (MST and MDFT); and

- $ 5 million, 5-year ACF-funded supportive housing grant to implement the state's first intensive supportive housing program for families in the child welfare system experiencing both chronic homelessness and high service need.

Populations Served

Connecticut uses a variety of programs, services, practices and strategies funded by state and local funds as well as other resources including the federal mental health block grant to meet the mental, emotional and behavioral health needs of all children, adolescents and their caregivers. Examples of specific target populations include those children/youth experiencing: general mental health disorders; SED; adverse traumatic life events; co-occurring substance abuse and mental health disorders; juvenile justice issues; and lesbian, gay, bisexual and transgendered and questioning (LGBTQ) individuals.

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

System of Care Infrastructure

The original "System of Care" concept was never fully realized in Connecticut. The existing collaboratives lack the resources and infrastructure to fulfill their leadership and executive function. As a result, each one has undertaken different activities and achieved varied results. Taken together, these networks cannot be considered a statewide system.

Regional Service System Development

There is a need to further develop and expand the regional service system. This includes continuing to build the DCF regional structure, increasing investment in regional networks of in-home and community services, increasing foster family recruitment and support, implementing the federal trauma and housing grant awards, and implementing the DCF health framework to address children's medical, dental, mental health, and other needs per the Juan F. Consent Decree Outcome Measure 15.

Specific "systems development" recommendations by The Continuum of Care Partnership include: establishing lead provider agencies at the regional or area office level with functions including centralized referral and case management, redesigning existing System of Care Collaboratives to support planning, stakeholder input, oversight and communications within the DCF regional infrastructure, and strengthening agency involvement with Value Options, the Administrative Service Organization for the CT Behavioral Health Partnership, in managing regional resource access and quality.

To advance this work, the Department has invested in a statewide needs assessment in partnership with the University of Connecticut's Health Center's Community Medicine and Health Care Division. There are three areas of work: capacity assessment including access and usage of key DCF-funded services; identification of current and future services, supports and resource gaps; and creation of regional resource maps. Findings are expected to be available in 2013.

Coordination of Services

Too often children with complex needs and their caregivers have poorly coordinated services, yet the coordination of care across providers and service systems is critically important to the overall success of the system. The effectiveness and efficiency of the rules and processes regarding how services are accessed, utilization is managed, and adjustments are made to better meet child and family needs can be as important as the quality of services. In addition, coordination of services and program development across child welfare, juvenile justice, adult and children's behavioral health, developmental, and healthcare service systems is necessary to prevent fragmentation and promote more efficient and integrated service delivery.

Too often there is inadequate coordination with local public schools, public health agencies, juvenile justice and other systems "at all levels," including data management and a communication infrastructure. Better linkages with schools are a high priority because it is a primary point of contact for almost all of Connecticut's children and a significant source of behavioral health referrals.

Funding and Revenue Maximization

The behavioral health service system is funded by a mixture of state, federal and local resources, private insurance, philanthropic organizations, school districts, individuals, families and others. When funding sources are aligned to maximize available resources and ease access to care, children and families are well served. When funding is not well aligned the child and family can be presented with a dizzying array of rules and procedures that create barriers to access and discontinuities in care. A well functioning system maximizes all available sources of revenue and blends funding streams to enhance the service array and improve access to care.

Continued fiscal planning based on DCF's Strategic Plan is necessary to improve state and federal revenue maximization and develop reinvestment priorities and methods. A critical area involves fiscal reallocation to family and community services, particularly given the return of children to their own communities as a result of the congregate care rightsizing initiative.

Child/Family Outcomes, and Performance-Based Contracting

There is a critical need to define, standardize and monitor performance indicators and outcomes for all types of purchased services and programs, thereby improving system efficiency, accountability, mental health and well-being for children and families. The department's move to measurable outcomes is guided by two requirements. First, Connecticut General Statutes Sec 17a-63a requires DCF to determine measurable outcomes for each type of private provider funded through DCF contracts, incorporate these outcomes into contracts, and include information on achievement of these outcomes and other quality indicators in annual evaluations of each such provider. Second, the Department has committed to apply the General Assembly's Results-Based Accountability framework agency-wide by the end of SFY 2013-14.

Data Management and Continuous Quality Improvement

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

A "data and information culture" is not pervasive throughout the system. Many reports do not display data in a manner that promotes its effective use, some stakeholders, especially families never see these reports, few managers are adequately trained in the use of data, and too few decision-making processes are built around data inputs. CHDI's Strengthening the Foundation: An Analysis of Connecticut's Outpatient Mental Health System for Children (May 2010) report found that for outpatient clinic services: "All stakeholders reported that data has not been extensively utilized to monitor treatment outcomes, inform outpatient treatment practices, or guide treatment decision-making. Clinicians also reported that they are the least likely to have data shared with them which can compromise the ability to use data to inform treatment."

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

There is a need to have one common data framework for reporting, including standards for data display, demographic categorization, and geographic representation. There is a need for provider training to ensure provider capacity to collect consistent data, draw correct interpretations and use data in meaningful ways to enhance service delivery and outcomes.

Data can not be shared broadly and regularly without formal protocols and the infrastructure for data sharing, such as internet-based data portals to facilitate public access to information. Funding sources that can support these needs are necessary.

At present no DCF facility utilizes an electronic medical record. The Department is in the process of working through an electronic records task force to develop and implement a plan to comply with HIPPA requirements and promote the common use of medical records technology.

Workforce Development

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

During the last four years, as programs requiring masters' level clinicians have expanded and more students seek degrees in higher paying professions such as business, finance, and technology, there is a shortage of clinicians, especially at outpatient behavioral health clinics where most children/youth are treated. As cited in CHDI's Strengthening the Foundation: An Analysis of Connecticut's Outpatient Mental Health System for Children (May 2010) report, administrators and clinicians cite "low pay, burnout, and limited opportunities for training, professional development, and career advancement as the primary factors" related to staff turnover. Other factors included "poor preparation for service delivery and insufficient supervision."

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

Supervision has suffered in response to flat funding and budgetary limitations. In many cases, supervision is either not provided, is infrequent, is limited to "administrative" supervision, or a low priority. Even when supervision is provided, supervisors may not have been adequately trained or provided with resources to support the supervisory role. It is critical to develop supervision models and support their implementation in the workplace through a variety of methods including pilot projects, implementation of evidence-based practices with embedded supervisory and consultative components, funding and reimbursement support of supervisory practice, and training and support programs.

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

Access and Service Capacity

The need for child and adolescent mental health services exceeds the available behavioral health resources, which is a similar trend across the nation. Between 7% and 9% of children and youth in the United States meet the criteria for serious emotional disturbance (SED) indicating the presence of a psychiatric disorder that seriously interferes with functioning at home, in school, and/or community. Most recent estimates are that up to 20% of children and youth have some form of psychiatric disturbance and almost 70% do not receive treatment for their disorder. Of Connecticut's 807,985 children/youth, this translates to an estimated 60,000 to 76,000 children and youth with SED and up to 100,000 additional children with some form of psychiatric disturbance requiring mental health care (Sources: U.S. Census Bureau; US DHHS Agency for Health Care Research and Quality; Collaborative Psychiatric Epidemiologic Surveys). DCF's Programs and Services Data Collection and Reporting System (PSDCRS) show that a total of 34,974 children/youth were served during SFY 2012. Of the total, 71% or 24,856 children/youth were reported as having SED. However, the PSDCRS database shows that less than 25% of these children/youth received evidence-based treatments tailored to their primary diagnosis. As another indicator of need, the SAMHSA, Survey on Drug Use and Health Model-Based Estimates, 2008-2009 and 2010-2011 indicates that 7.8 percent of youth, ages 12-17 (63,022 individuals) reported at least one Major Depressive Episode in the

past year, 2010-2011. Yet, the array of evidence-based services reported in the PSDCRS show that only approximately 6,000 children receive some type of evidence-based treatment.

It is well documented that rates of psychiatric disorder are even higher for those children living in poverty. It is estimated that 12.8% of Connecticut's children live below federal poverty levels (Source: January 2012 Annual Report of the Connecticut Child Poverty and Prevention Council). Although Connecticut has one of the highest state per capita incomes in the country, three of Connecticut's larger cities (Hartford, Waterbury and New Haven) have some of the highest child poverty rates in the nation. Psychiatric disorders are also higher amongst those involved with the child welfare and juvenile justice systems. In Connecticut there are approximately 4000 children/youth in out-of-home placement on any given day (Source: DCF LINK), which translates into a very conservative estimate of almost 400 children/youth with SED. Of those youth served in the DCF juvenile justice system, it is estimated that over half of the adolescents have some type of behavior disorder including mental illness and alcohol/drug dependence.

Access to behavioral health care for eligible children/youth is further challenged due to an uneven distribution of services across large, mid-sized and rural communities. Typically, larger communities deliver substantially more service units per youth and subsequently expend greater sums. Some communities may have a limited menu of service options or there may be wait lists for certain services. Sometimes the "right" type of service may not be available at the time of need. (Sources: DCF Programs/Services Contracts and Assigned Catchment Areas; DCF's PSDCRS SFY 2012).

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

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

Racial/Ethnic Disproportionality and Disparity

DCF is a multicultural agency, serving children and families from different backgrounds, races, ethnicities, creeds, sexual orientations, gender identities and linguistic ability. The diversity of the children and families brings challenges related to issues of racial and health equity as well as disproportionality within the child welfare and juvenile justice service systems. In 2010 DCF compiled the following data for children served.

a. Data on Children of Color. While children of color (that is, across all races and ethnicities that are not white/non-Hispanic) constitute about 37% of the total number of children in Connecticut, they constitute 58% of children referred as alleged victims of abuse or neglect, 61% of all children where abuse or neglect has been substantiated, and 60% of children in cases opened for DCF services. Children of color constitute 67% of all children in a DCF funded placement, whether a foster family or a congregate setting.

b. Data on African American/non-Hispanic Children. African American children constitute about 11% of the total child population in Connecticut, but 21% of all child welfare referrals and 22% of substantiations and cases opened for DCF services. They constitute between 27% of all placements, whether a foster family or a congregate setting.

c. Data on Children of Hispanic/Latino Ethnicity (any race). Latino children constitute about 19% of the total child population in Connecticut, but 28% of all referrals and 30% of all substantiations and open cases. Among all children in placement, Latino children account for 32%.

d. Data on Children of Other Races. The category of other race includes American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other, Multi-Racial and Missing/Unknown. These children constitute about 7% of the total population of children in

Connecticut and 9% of referrals, substantiations and open cases. They also constitute 6% of all children in placement.

"Disproportionality" in child welfare is said to occur when a group is under- or over-represented when comparing that group to the general population. A rate of disproportionality for a racial/ethnic group is calculated by dividing the percent of children in the child welfare population who are members of a racial/ethnic group by the percent of these children in the general population. If the result is greater than 1.0, children of that group are over-represented. If the result is less than 1.0, they are under-represented.

"Disparity" in child welfare is expressed through the calculation of a Disparity Index to show how disproportionality of one group compares with that of another. The Disparity Index is calculated by dividing the rate of disproportionality of one racial/ethnic group to that of another.

Calculating these two measures related to race/ethnicity with regard to DCF referrals provides clear evidence of both disproportionality and disparity. These data tell us that white children are under-represented in terms of referrals while African American and Hispanic children are over-represented. Further, African American children are 2.8 times more likely than white children to be referred while Hispanic children are 2.2 times more likely to be referred. The disproportionality rate and Disparity Index could also be calculated for other points in the case and placement process, and the results are likely to be no less striking.

Rates of Disproportionality in Relation to DCF Referrals, SFY 2010	**The Disparity Index in Relation to DCF Referrals, SFY 2010**
White Disproportionality: 0.66 African American Disproportionality : 1.87 Hispanic Disproportionality: 1.46	African American Disparity Index: 2.8 Hispanic Disparity Index: 2.2

The Department has launched an effort to focus on racial justice and the reduction of health and educational inequities for the youngsters who we serve. The agency-wide effort includes publication of the agency's first Health Equity report and the development of a Racial Justice work plan directed to identifying areas of policy and practice that contribute to disproportionality, racial/ethnic injustice and poor health outcomes among the children in care.

"System" Capacity Gaps

In October 2012, following a year of work with the broader stakeholder community, the DCF Continuum of Care Partnership made a series of findings and recommendations related to the system capacity in the following functional areas.

- Develop an easier process for families to access services (i.e. centralized referral);
- Enhance coordination of care across services and agencies, especially with local public schools, public health agencies, juvenile justice and other systems;
- Improve systems' planning, stakeholder input, oversight and strategic communication; and
- Provide better access to data on utilization and program quality.

Family/Caregiver Involvement

Too few families participate in overall system development and oversight as well as in their own case-specific care planning and treatment. The implementation of Kid Care in 2001 accelerated the Department's progress in increasing consumer and family involvement in planning and oversight of the statewide behavioral health system, and progress has been made in improving consumer, youth and family involvement in their own service planning and care. However, this movement has not yet matured to achieve a statewide family-driven system of care, a key finding of the Mental Health Needs

Assessment and Resource Inventory Summary Report (June 2007). Further, CHDI's Strengthening the Foundation: An Analysis of Connecticut's Outpatient Mental Health System for Children report (May 2010) found "no disagreement among stakeholders about the need for enhanced focus on family engagement."

One goal is youth and family participation in system design, planning, evaluation and oversight. The Department supports many strategies to promote participation including support of advisory bodies and advocacy groups, family participation in procurement of services and development of practice standards, consumer committees to analyze service data, and consumer survey methodologies. However, the progress that has been made falls short of effectuating a true family-driven and youth-guided process. Further, with the regionalization of services and programs for DCF clients as well as all clients served within their communities, this need is even more important. The Annual Report On The Status Of Connecticut's Community Collaboratives/Systems of Care (October 2012) recommended:

- Developing a formal infrastructure that facilities communication between multiple local initiatives such as Early Childhood Community Collaboratives, Foster Care Collaboratives and others;
- Implementing outreach activities to recruit other major system partners and informal supports; and
- Offering training to interested families on DCF's recent changes such as Strengthening Families Practice Model, Differential Response Services, Partners in Change, Trauma-Informed Care, and Six Cross-Cutting Themes.

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

One aspect of the Mental Health Needs Assessment and Resource Inventory Summary Report, completed by DMHAS under the Mental Health Transformation Grant in 2007 included a DCF Mental Health Transformation Survey. Through use of a self-reported questionnaire that solicited input from providers and parents, respondents were asked to rate the priority of each of the New Freedom Commission goals using a Likert scale. The highest priority for consumers was Goal 2 -Mental health care is consumer and family- driven, which was rated significantly higher than the providers' rating for this goal. It is clear that an important element of a transformed system of care includes that care is directed by people in recovery and their families. The CBHAC's Annual Report On The Status Of Connecticut's Community Collaboratives/Systems of Care (October 2012) cited the following needs/recommendations.

- Financial resources to support stipends, transportation and child care for families
- Orientation, education, knowledge and information about the behavioral health system of care
- DCF policy to ensure family involvement at all levels "from the waiting room to the board room," from the "micro" to the "macro," from the individual family to all families involved with DCF and the entire system

Through the implementation of many family-based evidence-based practices, the Department has promoted and supported the greater role of the family in the planning and oversight of their own care. However, other services that are not guided by a defined program model or that are not family-based do

not always actively involve families in the way that they should. Greater emphasis needs to be placed on insuring that family-based care planning is routinely incorporated into all treatment interventions. For example, the capacity of the Family Advocacy Program and Care Coordination, two services that embody the importance of family-driven service delivery, are limited and serve only a portion of children and families with SED. Two intensive Engaging Families Initiatives were completed within only two service types between 2010 and 2012 - the statewide Extended Day Treatment programs and 22 outpatient clinics. Further, although an ambitious training initiative was launched at the outset of Kid Care to educate stakeholders regarding the system of care principles, the training has not yet reached all stakeholders. Thus, many portions of the service system remain unaware of the critical importance of giving families voice about their needs, preferences and the design of their own care, and further many service providers have not received evidence-based training regarding family engagement protocols.

Childhood Trauma and Evidence-Based Treatments

There are a limited number of evidence-based treatments and promising practices available across the continuum of care. Connecticut's first foray into evidence-based practice focused on intensive community-based treatments that could divert youth from residential care. Although this focus was strategic and appropriate, it has resulted in less availability of these practices in less intensive outpatient settings and intensive residential and hospital levels of care. There is a need to have evidence-based practices readily available at all levels of care in the continuum of services. Only a small percentage of children are receiving such services. For example, the PSDCRS database shows the following number of children/youth receiving selected evidence-based treatments for SFY 2012.

- Therapeutic Foster Care 1,038 children/youth
- Multisystemic Therapy 116 children/families
- Functional Family Therapy 527 youth/families

Evidence-based treatments for traumatized children, youth and families are insufficient to meet the level of need. The prevalence of trauma is high in the general population, and higher in the foster care population. One of four children experience at least 1 potentially traumatic event before the age of 16, almost 2/3 experience more than one type of violence, and 4 in 10 children report witnessing domestic violence (David Finkelhor et al UNH). High risk populations are those that experience chronic traumatic situations including children who experience abuse/neglect, are in out-of-home placement, have been exposed to domestic violence, or are exposed to violence in their schools and communities. Rates for post-traumatic stress disorder are 21% for foster children versus 4.5% for the general population. Connecticut providers report that 70 to 80% of all children receiving mental health services have a history of traumatic events (CT PSDCRS - SFY 2012). Yet, there are few trauma-specific evidence-based treatments available to address the need, those that are available serve a small number of children/caregivers. For example, between 2007 and March 2010 1,012 children were assessed for TF-CBT using standardized measures and 854 children were identified as appropriate and began treatment. (Source: TF-CBT Monthly Metrics Child Health and Development Institute of the Connecticut Center for Effective Practice). This is a critical concern because it is well documented that those who are adversely impacted by traumatic experiences in childhood suffer lifelong consequences. These include poor physical and mental health, school failure, teen pregnancy, unemployment, and unsuccessful relationships.

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

and community providers continues to be a critical need. Another need is the dissemination of trauma-informed treatments to all levels of care including residential and inpatient settings.

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

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

Mental Health Needs of Foster Children

Children and youth involved in the foster care system have significant mental health needs that are not fully met. Data from the Juan F. Consent Decree for July - September 2012 reports that only 72% of foster children had mental health, behavioral health and substance abuse service needs met. Only 63% of cases included clinically appropriate, individualized family and children specific treatment plans. Between ½ and ¾ of youngsters entering foster care exhibit behavior or social competence problems requiring mental health care. More than ¾ of youngsters in foster care present with serious emotional disturbance. By the time they are teenagers, 63% of children in foster care have at least one mental health diagnosis; 23% have 3 or more diagnoses.

There is a need to continue to reduce the use of psychotropic medications for foster children. Nationally, 27% of foster children are prescribed antipsychotics; more than 9 times the rate of those on Medicaid who are not in foster care. In Connecticut, psychotropic prescriptions have declined. In 2010, 25.1% of DCF committed children/youth were prescribed psychotropic medication; decreased to 24.7% in 2011 and 22.8% in 2012. In spite of these reductions, there is more work to be done to continue this trend. If children receive effective treatments at the earliest possible point of contact with the system, this may prevent deteriorating mental health, support stabilization, and lessen the need for medications.

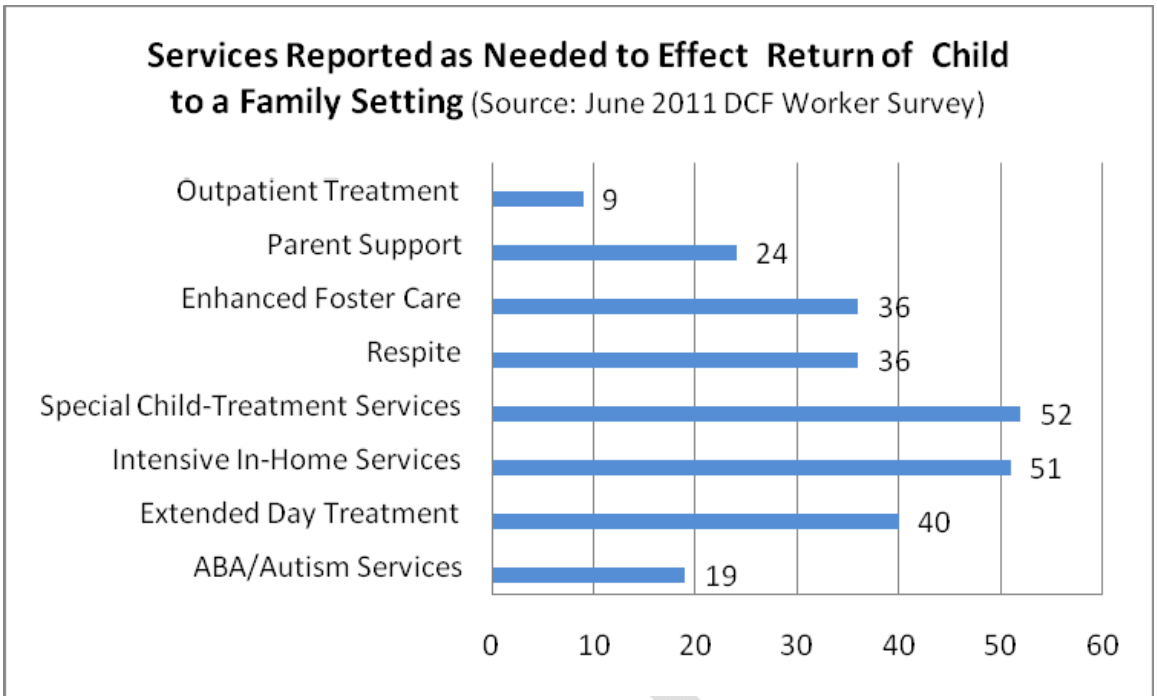
Home and Community-Based Services and Supports

Due to the reduction in congregate care placements and the overall need for behavioral health services, it is critical to expand family and community services to assure that each region has the progressive continuum of four levels of care.

Prevention	>	Early Identification & Intervention	>	Stabilization & Treatment	>	Medium & Long-Term Care

During 2011 and 2012 DCF closely examined data and the impact on the lives of children in the care and custody of the agency while residing in foster family and congregate care settings. This internal analysis, combined with a public-private Congregate Care Learning Community and the CT BHP shed light on the overall system of care and particularly what types of behavioral health settings and services are necessary within a continuum of community-based care to meet the health and well-being needs of children and reduce reliance on congregate care. The Annie E. Casey Foundation's Child Welfare Strategy Group assisted the Department in the re-design of therapeutic group homes and other services. The following information from the Congregate Care Rightsizing and Redesign: Young Children, Voluntary Placements and a Profile of Therapuetic Group Homes A Report In The "Fostering The Future" Series (August 2011) identifies the service needs at the community level.

When asked to indicate the services most needed to accomplish the return of individual children to a family setting, DCF social workers most frequently noted the need for intensive in-home services for the child and family, child-specific treatment services, day treatment, enhanced foster family care and respite services.



Too often there has been the practice of "stepping down" children from residential treatment to another congregate care setting prior to being transitioned to their family. This includes stepping children down to a therapeutic group home or the department's Therapeutic Foster Care Program. This practice is supported by residential treatment providers who recommend that the child needs "more work, more time, more structure and more practice" before they can be successful with their family. For the DCF area office staff, this step down plan generates less risk than returning the child directly home or with relatives. Parents as well have been acculturated to this belief and are requesting more treatment before accepting children home, particularly parents involved in the Voluntary Services Program. The practice of stepping down has potentially significant ramifications for children. Long stays in residential treatment, followed by long stays in group homes can potentially result in a child becoming institutionalized and dependent upon a high level of external structure. It becomes more difficult to transition the child to the family and community, and the family adapts to life without the child in the home. Research has shown that long length of stays in congregate care settings can also lead to heightened emotional and behavioral problems for children. The practice of some children needing to step down to another level of care also suggests that the residential treatment services provided did not adequately prepare either the child or their family for reunification and community living. This can occur when residential treatment centers focus heavily on managing the child's behavior and symptoms, as opposed to strengthening the child and -- equally importantly -- strengthening the family's ability to care for their child in their home.

Another practice issue involves "bumping up." When lower levels of care cannot be identified and made available for a child they can be bumped up to higher levels of care, even though they may not require that higher level of care. For example, if a therapeutic foster home cannot be found, a Comprehensive Assessment of Need and Strengths (CANS) is submitted for placement to a therapeutic group home. If there are no openings in a group home, the level of care is bumped up to residential treatment. This practice is contrary to providing services in the "least restrictive environment" and leads to children being "placed by default" in to higher levels of care.

A review of the data clearly points to the challenges the Department faces in meeting the needs of children 12 and younger with developmental disabilities, including those on the autism spectrum. Neither the child welfare system nor the children's behavioral health system was designed to

specifically address the unique and complex needs of these specialized populations. However, through the child welfare system or the Voluntary Services program, the Department often becomes responsible for providing comprehensive care to this group of children. Once community-based and in-home resources have been exhausted, congregate care is usually sought for these children. Other state agencies, including the Department of Developmental Disabilities (DDS) and the Department of Social Services (DSS) offer some specialized programming for children with cognitive challenges as do local Boards of Education. However, a comprehensive and coordinated network of care does not exist in a fashion that is commensurate with the behavioral health services available to assist children and the families of children with serious emotional disturbances.

This service challenge is amplified when addressing the needs of children with pervasive developmental disorders, as no state agency within Connecticut is currently mandated to provide comprehensive care for this group, and there are limited evidenced based practices available for the treatment of autism and PDD. As a result, several state agencies have established an intra-agency workgroup to address the service needs of this population. Together with the Office of Policy and Management, the Department of Mental Health and Addiction Services, Department of Developmental Services, Department of Children and Families, and the Department of Social Services are currently researching best practices for these children and youth, and identifying the services currently utilized. The potential for expanding the DSS Autism Waiver and procuring a Center of Excellence for Youth with Autism Spectrum Disorders is being considered, but remains in the planning stages.

Although the Department has expanded intensive in-home and other community-based services during the past decade, the development of services for children birth to 12 has not kept pace. In fact, very few DCF funded programs have been specifically designed to serve children 12 and younger. In Connecticut, the bulk of services for children 12 and younger are funded by other entities such as state and local school district initiatives (e.g. school readiness programs), DDS (e.g. Birth to Three), federal programs (Head Start and Early Head Start), grants and private foundations (Child First) and DSS (child care subsidies and EPSDT). Despite the presence of these programs, few have been brought fully to scale, have sufficient capacity, or are well coordinated with departmental programs and services. With the exception of the Early Childhood Consultation Partnership, Family Based Recovery, and some selected Extended Day Treatment programs, most of these services were not specifically designed to serve a younger population (although they will and do provide care to children 12 and younger). However, in order to maintain all children in this age group in their homes and communities in the presence of serious emotional disturbance, there will need to be a more robust array of services for younger children from screening and detection, through prevention, early intervention, and intensive community based services.

In February of 2009, the Child Health and Development Institute published Promoting Early Health and Learning: A Profile of Two Connecticut Communities. The report describes the coordination of an early childhood system of care in two communities (Middletown and Groton/New London) funded by the Graustein Foundation. Each community engaged in one year of planning and three years of implementation to improve the health of children ages birth to five years. A number of programs were implemented in each community focusing on social and emotional health, oral health, and physical health, nutrition, and exercise. Many of the lessons learned from this initiative are relevant to the department's efforts to better serve young children and prevent the use of out-of-home and congregate care. For example:

- Training local members of the early childhood community as spokespersons and champions helps to spread the word and promote sustainability;
- Hiring or designating a key staff person as a coordinator for early childhood in each community is highly recommended;
- Collaborations across agencies are important in order to implement systems approaches to problems such as expulsions from preschool.; and
- Connecting with state initiatives is critical.

In order to enhance the existing array of community-based services for those children that would otherwise be placed in congregate care, the Department must collaborate with other national, state and local initiatives and coordinating bodies. These include Zero to Three, the Connecticut Early

Childhood Cabinet, Local School Readiness Councils, the William Caspar Graustein Memorial Fund's Discovery Initiative (in 54 communities) and Child Health and Development Institute of Connecticut.

Using individualized services such as therapeutic support staff, behavior management, in-home therapy, assessment/evaluation, and medication management also supports the maintenance of children in their own homes. These services have been available as a result of the W.R. Settlement Agreement and should continue as part of the continuum of care. To date, half of the youngsters served with these wraparound services were functioning at a higher level or maintaining appropriate stability in their lives, 69% remained in the same community-based placement for the duration of the WR plan, and 88% continued to live in community-based settings.

Autism Spectrum Disorders

Connecticut does not have a comprehensive or coordinated service system to address the needs of individuals with autism and their families. Services are available through individual school districts, small programs in state agencies and private practitioners, but these are inconsistent in approach and quality and do not meet the level of need.

In 2011 the Connecticut legislature required a study of issues related to the needs of persons with Autism Spectrum Disorder (ASD). The Autism Feasibility Study workgroup, comprised of state agency representatives, providers, academia, advocates and consumer representatives was convened. Areas of inquiry included: prevalence of ASD; available evidence-based or promising treatments; utilization of state-funded or provided services; identification of service gaps based on utilization data; and recommendations for system changes.

A draft report was released in November 2012. Using the 1.14% prevalence rate from the Centers for Disease Control (March 2012) and the 2011 U.S. Census estimates for number of youth 18 years or younger, the estimated number of Connecticut youth with ASD is approximately 9,143 (and as many as 40,000 total individuals with ASD). Utilization data was reviewed, however, this included only data from state agency databases and Medicaid claims data. State agencies reported utilization data, however the data is limited to state agency databases and Medicaid claims data. It does not include commercial/private insurance service utilization

- There is inadequate access to effective services including behavioral treatment, psychiatric care, primary medical care, social skills and communication training, individualized educational support within the public and private education system, vocational support, housing, social/recreational opportunities and specialized residential/inpatient placement.

Other Service Gaps

Other gaps include:

- Non-traditional services for older youth, including: life skills, workforce readiness and transitional supports;
- In-state specialized treatment services for youngsters along the Autism Spectrum Disorder continuum as well as with eating disorders, problem sexual behaviors, substance abuse and fire-setting behaviors;
- Resources to manage mental health needs in school systems. Less than half of Connecticut districts have in-school health clinics that provide direct access. The school-based diversion initiative implemented in a number of schools has been effective in enhancing relationships with community-based agencies and increasing utilization of existing services and supports, however these services exist in limited areas of the state.
- Need to assure that all DCF youth with behavioral health issues transition to adult services offered by other state or community agencies in a timely and effective manner.

Safe, Stable and Affordable Housing

The need for safe, stable and affordable housing is a major issue for the state. Families referred for services to DCF frequently struggle with housing issues. For example, over the past five years, about 800 DCF-involved families awaited access to rental assistance payments from the Department of Social Services.

Step 3: Prioritize state planning activities
Step 4: Develop objectives, strategies and performance indicators.

Table 1: Priority Area and Annual Performance Indicators 1. Priority Area: Childhood Trauma	2. Priority Type (SAP, SAT, MHP, MHS): MHS
3. Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED	
4. Goal of the priority area: To assure that traumatized children, youth and their caregivers receive effective treatment to meet their needs.	
5. Strategies to attain the goal: a. Conduct trauma screening for all referrals at the 22 (27 in SFY 2015) outpatient children's clinics that have TF-CBT teams trained through a learning collaborative methodology. b. Provide data collection, reporting and analysis on the TF-CBT quality assurance and outcome data on a monthly basis. c. Offer performance incentives for best practices and outstanding performance providing TF-CBT, including meeting performance benchmarks. . d. Provide a 2-day introductory TF-CBT training for new team members and offer advanced training sessions and/or webinars for seasoned clinicians. e. Plan, deliver and evaluate a TF-CBT Annual Conference for all TF-CBT clinicians and supervisors, in partnership with family partners, clinic senior leaders and select DCF staff. f. Conduct strategizing and planning meetings every six months with the TF-CBT Senior Leaders. g. Maintain the TF-CBT Learning Collaborative website and TF-CBT Team Roster. h. Provide site-based in-person and telephone consultation to support TF-CBT programs, at least quarterly.	
6. Annual Performance Indicators to measure goal success:	
Indicator #1: Increase the number of children, youth and their caregivers who are offered Trauma-Focused Cognitive Behavior Therapy.	
a) Baseline measurement (Initial data collected prior to and during SFY 2014): average of 283 children/month, based upon monthly metric reports	
b) First-year target/outcome measurement (Progress – end of SFY 2014): average of 311 children/month, based upon monthly metric reports	
c) Second-year target/outcome measurement (Final – end of SFY 2015): average of 342 children/month, based upon monthly metric reports	
Indicator # 2: Increase the number of children, youth and caregivers who complete the TF-CBT treatment.	
a) Baseline measurement (Initial data collected prior to and during SFY 2014): 231 children completing TF-CBT successfully per year	
b) First-year target/outcome measurement (Progress – end of SFY 2014): 254 children completing TF-CBT successfully per year	
c) Second-year target/outcome measurement (Final – end of SFY 2015): 279 children completing TF-	

CBT successfully per year
d) Data source: Connecticut Center for Effective Practice, of the Child Health and Development Institute, TF-CBT Metrics Report
e) Description of data: The TF-CBT Metrics Report includes the number of children and youth that were offered TF-CBT on a monthly basis, by provider agency as well as the number of children and youth who completed the treatment.
f) Data issues/caveats that affect outcome measures: The numbers of children and families receiving TF-CBT are reported by clinicians at each agency on monthly metric reports. Clinicians may occasionally omit clients from their report, or may be using many TF-CBT components but not the entire treatment model. Thus, the number of clients reported is a conservative number that likely under represents the true number of children and families receiving TF-CBT or trauma-focused treatment based upon TF-CBT.

Table 1: Priority Area and Annual Performance Indicators 1. Priority Area: Prevention, Early Intervention and Treatment Services	2. Priority Type (SAP, SAT, MHP, MHS): MHP
3. Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED	
4. Goal # 1 of the Priority Area: To enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide	
5. Strategies to attain the goal: a) Use evidence-based curricula, ASIST, NAMI-NH CONNECT and Safe Talk to train youth, families, Department staff, and first responder agency staff through contracts with United Way and Wheeler Clinic b) Use evidence-based curricula, Assessing and Managing Suicide Risk (IAMSR) to train clinicians who deliver Emergency Mobile Psychiatric Services (EMPS) c) Implement awareness campaign that includes informational e-mails, Department website and suicide prevention brochures d) Engage in collaborative Suicide Prevention Social Marketing partnerships with DMHAS, and CT Suicide Advisory Board member agencies.	
6. Annual Performance Indicators to measure goal success:	
Indicator #1: Increase the number of individuals receiving suicide prevention and/or crisis response training	
a) Baseline measurement (Initial data collected prior to and during SFY 2014): 800 individuals	
b) First-year target/outcome measurement (Progress – end of SFY 2014): 880 individuals	
c) Second-year target/outcome measurement (Final – end of SFY 2015): 968 individuals	
d) Data source: Provider Reports - (United Way and Wheeler Clinic)	
e) Description of data: Reports are based on attendance records for the training sessions.	
f) Data issues/caveats that affect outcome measures: NA	
Indicator #2: Distribution of social marketing material throughout the state of CT.	
a) Baseline measurement (Initial data collected prior to and during SFY 2014): None	
b) First-year target/outcome measurement (Progress – end of SFY 2014): Distribution of 25,000 brochures, magnets, pens and wallet cards	
c) Second-year target/outcome measurement (Final – end of SFY 2015): Distribution of 40,000	
d) Data source: Provider Reports - (CT SAB, United Way and Wheeler Clinic) Report the total number of outreach activities and numbers of suicide prevention materials disseminated.	
e) Description of data: Reports are based on actual numbers of outreach activities and materials disseminated.	
f) Data issues/caveats that affect outcome measures: NA	
7. Goal # 2 of the Priority Area: Promote the statewide dissemination of evidence-based practices to achieve improved mental health and well-being for emotionally disturbed children and adolescents	

8. Strategies to attain the goal: a) Provide state-funded grants to contract providers to support the delivery of Therapeutic Foster Care, Multi Systemic Therapy, Functional Family Therapy and Trauma-Focused Cognitive Behavioral Therapy b) Develop interdepartmental partnerships to blend funding in order to maintain, and to the extent that funding permits expand these evidence-based practices c) Provide targeted assistance to providers on sustaining the delivery o f these treatments
9. Annual Performance Indicators to measure goal success:
Indicator #1: Increase the number of individuals receiving Therapeutic Foster Care, Multi Systemic Therapy, Functional Family Therapy and Trauma-Focused Cognitive Behavioral Therapy
a) Baseline measurement (Initial data collected prior to and during SFY 2014): 1880
b) First-year target/outcome measurement (Progress – end of SFY 2014): 1900
c) Second-year target/outcome measurement (Final – end of SFY 2015): 2000
d) Data source: Programs and Services Data Collection and Reporting System (PSDCRS) for TFC, MST, and FFT. CHDI Metrics Database for TF-CBT.
e) Description of data: Providers collect and report data about number of clients that received a particular evidence-based treatment at the time of discharge
f) Data issues/caveats that affect outcome measures: Self-report by providers that may be subject to data errors, lack of timely submittal, etc. Also, numbers served is impacted by clinician turnover, cost and time for training new clinicians, availability of trained supervisors to provide supervision, assure fidelity to model and manage quality assurance activities.

Table 1: Priority Area and Annual Performance Indicators 1. Priority Area: Family/Caregiver Involvement	2. Priority Type (SAP, SAT, MHP, MHS): MHS
3. Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED	
4. Goal #1 of the Priority Area: To assure that the voices, perspectives and input of family members are included in developing, planning and overseeing the statewide behavioral health system	
5. Strategies to attain the goal: a) Hire 10 Family System Managers (FSMs) at FAVOR b) FSMs to recruit, train and support youth and families c) Increase number of families that participate in committees, advisory bodies, policy reviews, and other venues	
6. Annual Performance Indicators to measure goal success:	
Indicator #1:	
a) Baseline measurement (Initial data collected prior to and during SFY 2014): ➢ Number of families served by Family Advocacy - 5000 ➢ Number of families recruited to serve in advisory capacity to DCF: internally or externally; or within the community - No baseline data	
b) First-year target/outcome measurement (Progress – end of SFY 2014): Number of families served by Family Advocacy -5300 Number of families recruited to serve in advisory capacity to DCF: internally or externally or within the community. 60 (10 new family members recruited, trained and supported to serve in each of the 6 DCF Regions)	
c) Second-year target/outcome measurement (Final – end of SFY 2015): Number of families served by Family Advocacy -5400 Number of families recruited to serve in advisory capacity to DCF: internally or externally or the community. Additional 60 (10 new family members recruited trained and supported to serve in each of the 6 DCF Regions	
d) Data source: PSDCRS and data collected by FSMs	
e) Description of data: Number of families served in family advocacy. Number of families recruited to serve in advisory capacity to DCF: internally or externally or within the community. Number of families serving on committees, etc as tracked by DCF.	
f) Data issues/caveats that affect outcome measures: Integrity of PSDCRS data source and other data collected through tracking methods	

Table 1: Priority Area and Annual Performance Indicators

Priority Area: Workforce Development

2. Priority Type (SAP, SAT, MHP, MHS): MHS

3. Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER): SED

4. Goal of the Priority Area: To promote the development of a more informed and skilled workforce who have interest and solid preparation to enter positions that deliver evidence-based in-home treatment programs

5. Strategies to attain the goal:

a) Provide funding and other support to the Higher Education Partnership on Intensive Home-Based Services Workshop Development-Sustainability Initiative through contract with Wheeler Clinic

b) Expand the pool of faculty and programs credentialed to teach the Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut curriculum and promote accurate implementation of course content that is current and up-to-date

c) Maintain and promote teaching partnerships between higher education and providers delivering evidenced-based treatments through ongoing coordination and assignment of provider and client/family guest speakers for the curriculum

6. Annual Performance Indicators to measure goal success:

Indicator #1: Increase the number of faculty that will be trained in the curriculum

a) Baseline measurement (Initial data collected prior to and during SFY 2014): 6 Faculty

b) First-year target/outcome measurement (Progress – end of SFY 2014): 12 Faculty

c) Second-year target/outcome measurement (Final – end of SFY 2015): 18 Faculty

d) Data source: PSDCRS and Report from Provider - Wheeler Clinic

e) Description of data: Total number of faculty trained

f) Data issues/caveats that affect outcome measures: NA

Indicator #2: Increase the number of students that will receive certificates of completion for the course

a) Baseline measurement (Initial data collected prior to and during SFY 2014): 50 students

b) First-year target/outcome measurement (Progress – end of SFY 2014): 55 students

c) Second-year target/outcome measurement (Final – end of SFY 2015): 60 students

d) Data source: PSDCRS and Provider Report - Wheeler Clinic

e) Description of data: Total number of students receiving certificates

Community Mental Health Services Block Grant
ESTIMATED EXPENDITURES - CHILDREN'S SERVICES
FY 2014-15

Category	FFY 14 Estimated Expenditure 10/01/13 - 9/30/14	FFY 15 Estimated Expenditure 10/01/14- 9/30/15
Respite for Families	425,995	425,995
Family Advocate Services	467,300	467,300
Youth Suicide Prevention/ Mental Health Promotion	50,000	50,000
CT Community KidCare (System of Care) Workforce Development/Training & Culturally Competent Care	65,000	65,000
Extended Day Treatment: Model Development and Training	30,134	30,134
Mental Health /Juvenile Justice Diversion	15,000	15,000
Trauma-Focused Cognitive Behavior Therapy - Sustainability Activities	161,000	161,000
Outpatient Care: System Treatment and Improvement Initiative	30,000	30,000
Workforce Development - Higher Education In-Home Curriculum Project	75,000	75,000
Other Connecticut Community KidCare***	20,000	20,000
TOTAL EXPENDITURES	**1,339,429**	**1,339,429**
TOTAL GRANT AWARD	**1,339,429**	**1,339,429**

Table 2: State Agency Planned Expenditures

Table 2 State Agency Planned Expenditures (Include ONLY funds expended by the executive branch agency administering the SABG and/or the MHBG*)							
Planning Period- From: 10/01/13 To: 9/30/15							
State Identifier: Connecticut - Children's Services							
Source of Funds							
ACTIVITY (See instructions for using Row 1.)	**A. Substance Abuse Block Grant**	**B. Mental Health Block Grant.**	**C. Medicaid (Federal, State, and local)**	**D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)**	**E. State funds**	**F. Local funds (excluding local Medicaid)**	**G. Other**
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*	$	$	$	$	$	$	$
b. All Other	$	$	$	$	$	$	$
2. Primary Prevention**	$	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$2,638,858	$	$1,200,000	$128,025,766	$	$
8. Administration (excluding program / provider level	$	$40,000	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$40,000	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$2,678,858	$	$	$	$	$
11. Total	$	$2,678,858	$	$1,200,000	$128,025,766	$	$

Table 6b: MHBG Non-direct Service Activities Planned Expenditures	
Table 6B MHBG Non-Direct Service Activities Planned Expenditures State Identifier: Connecticut - Children's Services	
Planning Period - From: 10/01/13 To: 9/30/15	
Service	**MH Block Grant**
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$ 20,000
Total Non-Direct Services	
Comments on Data:	

These funds support operation of the Children's Behavioral Health Advisory Council. Examples include: interpreters, administrative costs, etc.

C. Coverage for M/SUD Services

The State of Connecticut is in the process of developing plans for types of services to be covered by Medicaid and defining strategies to monitor the implementation of the Affordable Care Act. Therefore, we can not answer these questions at this time.

D. Affordable Insurance Exchange

We are unable to answer most of the specific questions because the work of the Connecticut Health Insurance Exchange is under development, with a scheduled release date for available QHPs on October 1, 2013. Below is a summary of the organization of the Exchange as well as the activities and progress to date.

The Connecticut Health Insurance Exchange was created by the Connecticut legislature in 2011 and is a quasi-public agency to satisfy requirements of the federal Affordable Care Act. The power of the Exchange is vested in a 14 member board. Its purpose is to increase the number of insured Connecticut residents, improve health care quality, lower costs and reduce health disparities while providing an exceptional consumer experience.

In order to maximize the potential of the Exchange's mission, given the magnitude of its goals and the ambitious timelines for establishment, a sustained and collaborative effort on the part of the State and our public and private stakeholder partners is critical. To that end, the Exchange has established four Advisory Committees to assist in a number of key areas. They will all serve to assist the Exchange in establishing policy, refining goals, delineating functions, and providing ongoing program evaluation. These four committees are non-voting bodies composed of a variety of stakeholders, selected by the Board to represent a broad array of interests in Connecticut. The four advisory committees are:

- Consumer Experience and Outreach
- Health Plan Benefits and Qualifications
- Brokers, Agents and Navigators
- Small Business Health Options Program "SHOP"

The Exchange has made steps in improving standard plan designs for products sold in the new marketplace beginning in October 2013. By setting specific, consistent criteria for plans offered in each of the Exchange's coverage tiers (bronze, silver, gold, and platinum), it will be easier for consumers to evaluate truly comparable products, improving transparency in benefits and coverage and highlighting overall value. Earlier this month, it was announced that nine insurance carriers submitted non-binding letters expressing their interest in joining the Exchange. Participating carriers will be required to submit plans which conform to the standard plan designs, but will also be allowed to sell an additional product offering in each tier which does not fit the design, in an effort to encourage product innovation and increase consumer choice.

The new criteria, approved by the Exchange Board of Directors, reflect a consensus of a wide range of stakeholders including providers, brokers, small business owners, and consumer representatives, in addition to substantial input and guidance given by the Exchange's Advisory Committees. All plans will provide comprehensive coverage, and preventative services will be provided at no extra cost beyond premium payment.
The goal of the new standard plan design criteria is to improve:

- Simplicity – Standard plans should be simple to understand and to administer.
- Consumer Focus – Enable consumers to get the basic care they need with the minimum cash expense.
- Primary Care Emphasis – Encourage people to seek preventative care to help maintain their health.

The Board of Directors also approved three additional silver metal plans that will be available to lower income households. These are designed to reduce out-of-pocket costs. All seven designs--the four standard tiers and three additional silver metal tiers--will have both premiums and out-of-pocket expenditures subsidized. Once carriers finalize their plans, they will begin filing and reviewing them with the Connecticut Insurance Department (CID). The CID must approve all forms and rates before a plan may be certified by the Exchange. At the conclusion of the process, expected to be in the third quarter of 2013, carriers who meet or exceed all the requirements will be announced.

Individuals, families, small business owners, advocates and brokers are invited to participate in "Healthy Chat" events during early 2013 hosted by the Connecticut Health Insurance Exchange (the Exchange). Each of the seven upcoming statewide town hall-style events is free and open to the public. The events are an opportunity to ask questions and engage in a dialogue about the big changes that could benefit health insurance buyers with Exchange leadership and health care reform experts. These town-hall meetings are a continuation of the "Healthy Chat" series launched in the second half of last year, which was recognized by the Center for Medicare and Medicaid Services and the Center for Consumer Information and Insurance Oversight as being a national best practice for outreach and engagement.

The Connecticut Health Insurance Exchange and The Office of the Healthcare Advocate have agreed to a partnership to administer Connecticut's Navigator and In Person Assistance Programs (NIPA). The NIPA is a key initiative to engage, educate and enroll individuals, who are often in underserved parts of the state, in health insurance coverage. NIPA encompasses the Navigator program, which is a required outreach component of the Affordable Care Act (ACA), as well the In-Person-Assistor program, which was added to the final blueprints for state exchanges issued by the Department of Health and Human Services, to further strengthen community based outreach. The two programs will be closely coordinated to offer a seamless and diverse contingent of well-trained civic, faith-based and community groups to educate residents and small businesses about their health coverage options and enroll them in coverage through the Exchange.

The Office of the Healthcare Advocate (OHA) has a long standing tradition of working on behalf of Connecticut consumers to ensure access to quality insurance by educating consumers about their rights under various health plans, helping them enroll in coverage and directly handling grievances and appeals when coverage is denied. OHA also engages in statewide community based outreach and education to small businesses and community organizations as well as executing multimedia marketing campaigns. Since 2010, OHA has been the federally designated Consumer Assistance Program (CAP) under the ACA.

The innovative partnership between the Exchange and OHA is the first of its kind in the country and has been lauded by the Center for Consumer Information and Insurance Oversight (CCIIO) as a potential model for other states in establishing their NIPA programs. The Exchange has applied for a federal grant to support the NIPA program, and is awaiting approval. Once approved, the Exchange will set up a competitive request for proposal process to solicit the best IPA organizations. It will also develop a comprehensive training program to train and certify individuals performing IPA duties leading to the Exchange's launch in October 2013.

The Exchange has selected Deloitte Consulting LLP to develop an d implement the Exchange's extensive operating technology and Internet website. This system will be used to determine eligibility and to enroll

individuals, families, and small businesses that purchase health care coverage through the Exchange's online marketplace.

E. Program Integrity

1. Does the state have a program integrity plan regarding the SABG and MHBG?
The State has assigned various individuals with specific responsibilities for overseeing program integrity, as described in # 2 below.

2. Does the state have a specific staff person that is responsible for the state agency‘s program integrity activities?
Connecticut's State Child Planner is the lead person that oversees the MHBG program integrity plan. In partnership with the administrator of behavioral health services, statewide program leads, regional system managers, program subject matter experts and fiscal specialists, management and oversight of MHBG funds, activities and outcomes is conducted on an ongoing, consistent basis. The Children's Behavioral Health Advisory Council and the Joint Behavioral Health Council also oversee the state plan. These councils receive periodic updates and data reports relative to progress to date, barriers, and achievements. Also, the Department's proposed MHBG budget is presented before the Appropriations, Public Health and Human Services Legislative Committees each year. This is an opportunity for further review and scrutiny of activities and results.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
The state utilizes a variety of program integrity activities to monitor the appropriate use of MHBG funds. These include: budget review; claims/payment adjudication; expenditure report analysis; compliance reviews; encounter/utilization/performance analysis and audits.

Connecticut has developed a uniform method of contracting for purchase of service (POS) and personal service agreements (PSAs). The process is administered by Office of Policy and Management (OPM) and provides uniform policies, procedures, and formats for contracting for services. DCF must follow the OPM contracting requirements. The OPM has issued cost standards for POS contracts that identify cost categories that are allowable or unallowable.

The DCF contracts with approximately 150 contractors for 600 different services. The provider contract covers a 3-year time period. Contracts can be amended during the contract period if the need arises. The contracted community mental health agencies are not-for-profit entities. Funding allocated to the community mental health providers is made on a historical basis in the form of a grant. The contract is the document considered as obligating the funds. The DCF Summary of Funding sheet identifies the State and Federal funds committed to the provider and identifies the amount of CMHS Block Grant funds and the CFDA number. The contract also includes language related to the restricted expenditures from Block Grant funds and an A-133 audit requirement.
The DCF providers are required to submit an 8-month expenditure report and an end-of-year expenditure report (90 days after close of the State fiscal year). The provider is also required to submit an annual A-133 audit to the Department (180 days after close of the State fiscal year). The A-133 audit is reviewed by using a protocol provided by OPM to determine completeness, conditions that may result in funds recovery, and overall fiscal well-being of the provider. Providers must explain any significant differences between the annual audit information and the 12-month expenditure report.

4. How **does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?**
Provider contract payments are made quarterly, with an initial payment representing 4 months of the total contract. Two subsequent payments are made in the amount of 3 months of the total contract amount. The final payment is made only after receipt and review of the 8-month expenditure report. The final payment is the remaining 2 months of the contract if expenditures are in accordance with the annual contract. The DCF may reduce the last payment should the 8-month expenditure report indicate significant program under expenditure.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Program Leads within DCF are assigned contract responsibility based on the service type of the contract. Program Leads know budgets for each of their programs, and there is flexibility to move funds within service or expense categories. Program Leads review reports from the PSDCRS, conduct site visits to providers, and intervene when problems are identified. They also meet with provider groups specific to service types on a regular basis.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for the uninsured population?

Provider contracts contain language that requires delivery of services for all eligible clients, including those who have no health insurance and those who have no means to pay even on a sliding fee scale. The Medicaid and private insurance status or lack thereof is tracked for every publically funded client through the PSDCRS.

7. How will the state ensure that Block Grant funds and state dollars are used to pay for services that are not covered by private insurance and/or Medicaid and that produce positive outcomes?

The Department has a long history of utilizing block grant funds to pay for services that are not covered by private insurance and/or Medicaid. Specifically, the majority of these funds (almost $ 1 million) pays for family advocacy services and respite care that is not eligible for Medicaid or funded by other sources.

F. Use of Evidence in Purchasing Decisions

1) Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?

Within the Clinical and Community Consultation and Support Team, the administrator, managers and program leads that oversee behavioral health services have a responsibility to be informed about evidence-based and promising practices and to keep abreast of the latest research including outcomes for emerging effective treatments and interventions. This commitment is consistent with one of the Department's cross-cutting themes - a learning organization. Further, the Academy for Family and Workforce Knowledge and Development remains committed to identifying and implementing the most effective training curriculums.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes. One example is a period of research and discussion that occurred over the course of several months in partnership with providers, families, developers and others about the most effective evidence-based treatments that might become a part of the menu of services at outpatient psychiatric clinics for children. The goal was to find effective treatments that would address the most common childhood disorders that are seen at outpatient clinics. The multidisciplinary state/provider/family group reviewed the recommended evidence-based treatments using national registries , in partnership with outpatient clinic providers to identify the

a) What information did you use?

The multidisciplinary state/provider/family work group reviewed the recommended evidence-based and promising treatments using national registries.

b) What information was most useful?

Most helpful was the national and other registries that provide specific treatment description, target population, results of clinical trials, costs, child/family outcomes, etc. It was also helpful to review websites specific to each treatment modality.

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

There are several forums to share and discuss evidence-based practices and the pros/cons of disseminating within the service delivery system in Connecticut. Examples include: CT Behavioral Health Partnership;

Children's Behavioral Health Advisory Council; Joint Behavioral Health Planning Council; CT Community Providers Association; and Provider-Specific meetings.

G. Quality

The Department will focus on the following areas:

- Health - level of functioning measure as reported by parent, youth and clinicians on the Ohio Scales;
- Home - stability of housing as reported at time of intake and discharge by clients;
- Purpose - level of connection with community as reported on Youth Satisfaction Survey

The National Quality Behavioral Health Framework has not been provided to states as of this date.

H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

The majority of community -based services are provided by clinicians at outpatient clinics. These clinics are expected to screen for trauma at the time of intake and to conduct further assessment whenever there are positive trauma screens for any referred child.

Effective July 1st 2013 the Department will implement universal trauma screening for all children, ages 4 to 17 who become involved with the agency. A standardized CT Trauma Screen has been developed. If there is a positive trauma screen, a referral to a behavioral health provider is required, using a standardized referral form accompanied by the trauma screen. Providers will also receive training on this screen and may chose to adopt this screen instead of their current practice.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

Yes. Effective July 1st all DCF-involved children who have a positive trauma screen will be referred to a community provider that is trained in evidence-based, trauma-specific assessment and treatment.

3. Does your state have any policies that promote the provision of trauma-informed care?

During the past 5 to 7 years the Department has been engaged in various activities to make Connecticut's system of care more trauma-informed, especially the child welfare system and to increase collaboration between child welfare and behavioral health providers of evidence-based trauma-specific treatments. The Department has just developed a soon-to-be released Trauma-Informed Care Practice Guide for all employees. The guide covers what trauma is, how it impacts children and families, treatments for recovery and practical interventions that a child welfare worker can take to lessen the impact and find ways to help children and families heal. Further, relevant child welfare and juvenile justice policies are now being reviewed by a multidisciplinary committee to assure that these policies contain trauma-specific language and trauma-sensitive practices.

Between March and June 2013 all frontline staff will receive a 2-day trauma training, using the updated NCTSN Child Welfare Trauma Training Toolkit and a 1-day training on the Connecticut Trauma Screen and Referral for Behavioral Health Services.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

The provider network offers a variety of trauma-specific treatments. These treatments are not available by every provider, and the do vary across regions of the state.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Child and Family Traumatic Stress Intervention (CFTSI)
Eye Movement Desensitization and Reprocessing Therapy (EMDR)
Attachment, Self-Regulation, and Competency (ARC)
Child Parent Psychotherapy (CPP)
Parent-Child Interaction Therapy (PCIT)
Trauma Affect Regulation: Guide for Education and Training (TARGET)

Many residential and day treatment providers utilize the Risking Connection model or Sanctuary model as a trauma-sensitive philosophy and approach to services.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?
Between 2007 and 2013, through a blending of state and federal funds including MHBG funds the Department has disseminated TF-CBT across 22 community mental health clinics using learning collaboratives based on the Breakthrough Series Collaborative model. An additional 6 clinics will receive the same training through a 9 month learning collaborative during SFY 2014, bringing the total TF-CBT teams to 28 across the state.

Beginning in SFY 2015 DCF, through its vendor/coordinating center - the Child Health and Development Institute 6 agencies will be trained in the Child and Family Traumatic Stress Intervention (CFTSI), developed by Dr. Steve Marans at Yale University. This is a short-term acute trauma intervention following the onset of a traumatic event. During SFY 2016 an additional 6 clinics will receive the same training.

The Department continues to explore funding and strategies for disseminating additional trauma-specific evidence-based treatments. Currently, we are researching the possibility of bringing the ChildSTEPS Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct Disorders.

I. Justice
1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
No, at this time there are no plans to do so.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
There is a concerted effort to complete a thorough assessment of the identified youth to determine the nature and extent of issues including any mental health or substance abuse problems. Whenever community-based services are appropriate and can be accessed by the youth and family, these referrals are made, provided there are no safety or other risk factors.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
Yes, during the past several years there have been numerous joint initiatives between, for example, the Court Support Services Division and the Department. These have included blending funding to offer evidence-based treatment services for the juvenile justice population. Another example is the Connecticut School-Based Diversion Initiative that is described under Prevention Services - Behavioral Health Assessment and Plan.

J. Parity Education
1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
The Department currently utilizes some of the block grant funds to educate and raise awareness about the issue of suicide prevention and treatment resources. Additional funds would be necessary to implement a statewide campaign to educate about the general issue of mental health parity.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc)
A well-funded, coordinated and broader multi-state agency, public and private partnership would advance awareness and understanding about benefits. The state continues to enhance its existing partnerships such as the CT BHP and joint interagency agreements to further disseminate information about services, benefits, costs, etc. Also, the Department utilizes the services of family advocates, peer specialists and regional family engagement specialists to disseminate information to specific populations.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?
Please see number 2 above.

K. Primary and Behavioral Health Care Integration Activities
Please refer to the Behavioral Health Assessment and Plan - Children's Section for details regarding primary and behavioral health care integration activities. This is described as one of the state's strengths for children's services.

L. Health Disparities
1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
The Department utilizes the Programs and Services Data Collection and Reporting System (PSDCRS) to track numbers served and outcomes by race, ethnicity, gender, LGBTQ and age. This is a "real time" online web-based data collection and reporting solution for community-based programs. Data is reviewed on a quarterly basis with provider groups.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
The PSDCRS also tracks primary language spoken in the home by client and provider/service type. The system has the capacity to isolate geographic areas, by towns/regions and report language needs.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
No plans are being developed at this time, with the exception of continuing to work through the CT Behavioral Health Partnership to review data and identify trends.

4. How will you use Block Grant funds to measure, track and respond to these disparities?
We do not plan to use block grant funds for this purpose during the next biennium.

M. Recovery
1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
Connecticut adopted the federally endorsed System of Care model as the basis for the state mental health plan in 1997 and established a coordinated network of community services and supports to meet the needs of emotionally disturbed children, youth and their families. The system of care is not a program; it is a philosophy of how care should be delivered. The hallmarks of the system of care approach include the following.

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

Core values include:

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

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

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
The Department of Children and Families does not have an Office of Consumer Affairs. However, parents of children with serious emotional disturbance and advocates are hired into leadership position through the state-

funded family advocacy umbrella agency, FAVOR. These individuals provide state, regional and local leadership to address both system and child/family level issues.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
Children and families have the option of seeking services from any type of service provider within their catchment areas. The broad array of community-based services includes: emergency mobile psychiatric services/crisis stabilization; respite services; intensive in-home services; extended day treatment services; routine outpatient behavioral health services; family advocacy services; and family/peer support services. Children, youth and families learn about the menu of services and programs at the time of intake and referral. Through a mutually respectful partnership between the child/family and the treatment provider, a careful assessment process results in a highly individualized treatment plan. The treatment provider seeks to understand the reason(s) for the child/family's referral, their expressed and felt needs, and the outcomes they desire. The child and family's strengths and skills are acknowledged and valued in the planning process. The family is viewed in the context of their culture, ethnicity, religion, and gender. All of these elements are considered in planning the right mix and frequency of services for the child/family, with the child/family serving as the main designer of the care plan through a shared decision-making process. Treatment providers may recommend particular treatments and a schedule of appointments to address the needs, but the family ultimately decides if these recommendations will meet their unique needs.

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

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

4. Does the state's plan indicate that an array of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible?
Yes, the Department offers an array of recovery supports and services to meet the comprehensive needs of children and their caregivers. These include but are not limited to: care coordinators, family advocates, intensive care managers, regional family engagement specialists, recovery coaches, therapeutic mentors, emergency crisis line and mobile services, crisis stabilization services, respite services, intensive in-home services, outpatient care, extended day treatment, consumer/family education, and supportive housing. Please refer to the Behavioral Health Assessment and Plan for details.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, families/significant others?
The Department offers several evidence-based treatments for traumatized children and their families such as Trauma-Focused Cognitive Behavior Therapy. This, and other treatments are family-based and include the active participation of caregivers throughout the episode of care. Several of the family advocacy agencies under FAVOR, such as African Caribbean American Parents of Children with Disabilities and Padres Abriendo Puerta provide education and support services for special racial/ethnic groups. To address the needs and issues of culturally relevant service delivery for those who identify as LGBT, each area office and each facility has subject matter experts through the Safe Harbors Project. Education and training occurs to support the needs of special populations, such as the True Colors Best Practice Conference each year that focuses on working with the Gay/Lesbian/Bisexual community.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
The state of Connecticut conducts ongoing training and technical assistance for child, adult and family mentors as well as others in the behavioral health service system. Although Connecticut has been providing strength-based, culturally and linguistically competent training for years, recently Connecticut has developed the Wraparound Connecticut Learning Collaborative, or WrapCT**.** This learning collaborative was an outgrowth of a Mental

Health Transformation State Incentive Grant (MHTSIG) activity. WrapCT's mission statement reads: "Our mission as a statewide learning collaborative is to educate, train, and promote the benefits of the values and principles of System of Care and the Wraparound Process."

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

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

The wraparound process is formally brought together in monthly (at a minimum) family- driven, Child and Family Team (CFTs) meetings. At each CFT the Plan of Care is reviewed and updated as appropriate. Families are able to share how the support, care and services to their family are progressing, thereby directly participating in the decision- making process and their Plan of Care (i.e. treatment plan). Concerns are addressed through the CFT meeting process.

7. Does the state have an accreditation program, certification program, or standards for peer-run recovery centers?
This is not applicable for children's services, but does occur for adult services.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems.
Please refer to BH Assessment and Plan for details regarding family/consumer services and supports and prevention activities.

Involvement of Individuals and Families

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

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

responsible for drafting a report to the Commissioner and Legislators making recommendations and commenting on the overall behavioral health service system. CBHAC has 32 voting members, 16 of whom are family members and/or caregivers and all committees strive to include at least 50% family members and/or caregivers. The current make-up of the Behavioral Health Services and Local Systems of Care Review Committee is 17 members, 10 of whom are family members.

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

2. Does the state sponsor meetings or other opportunities that specifically identify individuals‘ and family members‘ issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
There are various statewide meetings that include families, providers, state agency representatives and other stakeholders, usually convened by DCF's Behavioral Health Clinical Managers to assess system issues that have been identified by families. An example is the Outpatient Learning Community that was launched to address issues pertaining to family engagement and retention in care as well as data sharing and outcomes. There are two active work groups to discuss specific problems, barriers, and solutions. Family members participate in each of these groups, and one group - Family Engagement and Retention in Care is co-chaired by a family member.

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

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

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

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

improving how well individual provider organizations are able to truly align themselves with those values and principles.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
As described under the Behavioral Health Assessment and Plan - Housing Resources, the Department provides an array of housing options for its clients. These include: housing assistance and case management services for DCF families who are homeless or at risk of homelessness supplemented with vocational, mental health and educational supports; housing assistance and case management services for DCF young adults who are homeless or at risk of homelessness; community housing assistance to those youth living in a community housing environment that includes case management, supervision, education and vocational support or career development support, and life skills development services; and a variety of group home living options for youth ages 14 - 21 to avoid placement in a higher level of care.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?
The housing needs are described above. In addition, the Department received a $ 5 million, 5-year ACF-funded supportive housing grant to implement intensive housing support for families in the child welfare system experiencing both chronic homelessness and high service need. Housing services will be supplemented with an array of community supports such as vocational, mental health and social to strengthen success in community living.

N. Prevention
Please refer to Adult Services portion of the grant - Substance Abuse Prevention. DCF does not receive any Federal substance abuse block grant funds.

O. Children and Adolescents Behavioral Health Services
Connecticut's system of care approach is described in detail under the Behavioral Health Assessment and Plan. This section also describes the individualized care planning process, collaboration with other state and child serving agencies, and training on evidence-based treatments. As previously described in multiple sections, the PSDCRS is utilized to track service utilization and outcomes.

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

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

At the state level efforts have been made, and will continue to assure that tribal leaders are represented at various advisory bodies, committees and planning councils. Currently there is at least one tribal member on the Children's Behavioral Health Advisory Council, which is a recent addition to the composition of the membership.

Q. Data and Information Technology - Update
The Department has the capacity of providing unique client-level data for the purposes of the Uniform Reporting System. This covers the publically-funded behavioral health information system, known as Programs and Services Data Collection and Reporting System (PSDCRS). The system does assign a client identifier which is unique within a provider agency, and allows for unduplicated counts and aggregation of services by that provider.

There has been no change in the Department's two primary information systems.

1. The Department is responsible for the PSDCRS. The system is maintained by a private contractor which works closely with DCF staff. PSDCRS is DCF's web-based online data collection and reporting solution for community-based programs. It includes services provided to clients who are not involved with DCF, as well as those who are. Currently, there are 77 providers enrolled in the PSDCRS database. These providers represent community-based agencies that contract with the Department to provide one or more services to clients.

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

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

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

The Medicaid system is based on an encounter/claims based approach to payment. The data warehouse universe includes: Claims; Providers; Recipient; and Reference. Client level data includes information on individual date of service, type of service, service quality, and identify of provider. The system complies with federal data standards.

Technical assistance needs regarding data and information technology are multiple and complex. Examples of issues include data interoperability, IT system reform at development, design and application phases, and linkage/agreements with other state agencies.

R. Quality Improvement Plan

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

Connecticut Department of Children and Families

Behavioral Health Quality Improvement Plan
Quality Improvement Approaches/Tools by Program

Tools:
1) Standard Data Reports and Review Under PSDCRS.
2) Program Lead, Regional System Manager meets regularly with providers, reviews data, manages contract, and updates Practice Standards.
3) Evidence Based or Best Practice Program for which there is a standardized model-specific QA process that is overseen by a contracted vendor (*some programs incorporate evidence based components that are externally monitored).
4) Undergoes periodic and for-cause licensure inspections (by DCF).
5) Program Standards written into contracts.

6) Has completed or is in the process of a CT-specific formal program evaluation or research project.
7) Direct consumer feedback following completion of care.
8) Standardized training for all providers.
9) Pay for Performance Initiatives incorporated into management.
10) Youth Services Survey for Families (YSS-F) administered at time of discharge.
11) Ohio Scales administered at time of intake and discharge, and at periodic intervals.

Community Behavioral Health Services

BH Program	Acronym	Brief Description	QA/QI Tools Utilized
Care Coordination	CC	Provides community-based wraparound support and case management to children with SED and their families.	1, 2, 5, 6, 8, 10, 11
Extended Day Treatment	EDT	Provides 3 hours of after school milieu- based therapeutic recreation and clinical/rehabilitative services.	1, 2, 3*, 4, 5, 7, 10, 11
Emergency Mobile Psychiatric Service	EMPS	Provides home and community-based mobile crisis services to children and their families including short term stabilization services and linkage to care.	1, 2, 3, 4, 5, 7, 8, 9, 10
Family Advocacy	FAM ADV	Individuals with lived experience provide guidance and support to children and families receiving care coordination or other select services.	1, 2, 5
Family-Based Recovery	FBR	Intensive in-home service that works with mother's with young children who have a history of substance use/abuse and child welfare involvement. Program combines evidence-based treatment of adult substance abuse and best practices in early childhood support of development and promotion of attachment and bonding.	1, 2, 3*, 4, 5, 6, 8
Functional Family Therapy	FFT	Evidence-based intensive in-home service that works with children with moderate to severe externalizing and internalizing disorders and their families.	1, 2, 3, 4, 5, 8, 10, 11
Family Substance Abuse Treatment Service	FSATS	Intensive in-home service that is a variant of evidence-based MDFT that has a special engaging Mother's protocol.	1, 2, 3, 4, 5, 6, 8
Intensive In-Home Child and Adolescent Psychiatric Service	IICAPS	Best practice model for in-home family- based treatment of children with a wide array of psychiatric disorders.	1, 2, 3, 4, 5, 6, 8, 10, 11
Multi-Dimensional Family Therapy	MDFT	Evidence-based intensive in-home service that works with children with moderate to severe externalizing and internalizing disorders and risk for or current substance abuse and their families.	1, 2, 3, 4, 5, 6, 8, 10, 11
Therapeutic Mentoring	MENT	Community-based recreational and therapeutic support to children with SED.	1, 2, 5
Multi-Systemic Therapy	MST	Evidence-based intensive in-home service that specializes in working with children with moderate to severe externalizing disorders and risk for or involvement in the JJ system and their families.	1, 2, 3, 4, 5, 7, 8, 11

BH Program	Acronym	Brief Description	QA/QI Tools Utilized
Multi-Systemic Therapy, Building Stronger Families	MST - BSF	An adaption of MST for child welfare families.	1, 2, 3, 4, 5, 6, 7, 8, 11
Outpatient Behavioral Health Treatment for Children	OPCC	Community clinics that provides mental health evaluation, screening, treatment, and case coordination through individual, family and group therapies.	1, 2, 3*, 4, 10, 11
Outpatient Substance Abuse Treatment	OPSAT	Community clinics that provides co-occurring mental health and substance screening, case coordination in conjunction with individual, family and group therapies.	1, 2, 3*, 4, 5, 10
Multi-System Therapy - Problem Sexual Behavior		An evidence-based adaptation of MST that provides intensive in-home and clinic- based services to children with problem sexual behavior.	1, 2, 3, 4, 5, 7, 8, 10, 11
Respite	RESP	A family support service that pairs a trained behavior support staff with a youth and then engages in therapeutic recreation activities outside the home to give families respite from the demands of a child with SED.	1, 2, 5, 10
Project SAFE	SAFE	A community-based program that provides screening, evaluation and treatment to caregivers engaged in the child welfare system when substance abuse is suspected or been documented.	1, 2, 3*, 5

S. Suicide Prevention

Connecticut's Suicide Prevention Plan is provided as an attachment to the application. The state plans to update its plan during the upcoming year.

T. Use of Technology

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

The Department does have the capacity for webinars, however, there are no funds to promote other specific applications of Interactive Communication Technology. The Department would need to join forces with other state agencies to do so, and many other priorities such as health care reform take precedence

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

U. Technical Assistance Needs

At this time the state is working with SAMHSA to develop health homes for adult services. This may be expanded to children that meet certain diagnostic criteria. No other technical assistance is being provided at this time for children's services.

Areas of potential interest for technical assistance include: consultation with federal tribes in order to better understand their organizational structure and culture as well as effective outreach and engagement strategies with tribal leaders; assessing and understanding cost/benefit analyses for implementation and sustainability of evidence-based treatments; and strategies for state planning councils to review the statewide system.

V. Support of State Partners

State Partner	Role
1. Department of Developmental Services (DDS)	• Joint planning and coordination of services for clients involved with both DCF and DDS. Activities include: service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice/program evaluation.
2. Judicial Branch – Court Support Services Division (CSSD)	• Continue to strengthen the shared service network for youth that are involved with child welfare and juvenile justice systems. Activities include: shared blended funding for Multi-Systemic Therapy (MST) and Intensive In-Home Child and Adolescent Psychiatry Services (IICAPS); and continued collaboration on state/federally funded initiatives such as the MacArthur Foundation MH/JJ Action Network and State Wraparound Project.
3. Department of Public Health (DPH)	• Continued collaboration on the Personal Education Responsibility Program (PREP), the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, and Child FIRST.
4. Department of Education (DOE)	• Continued collaboration regarding school-based diversion of children involved in both child welfare and juvenile justice systems by intervening around mental health crises that might otherwise lead to arrest. Continued support of DCF's school-based suicide prevention and mental health promotion activities.
5. Department of Mental Health and Addiction Services (DMHAS)	• Joint planning and coordination of services for clients who are under the care of DCF and who are eligible for services through DMHAS. Activities include: joint planning for transition cases; regular communication to monitor the referral process, identify and resolve issues; and ongoing strategizing to address funding issues.
6. Department of Social Services (DSS)	• Continue the jointly managed CT Behavioral Health Partnership to strengthen an integrated behavioral health system for Medicaid eligible children and youth. Work collaboratively to improve access, quality and outcomes.

W. State Behavioral Heath Advisory Council

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

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

- Families of children with SED and primary (adult) consumers of mental health services/ persons in recovery who serve as advocates on citizen advisory councils may be nominated by the State Advisory Council, the legislature, Governor's office, local advisory boards, statewide organizations such as the National Alliance for the Mentally Ill - Connecticut (NAMI - CT), Advocacy Unlimited, Inc., Consumer Self Help, or volunteer individually;

- To create an integrated behavioral health and addiction services entity, the council has expanded to include families of children with substance abuse and primary (adult) consumers/persons in recovery of substance abuse services/persons in recovery who serve as advocates on citizen advisory councils, local advisory boards, statewide organizations such as the Connecticut Communities for Addiction Recovery (CCAR), Consumer Self Help, or individual volunteers.

- Providers of behavioral health and/or substance abuse services and members who represent public and private entities concerned with the need, planning, operation, funding and use of mental health services and related support services are recruited by the two departments and/or nominated by professional and trade organizations; and

- The Commissioners of those departments or agencies designate state agency representatives.

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

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

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

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

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

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

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

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

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

State Behavioral Health Planning Council Membership List Table 1

Table 1 – Voting Members – Non State Agencies Representatives

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Margaret "Peggy" Ayer	Adult MH Advocate, DMHAS State Board, Adult SMHP Council and Children's BH Council, CBHAC	Eastern Regional MH Board	151 Pond Road North Franklin, CT 06254-1224 T: 860-642-4318 E: msayer@adelphia.net
Kristie Barber	Adult MH Advocate, RMHB Exec. Dir., Adult SMHP Council	South Central CT Regional MH Board, Inc.	CT Valley Hospital PO Box 351 Middletown, CT 06457 T: 860-262-5027 F: 860-262-5028 E: rmhb2@aol.com
Sincilina Beckett	MH Provider, Children's BH Council, CBHAC		90 Fowler Street New Haven, CT 06515 T: 203-641-8667 sincilina@aol.com
Eileen Bronko	MH Provider, Children's BH Council, CBHAC		34 Fairfield CT Naugatuck, CT 06770 T: 203 723-0875 ebronko1@snet.net
Joan Cretella	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		225 Beach Street, Unit 2A West Haven, CT 06516 T: 203-933-4272 E: N/A
Robert Davidson	Adult Primary Consumer, RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	Eastern Regional MH Board	401 West Thames Street Campbell Building, Room 105 Norwich, CT 06360 T: 860-886-0030 F: 860-886-4014 E: ERMHB@Downcity.net
Michelle Drake	Parent of a Child with SED - Children's BH Council, CBHAC		E: AHAJ321@aol.com
Marcia DuFore	RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	North Central Regional MH Board	367 Russell Road, Bldg. 34 Newington, CT 06111 T: 860-667-6388 F: 860-667-6390 E: mdufore@ncrmhb.org

Table 1 – Voting Members – Non State Agencies Representatives

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Hal Gibber	Parent of a Child with SED – Children's BH Council, CBHAC	FAVOR, Inc.	2138 Silas Deane Highway Suite 100 Rocky Hill, CT 06067 T: 860-563-3232, Ext 201 F: 860-563-3961 E: Halgibber@favor-ct.org
Lorna Grivois	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		586 Westchester Road Colchester, CT 06415 T: (860) 267-6083 E: grivois620@comcast.net
Gabrielle Hall	MH Provider, Children's BH Council, CBHAC	Clifford Beers Clinic	370 James Street New Haven, CT 06513 T: 203-777-8648, Ext 207 F: 203-785-0617 E: ghall@cliffordbeers.org
Mary Held	Parent of a Child with SED - Children's BH Council, CBHAC		929 Bank Street Waterbury, CT T: 203-441-1887 E: Heldmary30@aol.com
Irene Herden	Adult MH Advocate, DMHAS State Board, Consumer Advocacy Group, RMHB member, Adult SMHP Council	South Central CT Regional MH Board	49 Bogue Lane East Haddam, CT 06423-1442 T: 860-873-1999 (H) F: 860-873-1999 (H) E: evherd@aol.com
Mui-Mui Hin-McCormick, MS, LMLT	MH Provider, Adult SMHP Council	Community Renewal Team, Asian Family Services	1921 Park Street Hartford, CT 06106 T: 860-951-8770, Ext 222 F: 860-233-2796 E: hinm@crtct.org
Norma Irving	Parent of a Child with SED - Children's BH Council, CBHAC		192 Affleck Street Hartford, CT 06106 T: 860-803-8754 Larry192@comcast.net
Lisa Jameson	Family Member of Adult Consumer, Adult MH Advocate, Adult SMHP Council		112 Bell-Aire Circle Windsor, CT 06096 T: (860) 796-9116 Jameson-one@sbcglobal.net
Marcy Kane, Ph.D.	MH Provider, Children's BH Council, CBHAC	Wellpath	36 Sheffield Street Waterbury, CT 06704 T: 203-575-0466 C: 860-217-5276 E: mkane@wellpathct.org

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

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Karen Kangas, D. Ed.	Adult Primary Consumer, Adult MH Advocate, Adult SMHP Council	Advocacy Unlimited, Inc.	300 Russell Road Wethersfield, CT 06109-1346 T: 860-667-0460, Ext 302 F: 860-666-2240 E: karen.kangas@mindlink.org
Darcy Lowell, MD	MH Provider, Children's BH Council, CBHAC	Bridgeport Hospital	267 Grant Street, Bridgeport, CT 06610 T: 860-384-3626 F: 860-454-4472 darcylowell@aol.com
Mary M. Martinez	MH Advocate, Adult SMHP Council; Children's BH Council, CBHAC		7 Mary Shepard Place, Apt 710 Hartford, CT 06120 T: 860-241-1040 & 860-816-0881 E: N/A
Debbie McCusker	Parent of a Child with SED - Children's BH Council, CBHAC		35 Maywood Street Waterbury, CT 06704 T: 203-757-7569 E: jamesmccusker@sbcglobal.net
George McDonald	Parent of a Child with SED - Children's BH Council, CBHAC		P.O Box 2617 Hartford, CT 06146 T: 860-794-6283 E: N/A
John McGann	MH Provider, Children's BH Council, CBHAC	Catholic Charities/ Catholic Family Services	203 High Street Milford, CT 06401 T: 203-735-7481 F: 203-735-5021 E: milford@cccfs.org
Tabor Napiello, MSW	MH Provider, Children's BH Council, CBHAC	Wheeler Clinic	91 Northwest Drive Plainville, CT 06062 T: 860-793-3551 F: 860-793-3371 E: tnapiello@wheelerclinic.org
Kim O'Reilly	**Chair: Adult SMHP Council;** RMHB Exec. Dir., Adult MH Advocate, Adult SMHP Council	Southwest Regional Mental Health Board	1 Park Street Norwalk, CT 06851 T: 203-840-1187 (office) F: 203-840-1926 E: swrmhb@optonline.net

List of Planning Council Members (Table 1) (Continued)

Table 1 – Voting Members – Non State Agencies Representatives

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Brian Reignier, MS	Adult Primary Consumer, Adult MH Advocate, Adult SMHP Council	River Valley Services, Human Services Advocate	H: 19 Irving Street Naugatuck CT 06457 HT: (203) 720-1048 WT: (860) 262-5362 WF: (860) 262-5356 E: Brian.Reignier@po.state.ct.us
Barbara Roberts	Family of Adult Consumer with SMI, RMHB member, MH Advocate, Adult SMHP Council	Northwest Regional MH Board	42 School Street Woodbury, CT 06798 T: 203-263-3250 E:Barbara114@sbcglobal.net
John F. Sims	Primary Adult Consumer, MH & SA Consumer Advocate, Rep of Minority Group (African Origin), Adult SMHP Council		118 Federal Street West Hartford, CT 06110 T: 860-232-8514 F: N/A E: N/A
Karen Smith	Parent of a Child with SED-Children's BH Council, CBHAC	Helping Hands CT	166 Green Manor Drive East Hartford, CT 06180 T: 860-890-0299 homenterprises@sbcglobal.net
Janine Sullivan-Wiley	Adult MH Advocate, RMHB Exec. Dir., Adult SMHP Council; Member of Family Focus Partnership (Youth System Collaborative)	Northwest Regional MH Board, Inc.	969 West Main Street, Suite 1B Waterbury, CT 06708 T: 203-757-9603 (Office) F: 203-757-9603 E: nwrmhb@snet.net
Cindy L. Thomas	Parent of a Child with SED-Children's BH Council, CBHAC		167 Saltonstall Ave New Haven, CT 06513 T. 203-691-8962 Home T. 203-901-9911 Cell E: cindythomas1370@yahoo.com
Dominique S. Thornton, JD	Adult MH Provider, MH Advocate, Adult SMHP Council	Mental Health Association of Connecticut, Inc.	20-30 Beaver Road Wethersfield, CT 06109 T: 860-529-1970, Ext 11 F: 860-529-6833 E: dthornton@mhact.org
Dave Tompkins	**Co-Chair, Children's BH Council, CBHAC;** Child MH Provider	The Children's Home	60 Hicksville Road Cromwell, CT 06416 T: 860-635-6010, Ext 391 F: 860-398-0397 E: Dtompkins@childhome.org
Jan VanTassel, Esquire	Adult MH Advocate, Adult SMHP Council	CT Legal Rights Project	CT Valley Hospital, Shew-Beers Hall P. O. Box 351, Silver Street Middletown, CT 06457 T: 860-262-5042 F: 860-262-5035 E: Jvantassel@clrp.org
Doriana Vicedomini	**Co-Chair, Children's BH Council, CBHAC;** Parent of		317A Thompsonville Road Suffield, CT 06078

	a Child with SED-Children's BH Council, CBHAC		T: 860-668-5228 DMV35@aol.com
Cara Westcott	MH Provider, Children's BH Council, CBHAC	United Community and Family Services, UCF Health Center, The Meadows Center	47 Town Street Norwich, CT 06360-2315 T: 860-892-7042, Ext 409 F: 860-886-6124 E: cwestcott@ucfs.org
Curtis Willey	Primary Adult Consumer, MH & SA Consumer Advocate, Adult SMHP Council	Connecticut Behavioral Health Partnership	500 Enterprise Drive, Suite 4-D Rocky Hill, CT 06067 T: (860) 263-2168 F: (860) 263-2166 E: Curtis.Willey@valueoptions.com
Susan Williamson	MH Provider, Children's BH Council, CBHAC	Care Coordinator Wellmore	11-D Trinity Hill Drive Durham, CT 06422 T: (203) 756-7287 ext 106 E: swilliamson@wellpathct.org

List of Planning Council Members (Table 1) (Continued)

Table 1 – Voting Members – Non State Agencies Representatives

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Vacancy	Adult SMHP Council – Substance Abuse Consumer/ Person in Recovery		
Vacancy	Adult SMHP Council – Substance Abuse Consumer/ Person in Recovery		
Vacancy	Substance Abuse Family Member		
Vacancy	Substance Abuse Family Member		
Vacancy	Substance Abuse Provider		
Vacancy	Parent – Children's BH Council - Governor's Appt		
Vacancy	Parent - Children's BH Council - Majority Leader of the House Appt.		
Vacancy	Parent - Children's BH Council - Speaker of House Appt		
Vacancy	Parent - Children's BH Council - State Advisory Council Appt **Application Pending**		

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

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

List of Planning Council Members (Table 1) (Continued)

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

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

List of Planning Council Members (Table 1) (Continued)

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

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Dr. Mark K. McQuillan Commissioner (M)	State Agency, State Employee - Children's BH Council	Dept. of Education (SDE)	165 Capitol Avenue, Room 305 Hartford, CT 06106 T: 860-713-6500 F: 860-713-7001 E: Mark.McQuillan@po.ct.gov
Jewel Mullen, MD Commissioner (M)	State Agency, State Employee	Dept. of Public Health (DPH)	410 Capitol Avenue Hartford, CT 06106 T: 860-509-7101 F: 860-509-7111 E: Jewel.Mullen@ct.gov
Charles Nathan (A) Represents DPH Commissioner	State Agency, State Employee	Dept. of Public Health (DPH)	410 Capitol Avenue Hartford, CT 06106 T: 860-509-7127 F: 860-509-7160 E: Charles.Nathan@ct.gov
Lynne Neff, (A) Represents DOC Commissioner Correctional Health Services Manager	State Agency, State Employee & MH Provider – Adult SMHPC	Dept. of Correction (DOC)	24 Wolcott Hill Road Wethersfield, CT 06109 T: 860-692-6958 F: 860-506-6068 E: Lynne.Neff@po.state.ct.doc
Scott R. Newgass (A) Represents SDE Commissioner	State Agency, State Employee - CBHAC	State Dept. of Education (SDE)	25 Industrial Park Road Middletown, CT 06457 T: 860-807-2044 F: 860-807-2127 E: scott.newgass@ct.gov
Terrence Macy, Commissioner (M)	State Agency, State Employee	Dept. of Developmental Services (DDS)	460 Capitol Avenue Hartford, CT 06106 T: 860-418-6011 F: 860-418-6009 E: Terry.Macy@ct.gov
Paul Piccione, Ph.D. (A) Represents DSS Commissioner	State Agency, State Employee	Dept. of Social Services (DSS)	25 Sigourney Street Hartford, CT 06106 T: 860-424-5160 F: 860-424-5206 E: Paul.Piccione@ct.gov
Patricia A. Rehmer, MSN, Commissioner (M)	State Agency, State Employee, Adult MH Provider	Dept. of Mental Health & Addiction Services (DMHAS)	410 Capitol Avenue Hartford, CT 06134 T: 860-418-6969 F: 860-418-6691 E: Pat.Rehmer@po.state.ct.us

List of Planning Council Members (Table 1) (Continued)

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

Name	Type of Membership	Agency or Organization	Address, Phone & Fax & E-Mail, if Applicable
Nikki Richer (A) Represents DMHAS Commissioner	State Agency, State Employee, Adult MH Provider (Young Adults) - CBHAC	Dept. of Mental Health & Addiction Services (DMHAS) Young Adult Services (YAS)	YAS, CVH P.O. Box 351 Middletown, CT 06457 T: 860-262-6995 F: 860-262-6980 E: Nikki.Richer@po.state.ct.us
Wiley Rutledge (A) Represents OP&A Director	State Agency, State Employee – Adult State Mental Health Planning Council	Office of Protection & Advocacy (OP&A)	60-B Weston Street Hartford, CT 06120-1551 T: 860-297-4360 F: 860-566-8714 E: Wiley.Rutledge@po.state.ct.us
Rachel Sherman (A) Represents OP&A Director	State Agency, State Employee - Children's BH Council (CBHAC)	Office of Protection & Advocacy (OP&A)	60-B Weston Street Hartford, CT 06120-1551 T: 860-297-4320 F: 860-566-8714 E: Rachel.Sherman@po.state.ct.us
Maureen Thomas, Ph.D. (A) Represents DDS Commissioner	State Agency, State Employee – Children's BH Council (CBHAC)	Deputy Commissioner Dept. of Developmental Services (DDS)	370 James Street New Haven, CT 06513 T: (203) 974-4268 F: (203) 974-4211 E: Maureen.Thomas@ct.gov
Barbara Parks-Wolf (M) Represents Secretary of OPM	State Agency, State Employee	Office of Policy & Management (OPM)	450 Capitol Avenue Hartford, CT 06106 T: 860-418-6442 F: 860-418-6495 E: Barbara.Wolf@ct.gov
Paula Zwally (M)	State Agency, State Employee, Adult MH Provider (Director of Compliance)	Greater Bridgeport Community Mental Health Center	1635 Central Avenue Bridgeport, CT 06610 T: (203) 551-7464 E: Paula.Zwally@po.state.ct.us

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

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

Planning Council Composition by Type of Member (Table 2)

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

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

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

3. Planning Council Charge, Role and Activities

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

- To review plans provided to the Joint MHP Council pursuant to section 1915(a) by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), and to submit to the Commissioners of those departments any recommendations of the Joint SMHP Council for modifications to those plans;

- To serve as an advocate for adults with serious mental illness, and children with SED and their families, as well as other individuals with mental illness or emotional problems; and

- To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Connecticut.

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

- Tracked proposed legislation and provided testimony to oppose legislation that would adversely impact behavioral health services for children and families;

- Submitted recommendations to the State Advisory Committee, per the CBHAC by-laws, regarding the behavioral health needs of youth and their families in Connecticut;

- Continued to review Practice Standards for services and programs;

- Continued to recruit new members;

- Continued participation on the CT Behavioral Health Partnership Oversight Council;

- Continued to work collaboratively with the Adult Council to focus on needs and services for transitioning youth;

- Provided the CBHAC members and guests with presentations on new and developing initiatives within Connecticut, data relating to behavioral health services in Connecticut and nationally, and DCF strategic planning and reviews of the Mental Health Block Grant progress report;

- Continued to sponsor quarterly meetings of the state's Community Collaboratives;

- Participation on Partnering with Parents, a statewide group that brings together entities that focus on parent training; and

4. State Mental Health Planning Council Comments and Recommendations

(Section 1915(a))

Connecticut is required to submit a letter from the SBHPC containing any recommendations for modifications to the State Plan received by the state, regardless of whether the state has accepted the recommendations. The draft FFY 2014 – 2015 CMHS Block Grant State Plan was posted on the state websites, the Adult services on the DMHAS website and the Children's services on the DCF website. Any comments from the public were shared with the Joint MHP Council. The Council met on March , 2013 to provide comments. Prior to the meeting, the adult and children's portion of the Joint BHP Council met and reviewed their respective parts of the plan, and provided comments and recommendations. Final recommendations, based upon the Council's review are provided with the joint letter from both Council co-chairs.

X. Comments on the State BG Plan

The Children's BH Council requested that the following document be included as comments.

1. ANNUAL REPORT ON THE STATUS OF CONNECTICUT'S COMMUNITY COLLABORATIVES/SYSTEMS OF CARE, Presented to the Department of Children and Families OCTOBER 2012

Overview

Per state statute ((PA00-188) the Children's Behavioral Health Advisory Committee (CBHAC) provides an annual report on the status of Connecticut's Local Systems of Care, organized through 25 Community Collaboratives.

The goals of these Community Collaboratives/Systems of Care (CC/SOC) is to ensure a coordinated network of care to serve the ever-growing and complex issues that face families who are raising children with significant emotional and behavioral health issues. This network of care is designed to meet the needs of all children and youth in child protective services, juvenile justice, behavioral health, substance abuse, and prevention. CC/SOC promote and assist communities to avoid fragmentation and ensure a continuum network of care that is family-driven, culturally- and linguistically-competent, and community-based.

This report for State FY2011/2012 is divided into three sections. The first section includes highlights that occurred during the year. The second summarizes results of a survey that were based on information gathered in break-out sessions of the Statewide Council of Community Collaboratives (SCCC, a subcommittee of CBHAC) tri-annual meeting held on October 12, 2012. The final section proposes recommendations for next steps.

Annual Highlights

- Last year's response from Commissioner Katz to the 2011 Annual Report enabled several important events to occur (the following list is not all-inclusive):
  a. A significant increase in the number of Care Coordinators enabled Connecticut to enroll over 200 additional families into Care Coordination.
  b. Eight new positions, Family Systems Managers, were created that will lead to continued support for and enhance family involvement in collaboratives
- Six Regional Advisory Councils continued to support the regional structure that began in December 2011.
- A statewide meeting of Community Collaborative co-chairs was held on October 12, 2012. Although this meeting has been convened before, last October's meeting included not only attendees from Community Collaboratives, but also from LIST's and Discovery Early Childhood Community Collaboratives. Feedback from the six regions indicated common challenges, e. g., family representation and need for administrative support to the local Community Collaboratives.

Survey Results:

In previous annual reports, survey data were collected electronically from participating CC/SOC and highlighted membership, attendance, sub-committees and governance. As the SCCC continues to grow and expand its efforts to be inclusive of all community collaboratives (i.e., Early Childhood Community Collaboratives, Foster Care Collaboratives, LIST's, DCF RAC's and others), this year's data collection method reflects both expansion and inclusiveness.

Rather than data collected from an annual survey, this year's data collection reflects the combined efforts of participants at the October 2012 SCCC quarterly meeting. The purpose of this meeting was to work in partnership with the invited guests to increase the family voice and to increase collaborative efforts among local initiatives without creating additional burdensome meetings. Participants took part in breakout sessions, assembling into six groups that reflected the six Department of Children and Families' (DCF) regions. Therefore, each group comprised co-chairs and others from each of the above- mentioned collaboratives for their respective regions.

The following were the results of the breakout sessions:

1 Is there enough family voice at each meeting?

- Family voice and input is valuable and essential
- Family voice contributes to success and good outcomes
- All Regional Advisory Councils articulated a need for more family involvement
- All regions agreed for the need of family outreach activities
- Families need consistent information about dates, times, locations
- Financial resources are needed to support stipends, transportation and childcare for families
- Families need orientation, education, knowledge, and information about the system
- Regular helpful communication should be provided directly to families

2. Has there been regular communication between groups?

- A need for a formal infrastructure that facilitates communication between multiple local initiatives was identified (i.e., Early Childhood Community Collaboratives, Foster Care Collaboratives, LIST's, DCF RAC's and others) including neutral leadership
- Outreach activities need to be established for the recruitment of other major system partners and informal supports

The SCCC will continue to support the growth of system-wide collaboration between all initiatives at both regional and statewide levels. The expectation is that collaborations among local groups will occur more frequently as formal infrastructure continues to build. In addition, tri-annual statewide meetings will provide the opportunity for the SCCC to review progress made and barriers faced by the various collaboratives in the six regions. Finally, Family Systems Managers, newly-created and state-supported positions in FAVOR, will focus on increasing family voice; and, in collaboration with local initiatives, decreasing the number of meetings in a way that will meet the objectives of these diverse groups who typically have common goals.

Recommendations

The following recommendations address three of DCF's Cross-cutting Themes: Family-centered everything; leadership, management, and accountability; and, building a learning organization.

1. We recommend that DCF develop practice standards for all service categories and update those that are out-dated, including community collaboratives.
2. Develop DCF policy to ensure family involvement at all levels "from the waiting room to the board room"; from the "micro" to the "macro"; from the individual family to all families involved in DCF and the entire system.
3. Ensure family involvement and participation in all DCF meetings.
4. Identify, recruit, and train families at each of the local DCF area offices about meaningful family participation in the "systems".
5. Train all interested families in DCF Partners in Change; Strengthening-Families Practice Model; Family Assessment Response; Trauma Informed Practice; Six Cross-Cutting Themes; and, Principles of Partnership.
6. We recommend that DCF, DDS, DSS, SDE and other state departments ensure positive outcomes from the Interagency Autism Feasibility Study (state departments to maintain, reports back to CBHAC).

2. Feedback from Doriana Vicedomini, CBHAC Co-Chair and Family Member

For purposes of feedback for the MHBG applications here are some suggestion or issues that were brought up today by parents at the CBHAC meeting:

The need for prevention programs to ensure that the child, the family and the community are being supported in getting the help they need early before tragedies happen.

We continue to need to re-invest in community based services that can meet the need of children and families with mental health needs.

We need focus on meaningful results that connect youth to the community so that they are building connections and keeping youth from being isolated.

Kids and families want to feel connected to the community and want to feel "normal". Whenever possible treatment should reflect that.

An outing with a therapeutic mentor is much more inviting then attending therapy weekly with an adult who is twice your age. It is often difficult to find those services in the community especially for youth with specialized needs particularly aggressive or acting out sexually.

There is a gap in services for those kids who need intensive support for those youth who are returning from residential.

Some children who have been taken into DCF custody and put into a residential placement are then

medicated against some parents wishes. Beginning February 1, 2013 before any removal from a home can happen by DCF there must be a Child and Family Team meeting to determine if the removal is necessary but what happens to the children who are currently removed from their homes?

3. Feedback from CBHAC Member

Dear Mrs. Cloud
I only have my personal experiences to go off of and the problem I see everyday through my childrens fathers is that both of them came out of jail where they received any meds they needed on a daily basis for the mental health issues they are going through. Now both of them are out without anywhere to call home except shelters who are not helping them to figure out how to get their medical needs taken care of considering the fact that they do not have health insurance. One is manic depressive/Bi-polar and the other is Bipolar/adhd and since they have left incarceration I have seen their mental health declining week by week and now I can't even talk to them about their issues because they cannot handle the discussion.These two men are exhibiting aggressiveness,aggitation with their situation/everyone,feelings of hopelessness,anger,and being overwhelmed and blame the world for all their problems etc.They have threatened me and they rarely but do speak of harming themselves and others and I do not know how serious they are or what to do about it.This is what leads to serious bad behavior.One has went so far as to take my son from the bus stop and refused to let him go until police got involved.What if the feelings he has been exhibiting that I mentioned before were out of control or at it's peak that day,he could have seriously harmed my child or worse.Someone needs to think about these people who are being let go from the system and not followed up with. At any point in time they could "snap" and then it's way too late. We need to find a way to track these individuals with documented mental health issues that are in the jail system and find out how they are dealing with life on the outside so they do not become victims of their own hand or leave victims they have harmed or worse. If we could at least check on them that would be a start. Some people leave incarceration and are followed by a parole officer,why can't we follow the people with significant mental health issues in someway like that.Yes it may be costly but what is the cost in the end if we do not do it.We do not have time to wait any longer,these people need help now before they walk into someone who rubs them the wrong way and havoc breaks loose or they make plans to harm themselves,their families or many others.