

Child Mental Health Policy Recommendations  
to the Transition Team of Governor-Elect Dannel Malloy

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December 20, 2010

*Attached, please find the four child mental health policies we would like to submit to the Transition Team of Governor-Elect Malloy for consideration. **Our recommendations are based on the following assumptions and criteria:***

- **Mental health problems have the potential to affect ALL Connecticut families** as emotional-behavioral stability in children is impaired by the following factors:
  1. Alcohol and drug abuse;
  2. Academic failure;
  3. Family discord, including divorce or separation;
  4. Experiencing or witnessing sexual or physical trauma;
  5. Financial strain and lack of basic needs;
  6. Experiencing or perpetrating bullying or cyberbullying;
  7. Chronic medical problems.
- **Connecticut is experiencing a child mental health crisis** in that 200,000 children struggle with diagnosable mental illness, yet only about 25% have access to services they need and deserve.
- While addressing acute psychiatric crises is important, we need to **allocate resources to the least restrictive and most appropriate community-based services** to promote healthy child development and good mental health as a way of preventing future emotional-behavioral emergencies.
- **Schools are the biggest providers of mental health services to children in Connecticut.**
- The child mental health crisis has resulted in the following challenges as outlined in Governor-Elect Malloy's Policy Project:
  1. A widening academic achievement gap and more special education in our schools;
  2. Overuse of juvenile justice for mental health services due to a lack of community-based supports;
  3. More broken families, dependency, unemployment, and lost productivity in our workforce;
  4. Higher public and private insurance costs for other health care consequences;
  5. More addictive self-medication through smoking, drug and alcohol abuse, and gambling.
- Several of the key factors contributing to our child mental health crisis can be ameliorated **through bold leadership that changes bureaucratic culture, introduces a sense of urgency to cross-agency collaboration and coordination**, calls for a comprehensive analysis of current and future child mental health service needs, and promotes "no wrong door of entry" for any child in need of mental health care.
- Broad-based education programs designed to reinforce the basics of child development and behavioral management strategies will go a long way toward **empowering parents and teachers with skills that will prevent crises long before they emerge.**
- The critical shortage of child and adolescent psychiatrists can be addressed in part through the cross-training of primary care physicians and the promotion of telepsychiatry services.
- Our state largely depends on a wait-to-fail approach and spends millions of dollars on programs with little or no research supporting their continued use. As a result, **we have submitted a set of proposals that include the following elements:**
  1. **Actionable and cost-effective recommendations;**
  2. **Early childhood support for healthy development;**
  3. **Family-centered services;**
  4. **Evidence of cross-agency collaboration and an emphasis on care coordination;**
  5. **Extension of existing, high-quality services with data or research to support their efficacy;**
  6. **Support the development of a continuum of care that spans the home, school, and community.**

**EARLY CHILDHOOD MENTAL HEALTH PREVENTION AND INTERVENTION SERVICES:  
A CUTTING EDGE POLICY SUPPORTED BY NEUROSCIENCE**

**I. Statement of the Issue**

- Lack of health and mental health support services for very young children (0-5 years) and their families contributes to poor developmental outcomes and physical, emotional and academic difficulties across the lifespan. Addressing this can result in: (1) Early identification and treatment developmental and emotional problems; (2) Intervention during a period of rapid brain development that scientific research has demonstrated to have most long-lasting, significant positive outcomes on children's health, mental health, and academic success; (3) Improvement in caregiver-child relationships that are proven to buffer the developing brain from high stress or "toxic" environments.

**II. Proposed Action**

**A. Priorities**

1. Identify an existing model such as Child FIRST for high-risk young children and families that includes screening, assessment and intervention; the model must have robust data to demonstrate it has the power to decreased child emotional and behavioral problems, improve child language, decreased maternal depression, decrease DCF involvement, and increased access to existing community-based services.
2. Expand that model to all 15 DCF Areas in CT to ensure that all highly vulnerable children and families have access to comprehensive intervention.
3. Expedite DCF certification of home-based mental health treatment so that all new sites can obtain Medicaid reimbursement, thereby leveraging federal Medicaid dollars to support high quality, needed services
4. Maximize effectiveness of CT state dollars by reorganizing state agency programs so that they are both evidence-based and are able to leverage matching federal Medicaid reimbursement
5. Utilize federal funding opportunities to maximize program financing to include EPSDT (children's prevention legislation under Medicaid), CAPTA, and home visiting grants under the Affordable Care Act (PPACA)
6. Continue strong public/private partnership with philanthropy to support comprehensive community-based planning and implementation for early childhood and school readiness that fully integrates health and mental health with early care and education and family support services, using an RBA framework.

**B. Fiscal impact**

1. Prevention and early intervention generate the highest return on investment. Compare \$6,000 for Child FIRST services for a family of four with \$700,000 - \$900,000 for psychiatric hospitalization for a single child for a year, or the costs of DCF involvement or special education.
2. Leveraging federal Medicaid dollars, home visiting funds from PPACA, and CAPTA grants can bring a marked increase in needed services to Connecticut
3. Public-private partnerships have already leveraged \$4.5 million dollars in support of Child FIRST replication from the Robert Wood Johnson Foundation, Children's Fund of CT, Graustein Memorial Fund, and CT Health Foundation. Significant additional philanthropic dollars can be leveraged with documentation of ongoing State of CT support.
4. Investment in early childhood mental health will prevent the need for more costly services including DCF involvement, special education, more intensive clinical treatments, and involvement in juvenile justice services.

**C. Tie-in to Malloy/Wyman campaign policy?**

- The above emphasizes maximization of federal funds as promoted by the Malloy/Wyman team; as with Autism, early intervention for children's mental health is critical, including universal screening,

assessment, and access to multidisciplinary treatment; mental health policy is addressed in the Campaign Policy Book, noting 1 in 5 children suffer from a diagnosable mental illness.

### III. Long-term Needs/Vision

- Ensure all young children (0-5) in Connecticut have access to comprehensive health and mental health services within a **coordinated early childhood system of care** that includes promotion, prevention, early identification, and effective treatment.
- Avoidance of utilization of expensive services as children grow and develop along negative developmental trajectories (intensive mental health treatments, hospitalizations, residential treatment, special education services, justice involvement and incarceration).

### IV. Jobs Impact & Other Benefits

- Attract federal Medicaid funds, strengthen relationships between well-funded, national philanthropic organizations and local service providers.

#### Supporting documents:

Lowell DI, Carter AS, Godoy L, Paulicin B, Briggs-Gowan MJ: A randomized controlled trial of Child FIRST: A comprehensive home-based intervention Translating research into early childhood practice. *Child Development* 2011: 82; National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

National Scientific Council on the Developing Child (2004). *Children's Emotional Development is Built into the Architecture of their Brains: Working Paper No. 2*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

National Scientific Council on the Developing Child (2008). *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life: Working Paper No. 6*. Retrieved from [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

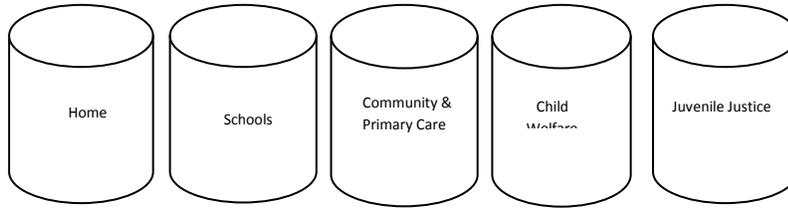
Perry, D. F., Kaufmann, R. K., & Knitzer, J. (Eds.). (2007). *Building bridges: Linking services, strategies, and systems for young children and their families*. Baltimore, MD: Paul H Brookes Publishing.

## BEHAVIORAL HEALTH LEADERSHIP AND INTERAGENCY COLLABORATION

### I. Statement of Issue:

- DCF's behavioral health charge has a secondary status in the daily culture and structure of the DCF system.
- The lack of behavioral health leadership at the highest levels is a strong contributor to the fragmentation across the agency's "silos" of behavioral health, child protection, and juvenile justice.
- From 1998 to 2007, the referrals from DCF to the DMHAS rose from 41 to 1,829, an increase of almost 4500%. This does not include the new young adult cases accepted directly by the adult system. DMHAS estimates that young adults account for an estimated 35% of their incoming clients.<sup>i</sup>
- There is a lack of appropriate services and transition planning for youth and young adults transitioning into the adult mental health system. Specialized Young Adult Services are only available in certain parts of the state.<sup>ii</sup>
- Poor inter-agency coordination and communication in the transitioning of young adults from DCF to DMHAS results in a high financial and social cost to Connecticut taxpayers. DCF and DMHAS are required by departmental policies and a memorandum of understanding (MOU) to create and execute transition plans for each young adult that is moving from DCF to DMHAS care. However, plans are often not written or, when they do exist, are not followed; poor transitions lead to higher school dropout and suicide rates, increased homelessness, elevated unemployment rates, and rising criminal justice involvement.<sup>iii</sup>

*We must break down silos that separate the settings in which mental health services are delivered in Connecticut.*



\*Schools are de facto the largest provider of mental health services to children in the U.S.

## II. Proposed Actions:

- Multiple state agencies have responsibility for the creation, delivery, financing and implementation of mental health services. The Office of the Attorney General also has a responsibility to make sure that the mental health parity law is adhered to. All responsible agencies need to coordinate the planning and delivery of mental health services, communicate effectively, jointly assess needs, monitor and make accountability certain, and avoid investing in competing or redundant services.
- The broader mandate of DCF as the children's behavioral services system has been buried in child welfare and should hold a central and upper-level focus within the agency. High-level leadership in behavioral health is necessary to achieve this goal and a reorganization of DCF to give primacy to behavioral health issues.
- A DCF led and coordinated planning process with CT's Child Guidance Clinics, children's residential providers, families and advocacy organizations, and other relevant stakeholders to bring out of state placements back into CT and strategically plan for the mainstreaming of these children back into their communities.
- Hold DCF and DMHAS accountable for timely transition planning and collaborative programming. Codify the MOU between the two agencies.
- Develop statewide availability of specialized Young Adult Services
- At a minimum, DCF and DMHAS should be required to report annually to the Administration and legislative committees of cognizance on their process for transitioning children to DMHAS as they age out of DCF care to provide a clear picture of the population and needs. The report should include a detailed description of the population, their diagnostic profiles, the transition process, and barriers to attaining specific service metrics.

***Tie-in to Malloy/Wyman Campaign Policy:*** These recommendations address the following policy targets highlighted by The Policy Project: 1) "Assuring access to effective mental health care for all in need" 2) "Investing more in community-based treatment" 3) "Spending Connecticut dollars in Connecticut" 4) "Institute Benchmarks and Greater Accountability"

***Long-term Needs/Vision:*** 1) Increased attention and access to behavioral health services across relevant state agencies and systems. 2) DCF will be able to embrace its mandate and come out from under the consent decree. 3) Better outcomes for Connecticut's children and families and less cost to the state. 4) A "no wrong door" approach to supporting mental health in children; all children have access to the same range and quality of services regardless of the point at which they access the "system".

***Jobs Impact & Other Benefits:*** 1) Savings to the state by avoiding the complex needs of the growing population of young adults who are failed by the DCF system 2) Diversion of children from expensive inpatient hospitalization or residential placement, saving hundreds of thousands of dollars per child per year. 3) Youth transferred to DMHAS with successful transition plans are more likely to make positive adjustments, require fewer services, and be stable and productive. 4) All funds used to treat high needs children using inpatient hospitalization or residential placement will be **spent on Connecticut services and jobs.**

**III. Potential Dissenting Opinions & Other Relevant Items:** 1) State agency leadership and staff may have concerns regarding greater accountability and documentation, as well as issues related to competing resources and separate programming budgets.

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<sup>i</sup> Department of Mental Health and Addiction Services (DMHAS), Legislative Report, *Young Adult Services: Current Status and Future Directions*, 2007.

<sup>ii</sup> Department of Mental Health and Addiction Services (DMHAS), Legislative Report, *Young Adult Services: Current Status and Future Directions*, 2007.

<sup>iii</sup> State of Connecticut Office of the Child Advocate, *Young Adults in DCF Care: What Happens to Young Adults Who Must Transition from the Department of Children and Families to the Department of Mental Health and Addiction Services or the Department of Mental Retardation?*, 2007.

**Additional Supporting Documents:**

North Central Regional Mental Health Board, *Young Adults Services: System or Regional Recommendations*, 2008.

Blackorby, J. et al (2003). The academic performance of secondary school students with disabilities. *The Achievements of Youth with Disabilities During Secondary School*. Menlo Park, CA:SRI International.

“The State of Children’s Mental Health in Connecticut: A Brief Overview” (Connecticut Voices for Children. 2000)

“The Cost of Failure” (State of Connecticut Office of the Child Advocate. 2000)

Regional Mental Health Boards of Connecticut, *2007-09 Review and Evaluation Summary Report: Statewide Review of Young Adult Services*.

\* Burns BJ, Costello EJ, Angold A, Tweed D et al. Children’s Mental Health Service Use Across Service Sectors, Health Affairs, Vol. 14, No. 3, 1995: 149-159.

**BOLSTERING SCHOOL-BASED MENTAL HEALTH: A POLICY TO ADDRESS OUR CHILD MENTAL HEALTH CRISIS AND NARROW THE ACADEMIC ACHIEVEMENT GAP**

**I. Statement of the Issue**

- Research shows that Connecticut’s achievement gap, the worst in the nation, will not improve unless schools attend to students’ social and emotional needs while promoting academic success.
- Research further demonstrates that schools act as our state’s de facto mental health system; about 75% of children receiving mental health services do so in a school setting.<sup>1,2</sup>
- Comprehensive school climate strategies are key to addressing the achievement gap and bullying, while school-based mental health clinics boost access to much-needed mental health services for children.
- Schools are motivated to address school climate, yet lack resources, data, a support network, and coordinated training options to help them implement practices specified by state law.
- The rate at which Connecticut schools use emergency seclusion and restraints as a behavior management strategy is about ten times greater than in California – last year there were more than 18,000 incidents in our state.
- There are too many children in our schools who are at risk for juvenile justice involvement and lack the appropriate community based services to alter their trajectories.

**II. Proposed Actions**

**A. Prioritization Schedule**

1. Establish a coordinated statewide training network using *National School Climate Standards* as a guide and train new providers in evidence-based, community-proven approaches, including – but not limited to – Olweus Bullying Prevention Program and Positive Behavioral Interventions and Supports (PBIS).
2. Strengthen and expand school-based mental health clinics by financially healthy community-based organizations, including – but not limited to - Federally Qualified Health Clinics (FQHC) to access Medicaid funds and appropriate federal grants.

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3. Bolster the monitoring of in-school emergency seclusion and restraints of children and aim to lower the number of yearly incidents significantly.
  4. Implement programs, including – but not limited to – the Connecticut School-Based Diversion Initiative (SBDI) to prevent at-risk students from entering the juvenile justice system; such systems aim to build partnerships with Emergency Mobile Psychiatric Services (EMPS) providers to provide immediate crisis stabilization and linkages to appropriate community-based supports.<sup>3</sup>
  5. Maintain state funding levels to all 62 school-based Family Resource Centers (FRCs) as they provide families with a single point of entry to essential support services as well as direct service programs upon which state social service and education agencies depend.<sup>4</sup>

#### B. Fiscal Impacts

1. Statewide network for training and information-sharing: **Minimal impact on state budget.** Recommendation is to leverage private/corporate support to train new providers and to organize conferences. Schools can pay for some services using existing funds, while the State Department of Education (SDE) may re-allocate funding/staff to expand trainings.
2. School-based mental health clinics managed by financially robust community providers: **No impact on state budget, inflow of federal funds for services and infrastructure.** Financially healthy providers – like FQHCs - are well-funded through Medicaid dollars and federal grants that can be directed to service delivery, capital expansion, and hiring.

#### C. Tie-in to Malloy/Wyman campaign policy

- The overall impact of addressing school climate and expanding the network of school-based mental health clinics is to *emphasize prevention and early intervention, provide access to effective mental health care for all in need, and to eliminate barriers to learning so that teachers can teach, thus narrowing the achievement gap.*

### III. Long-term Needs/Vision

- Improving school climate is a prevention strategy with proven efficacy that will yield positive outcomes for in both academic achievement and behavioral health.
- The presence of school-based mental health clinics also enhances school climate in that school professionals can focus on learning, while leaving behavioral emergencies to mental health clinicians.
- School-based services will reduce the need for involving school resource officers and the legal system.

### IV. Jobs Impact & Other Benefits

- The inflow of federal funds for school-based mental health clinics will lead to new jobs for clinicians and for construction workers during capital expansion projects.
- A federal Safe Schools/Healthy Students grant could create new SDE jobs.
- Improved school climates will bolster morale of teachers, reduce bullying incidents, decrease school dropout rates, and dissipate the stigma associated with seeking mental health treatment.
- Programs like SBDI enhance relationships between schools and local EMPS providers and community-based supports.
- School-based FRCs are local drivers and hubs of interagency collaboration, a central theme to improving the delivery of mental health services for children.

### V. Potential Dissenting Opinions & Possible Responses

- Opinion: Schools feel intense pressure to raise achievement scores and sometimes believe that attention paid to social and emotional issues takes away from instructional time.

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- Response: Speak to the school superintendents who have welcomed these programs into their districts. They have reaped the benefits of improved educational and behavioral outcomes.

<sup>1</sup> Ronos M and Hoagwood K. School-Based Mental Health Services: A Research Review. *Clinical Child & Family Psychology Review*, Vol. 3, No. 4, 2000: 223-241.

<sup>2</sup> Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, *Health Affairs*, Vol. 14, No. 3, 1995: 149-159.

<sup>3</sup> Bracey JR, Vanderploeg JJ, Franks RP. Connecticut School-Based Diversion Initiative: A Brief Progress Report. Connecticut Center for Effective Practice. 23 Nov 2010.

<sup>4</sup> A report on FRC outcomes: <http://www.sde.ct.gov/sde/cwp/view.asp?A=2678&Q=320774>

## SPEND SMARTER AND KEEP MENTAL HEALTH DOLLARS IN CONNECTICUT

### I. Statement of Issue:

- Connecticut is experiencing a child mental health crisis in that 200,000 children struggle with diagnosable mental illness, yet only about 25% have access to services they need and deserve.
- Millions of dollars are flowing out of Connecticut to pay for intensive inpatient mental health care. Children and youth with specialized treatment needs have extremely limited access to in-state treatment programs and are routinely referred out of state. There are more children admitted to out-of-state treatment facilities than to in-state facilities. This makes it more difficult for parents to visit their children and interferes with effective discharge and transition planning back into the child's home and community.
- Our state largely depends on a wait-to-fail approach, leading to increased utilization of expensive services such as inpatient hospitalization and residential treatment.
- Our children and their families struggle to access community-based services in part due to underinvestment in low-cost strategies. For example, there is only 1 DCF care coordinator serving 11,000 children in the Hamden/North Haven catchment area.
- Children with mental health needs are not effectively served through private insurance coverage. Thousands of children who are covered by insurance have no way of accessing mental health services. The state pays the cost of people on private insurance who must shift to state-funded services to get needed care.

### II. Proposed Actions:

- **Keeping Connecticut dollars in Connecticut** to help bolster the state's child mental health services infrastructure, from prevention services to high acuity inpatient care.
- Reallocate existing behavioral health resources to implement and sustain evidence-based practices (EBP's) and promising practices whenever possible. EBP's with proven outcomes can leverage federal funds through Medicaid to achieve a minimum of 50 cents on the dollar.
- Systematically collect and analyze data within and across services to promote delivery of best practices and enhance performance of service providers.
- Extend the Behavioral Health Partnership (BHP) model and covered services to Sustinet and private insurance; managing and coordinating services (utilization management), covering a comprehensive service continuum, and reducing incentives for the denial of care. The BHP has emerged as a critical success, helping to efficiently distribute scarce mental health dollars, while boosting key quality indicators. At a minimum, private insurance companies should be required to cover medically necessary and appropriate mental health services and treatments for children (as the state currently requires for autism spectrum disorders, PA 09-115).

*Tie-in to Malloy/Wyman Campaign Policy:*

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These recommendations address the following policy targets highlighted by The Policy Project: 1) “Assuring access to effective mental health care for all in need” 2) “Investing more in community-based treatment” 3) “Spending Connecticut dollars in Connecticut”

**Long-term Needs/Vision:** Children will be more likely to remain in their homes and communities. Use of EBP’s can be an alternative to the most costly mental health services. EBPs typically have shorter duration of treatment with better outcomes than treatment as usual. EBPs have demonstrated long lasting effects. Early intervention and appropriate treatment can prevent the development of more serious, costly disorders across the lifespan. By **improving access**, the current disparities in access to mental health care will be diminished.

**III. Jobs Impact & Other Benefits:** 1) States employing EBP’s in place of standard treatment have **saved an average of \$30,000 per child**. 2) Bolstering community-based services using evidence-based programs will help divert children from expensive inpatient hospitalization or residential placement, **saving hundreds of thousands of dollars per child per year**. 2) All funds used to treat high needs children using inpatient hospitalization or residential placement will be **spent in Connecticut and create jobs in the state**. 3) Extending BHP covered services and a non-risk model to Sustinet and private insurance will greatly reduce the reliance on the state for coverage and services for children and families with mental health services needs. It also has the potential to generate a funding stream for other needed reforms across the system, as outlined in the “Mental Health Care ‘Blueprint’ for Children in Connecticut.” This plan utilizes the dollars that the health insurance companies use for mental health and pools it in a state fund -- as we currently do for immunizations.

**IV. Potential Dissenting Opinions & Other Relevant Items:** 1) Insurance Industry - insurers will need to be incentivized to buy-in to the “Blueprint.” The idea is to pay more for efficiency and outcomes, and the model has the potential to save them money (see the “Mental Health Care ‘Blueprint’ for Children in Connecticut” by the *Joint Task Force of the CT Chapters of the American Academy of Pediatrics and Child and Adolescent Psychiatry*).

**Supporting documents:**

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