

Appropriations  
Committee

Children's  
Behavioral  
Health Forum

December 13,  
2021

# Connecticut's Children's Behavioral Health System

## A Multi-Agency and Multi-Branch Collaboration



# Children's Behavioral Health Forum

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December 13,  
2021

## Order of Speakers

1. Vannessa Dorantes, Commissioner, Department of Children and Families
2. Charlene Russell-Tucker, Commissioner, State Department of Education
3. Jordan Scheff, Commissioner, Department of Developmental Services
4. Deidre Gifford, Commissioner, Department of Social Services
5. Heather Aaron, Deputy Commissioner, Department of Public Health
6. Patrick Carroll, Chief Court Administrator, Judicial Branch
7. Kelli-Marie Vallieres, Executive Director, Office of Workforce Strategy
8. Victoria Veltri, Executive Director, Office of Health Strategy



# Overview of Children's Behavioral Health System

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VANNESSA DORANTES  
DCF COMMISSIONER

# Current Issues

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- ❖ American Academy of Pediatrics has declared a national emergency regarding children's mental health
- ❖ Nationally, this is a seasonal problem which has been exacerbated by the pandemic
- ❖ Hospital emergency departments (EDs) are seeing high volumes of children with behavioral health (BH) needs, many arriving by ambulance
- ❖ Supporting CCMC's requests for assistance
- ❖ Current crisis is straining inpatient behavioral health capacity, causing children to spend extended periods of time in the ED awaiting placement in other institutions
- ❖ Relevant state agencies have been working to address the chronic underlying problems over the last several months

# State Agency Collaboration

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- ❖ DCF – Statutory responsibility for children’s BH; directly operates or contracts for BH facilities and services for children
- ❖ SDE – Social-Emotional Learning initiatives, school-based BH services
- ❖ DDS – Manages services for children with intellectual disabilities
- ❖ DSS – Largest payer of children’s BH services; enrolls providers, designates what services can be covered and determines pay rates; statutory responsibility for individuals on the autism spectrum
- ❖ DPH – Licenses hospitals, school-based health centers, oversees emergency transport systems
- ❖ OWS – Evaluates ways to attract professionals to the BH field
- ❖ OHS – Manages the “Certificate of Need” (CON) process for hospitals; reviews and approves hospital requests to expand or reduce beds or service categories
- ❖ DMHAS – Statutory responsibility for adult BH system; directly operates or contracts for BH services for adults, some of which also treat older adolescents
- ❖ OPM – Budget and policy oversight
- ❖ Judicial Branch –Standardized procedure for identifying the mental health needs of juveniles under its jurisdiction

# Levels of Care

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- ❖ The CT Behavioral Health Partnership (CTBHP) was created to determine the appropriate treatment for a Medicaid eligible child with behavioral health needs
- ❖ The legislature empowered the CTBHP to establish the guidelines that ensure effective use of state and federal treatment funds
- ❖ The guidelines only apply to children who receive healthcare through Medicaid and not those using private commercial insurance
- ❖ There are 17 levels of care where a child may be treated after assessment by the CTBHP, from in-home supports to long-term inpatient hospitalization
- ❖ A child can receive treatment at a lower level of care but not a higher level of care unless approved by the CTBHP

# Population Served by DCF

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- ❖ DCF is the lead state agency for children's behavioral health services
  - ❖ Mental health services
  - ❖ Substance use disorders
  - ❖ Suicide prevention
  - ❖ Juvenile justice diversion
- ❖ All children under age 18
- ❖ Children in foster care at age 18 can voluntarily remain in DCF care until the age of 21 and continue to receive services and support

# DCF Actions

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- ❖ Reviewed existing strategic plans for guidance
  - ❖ Children's Behavioral Health Plan: [www.plan4children.org](http://www.plan4children.org)
  - ❖ State Suicide Prevention Plan [www.preventsuicidect.org](http://www.preventsuicidect.org)
- ❖ Developed Children's Behavioral Health resource guides for parents: [Support & Services | Wrap CT \(connectingtocarect.org\)](http://Support & Services | Wrap CT (connectingtocarect.org))



# Funding Sources

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- ❖ General Fund Appropriation
- ❖ Community Mental Health Services Block Grant (CMHBG)
- ❖ American Rescue Plan Act (ARPA)
- ❖ Health Resources & Services Administration (HRSA)

# General Fund Appropriation

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- ❖ Support from the Governor and the Legislature has allowed DCF to develop a strong network of care
- ❖ DCF budgeted amounts for behavioral health services:
  - ❖ Community Programs – both contract and fee-for-service - \$76.4 million
  - ❖ Congregate Care – both contract and fee-for-service - \$71.5 million
  - ❖ State-Operated Institutions - \$45.1 million

# Solnit Children's Center

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- ❖ The Solnit Center is a state-operated psychiatric facility for children that includes both inpatient and psychiatric residential treatment facility (PRTF) capacity in Middletown (Solnit South), as well as a PRTF in East Windsor (Solnit North)
- ❖ Solnit South PRTF treats girls (ages 13-17) and has 14 beds; 44 inpatient beds
- ❖ Solnit North PRTF treats boys (ages 13-17) and has 30 beds
- ❖ COVID-19 restrictions required the census to be modified with beds being kept vacant to accommodate potential isolation for infection and to maintain recommended social distancing protocols
- ❖ DCF is working to restore the pre-pandemic census at Solnit Hospital

# Services for Juvenile Justice Population

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- ❖ After the transfer to the Judicial Branch's Court Support Services Division (CSSD), DCF has continued to contract for many programs that are targeted at children in the juvenile justice system who fall under DCF's behavioral health mandate
- ❖ DCF contracts for services and provides slots that include youth being served by CSSD
- ❖ DCF budgets more than \$23 million annually for this population
- ❖ Most prominent resources:
  - ❖ Multisystemic Therapy (MST)
  - ❖ Multidimensional Family Therapy (MDFT)
  - ❖ Functional Family Therapy (FFT)
  - ❖ Adolescent Community Reinforcement Approach (ACRA)
  - ❖ Juvenile Review Boards (JRB)

# CMHBG-Funded Initiatives

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- ❖ Mobile crisis hub development with electronic appointment scheduling
  - ❖ \$250,000 total (exploration of platforms)
- ❖ Development of the Regional Suicide Advisory Boards: prevention, outreach and postvention activities
  - ❖ \$500,000 total
- ❖ Urban Trauma Performance Improvement Center
  - ❖ \$500,000 total
- ❖ Promotion of National Culturally and Linguistically Appropriate Services Standards and Racially Just Health Equity Plans for community providers
  - ❖ \$200,000 total
- ❖ Children's Behavioral Health Plan Systems Improvements
  - ❖ \$250,000 total
- ❖ First Episode Psychosis (FEP) Learning Community
  - ❖ \$480,000 total (\$120,000 annually next 3 years)

# CMHBG-Funded Initiatives

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- ❖ Child and Family Empowerment project
  - ❖ Empowering children with mental health issues who are being identified through a social determinants of health lens
    - ❖ \$400,000 total (\$200,000 annual for 2 years)
- ❖ System Collaboration on Student Mental Health project
  - ❖ \$500,000 total (\$166,666 annual for 3 years)
- ❖ Child mental health plans through promotion of Gizmo's mental health book and curriculum
  - ❖ \$400,000 total (\$200,000 annual for 2 years)
- ❖ Workforce development focused on increased competency development for special populations
  - ❖ Intellectual/developmental disability, eating disorders, problem sexual behavior, FEP, etc.
    - ❖ \$961,932 total (~\$240,000 annual for 4 years)

# ARPA-Funded Initiatives

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## Immediate/Near-Term Solutions

- ❖ 12 Intensive Transition Care Management teams to improve throughputs from acute levels of care
  - ❖ \$1 million (annually for 2 years)
- ❖ Mobile crisis 24/7 enhancements
  - ❖ \$1.4 million (annually for 2 years)

# ARPA-Funded Initiatives

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## **Medium/Long-Term Solutions**

- ❖ Develop Urban Trauma Network
  - ❖ \$1 million
- ❖ Develop Behavioral Health Urgent Care Centers (BHUCC) and Crisis Stabilization Centers
  - ❖ \$2 million (annually for 2 years)



# Contract and RFP Process

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- ❖ Funds budgeted for improvements must be distributed following state laws and procedures to ensure appropriate fiscal controls and oversight
- ❖ Existing contracts must be properly amended and executed
- ❖ New programs (BHUCC, Stabilization Centers) must be appropriately posted and vetted
- ❖ DCF consulted community providers on funding needs and determination of gaps in the behavioral health service array
- ❖ ARPA funding must be reconciled with the federal rules

# Contract and RFP Process

TOUCHPOINT	SUMMARY	TIMEFRAME
Planning & Service Development	Design of the service, identification of key components, analysis of need, determination of capacity	2-4 weeks
RFP Drafting & Finalization	Writing the RFP, determining procurement schedule	2 weeks
OPM Request & Approval	Required per statute (any contract in excess of \$50,000)	1 week * <i>(completed concurrent to 2 week RFP drafting period)</i>
Scope of Service Development & OAG Approval	Drafting of contract scope and review by OAG (required for any contract in excess of \$25,000)	2 weeks * <i>(completed concurrent to 2 week RFP drafting period)</i>
RFP Evaluation Plan Development & Approval	Required per OPM Procurement Standards. Designates RFP Evaluation Committee, scoring criteria and establishes operating guidelines for the RFP	1 week * <i>(completed concurrent to 2 week RFP drafting period)</i>
RFP Release & Process	Posting to CT Source, newspapers and DCF website. RFP process (Bidders Conference, Questions & Answers, Letter of Intent, Proposal submission)	7 weeks

# Contract and RFP Process (Cont.)

TOUCHPOINT	SUMMARY	TIMEFRAME
Proposal Review & Evaluation	Review and scoring of proposals by Evaluation Team	2 weeks
Proposal Award	Review and Award by Commissioner	1 week
Contract Negotiations	Negotiation of contract with awardee(s)	1 week
Contract & Budget Development	Assembly of contract and budget completion by provider	1 week
Contract Signature	Signature by provider, DCF and OAG	1-2 weeks
Contract Execution & Payment	---	---

**Timeline from Identification of Funding to Release of Funding: 20 weeks (4-5 months)**

# HRSA-Funded Initiative

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## **ACCESS Mental Health Expansion - \$445,000 (January 2022)**

- ❖ Providing real-time psychiatric consultation, care coordination and education to primary care physicians across the state
- ❖ Expanding services to support all youth ages 21 and younger
- ❖ Services provided regardless of insurance coverage
- ❖ Beacon Health Options subcontracts with three community hubs:
  - ❖ Wheeler Clinic
  - ❖ Yale
  - ❖ Hartford HealthCare

# 2021 BH Legislation

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- ❖ PA 21-35 - Establishes a working group to develop recommendations for the strategic expansion of school-based health center services with a focus on providing onsite mental, emotional or behavioral health services to children and adolescents at school
- ❖ PA 21-46 - Requires the Youth Suicide Advisory Board and Office of the Child Advocate to jointly administer Question, Persuade, Refer (QPR), an evidence-based youth suicide prevention training program in each local and district health department
- ❖ PA 21-116 - Requires DCF to develop and annually review and update a document for each mental health region designated by DMHAS describing the behavioral and mental health evaluation and treatment resources available to children
- ❖ PA 21-2 June Special Session - State Budget
  - ❖ Provides funding for DCF to hire additional nurses at Solnit North
  - ❖ Provides additional funding for Youth Service Bureaus and Juvenile Review Boards



CONNECTICUT STATE DEPARTMENT OF EDUCATION

# **CSDE's Commitment to Addressing Schools' Social-Emotional and Behavioral Health Needs**

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**Appropriations Committee Informational Forum on  
the Children's Behavioral Health System**

Commissioner Charlene M. Russell-Tucker  
December 2021

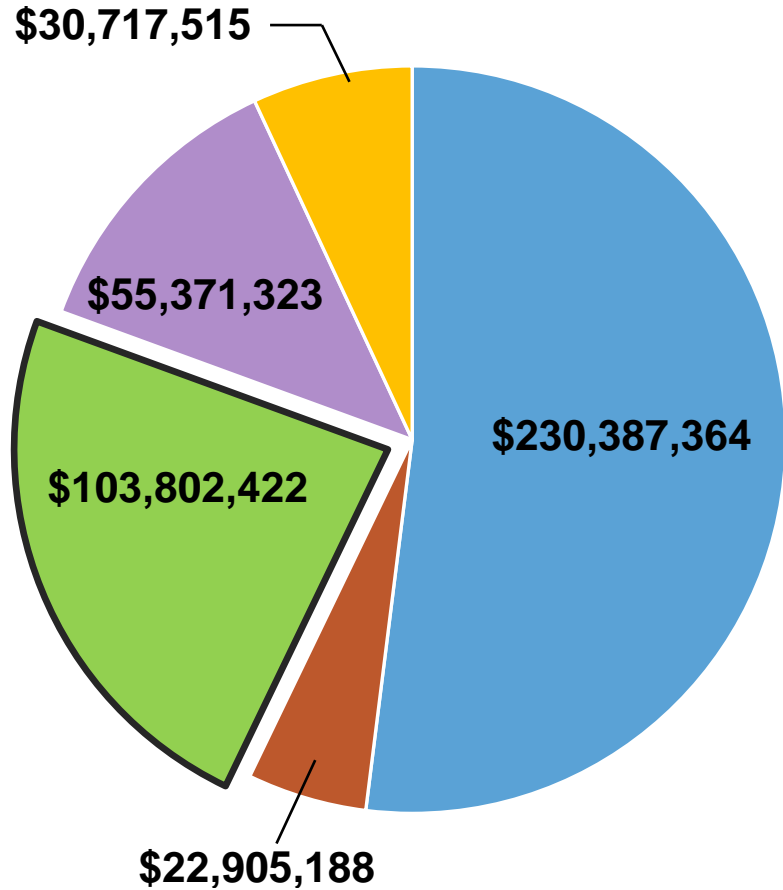
# CSDE's Priorities to Guide Investment Decisions

## Five State-Level Priorities

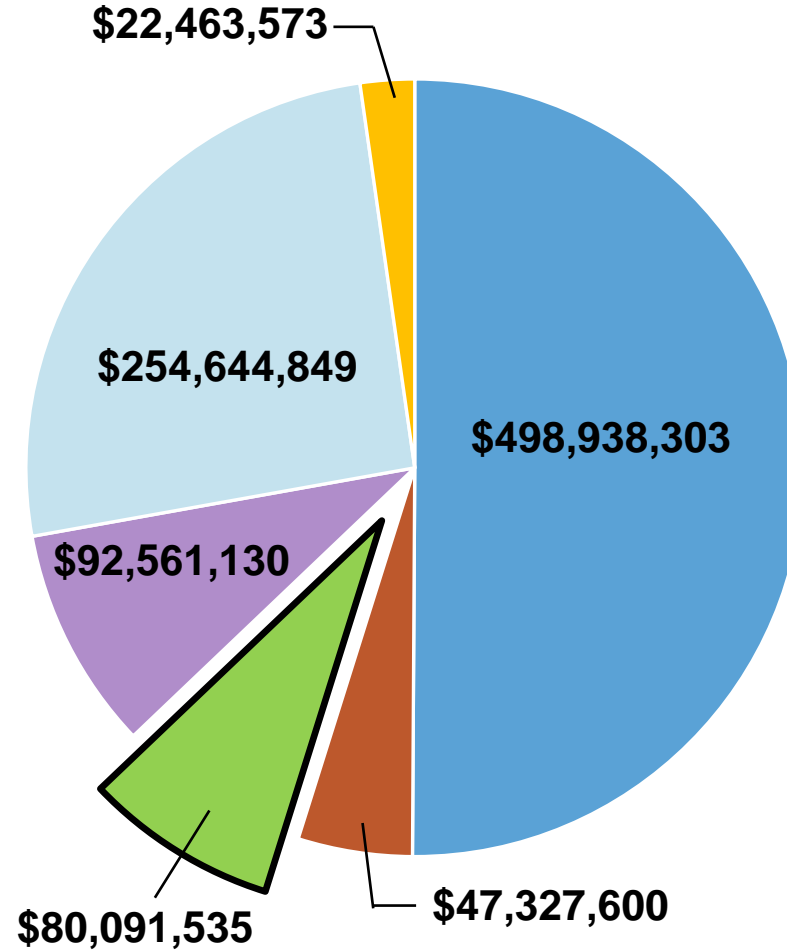
*guiding the investment of more than \$1.7 billion in Federal Elementary and Secondary School Emergency Relief (ESSER) funds since the start of the pandemic*

- ✓ Learning Acceleration, Academic Renewal, and Student Enrichment
- ✓ Social, Emotional, & Mental Health of the Students & School Staff
- ✓ Strategic use of Technology, Staff Development, & the Digital Divide
- ✓ Family & Community Connections
- ✓ Building Safe & Healthy Schools

## ESSER II District Investments by Priority Area



## ARP ESSER District Investments by Priority Area



- Priority 1: Learning Acceleration, Academic Renewal and Student Enrichment
- Priority 2: Family and Community Connections
- Priority 3 - Social, Emotional, and Mental Health of Students and Staff
- Priority 4: Strategic Use of Technology, Staff Development and the Digital Divide
- Priority 5: Building Safe and Healthy Schools
- Other



# Highlighted District Investments in Social, Emotional, & Mental Health

Investments have been made to support students and school staff to re-engage with their school communities as schools returned to in-person learning.

District Highlights
<ul style="list-style-type: none"><li>• Contracting with local health providers to expand mental, physical, and behavioral 1-to-1 services both during and after the school day</li><li>• Continuing and expanding district Social-Emotional Learning (SEL) teams to monitor staff training and implementation</li><li>• Professional development on trauma-informed practices; culturally relevant pedagogy; SEL; Diversity, Equity, and Inclusion (DEI); and non-discriminatory policies and practices</li><li>• Establishing districtwide common language, plus procedures in conflict resolution</li><li>• Hiring Behavioral Tutors to address learning loss and implement SEL practices</li><li>• Creating a district ‘train-the-trainer’ model for therapeutic crisis intervention</li></ul>

Across CT, **there has been a 6% increase in full-time equivalent counselors, social workers, and school psychologists** to provide necessary academic and social-emotional/mental health supports to students.



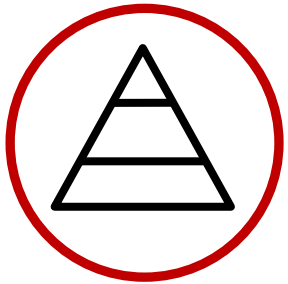
# CSDE Current Initiatives & Investments



**Project AWARE:** 5-yr, SAMHSA-funded initiative using trauma-informed, multi-tiered system of supports for addressing mental health and preventing violence among school-age youth



**Learner Engagement and Attendance Program (LEAP):** \$10.7M program providing targeted support to 15 districts through home visits in order to improve attendance and engagement, as well as address chronic absenteeism



**Tiered Supports for School Discipline:** Advised by the CT School Discipline Collaborative, developed tiered system of supports aimed at reducing school discipline and disproportionality



**Statewide Behavioral Health Landscape Scan & Focus Group:** Snapshot of emerging trends, concerns, and work taking place in schools regarding mental health services



**Webinars & Digital Resources:** Free, online resources to assist students, parents, caregivers, educators, and student support personnel, as well as virtual events to engage in social, emotional, and mental health discussions

# CSDE Current Initiatives & Investments



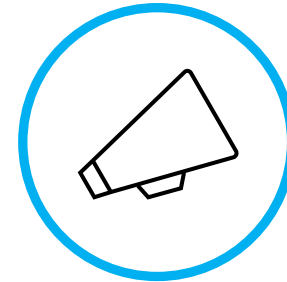
**Statewide SEL Landscape Scan:** Systematic collection of data, offering insight into great work already taking place in districts, plus emerging concerns and trends related to SEL for K-12 across CT



**Designed SEL Hub:** Providing on-demand resources to inform, educate, and develop compassionate learning spaces, as well as accelerate learning and advance equity



**Components of Social, Emotional, and Intellectual Habits:** Framework for districts to integrate SEL content into lessons so that K-3 students can learn, practice, and model essential personal life habits that will contribute to academic and personal success



**Student & Teacher Engagement:** Boosting student participation (e.g., Voice4Change) & educator recruitment & retention efforts (e.g., TEACH CT)



**Devereux Student Strengths Assessment (DESSA) System:** Free tool to measure 8 SEL competencies and quickly assess students for SEL attributes, available to all districts

# CSDE Planned Initiatives & Investments



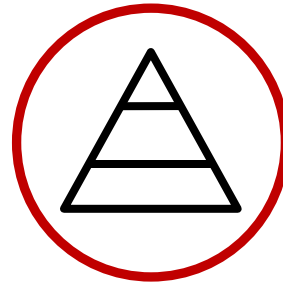
**Behavioral Health Pilot:** ‘Big Audacious Goal’ to create a scalable/ sustainable system of coordinated care for all K-12 schools to provide comprehensive behavioral and mental health supports and services to students and staff



**Healthy and Balanced Living Curriculum Framework:** Research-based, theory-driven framework providing districts with a best practice approach to implement a planned, ongoing, and sequential pre-K-12 curriculum that addresses the physical, mental, social, and emotional dimensions of health



**Support for Youth in the Criminal Justice System:** In partnership with programs serving students involved with the juvenile justice system, providing high-quality instructional resources, devices, and access to digital curricula to align with public school settings



**Continued Support Addressing School Discipline:** Using 2018-19 district tiers to identify LEAs needing additional support in their efforts to reduce and eliminate disparities in school discipline



**Comprehensive School Counseling Framework:** Providing a proactive, preventative, and early intervention model for school counselors to support all students in reaching their full potential and acquire critical skills in the areas of academic, career, and SEL

# Children's Behavioral Health System

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JORDAN SCHEFF  
DDS COMMISSIONER

# Department of Developmental Services:

## *Statutory Definition of Eligibility*

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**Sec. 1-1g. “Intellectual disability” defined.** (a) Except as otherwise provided by statute, “intellectual disability” means a significant limitation in intellectual functioning existing concurrently with deficits in adaptive behavior that originated during the developmental period before eighteen years of age.

(b) As used in subsection (a) of this section, “significant limitation in intellectual functioning” means an intelligence quotient more than two standard deviations below the mean as measured by tests of general intellectual functioning that are individualized, standardized and clinically and culturally appropriate to the individual; and “adaptive behavior” means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for the individual's age and cultural group as measured by tests that are individualized, standardized and clinically and culturally appropriate to the individual.

# Department of Developmental Services:

## *Eligibility Criteria*

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Eligibility determined by DDS psychologists, based on documentation of appropriate test measures

Valid full-scale IQ that is two standard deviations below the mean

- For most test measures = 69 or below
- Discrepancies of more than 1.5 standard deviations between IQ indices (verbal comprehension, perceptual reasoning, working memory, processing speed) may invalidate the test → in which case, more specific measures are used to assess

*Concurrent* deficits in adaptive functioning

- Main domains: practical (e.g., self-care), conceptual (e.g., money), social skills

All of this must be evidenced during the developmental period from birth to 18 years

# Department of Developmental Services:

## *Behavioral Services Program (BSP)*

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DDS BSP is the department's primary program for delivering behavioral health supports to children

Eligibility conducted by DDS psychologists

- Pre-existing eligibility for DDS
- Evidence of an emotional, behavioral, or mood disorder diagnosis
- Ages 8 – 18 years

If the child also has a diagnosis of autism spectrum disorder then the family is directed first to Beacon Health Options Autism Division for state plan services, in coordination with DSS

If the child also has a mental health diagnosis then the family is directed first to DCF Voluntary Care Management



# Department of Developmental Services:

## *Behavioral Services Program (BSP) (Cont.)*

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DDS BSP is intended to be an in-home program

- Behaviorist for behavior plan
- In-home direct care
- Out-of-school hours

Certain exceptions have been made for out-of-home placements (residential schools, treatment facilities, group homes)

BSP Respite – DDS is currently preparing to launch a respite center for children in BSP to have planned weekend respite opportunities (DDS Respite Centers are typically only for individuals with no annualized residential funding)

Children's Step Up/Down Unit – Plans are underway to develop a Step Up/Down Unit for children with ID who are at risk of hospitalization or are transitioning out of a hospitalization due to significant behavioral health concerns (modeled after DDS adult Step Up/Down Unit).

Many partnerships with sister agencies to collaborate on jointly eligible children – DCF, DMHAS, SDE/LEAs, CSSD, etc.

# Department of Developmental Services: *Challenges & Opportunities*

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## Challenges

- Healthcare workforce – significant staffing shortages across the sector and especially for more complex cases
- Diagnostic overshadowing bias – when ID is in the picture, false assumptions that every clinical-behavior issue is related to it, rather than other comorbid conditions

## Opportunities

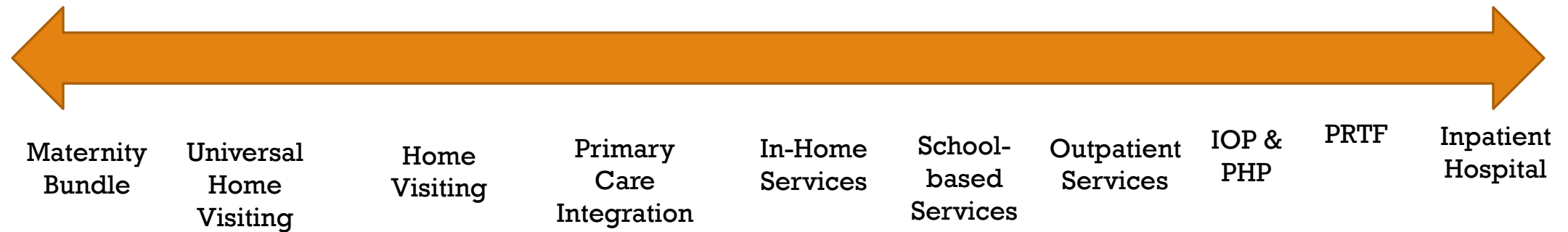
- Tiering service rates to account for more complex/higher level work
- Step Up/Down programming to ease hospital burden and more appropriately serve children
- Respite to give families and children a break and change of pace
- Streamline partnerships between sister agencies to make it easier for families to access the right supports (e.g., current project to look at dually licensing and training DDS Community Companion Home and DCF foster care providers)

# Children's Behavioral Health System Medicaid Response

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DEIDRE S. GIFFORD  
DSS COMMISSIONER

# Assessment of the Entire Continuum



# Short-Term Initiatives

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Initiative	Status
Pediatric Inpatient Hospital Bed Expansion- Round 1	<ul style="list-style-type: none"><li>• Bulletin Issued in June 2021</li><li>• Hospital for Special Care expansion – 8 beds (for special needs, autism, and intellectual disability)</li></ul>
Intensive Transition Care Management RFQ Issued	<ul style="list-style-type: none"><li>• June 2021</li><li>• Contracts being negotiated at this time</li></ul>
4% Rate Enhancement to raise salaries and benefits	<ul style="list-style-type: none"><li>• Implemented in November 2021</li></ul>
Pediatric Inpatient Hospital Bed Expansion- Round 2	<ul style="list-style-type: none"><li>• Bulletin re-issued in November 2021</li><li>• Formal submission by ECHN</li></ul>

# Medium-Term Initiatives

Initiative	Status
Mobile Crisis Enhancement	Medicaid enhanced match for improved and enhanced mobile crisis system effective 4/1/22
Outpatient Alternative Payment Model (APM)/Care Management Entity Development	Multi-state agency workgroup developing outpatient APM/care management entity concept
Universal Home Visiting/Home Visiting	Under development with Office of Early Childhood (OEC)
Infant and Early Childhood Mental Health	Under development with DCF and OEC
School-based Mental Health	<ul style="list-style-type: none"><li>• Review role of school-based health clinics</li><li>• Assess expansion of evidence-based, school-based mental health interventions</li></ul>

# Children's Behavioral Health System

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HEATHER AARON  
DPH DEPUTY COMMISSIONER

# Connecticut Department of Public Health:

## DPH Role in the Childhood Mental Health Crisis





# Current Actions

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## Working with Sister Agencies

### Connecticut Hospital Association (CHA) Incident Command Participant

- Staying up to date
- Assisting with decisions on staffing and bed availability
- Diversion

## Monitoring Capacity to meet demand and serve patients

### Practitioner and Facility Licensing

- Identifying ways to expedite
- Effective October 1, 2021, DPH will issue the appropriate license or credential to a state resident who is currently licensed in another state or territory, or the spouse of an active-duty service member stationed in Connecticut, that meets specific experience and background requirements

# Challenges

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## PA 21-9

- License requirements are set by statute. PA 21-9 does not give DPH Commissioner authority to allow all practitioners to practice telehealth across state lines but does give the Commissioner authority to waive regulations:

*Notwithstanding sections 4-168 to 4-174, inclusive, of the general statutes, from the period beginning on the effective date of this section and ending on June 30, 2023, the Commissioner of Public Health may **temporarily waive, modify or suspend any regulatory requirements** adopted by the Commissioner of Public Health or any boards or commissions under chapters 368a, 368d, 368v, 369 to 381a, inclusive, 382a, 383 to 388, inclusive, 397a, 398, 399, 400a, 400c, 400j and 474 of the general statutes as the Commissioner of Public Health deems necessary to reduce the spread of COVID19 and to protect the public health for of the purpose of providing residents of this state with telehealth services from out state practitioners*

- Through 19a-131j, DPH Commissioner can grant some specialists (not all) a temporary 60-day exemption, but this is not a permanent solution.
  - This authority only exists under an emergency declaration

# Ongoing Initiatives

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## School-Based Health Centers Expansion

- \$12 million from a COVID-19 related Crisis Cooperative Agreement (Co-Ag) grant
- Legislatively mandated working group

## Hospital Reporting

- New comprehensive dashboard of adult and child behavioral health bed availability across all state-run and private hospitals reported directly to the commissioner on a daily basis

## Interstate Compacts Discussions

- Looking at compacts for physicians, APRNs, nurses (LPN/RN), psychologists, and physical therapists through separate working groups
- There are not any active compacts for LCSWs, but the national association is exploring this concept

# Appropriations Committee Forum on Children's Behavioral Health

JUDICIAL BRANCH  
Court Support Services Division

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PATRICK CARROLL  
CHIEF COURT ADMINISTRATOR

# Judicial Branch Juvenile Services – Juvenile Probation

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## **Population Served by Juvenile Court**

- The Superior Court for Juvenile Matters has jurisdiction for delinquency cases of children ages 10 through 17 - *at the time of an alleged offense*. Most children referred are between 15 and 17 years old.
- In FY 2020-21, 4,216 children were referred to the Juvenile Court.

## **Juvenile Probation Assessment of Behavioral Health Needs**

- Juvenile Probation has a standardized procedure for identifying the mental health needs of juveniles under the jurisdiction of the court, which includes administering a risk and needs assessment and mental health and trauma screening tools, and making referrals for court-based evaluations.
- Mental health disorders are prevalent among justice-involved children. Research shows approximately 65-75 percent of arrested children each year in the United States have a diagnosable mental health disorder.

(Cocozza, J., & Skowyra, K., 2007)

# Judicial Branch (JB) Juvenile Services – Juvenile Probation

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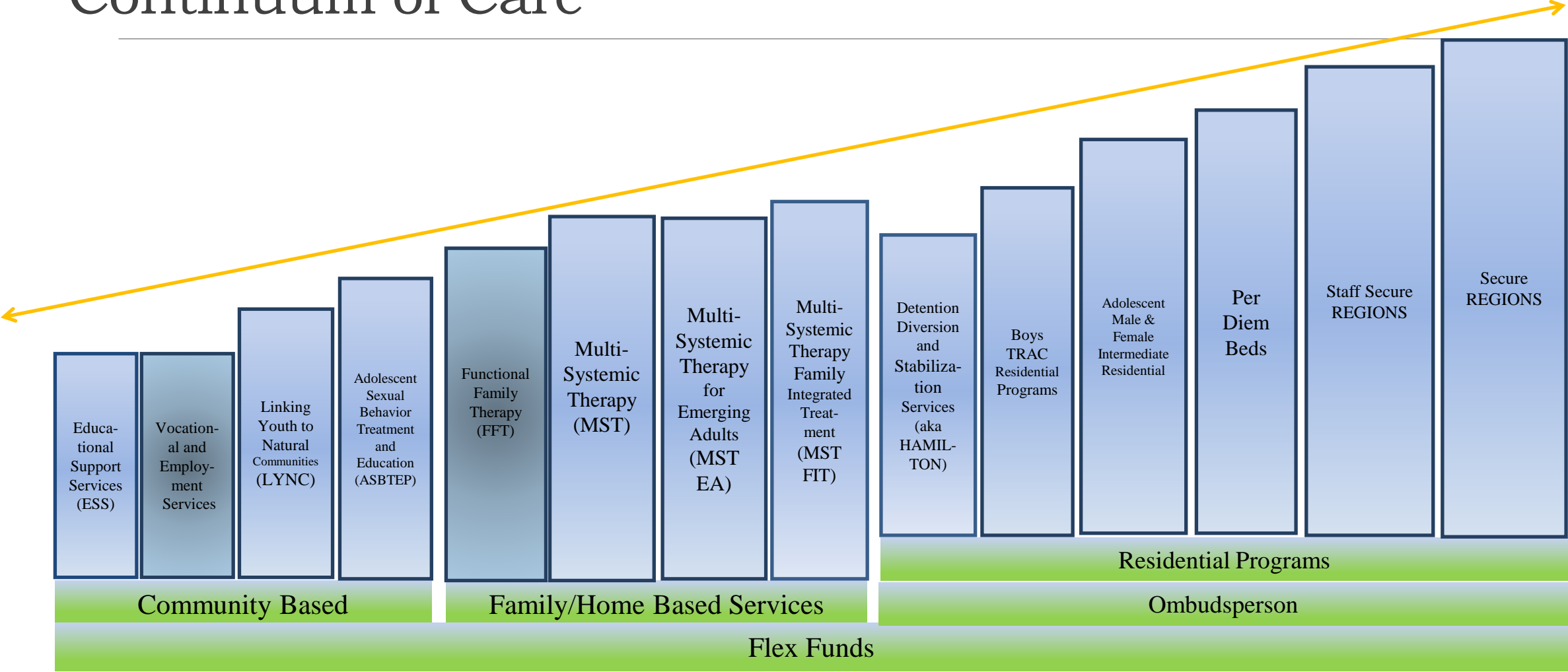
## **Scope of Population Needs/Common Diagnoses**

- Depressive Disorders
- Trauma and Stressor-Related Disorders
- Anxiety Disorders
- Disruptive, Impulse-Control, and Conduct Disorders
- Neurodevelopmental Disorders
- Substance-Related and Addictive Disorders
- Parent-Child Relational Problems, History of Child Maltreatment & Neglect Problems, Academic or Educational Problems, Housing & Economic Problems

## **Current Treatment Options**

- Services are accessed through the Children's Behavioral Health System (mobile services, crisis stabilization, community-based supports, intensive in-home, outpatient clinics, inpatient)
- JBCSSD's continuum of contracted services – see next slide

# 2021 JBCSSD Juvenile Community and Residential Continuum of Care



# Judicial Branch Juvenile Services – Contracted Programs

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## **Home-Based Services - MultiSystemic Therapy (MST) and Functional Family Therapy (FFT)**

- Statewide, evidence-based programs shared by JBCSSD and DCF
- Licensed clinicians serve 12-17 year old serious, chronic, violent delinquent youth and their families
- Both interventions are recognized by Washington State Institute for Public Policy, among others, for biggest returns on investment

## **Multisystemic Therapy – JBCSSD contracts**

- 190 slots serving 475 families annually; \$4.25m annual budget

## **Functional Family Therapy – DCF contracts**

- 12 slots serving 30-35 families annually; \$160,000 annual cost to JB, through MOA with DCF



# Judicial Branch Juvenile Services – Residential Services

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## **Population Served by Pretrial Detention and Residential Programs**

- Juveniles ordered to residential treatment by the Court as a condition of release from pretrial detention or as a condition of probation supervision
- Generally ages 14 – 18
- 379 detention admission involving 299 unique children in FY 2021
- 212 admissions for residential treatment in FY 2021

## **Assessment of Behavioral Health Needs**

- Pretrial Detention/Residential Centers have an in-house medical and mental health clinic
- Probation completes risk and needs assessment and mental health and trauma screening tools
- Court-ordered forensic evaluations completed by Clinical Coordinator (licensed mental health clinician) assess for drivers of violent and general delinquent behavior and recommending treatment intervention, level of care, and level of security

# Judicial Branch Juvenile Services – Residential Services

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## **Scope of Needs of the Pretrial Detention and Residential Populations**

- Generally, early-onset, chronic and persistent mental health and substance use disorders
- Childhood-onset and pattern of disruptive, impulse-control and conduct disorders
- Many children exhibit proactive and reactive aggression and the need for highly structured and supervised environment

## **Current Residential Program Options**

- 2 - 3 week Respite, Assessment & Brief Intervention (HAMILTON)
- 45 day Respite, Assessment & Treatment (TRAC)
- 6 month Intermediate Treatment (AMIR, AFIR)
- 6 month Specialized Community Bed licensed by DCF
- 4 – 8 month Staff-Secure or Hardware Secure (REGIONS)
- Dialectical Behavior Therapy is primary treatment modality in JBCSSD programs

# Judicial Branch Juvenile Services

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## **Challenges of Community-based and In-home Programs**

- Limited resources in some communities
- Multisystem involved families often difficult to engage
- Limited access to technology including Wifi for many families
- Licensure requirement for MSWs limits hiring and retention, particularly among bilingual candidates
- Small caseloads and model design lead to interruption of services when staff turnover

# Judicial Branch Juvenile Services

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## Challenges of Residential Programs

- Children detained for aggression (repeated arrests for disorderly conduct, breach of peace, threatening, interfering, assault 3rd) resulting from impulsivity/reactivity due to untreated mental health disorders, not antisocial thinking or attitudes
- Low wages for licensed clinicians (LCSW, LPC, LMFT) and childcare staff in residential programs results in inexperienced staff, staff shortages, and less effective outcomes
- Budget for residential programs does not reflect current workforce trends and difficulty of recruiting and retaining qualified **and** experienced staff to work in 24/7 programs
- Limited medical staff hours to treat chronic medical issues, like diabetes
- As more children are diverted from juvenile court, children with more complex needs and aggressive behaviors require more robust and better resourced interventions

# Judicial Branch Juvenile Services

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## Need to Improve Access and Outcomes

- Competitive wages
- Removal of licensing requirement for MSWs
- Universal access to technology and Wi-Fi capability
- Billing for virtual behavioral health and family services
- Peer support for parents/guardians
- Credible messengers for juveniles
- Front-end diversion programs **and** psychiatric residential treatment facility care for aggressive children
- Additional medical hours and greater staffing levels to treat complex behavioral health needs
- Re-entry group home and independent living resources for delinquent children not involved with child welfare

# Children's Behavioral Health System

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OFFICE OF WORKFORCE STRATEGY EXECUTIVE DIRECTOR  
KELLI-MARIE VALLIERES

# COVID-19 has exacerbated a pre-existing workforce shortage in mental health and nursing.

CT was already short on registered nurses but COVID-19 has increased the demand by over 100%

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The length of mental health and nursing degrees, which are at a minimum 4-year bachelors degrees, make it challenging to address this immediate crisis

The problem is getting worse as these workers are leaving their jobs due to burnout, mandated scheduling, and other factors

These degree pathways are expensive and often preclude underrepresented populations from gaining the same access to these careers

Critical faculty shortages exist that prevent needed additional enrollment capacity at our institutions

# Action can be taken to mitigate the pandemic's impact on the mental health workforce

Gaps	Students are not enrolling in mental health-related educational programs at a rate that matches the current demand from employers		Most occupations in the mental health industry rely on expensive 4-year degrees but there is an immediate demand that must be filled	
Proposed Solutions	<b>Work directly with employers to provide incentives for mental health professionals to relocate their practice to CT</b>	<b>Develop alternative postsecondary pathways for individuals to earn a degree in these fields (e.g., accelerated BA programs, apprenticeships, etc.)</b>	<b>Offer scholarships (e.g., for graduates to practice in state, loan forgiveness, promise programs) for students to enroll in mental health BA pathways</b>	<b>Identify individuals who hold appropriate degrees in key fields but who did not pursue licensure to practice</b>
Perceived Barriers	Employers must be willing to provide additional funding to incentivize individuals	Determining the level of effort this would require for educational institutions	Carve out additional state or federal dollars to go towards these scholarships	Offering the right level of incentives for these individuals to re-enroll into a postsecondary program
Keys to Success	Determining whether the state can offer matching funds to employers to incentivize their participation	Engaging private colleges and public universities quickly while researching out of state models/curriculum to leverage	Determining whether higher ed institutions can offer matching funds to students	Developing a mechanism for identifying these types of individuals
Anticipated Cost	\$ \$ \$ \$		\$ \$ \$ \$ \$	



# Similar challenges exist in developing a stronger pipeline for nurses in Connecticut

## Nursing Faculty Shortage

- Over 7,000 qualified nursing students were denied admission to registered nursing programs because of nursing faculty shortages across the state
- Section 20-90-51 of the general statutes allow a temporary or permanent waiver removing the requirements that nursing faculty need to have advanced degrees. Currently educational institutions are only allowed to have 10% of their faculty from a waiver

## Nursing Practitioner Shortage

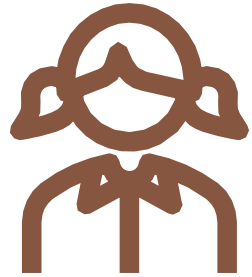
- The pandemic has exacerbated the need for nurses in CT
- Nursing degrees are typically four years and expensive but there is an immediate hiring need from employers
- Only 8% (584) of students enrolled in RN education were enrolled in an accelerated BA program and only 34% (2,435) are in an associate's degree program

## Proposed Solutions

- Survey schools to determine current and forecasted faculty and what the needs would be to grow the size of the nursing workforce
- Utilize the state's licensing system to recruit retired nurses as part-time faculty using CT's Clinical Faculty Prep Course
- Develop a statewide marketing campaign for nurse faculty
- Modernize the waiver process to be more flexible and increase the percentage of faculty at institutions who can have a waiver
- Pilot a program where individuals who have earned 9 credits in their nursing master's program could be hired to teach while finishing their graduate degree
- Augment existing fast-track program for LPN students to enter AA programs since LPNs would only need one year to be an RN
- Increase enrollment in accelerated RN programs, which allows someone to be an RN in 12-15 months if they have a BA plus credits
- Partner with employers to develop hiring practices focused on 2-yr degrees to alleviate short-term needs while giving these workers the flexibility to continue to earn academic credit while employed
- Develop programs for incumbent nurses to engage in academic progression in specialty areas, maximizing retention

The Office of Workforce Strategy is currently partnering with the CT League of Nursing and the CT Center for Nursing Workforce to develop a budget for implementing these recommendations.





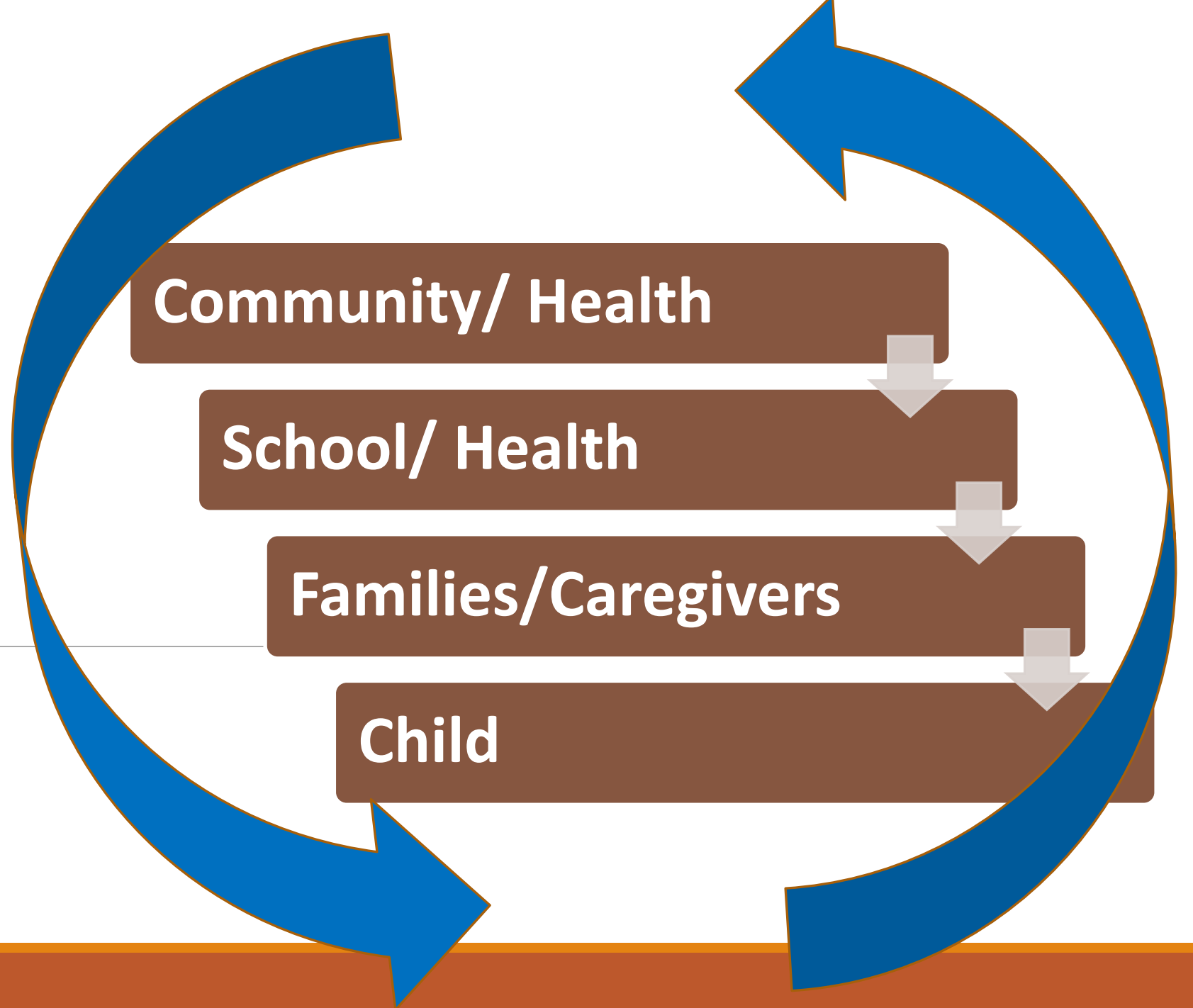
Child's Mental,  
Behavioral and  
Physical  
Health

Community/ Health

School/ Health

Families/Caregivers

Child



NLN

Connecticut League  
for Nursing



CONNECTICUT  
**NURSES**  
ASSOCIATION

CNFF  
CONNECTICUT NURSES'  
FOUNDATION

Increase the opportunities for students across CT to participate in courses for attainment of college credit leading to healthcare careers

Align educational progression/stackable credentials in high demand healthcare roles

Increase the number of healthcare faculty

Increase capacity of nursing programs to enroll qualified students (Currently enrolling 24% of QUALIFIED Applicants)

Strengthen transition to practice models to support retention of new graduates

Increase incumbent worker training for existing healthcare workforce to transition to new and in demand roles

Increase funding to support educational progression to in demand healthcare roles

Adapting a systems approach to promote positive work culture and to reduce burnout rates to retain and attract healthcare workforce

Increase funding for loan forgiveness, scholarship, tuition reimbursement programs for high demand healthcare roles

Increase access to mental health providers and practices by supporting Mental Health APRN practices

A Systematic Approach to  
Stabilizing the Healthcare  
Workforce

# Proposed Solutions to Build Children's Behavioral Support in CT

## Immediate (12-15 months)

- Recruit new graduates and upskill with PMH specialty training and certification. Potential candidates CHW, HHA/PCA/CNA, PNs and RNs
- Elevating Mental health through School- Community Intervention
- Offer Post-graduate Certification in Psych Mental Health to APRNs to increase access to providers with prescriptive privileges and able to provide counseling

## Midterm (2-3 years)

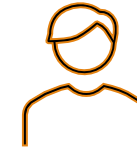
Accelerated Bachelors/Masters for Behavioral Health counseling roles- Social work/ Psychologists

## Long term ( 4+ years)

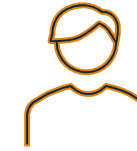
Increase number of dual degree health career pathway programs in High Schools



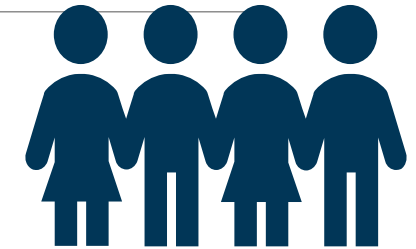
School  
Psychologist



School Social  
Worker



School Nurse



380 children



205 Districts



513,000 Children

**Elevating Children Mental And Physical Health Through School and Community Based Interventions**

## Elevating Mental and Physical Health through School – Community Interventions

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Statewide School  
Nurse Workforce  
Education &  
Training

School Health  
Providers  
Behavioral  
Health Training

Interdisciplinary  
Health Team

School-  
Community  
Mental Health  
Advisory



# Increase Enrollment Capacity at Associate Degree RN and Accelerated BSN Programs

by 20% over the next 3 years

Increase clinical faculty to educate, transition and onboard nursing students

Increase Enrollment in Charter Oak PN- RN Fast Track program

1

Engage Employers  
Joint Appointment  
Agreements and  
Workforce Data  
Collection

2

Statewide  
Marketing  
Campaign to  
Recruit and Train  
Nurse Faculty

3

Eliminate/  
Modernize Faculty  
Waivers for MSN  
Educators

- Award Credential Credit Transfers for CNA and PNs career progression
- Diversify clinical placement and onboarding opportunities for in-demand



**Connecticut League  
for Nursing**





# Children's Behavioral Health System

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VICTORIA VELTRI

OFFICE OF HEALTH STRATEGY EXECUTIVE DIRECTOR

# OHS - Status of the *Roadmap for Strengthening and Sustaining Primary Care*

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OHS began work in Spring 2021 with its Primary Care Subgroup to:

1. Make recommendations for primary care spending targets, as required by Executive Order No. 5.
2. Design a strategy (the “Roadmap”) to complement the primary care target for more effective and efficient primary care that will better meet the needs of patients and support primary care professionals.



## Roadmap strategies focus on:

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1. Core function expectations of primary care practice teams
2. Resources and supports to help practice teams master the core function expectations
3. Methods to assess and recognize practice team performance
4. Voluntary primary care alternative payment models, beyond fee-for-service (FFS), to reimburse primary care

## OHS adopted 11 core functions it believes will lead to high-quality primary care (1 of 2)

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1. Care delivery is centered around the patient, including developing **trusted relationships...**
2. Care delivery is **team-based...**
3. Practices designate a **lead clinician** for each patient...
4. Practices **coordinate care** for its patients and are supported with **embedded clinical care management and non-clinical care coordination personnel...**
5. **Behavioral health** is integrated into the practice...
6. Practices deliver “**planned care**” at every visit...

# OHS adopted 11 core functions it believes will lead to high-quality primary care (2 of 2)

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7. Care is easily **accessible and prompt** ...and **culturally and linguistically competent**.
8. Care delivery follows **evidence-based** guidelines...
9. Practices **engage and support** patients...
10. Practices **use patient information and data** to identify care needs... and inform **quality and equity improvement** activities.
11. Practices identify **social risk factors** ...and are knowledgeable about **community resources** to address them.

# MHPAEA – Mental Health Parity and Addiction Equity Act

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Federal law -Requires health plans to test certain “limitations” in six classifications of services: (1) In-Patient/INN\* (2) Out-Patient/INN (3) In-Patient/OON\* (4) Out-Patient/OON (5) Emergency Services (6) Pharmacy Services.

- Quantitative treatment limitations (QTLs) - includes deductibles, copays, coinsurance, and out-of-pocket maximums. quantitative treatment limitations include annual, episode, and lifetime day and visit limits, and for example, number of treatments, visits, or days of coverage QTLs generally cannot be more restrictive than those for medical/surgical benefits.
- Non-Quantitative treatment limitations (NQTLs) – Includes review of medical necessity criteria, prior authorization, formulary design, etc. MHPAEA requires that health plan practices are comparable and applied no more stringently than medical/surgical benefits.

CID charged with monitoring parity for commercially insured plans.

- Plans must submit compliance reports to CID effective this year– see [Bulletin MC-24 \(ct.gov\)](#) under P.A. 19-159 (Conn.Gen.Stat. § 38a-477e)
- Plans also submit information through the rate filing process

Self-funded plans are regulated solely by the USDOL – 70% of the privately insured population in CT

Note that the ACA restricts payment of federal funds for new state coverage mandates enacted after 2011

\*INN= In-network, OON=Out-of-network