

PA 13-178
**An Act Concerning the Mental, Emotional
and Behavioral Health of Youth**



**Connecticut's Children and Youth
Healthy, Safe, Smart and Strong:**

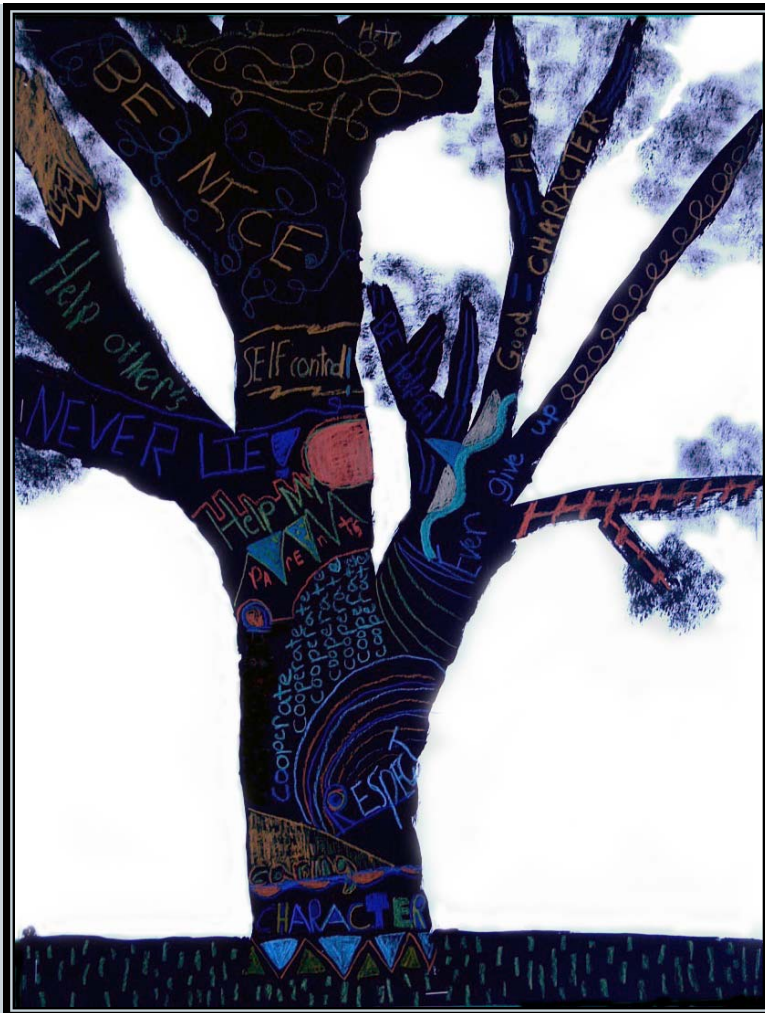
Connecting the Dots

This is an evolving presentation by the
CT Department of Children & Families

Revised September 16, 2013

Newtown brought sorrow and pushed CT to focus on child and family mental health & well-being

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“Newtown gave the year a different shape and leaning. It produced numerous agenda points, including gun access and safety, how to protect children against a culture of violence, the community mental health system, and the important role of families and community in holding the overall fabric of a society together. The issues that exploded in Newtown pour into every town.”

*Annual Report of the
CT Commission Children, 2012*

“An Artistic Student Tribute to Newtown.” CT Commission on Children

Part I: Unpacking PA 13-178

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Purpose of the Act

People who need to be at the table

Key Dates: Developing the MH Implementation Plan

Eight Required Strategies in the MH Implementation Plan

Interagency Requirements related specifically to DCF

Requirements of the Office of Early Childhood

Requirements of the Department of Developmental Services

Requirements of the Judicial Branch, with DCF and the

Department of Corrections

Improving school and community health/mental connections

Requirements related to Reimbursement

New Children's Mental Health Task Force

PA 13-178: An Act Concerning the Mental, Emotional and Behavioral Health of Youth

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Identify, prevent, address and remediate the mental, emotional and behavioral health needs of all children within the State of Connecticut

Coordinate and expand services that provide early intervention for young children, specifically home visiting services and the CT Birth to Three program

Expand training in children's mental, emotional and behavioral needs for school resource officers, pediatricians, child care providers and mental health professionals

Understand whether the lack of appropriate treatment for children and young adults may lead to placement within the youth or adult justice systems

Seek funding for public and private reimbursement for mental, emotional and behavioral health services

Many people, organizations and sectors have a role to play in PA 13-178

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| | |
|---|--|
| State Agencies | Departments of Children and Families, Social Services, Developmental Services, Public Health and the CT Office of Early Childhood, State Dept of Education, and agencies who seek public/private reimbursement for services |
| Judicial System | The Courts, Juvenile justice providers, Adult correctional providers |
| Community Agencies and Professionals | Schools (School resource officers), Mental health providers, Child care providers, Pediatricians, B-3 providers, Home visiting agencies |
| Funders | Public and private sector (e.g., Medicaid, private insurance, philanthropy) |
| People | Children and youth, Families, Advocates and other interested people |
| Statewide Services | United Way of CT 2-1-1 System |

Developing the MH Implementation Plan

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By October 2014, DCF must develop a comprehensive MH Implementation Plan – with broad interagency and public participation – to meet the mental, emotional and behavioral health needs of all children and youth in Connecticut.

A progress report is due to the Governor and the General Assembly in April 2014.

Beginning in October 2015, biennial status reports are to be presented to the Governor and the General Assembly, including any “data driven recommendations” for changing the plan.

8 strategies that must be addressed within the MH Implementation Plan

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- Employ prevention-focused techniques that emphasize early identification and intervention, including specific interagency efforts
- Ensure access to developmentally appropriate services
- Offer comprehensive care within a service continuum
- Engage communities, families and youths in planning, delivery and evaluation of services
- Sensitivity to race, culture, language and ability
- Establish Results Based Accountability (RBA) measures to track progress toward the Act's goals and objectives
- Apply data-informed quality assurance strategies
- Improve school and community-based mental health integration.

Interagency Requirements of PA 13-178 related specifically to DCF and the Plan

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To enhance early interventions, consumer input, and public accountability, the Plan must specify strategies to increase:

- Family and youth engagement in medical homes, with the Department of Public Health
- Data collection on each program's results, including information on (a) treatment response times, (b) provider availability, and (c) access to treatment options, in collaboration with each state funded program that addresses mental, emotional and behavioral services
- Awareness of the 2-1-1 Infoline in collaboration with the Department of Social Services.

Requirements of the Office of Early Childhood: Targeted professional development

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To the extent that private, federal or philanthropic funding is available, the new Office of Early Childhood must provide **professional development training to pediatricians and child care providers** to:

- Help prevent and identify mental, emotional or behavioral health issues in children
- Use the Infant and Early Childhood Mental Health Competencies
- Focus on maternal depression and its impact on child development

Requirements from the Office of Early Childhood: Home visiting recommendations

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Through the Early Childhood Education Cabinet (by December 1, 2014), the Office must provide recommendations for implementing the coordination of **home visiting programs** serving vulnerable families with young children, including prevention, early intervention and intensive intervention.

Vulnerable families include those facing poverty, trauma, violence, special health care needs, mental, emotional or behavioral health care needs, substance abuse challenges and teen parenthood.

Seven areas must be addressed, including a common referral process, core workforce competencies, coordinated training, common outcomes, shared reporting system

Note: DCF sits as a member of the Cabinet and also funds a core home visiting program (with DPH) – Child FIRST

Creating a cross-agency public education campaign

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With DCF, the Department of Public Health and the State Department of Education, the Office of Early Childhood – **to the extent that private funding is available** – shall design and implement a **public information and education campaign**. The Office must report beginning October 1, 2014 on the status of the public information campaign.

The campaign must include:

- Information on access, reimbursement and the importance of the child-adult connection in the early years
- A list of emotional landmarks and ages of attainment
- Strategies for parents on executive functioning and self-regulation
- Information for parent on methods to cope with children's MH issues at various stages.

Role of the Department of Developmental Services

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The Connecticut Birth to Three (B-3) system is required to provide mental health services to any child eligible for early intervention under Part C of IDEA.

The B-3 program must refer any child not eligible for services to a licensed mental health care provider for evaluation and treatment, as needed.

NOTE: This change will provide better access for children referred to the B-3 program by DCF and early childhood provider system.

A research partnership between Judicial Branch, DCF and the Department of Corrections

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This permits (but does not require) the Judicial Branch -- in collaboration with the Departments of Children and Families, and Corrections -- to seek public and private funding for a study of youngsters with a primary mental health need who enter the juvenile justice systems.

Data sought will address racial issues, consequences of inappropriate referrals and recommendations to ensure proper treatment.

NOTE: This relates to work DCF is now engaged in with Court Support Services through Georgetown University.

Improving school and community health/mental connections

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Collaboration between health care providers and school boards, to improve:

- Coordination and communication for prompt identification and referral of children with mental, emotional or behavioral health issues to appropriate treatment
- Planning for any follow-up with the child and family.
- Strategies shall include – **but not be limited to** -- Memoranda of Understanding, referral and outreach policy or protocols, liaison between entities.

This work must include Emergency Mobile Psychiatric Service providers, community-based mental health agencies, school-based health care centers and the contracting authority for each local or regional board of education.

Note: This will need to involve DCF as a core EMPS funder.

More on school board actions: Training School Resource Officers

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If federal funds are available, local law enforcement agencies and local/regional school boards that employ **School Resource Officers (SROs)** must train SROs in nationally recognized best practices that prevent students with mental health issues from being (a) victimized or (b) disproportionately referred to the juvenile justice system because of their mental health issues.

Note: This work may be aided by the DCF Education Division and the DCF Unified School District #2.

Requirements related to Reimbursement

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The “state” must seek existing public and private **reimbursement** for mental, emotional and behavioral health services (a) delivered in the home and in elementary/secondary schools and (b) through the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program managed through the Department of Social Services.

NOTE: This work must be connected to CT’s State Health Innovation Plan (Payer Workgroup), being developed in concert with the Health Care Reform Cabinet, chaired by Lt. Governor Nancy Wyman.

Children's Mental Health Task Force

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A new task force is established to (a) study the effects of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on children's mental, emotional and behavioral health and (b) advise the Governor and the General Assembly on how to coordinate and administer the impact of these effects using a Results Based Accountability framework.

Part II: The DCF Context

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Healthy, Safe, Smart and Strong: DCF's RBA Framework

Overview of the 2012-2015 DCF Strategic Plan

Seven Cross-Cutting Themes

**Healthy Children, Families, Workforce and Communities in
context**

DCF Continuum of Care Partnership

DCF's Goal for All Children in Connecticut: Optimal Health and Wellness

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HEALTHY

Experience age-appropriate
cognitive, physical,
behavioral-emotional, and
social development

Have a permanent connection
with a family

SAFE

Experience safety at home, at
school and in the community

Make positive behavioral and
life choices

**Optimal
Health &
Wellness**

SMART

Achieve educational success

Develop special interests and
talents

STRONG

Develop internal resilience in
the face of trauma, adverse
experiences, and inequity

Connect with protective factors
in their community

The 2012-2015 DCF Strategic Plan guides our work for the children we serve

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- Manage DCF operations and change (Strat. #8)
- Maximize revenue and develop new investment resources (Strat. #9)

Results-based agency management

Yields more effective services

- Strengthen family-centered practice (Strat. #2)
- Expand regional networks of services (Strat. #3)
- Continue congregate rightsizing (Strat. #4)
- Increase agency and community partnerships (Strat. #6)

To address the needs of children, families & the workforce

- Support public/private workforce (Strat. #7)
- Focus on identified populations of children & families (Strat. #5)
- Increased investment in prevention, health promotion, early intervention and educational success (Strat. #1)

And improve child and family well being

- Healthy, safe, smart and strong children and families

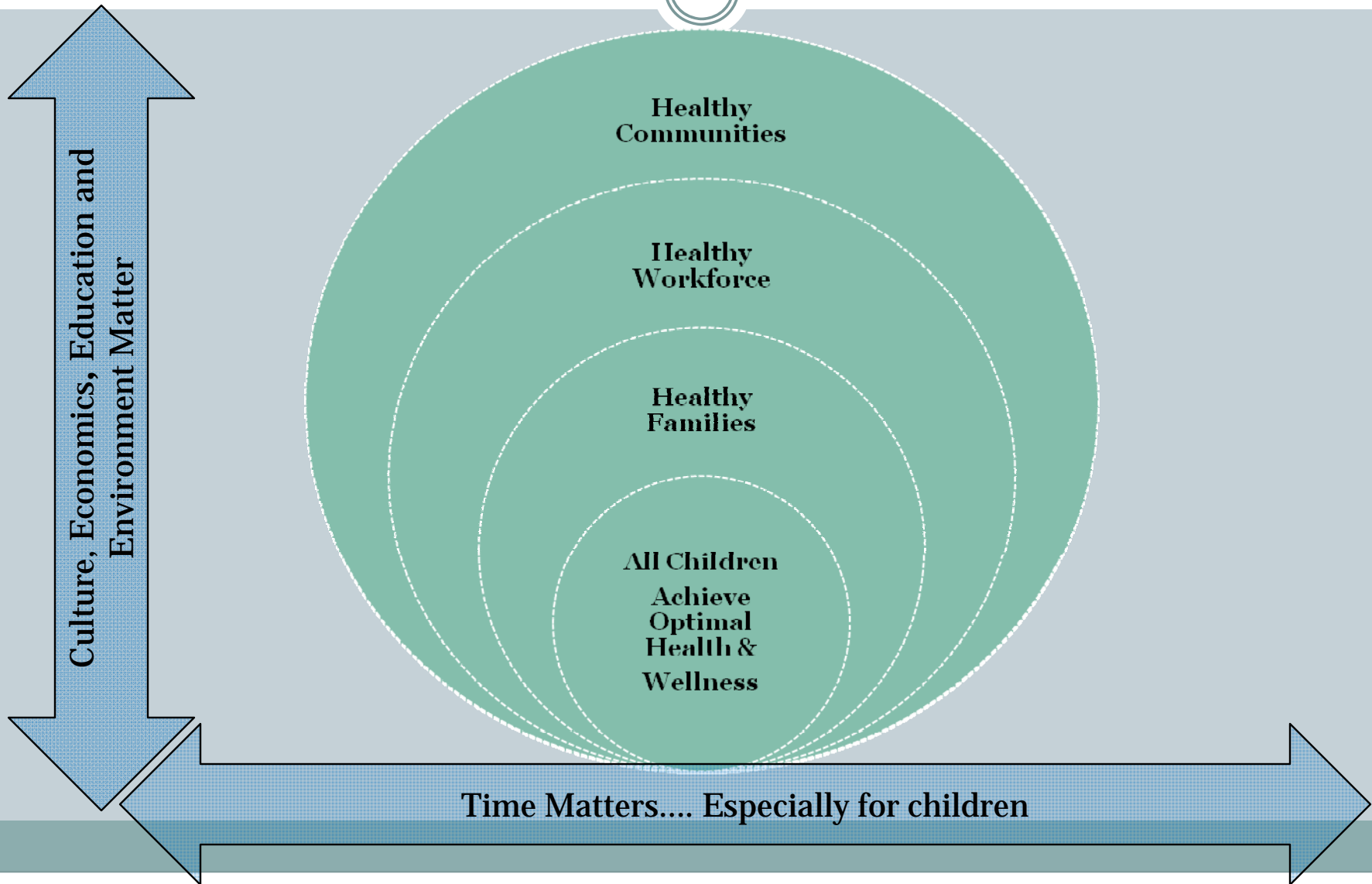
DCF work is guided by 7 agency-wide cross-cutting themes

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- ❑ Implementing strength-based family policy, practice and programs
- ❑ Applying the neuroscience of child, adolescent and young adult development
- ❑ Expanding trauma-informed practice and culture
- ❑ Addressing racial justice issues across policy and practice
- ❑ Building new community and agency partnerships
- ❑ Improving leadership, management, supervision and accountability
- ❑ Becoming a learning organization

Community, workforce, time and context matters

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DCF Continuum of Care Partnership

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Established in the fall of 2011 to provide advice and guidance to the Department related to the expansion of foster family care, the rightsizing of congregate care, data development, financing and public-private training issues.

Public-private members, beginning with 24 individuals and expanding to over 125 individuals engaged in the work

All work, resources and meeting minutes are [online](#).

Most recent report (December 2012) -- [Guiding Change: The First Year Report of the Continuum of Care Partnership](#)

The principles of the DCF Continuum of Care Partnership (Dec. 2011) align well with PA 13-178

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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. Family-based regional and community services are 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

Continuum of Care Partnership Principles, continued...

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6. Increase the direct participation of youth, parents and family members in the case process from entrance 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 for strategic planning, communications and accountability, and expanded training partnerships.

Part III: Connecting with new partners and new initiatives

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The CT Office of Early Childhood

Healthy CT 2020:

[Connecticut's State Health Improvement Plan](#)
(Department of Public Health)

[Connecticut's State Health Innovation Plan](#)
(a CMS federal innovation Round One grant to CT)

[ACCESS Health CT](#)

Years of work culminate in Connecticut's new Office of Early Childhood

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“We are transforming how we address early childhood care and development in Connecticut...”

“Engaging in a comprehensive approach for the delivery of services to children and their parents means better, more focused programming, and is an important addition to the education reforms that are already underway.”



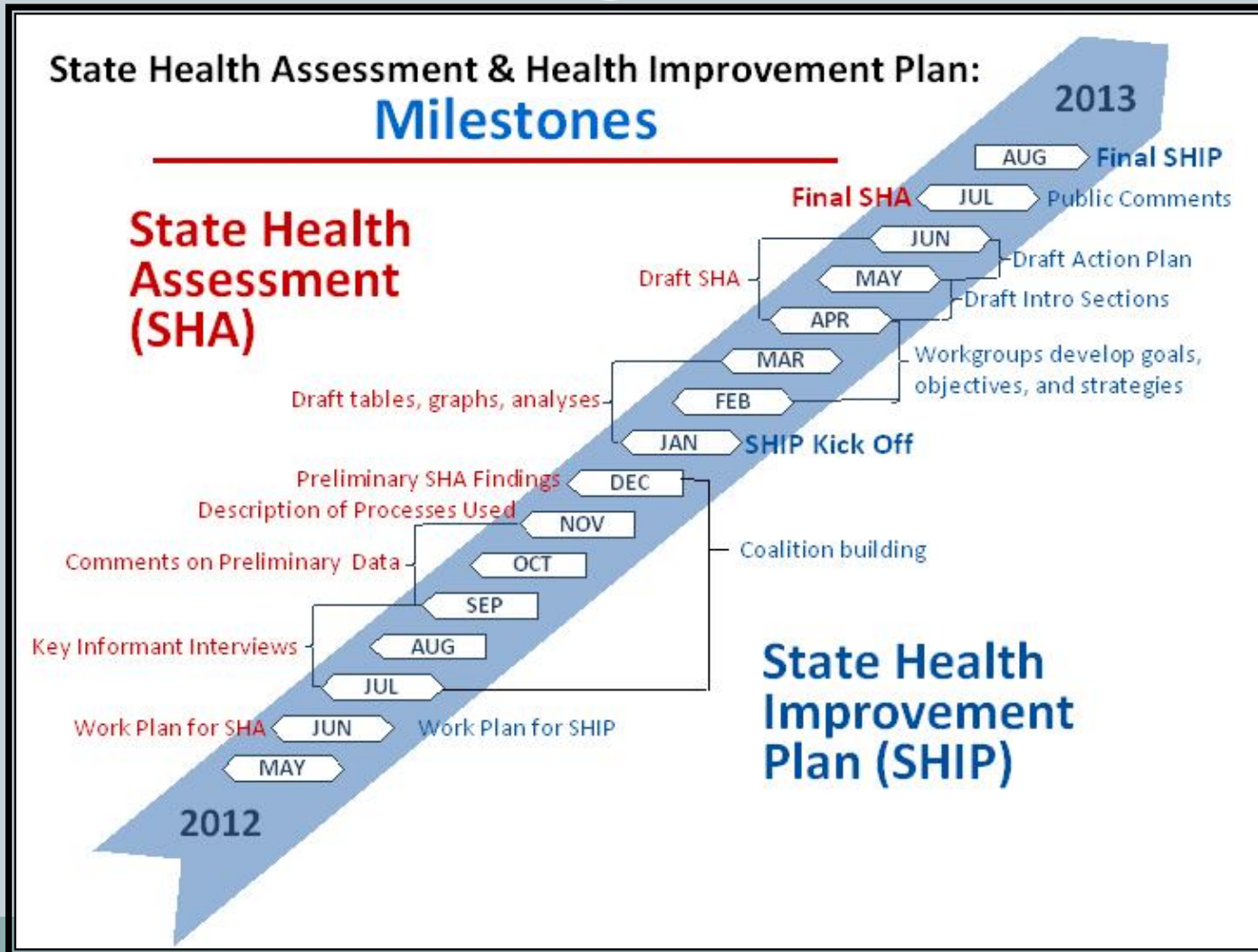
“When we improve early childhood education, we set a foundation for our young people that they will build on their entire lives.”

Governor Dannel Malloy, February 2013. Office established June 2013.

Photo Courtesy of The Connecticut Mirror

Healthy Connecticut 2010: State Health Improvement Plan

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Healthy Connecticut 2020: Draft focus areas

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As of July 17, 2013, seven focus areas had been identified, along with a set of objectives for each:

- Chronic Disease
- Environmental Risk Factors and Health
- Health Systems
- Infectious Disease Prevention and Control
- Injury Prevention
- Maternal, Infant and Child Health
- Mental Health and Substance Abuse

Healthy Connecticut 2020:

Draft focus area: Maternal, infant and child health

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Focus area #6: Maternal, Infant and Child Health

Goal: Optimize the health and well-being of women, infants, children and families with a focus on disparate populations

- Preconception and Pregnancy Care (including teens)
- Birth outcomes: Infant, fetal, and maternal mortality and morbidity
- Reproductive and sexual health
- Child health and well-being (well-child visits, oral health visits, developmental screens)
- Infant and child nutrition

Healthy Connecticut 2020:

Draft focus area: Mental health & substance abuse

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Focus area #7: Mental Health and Substance Abuse

Goal: Improve overall health through the lifespan, through access to quality behavioral health services that include screening, early intervention, prevention and treatment

- Address mental health and mental disorders (depression screening, reciprocal referrals between MH and primary care providers, decrease homeless among individuals and families not connected to MH services)
- Reduce alcohol and other substance abuse
- Address autism spectrum disorders (early screening data, referrals to B-3)
- Decrease suicide and suicide attempts
- Increase trauma screening by primary care and behavioral health providers

The design of health reform in CT is advanced through the [State Health Innovation Plan](#)

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Connecticut was awarded a \$2.8 million Round One federal State Health Innovation Plan grant, through the Office of Healthcare Reform, to create a “statewide population health model” (i.e., State Innovation Model) for health care reform.

The project has included extensive barrier analyses, continuing venues for consumer and stakeholder input, and the operation of 4 workgroups.

Barriers in the behavioral health care system have been identified with some suggestions for resolution. [See August SIM 2013 report to the Health Care Cabinet.](#)

SIM Work Groups

- [Care Delivery](#)
- [Payment Reform](#)
- [Health IT](#)
- [Workforce](#)

ACA Health Care Reform launches with ACCESS Health CT

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“Access Health CT is a new health insurance marketplace being developed by the State of Connecticut to satisfy the requirements of the federal Affordable Care Act. Our mission is to increase the number of Connecticut residents who are insured, lower their costs, promote health and eliminate health disparities. Access Health CT will operate at no cost to the state or its taxpayers.”



Next Steps

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**Listening Session with Advocacy and Provider Associations
September 9, 2013**

**DCF Continuum of Care Partnership meeting
September 16, 2013**

**Working Groups established and operational by
October 21, 2013 Partnership meeting**

**Community Listening sessions continue/ Link with DPH forum results
Data gathering/ Analysis and synthesis of extant reports**

**Linkages to key health initiatives and other agency work
October -November 2013**

Additional Resources Online

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[The DCF Continuum of Care Partnership](#)

[DCF 2012 – 2015 Strategic Plan PPT](#)

[Public Act 13-178](#), CT General Assembly