Transforming Children's Behavioral Health
Policy and Planning Committee

AGENDA

February 1, 2024
10:00 am – 11:30 am
Virtual Meeting via Zoom
Watch on YouTube or CT-N

Welcome and Opening Remarks	Representative Tammy Exum Claudio Gualtieri, Senior Policy Advisor to the Secretary, OPM Senator Ceci Maher
Review and Acceptance of Minutes	
Updates	Tow Youth Justice Institute
Early Interventions for Lasting Impact: A Dive into Early Childhood Behavioral Health	Parent Story Office of Early Childhood Department of Children and Families EdAdvance Child First, Inc

Next Meeting: March 6, 2023

TCB Meeting Minutes

January 10, 2024
2:00-4:00 PM
LOB – 300 Capitol Avenue Hartford, Room 2C
Virtual Option Available

Attendance:

Alice Forrester
Anne Dauphinaias
Ashley Hampton
Carol Bourdon
Carolyn Grandell
Catherine Osten
Ceci Maher
Claudio Gualtieri
Deidre Gifford
Derrik Gordon
Edith Boyle
Gerard O'Sullivan
Howard Sovronsky
Jeana Bracey
Jody Terranova
Kai Belton
Kimberly Karanda
Lorna Thomas-Farquharson
Michael Powers
Micheal Moravecek
Micheal Patota
Mickey Kramer
Michelle Scott
Sarah Eagan
Sean King
Shari Shapiro
Tammy Freeberg
Tammy Venenga
Toni Walker
Michael Williams
Yann Poncin

Welcome and Introductions:

The meeting commenced with welcomes, announcements, and instructions for attendance. The highlighted presentations continued the December presentation on Sustainability Efforts through Commercial Insurance and Accessing the Continuum of Care: Intensive Home-Based Services. A motion was made, and the minutes of the previous meeting were approved unanimously.

Updates:

On January 5, TCB members participated in a Level-Setting Training session. The session was designed to lay the foundation for future TCB work and included experiential activities. A networking lunch was also provided to encourage relationship-building among the committee members. Additionally, the training covered topics such as 'Understanding Children's Behavioral Health in Connecticut', 'Overview of the Behavioral Health Treatment System for Children in Connecticut', 'Mental Health Treatment for Young Children', and 'Children and Youth with Neurodevelopmental Disorders'. The following trainers participated in the TCB Level Setting program: Rachel Keyworth, M.Ed., CTRS, Dr. Melissa Whitson, Ph.D., Dr. Laine Taylor, DO, MBA, Dr. Jeana Bracey, Ph.D., Dr. Elisabeth Cannata, Ph.D., Dr. Darcy Lowell, MD, Jennifer Nadeau, LCSW, and Dr. Michael Powers, Psy.D. Tow Youth Justice Institute and TCB Chairs thanked all these trainers for their commitment and willingness to share their expertise in supporting TCB's efforts. A second day of Level-Setting Training will take place after the legislative session. This day will focus on working towards building the strategic plan. Details about a potential third day will be shared later.

Sustainability Efforts through Commercial Insurance

Carelon Behavioral Health, formerly known as Beacon Health Options, plays a crucial role in Connecticut's behavioral health and insurance landscape, serving as the Administrative Service Organization (ASO) for mental health, behavioral health, and substance use services under Medicaid. Collaborating with the Department of Children and Families (DCF), the Department of Social Services (DSS), and the Department of Mental Health and Addiction Services (DMHAS), the ASO manages Medicaid and community services, impacting over 900,000 individuals. The Child & Family Division, focusing on family-centered approaches, contributes to CT's Behavioral Health System of Care, annually serving 10,000+ youth and families The division actively contributes to a comprehensive system of care, including doc-to-doc psychiatric consultation. The Carelon Behavioral Health Commercial Division, independent from CTBHP and Child and Family Divisions, leads as the Behavioral Health clinical and network lead for Anthem Blue Cross and Blue Shield in Connecticut. Staff, leadership, and resources in this division are distinct and separate.

Diversified insurance coverage in Connecticut includes: Self-Insured (37%), Medicaid (26%), Medicare (19%), Large Group – Fully-Insured (7%), Uninsured (5%), Small Group—Fully-Insured (3%), and Individual—Fully-Insured (3%). Within the Commercial Market, the majority is self-insured (74%), followed by Large Group—Fully-Insured (15%), Individual—Fully-Insured (6%), and Small Group—Fully-Insured (5%)

Carelon Behavioral Health has achieved significant milestones, such as expanding ASO services, launching the Child & Family Division, and introducing Preventive Care Management, emphasizing a commitment to comprehensive services for all age groups and collaborative efforts with Anthem to enhance behavioral health quality in the state.

Accessing the Continuum of Care: Intensive Home-Based Services

A mother and her son opened the presentation by sharing their journey with children's behavioral health care for her son, who faced challenges from a young age. The story included struggles with finding suitable care, navigating various therapists and centers, and the eventual discovery of In-Home Therapy (IICAPS). The in-home therapy was a turning point, helping her son build trust, progress positively, and navigate crises. Despite challenges, the in-home care team provided crucial support, enabling her son to graduate high school, attend Gateway, and remain hospital-free for five years. The speaker emphasizes the importance of accessible in-home programs such as IICAPS tailored to individual needs and highlights the overwhelming demand for such services.

Elizabeth Cannata, VP of Community-Based Family Services at Wheeler Clinic, provided an in-depth overview of the evolution of children's behavioral mental health care in Connecticut, emphasizing models such as Multi-Dimensional Family Therapy (MDFT) and Multi-Systemic Therapy (MST). The presentation highlighted Connecticut's efforts since 1999 to enhance the behavioral health treatment system, aligning with national priorities of early detection, access, evidence-based practices, and strengthening families collaboratively. Connecticut has implemented community-based treatments for diverse needs, addressing justice-involved youth and emphasizing family involvement in treatment teams. The state collaborates on research-

supported treatments, committing to a holistic approach outlined in the CT Children's Behavioral Health Plan and CT Family First Plan. The comprehensive Connecticut behavioral health system offers various levels of care, including outpatient services, intermediate care, partial hospitalization, residential care, and inpatient hospitalization. The first level is outpatient services, which include clinic-based options like specialized programs in psychiatric clinics (such as MATCH, TF-CBT, and SSTRY), School-Based Health Centers, Private Practices, Integrated Care, and Youth Service Bureaus. Home-based outpatient services, such as Functional Family Therapy, are also available for a more personalized approach. The next level is intermediate care, which can be clinic-based includes Extended Day Treatment, Intensive Outpatient Programs (IOP) or home based services such as Child First, IICAPS, Multisystemic Therapy, MST FIT, MST PSB, Multidimensional Family Therapy (MDFT), and HYPE Recovery. Partial hospitalization is the next level, which includes office-based programs like Partial Hospital Programs (PHP). Residential care is also available, including Short-Term Assessment and Respite Homes, Psychiatric Residential Treatment Facilities (PRTF), and Therapeutic Group Homes. The highest level of care is inpatient hospitalization. Crisis stabilization services, such as Mobile Crisis Intervention Services (EMPS), Urgent Crisis Centers, Emergency Rooms, and Subacute Crisis Stabilization are available across all levels.

Multi-Dimensional Family Therapy

Multi-Dimensional Family Therapy (MDFT) is a targeted intervention for individuals aged 9 to 18 dealing with substance use and disruptive behavior challenges in various settings. With 2-3 weekly sessions for 4-6 months, involving parents, youth, and family, led by a therapist (master's level) and therapist assistant (BA level), MDFT incorporates case management for resource access, collaboration, positive youth activities, drug testing, and 24/7 crisis availability. Supported by extensive research, MDFT has shown significant reductions in substance use, arrests, negative peer involvement, and improvements in psychological functioning, family relationships, parenting, and school or job performance, outperforming evidence-based group treatment. In FY 2023, all 12 standard MDFT programs in CT reported positive outcomes at discharge, including high percentages of youth living at home, no new arrests, engagement in education or employment, avoidance of hard drug use, stable mental health functioning, and families resolving issues without resorting to violence. Providers like Boys & Girls Village, Child and Family Agency of Southeastern CT, Community Health Resources, Community Mental Health Affiliates, United Community & Family Services, and Wheeler offer MDFT services, funded by DCF grants, Medicaid, and Anthem (commercial insurance). Adaptations for Opioid Use Disorder recovery, known as Helping Youth & Parents Enter Recovery (HYPE-Recovery), encompass full MDFT, Medically Assisted Treatment (MAT), and Recovery Management Check-up Support (RCMS), with an expanded age range up to 21 years old.

Multisystemic Therapy - MST

Multisystemic Therapy (MST) is a targeted family intervention program for at-risk youth aged 12-18, addressing severe disruptive behavior and aiming to prevent out-of-home placement, juvenile justice involvement, or substance misuse. The MST approach involves three weekly sessions for 3-5 months, focusing on supporting parents, setting clear expectations, monitoring youth, and identifying parenting supports. With a therapist (master's level), drug testing, and 24/7 crisis availability, MST has extensive research support, including 96 published studies as of January 2023, demonstrating better outcomes than "treatment as usual." In Connecticut, MST services were provided to 626 individuals, achieving a 90% "Not Arrested" rate. Demographically, White (non-Hispanic), Hispanic/Latinx, and Black or African American individuals comprised the largest groups served. Connecticut MST providers, including Connecticut Junior Republic (CJR), North American Family Institute (NAFI), Village for Families & Children, and Wheeler, receive funding from DCF grants, Medicaid, and Anthem. Adaptations include MST for Problem Sexual Behavior (MST-PSB), MST for Emerging Adults (MST-EA), and MST Family Integrated Transitions (MST-FIT)..

Intensive In-Home Child and Adolescent Psychiatric Services - IICAPS

Victoria Stob, Co-Director of the Yale IICAPS model, provided an overview of Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS), offering 4-6 hours of weekly support through parent, child, and family sessions. IICAPS teams, led by master's level clinicians, employ a trauma-informed approach addressing mental health in various domains. The program caters to children and adolescents aged 4-18 facing emotional or psychiatric challenges, disproportionately supporting racial and ethnic minority groups. Notably, 67% report complex trauma experiences, and about half of IICAPS parents acknowledge their child experiencing 4+ adverse childhood experiences (ACES). Positive outcomes include a 73% treatment completion rate, with 50% of cases showing reliable clinical changes. Completers experience significantly reduced service utilization, with 60% fewer hospital admissions, over 50% fewer inpatient days, and 40% fewer ED visits. Improvements are sustained for 6 months post-discharge for 73% of families completing treatment. Funding sources include Fee-For-Service, Medicaid, and private insurance, with DCF grants supporting model development. As of 2023, the IICAPS network comprises 16 sites, primarily located on the West Side of the state.

Functional Family Therapy - FFT

Kenneth Lacilla, LCSW, presented the landscape of Functional Family Therapy (FFT), an evidence-based intervention for at-risk youths aged 11 to 18, addressing diverse issues. Applied in multiethnic contexts, FFT is a short-term, strength-focused family counseling model conducted in the home. Connecticut's FFT outcomes for 2022-23 reported a 65% completion rate, with 47% noting substantial improvement and 95% observing some improvement or greater. Treatment completers showed positive results, with 100% remaining in the home/community. Connecticut's

FFT utilization reached 60% in FY 22, coinciding with increased referrals and three out of six teams meeting the FFT national standard of 70% utilization. Among the 391 youths served by FFT in Connecticut in 2022, the majority were White/Caucasian (41%), followed by Latinx (14%), Black (10%), and Bi-racial (9%). The program is well-trained, well-studied, and well-supported, meeting all FFT National Standards for Program Fidelity and a Federally approved "Well Supported" Family First Program, recognized as effective by various authorities.

Carrie Bourdon, LCSW, Executive Director of Carelon Behavioral Health, gave an overview of the Medicaid youth profile in 2022, emphasizing in-home services. In 2022, the Medicaid Youth Population Profile in Connecticut showed that 16.9% of all Medicaid Youth, totaling 64,060 individuals, utilized behavioral health services. In-home services, including IICAPS, FFT, MDFT, and MST, were utilized by 0.7% of the Medicaid Youth population. However, there was a decrease in IICAPS utilization from the previous year. An analysis of Youth In-Home Service Utilization revealed that 5% of youths concurrently utilized both IICAPS and another in-home service, with significant rates of psychiatric hospitalization and emergency department visits among IICAPS-involved youth. The second quarter of 2023 saw a temporary emergency period with no prior authorization requirements, recording 443 in-home service admissions. IICAPS emerged as the most utilized service, comprising 68.6% of admissions but experienced a notable decrease. The broader child mental health crisis in Connecticut has strained the In-Home Family Therapy workforce, leading to shortages, staff retention challenges, and reduced clinical expertise. Urgent legislative support is needed, emphasizing adjustments to Medicaid reimbursement rates, increased grant funding, and commercial insurance inclusion for in-home family therapy programs to ensure equitable care and preserve the state's continuum of child mental health services.

Next Meeting:

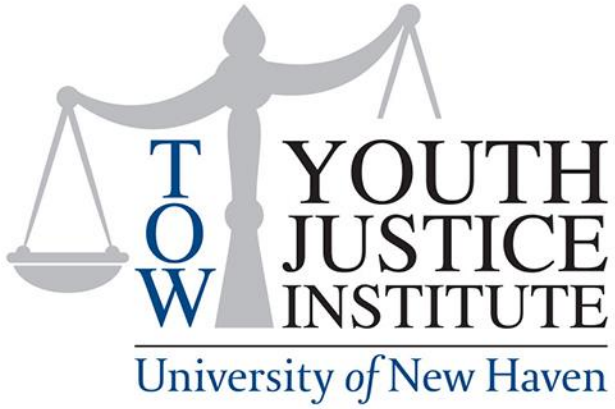
February 1, 2024
10:00- 11:30 AM
Virtual Only

TCB members (in-person/virtual) must scan the QR code to confirm attendance.

https://forms.office.com/r/ezjJkHHiiS

TOW YOUTH JUSTICE INSTITUTE
University of New Haven

Transforming Children's Behavioral Health Policy and Planning Committee



February 1, 2024

10:00 AM – 11:30 AM

Virtual

Meeting Facilitation

- **Mute on Zoom**

  Participants must remain muted on Zoom unless speaking.

- **Hand raising**

  Virtual attendees should use the hand raise feature on Zoom for questions and comments.

- **Questions at End**

  Hold questions and comments until presenters have finished speaking.

- **TCB only**

  Only TCB members may ask questions and make comments.

- **Recording**

  This meeting is being recorded.

Meeting Overview

- **Opening Remarks**
  Tri-Chairs
- **Acceptance of January Meeting Minutes**
- **Updates** - Tow Youth Justice Institute
- **Early Interventions for Lasting Impact: A Dive Into Early Childhood Behavioral Health Services in CT**

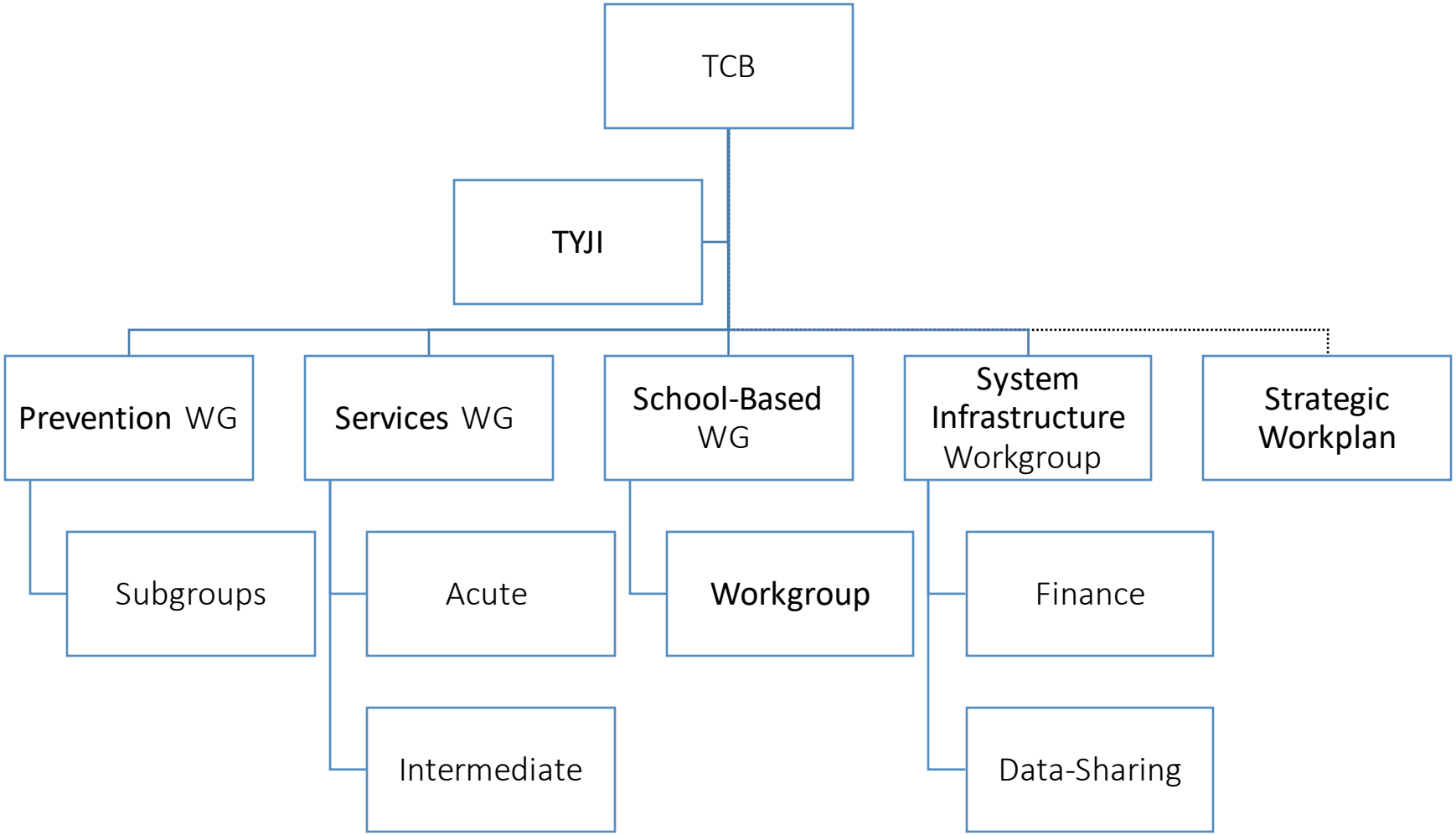
  Parent Story - Early Childhood Consultation Partnership (ECCP®)

  Lorna Thomas-Farquharson,PsyD, Program Manager – Office of Early Childhood
  Elena Trueworthy, Deputy Commissioner – Office of Early Childhood

  Francis Gregory, Administrator for the Division of Behavioral Health Community Services, Department of Children and Families
  Stephanie Bozak, PsyD, Behavioral Health Clinical Manager, Division of Behavioral Health Community Services, Department of Children and Families

  Michelle Anderson, MSW, Director of Early Childhood and Family Programs - EdAdvance
  Darcy Lowell, MD, Founder and CEO Child First, Inc

Draft Organizational Chart



Workgroup Kickoff Timeline

Phase 1 March

- Infrastructure WG
- Services WG

Phase 2 (May – June)

- Prevention WG
- School-Based WG

Phase 3 (June – After Legislative Session)

- Strategic Plan WG

Next Meeting

- March 6, 2024 2:00 PM

Early Interventions for Lasting Impact

A Dive into Early Childhood Behavioral Health Services

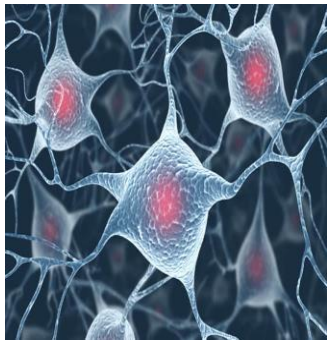
Parent Story

Why is it so important to address mental health problems in very young children?

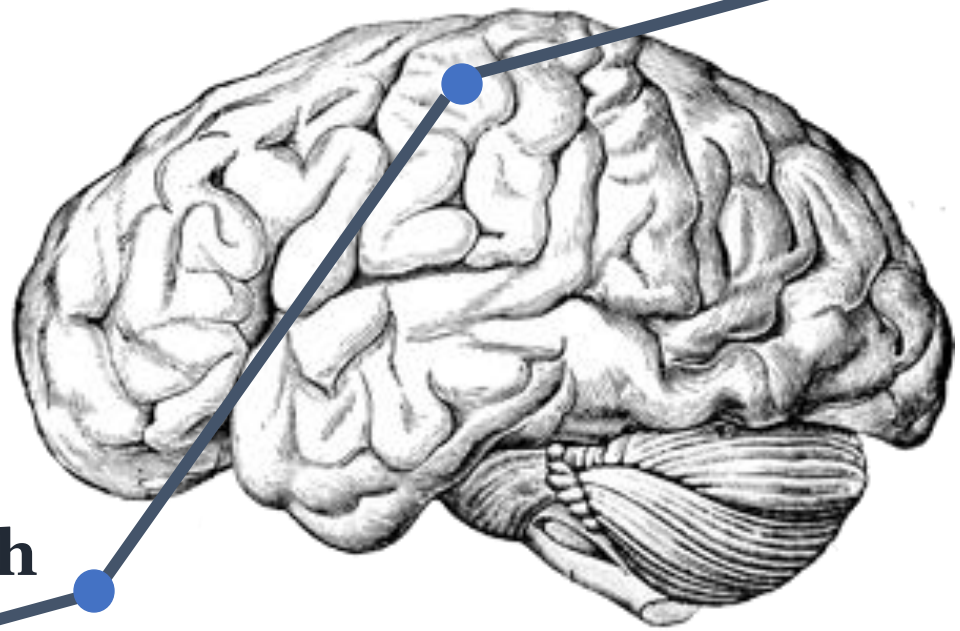
- Prevalence of mental health problems in children 0-5 years:
  - Overall prevalence of diagnosable mental health disorders = average 16-20%
  - Children that live in poverty (<100% of FPL) = up to 22-26%
  - Children who are victims of child maltreatment have nearly 4-fold greater risk = 49%
- Must be a continuum of care based on level of need – each child and family are unique.
  - Promotion, prevention, early identification and screening, early intervention, and intensive home-based treatment
  - Need the right service, at the right time, with the right intensity, in the right place.
- All interventions with young children must include the caregivers. The whole family benefits.
- If we are going to **stop the pipeline** of older children needing intensive services, residential treatment, and hospitalization, we must identify and intervene at the earliest possible time.
- Addressing issues early would prevent suffering and **save millions of dollars.**
- In spite of all the scientific knowledge that we now have, young children have been left out.

Brain Development

In the first three years



250,000
New neurons
every **MINUTE**



Prenatal

Birth

1 year

3 years

80% of
brain growth is
COMPLETE

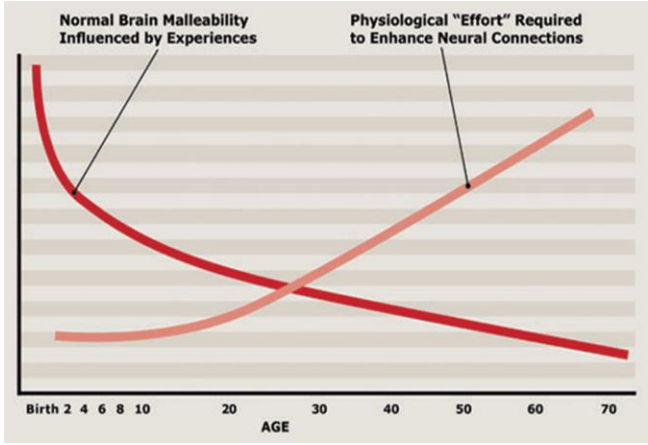
50 ➡ 1000 trillion
synapses at a rate of
1 million per SECOND

child first

Understanding Child Development

- Neural networks are wired from the bottom up.
- Early connections serve as the scaffold or foundation for all later connections and all future learning.
- Genes and early life experiences interact **together** to shape the architecture of the developing brain: **NATURE AND NURTURE**
- The **caregiver-child relationship is most critical**. It is the **back and forth interaction of contingent, reciprocal responses** between parent/caregiver and child ("serve and return") which largely determines how the wiring of the brain will take place.
  - Whether the foundation will be **strong and solid,** or **weak and fragile** is determined by the child's early experience.

- **Brain plasticity** is enormous at birth, but then decreases over time.
  - Change is easy early in development.
  - Change is much more difficult and costly with increasing age.
    - Intervention is extremely costly.



Promoting the Health of Our Children

Definition of Infant and Early Childhood Mental Health

Zero to Three

"IECMH is the developing capacity of the infant/young child to form **close and secure relationships**; **experience, manage, and express a fully range of emotions**; and **explore the environment and learn** – all in the context of **family, community, and culture."**

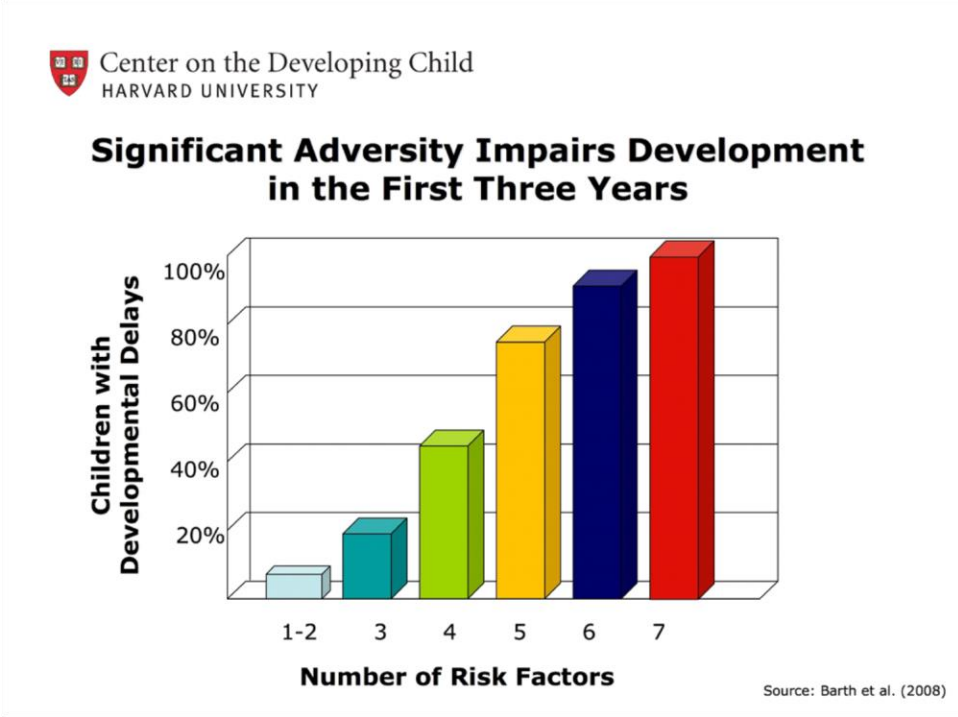
We know that when early relationships are protective, nurturing, responsive, stable, and predictable, children thrive. They develop secure attachments, **social-emotional / mental health,** as well as cognitive and physical health**.**

Brain Science – Impact of Adversity

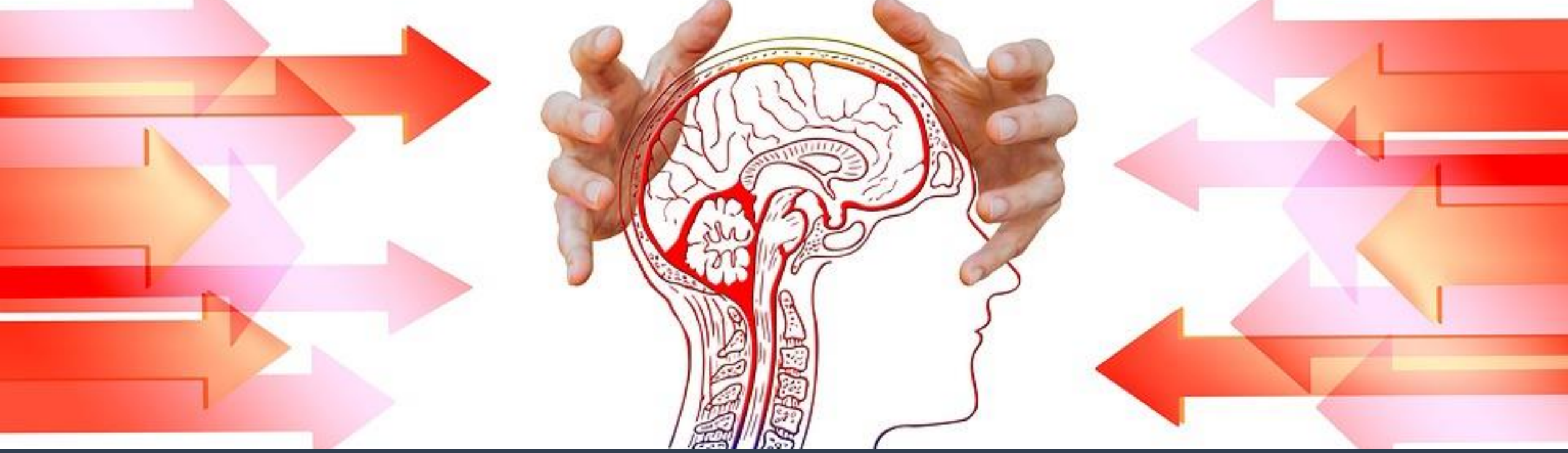
High levels of stress and adversity can significantly damage the young developing brain. These experiences rewire neural pathways so that they are primed to be on high alert.

Toxic Stress or ACEs:

- Extreme poverty
- Domestic and community violence
- Trauma and child abuse
- Caregiver depression, PTSD, and other mental health issues
- Substance misuse
- Homelessness
- Isolation and lack of social and community supports
- Racism/Inequity
- Child neglect
- Incarceration
- Unemployment
- Poor health care
- Lack of education
- Poor quality childcare
- Food insecurity
- Unmet basic needs



Science tells us that to promote child emotional health, we must focus both on **nurturing relationships**, which are protective, and **decrease the stressors** in the life of the family.



Toxic stress and ACEs cause a rise in cortisol and epigenetic changes which damage the developing brain and can lead to lifelong problems

Mental illness

Academic failure and/or learning disabilities

Chronic health problems

What Do Mental Health Problems Look Like in Young Children

- Young children express their feelings (e.g., joy, anger, fear, sadness, pain, anxiety, empathy, pride) through their bodies and their behavior.
- Behavior is how they communicate. All behavior has underlying meaning.
- Behavior must be interpreted in the context of the stages of development, familial expectations, and culture.
  - This determines whether the behavior is a due to a normal developmental expectation or challenge or to a disturbance that indicates that the child is experiencing excessive mental/emotional distress. (Examples: crying, sleep disturbance, vomiting, biting, tantrums)
- Children depend on their primary caregivers to mediate their experiences – especially if the experiences are stressful. This teaches them how to self-regulate; it makes stress **tolerable** and a source of learning.
- If parents/caregivers are overwhelmed, dysregulated, anxious, depressed, angry, abusive, withdrawn, using substances, and/or absent – the child's stress can be **toxic** and lead to brain and metabolic changes, expressed as behavioral/mental health disturbances.

Disorders of Infancy and Early Childhood

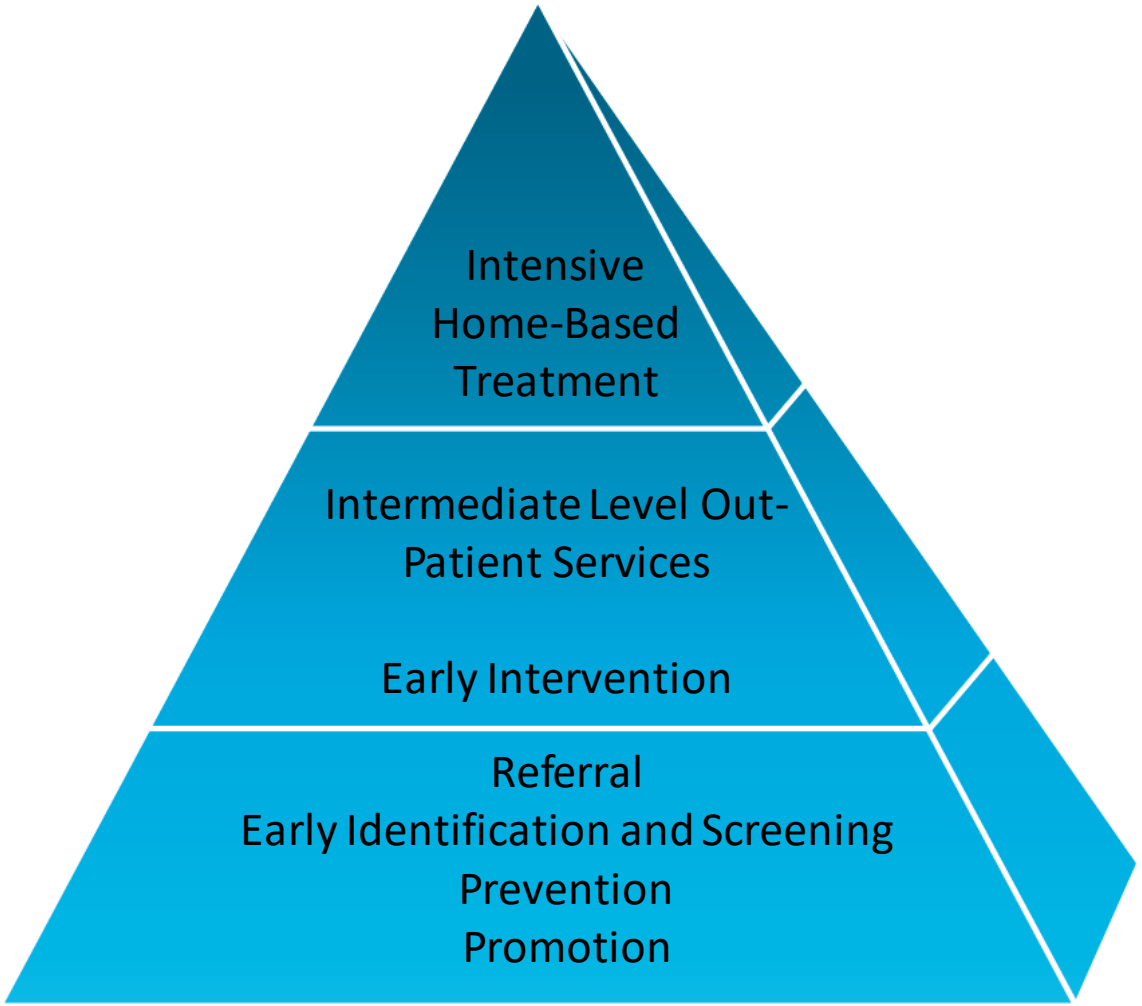
- **Genetic or biologically based** disorders (including toxic exposures) include: Autism, Sensory Responsivity, Neonatal Abstinence Syndrome, Attention Deficit Hyperactivity Disorder, high lead exposure, Tourette's Syndrome
  - Impact of biology is always mediated by the environment.
- **Relationship/environmental disturbances** include: Anxiety (separation, social), Depression, Posttraumatic Stress Disorder, Adjustment Disorder, Reactive Attachment Disorder, Sleep Disorders, Excessive Crying Disorder, Grief Disorder, Obsessive Compulsive Disorder
- **Symptoms of emotional distress** are seen in many different mental health disorders.
  - Inconsolable crying, bodily dysregulation with vomiting or diarrhea, food rejection or overeating, sleep disturbances, persistent nightmares, aggression (biting, kicking), defiance, poor peer relationships, frequent and severe temper tantrums, unusual fears or constant worries, repetitive play, anxiety at separation or in social situations, lack of seeking comfort from primary caregivers, freezing, hyperactive, difficulties with attention or concentration, lack of energy, withdrawal, sadness, isolation, regression in developmental milestones, poor eye contact, unusual bodily movements, obsessions, explosive emotional reactions, self-harm, harm to animals.

Need to address the underlying problems, not just the symptoms.

Based on scientific research:

- Promote responsive, nurturing, protective parent-child relationships to heal and protect child's developing brain from high stress.
- Connect families with comprehensive services and supports to decrease stressors and enhance development.
- Together, they build **child and family resilience**.

Landscape of Early Childhood in CT: Public Health Pyramid



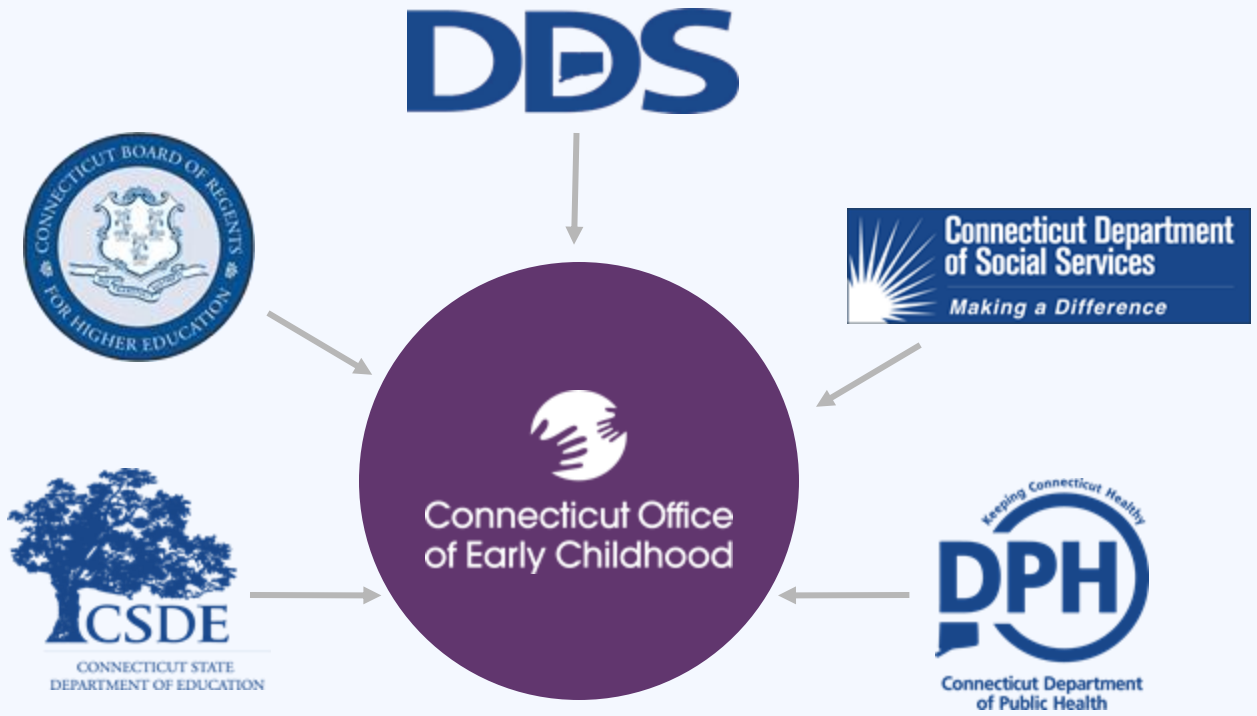
Need a continuum of supports and services to address the unique priorities and needs of the child and family, so that they have:

- The right type of service
- At the right time
- At the right level of intensity
- In the right place.

How the Office of Early Childhood (OEC) came to be...

Prior to 2013, services for young children in Connecticut were dispersed among five state agencies: Department of Education, Social Services, Board of Regents, Developmental Services, and Public Health. The Office of Early Childhood was created in 2013 to unify and improve delivery of services for young children in Connecticut within one agency.

On May 28, 2014, Public Act 14-39 signed by Gov. Dannel P. Malloy establishing the **Office of Early Childhood**.



Who is served by the Office of Early Childhood...

The earliest years of a child's life have a huge impact on that child, shaping who the child will grow up to be, affecting their future health, education, and success. Helping young children learn, develop, and overcome barriers will have benefits that last a lifetime.

Partnering with families through family engagement is essential. OEC works hard to support and strengthen families in Connecticut.

OEC is a state agency that oversees a network of programs and services that help young children and families thrive. A key part of that work is **supporting providers, teachers, and other professionals** who've dedicated their careers to caring for and educating children.

The OEC focuses on children from birth into grade school

Connecticut is home to 181,607 children under the age of five

Overview of children served by Connecticut Office of Early Childhood & other early childhood partners

Early Care and

- **School Readiness: 11,879** school readiness spaces
  8,708 children participated
- **Child Day Care Centers: 4,052**
  2,998 children participated
- **Smart Start: 650**
  650 children participated
- **Connecticut Even Start Family Literacy Program:**
  69 children and 48 adults (from 37 families)
- **Child Care Subsidies (Care 4 Kids):** 25,124 children in **1,6814** families received C4K services by 5,494 providers.
- **Public School Preschool**
  (Local Education Agency funded):
  15,300 children enrolled (2020-2021)

Home Visiting

- **Parents as Teachers: 2,425** children and 2,307 parents served
- **Child First: 343** children and 354 parents served
- **Nurse Family Partnership: 118** children and 149 parents served
- **Early Head Start: 58** children and 52 parents served

Services for Young Children and Families

- **Early Intervention** supports families with children under age 3 identified with developmental delays or disabilities.
- **Birth to 3 (IDEA Part C): 10,155** referrals, of which 8,695 children were evaluated, of which 6,492 (75%) were deemed eligible.
- **11,395** children under age 3 with an Individualized Family Service Plan (IFSP) were supported.
- Upon exiting at age 3, **2,105** children were eligible for IDEA Part B.

Head Start and Early Head Start

- **Head Start: 3,296** children ages 3 to 5 in 22
- **State Head Start Supplement:** funds 47 sites in 34 communities to create 264 additional full-day/full-year spaces and 994 additional extended day/extended year spaces, serving **730** children.
- **Early Head Start: 1,674** children ages birth to 3 and 70 pregnant women in 18 programs (center-based, family child care, and/or home visiting).
- **Early Head Start-Child Care Partnership**: has 3 grantees who fund 44 providers to serve **222** children (monthly average).

Children by Race & Ethnicity, 0-4 years of age (2020):

0.5% American Indian/Alaska Native
6% Asian
12% Black
28% Hispanic or Latino
0.5% Native Hawaiian/Other Pacific Islander
50% White
4% Two or more races

32,256 Children enrolled in public school kindergarten in Connecticut in the 2020-2021 school year.

16.3% of students in Connecticut public schools have special education status.

42.7% of students in Connecticut public schools qualify for free/reduced lunch.

12.3% of children (under age 18) in Connecticut are in households with income below Federal Poverty Level.

15.5% of children (under age 18) are in families that receive Food Stamps/SNAP.

69,521 three- and four-year-olds in Connecticut (2017 + 2018 births)

Role of Connecticut Office of Early Childhood OEC's mission and vision...

OUR MISSION

To partner with families of young children to advance equitable early childhood policies, funding and programs; support early learning and development; and strengthen the critical role of all families, providers, educators, and communities throughout a child's life. We will assertively remove barriers and build upon the strengths of historically disenfranchised people and communities to ensure fair access to OEC resources.

OUR VISION

All young children in Connecticut are safe, healthy, learning, and thriving. Each child is surrounded by a strong network of nurturing adults who deeply value the importance of the first years of a child's life and have the skills, knowledge, support, and passion to meet the unique needs of every child.

How we conceptualize behavioral health

Behavioral health is how our mental health, physical health, and spiritual health affect our well-being and behaviors.

Mental health
includes our emotional, social and psychological well-being. It affects how we think, feel and act.

Spiritual health
is how we view our purpose and place. It affects the ways we connect with the world around us.

Physical health
is the normal functioning of our bodies. It affects how we grow, feel, and move.

Good behavioral health is important for children and adults. It helps us cope with life's stresses and reach our goals. Just like we care for our bodies and physical health, it is important to care for our minds. The tools for emotional wellbeing are lifelong skills that can be passed down for generations.

Behavioral health initiatives within OEC

Pyramid Model	The Pyramid Model is a framework that provides programs with guidance on how to promote social emotional competence in all children and design effective interventions that support young children who might have persistent challenging behavior.
ECCP (Early Childhood Consultation Partnership)	The Early Childhood Consultation Partnership (ECCP) is a strengths-based, mental health consultation program designed to build the capacity of caregivers by offering support, education, and consultation. ECCP is developed to meet the social-emotional needs and/or developmental concerns of children birth to five. Services are child-specific and provided in the classroom and home.
Insecure Housing Training and Support	Operating through a lens of equity, provide training on homelessness and housing instability and increase awareness of the McKinney-Vento Homeless Assistance Act. To increase awareness on how homelessness is a traumatic experience impacting children's development in lasting ways, including malnutrition, maltreatment, multiple school placements, and exposure to violence.
Suspension & Expulsion	Operating through a lens of equity, advocating to decrease suspension/expulsion rates of children with behavioral and social/emotional needs. Educating on the importance for inclusion in early care childcare settings where Black and Brown children are disproportionately impacted.

Behavioral health initiatives within OEC

Mind Over Mood (MOMs)	The Mind Over Mood Initiative addresses maternal mental health within early childhood Home Visitation in multiple ways. One key component is the development of partnerships with independent practice therapists statewide. Mind over Mood is building a community of specialized perinatal mental health and attachment psychotherapists to attend to the unmet clinical needs of marginalized mothers who may be affected by trauma, socioeconomic stress, racial oppression and low social support.
Connecticut Association of Infant Mental Health (CT-AIMH)	CT-AIMH offers education and expertise in infant and early childhood mental health. CT-AIMH works to promote, support and strengthen nurturing, quality relationships for infants, young children and their caregivers, within the context of family, community and culture, through education, advocacy, and professional development. CT-AIMH promotes and holds a set of Competency Guidelines® that lead to an Endorsement in Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®.
Help Me Grow/ Sparkler	Sparkler is a family engagement tool that empowers parents and caregivers as first teachers. Developmental Screening: Sparkler offers the mobile Ages & Stages Questionnaires® (ASQ-3 and ASQ:SE-2) to families on their smartphones/tablets to check on their children's development. A library of 1500+ off-screen play-based learning activities aligned with the Early Learning Outcomes Framework, plus a library of tips for parents/caregivers. Connection and support — Sparkler offers regular tips and two-way messaging between parents/caregivers and early childhood providers, who can connect them with resources and support. Sparkler is available to families on iOS and Android devices, in English and in Spanish. Sparkler also provides a web-based dashboard that enables educators, pediatricians, home visitors, and other providers to monitor and engage with the families they support.

Behavioral health initiatives within OEC

Doula Project	Doula project is intended to centralize a referral network for parents enrolled in home visiting who are interested in Doula services. The project seeks to increase and diversify the Doula workforce by offering regional training to current home visiting staff interested in the field and/or community members interested in becoming doulas. A goal is to reduce low birth weight babies, birth complications involving mothers or their baby, increase in initiation of breastfeeding, and increased mother's self-efficacy regarding her own pregnancy outcomes. Another goal is to shift the normal practice of systems to connect more families with services that will help them achieve their goals and improve their health, education, and economic outcomes.
Head Start Collaboration	Early Head Start and Head Start are programs funded and monitored by the federal government, Office of Head Start. The program focuses on promoting school readiness for infants, toddlers, and preschoolers for families that meet income eligibility requirements. Head Start programs also support children with identified needs (such as physical and developmental delays), children in foster care, and children experiencing homelessness. Early Head Start serves children from prenatal-2 years-old; Head Start serves children from 3-5 years-old and their families. Head Start programs are required to meet federal Head Start standards across all domains (known as the highest quality standards in early childhood).

Current funding within OEC allocated towards behavioral health: **$15,211,136**

Total available funding for behavioral health excluding grant $ (i.e. PDG) and time-limited federal $ (i.e. ARPA): **$7,635,848**

Funding overall comes from ARPA Discretionary, PDG B-5 Renewal Grant (grant has sunset), CCDF, CBCAP, B23, and State Contribution Early Head Start

Instead of behavioral health efforts operating in silos by department, initiatives will operate under an OEC umbrella taking a Primary, Secondary, and Tertiary Preventative Stance…

Behavioral Health w/in ECE

+

Behavioral Health w/in Home Visiting

+

Behavioral Health w/in Birth to Three

+

Behavioral Health w/in Early Head Start

Behavioral Health w/in OEC

"An ounce of prevention is worth a pound of cure"

When it comes to community-based intervention efforts, there are three types of interventions, or preventative measures: primary prevention, secondary prevention, and tertiary prevention: According to ChildWelfare.gov:

Primary prevention directed at the general population to prevent maltreatment before it occurs (universal). All members of the community have access to and may benefit from these services. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might include:

- Public service announcements that encourage positive parenting
- Parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting
- Family support and family strengthening programs that enhance the ability of families to access existing services, and resources to support positive interactions among family members
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect

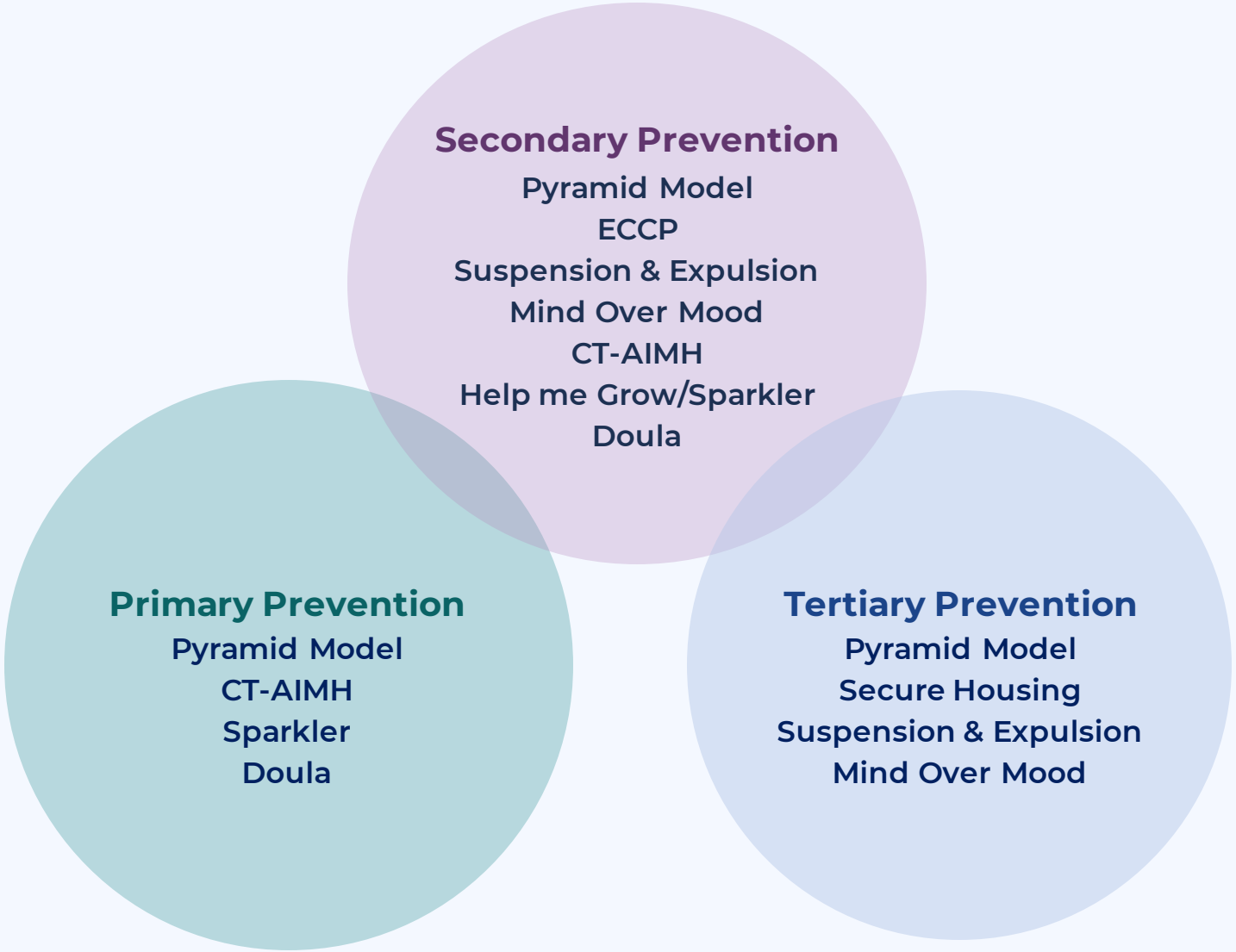
Secondary prevention targeted to individuals or families in which maltreatment is more likely (high risk) and are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities or neighborhoods that have a high incidence of any or all of these risk factors. Approaches to prevention programs that focus on high-risk populations might include:

- Parent education programs located in high schools, focusing on teen parents, or those within substance abuse treatment programs for mothers and families with young children
- Parent support groups that help parents deal with their everyday stresses and meet the challenges and responsibilities of parenting
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes
- Respite care for families that have children with special needs
- Family resource centers that offer information and referral services to families living in low-income neighborhoods

Tertiary prevention targeted toward families in which maltreatment has already occurred (indicated) and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These prevention programs may include services such as:

- Intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for a short period of time (e.g., 6 to 8 weeks)
- Parent mentor programs with stable, non-abusive families acting as "role models" and providing support to families in crisis
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes
- Mental health services for children and families affected by maltreatment to improve family communication and functioning

OEC behavioral health initiatives cont.



An Ounce of Prevention is Worth a Pound of Cure...

The ideal approach to prevention includes all three levels, which results in a comprehensive service framework focused on improving outcomes for children and families.

Why is mental health in children important?

Promoting children's mental and behavioral health underlies healthy development and health equity across the lifespan. Advances across broad areas of behavioral, social and neuroscience inform practice, programs, and policy in child and adolescent mental and behavioral health.

Childhood and adolescence provide critical periods for prevention, early detection, and intervention to promote child mental and behavioral health.

Disorder presentations are affected by biological determinants, environmental influences and genetics, including prenatal development and exposures and subsequent nutrition, in an interplay that is multi-determined and complex.

Additionally, when children have a mental and behavioral health disorder, they often develop academic impairments or difficulties leading to educational underachievement due to frequent absences, higher rates of suspension or expulsion, or failure and dropout from high school.

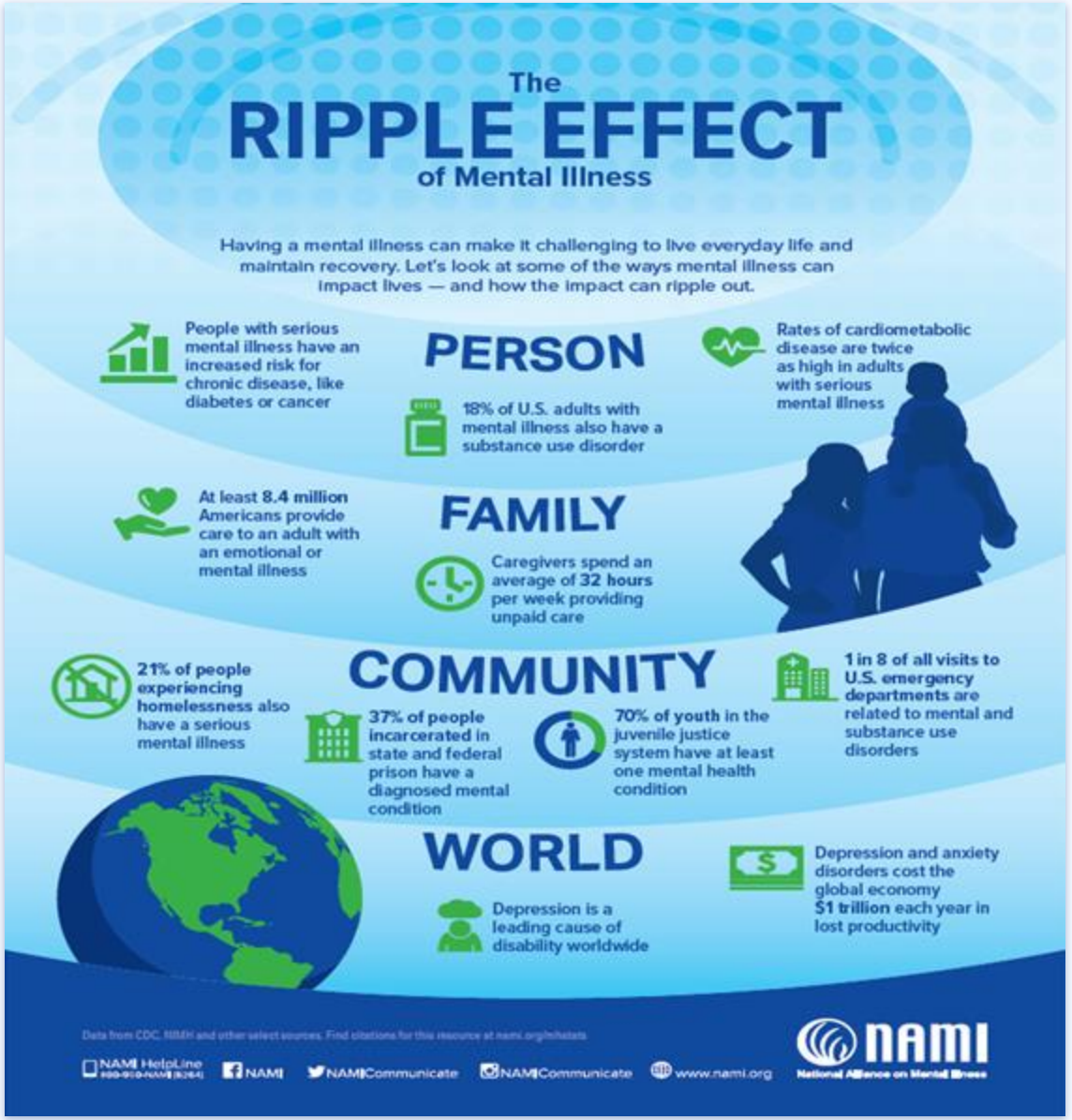
Promoting mental and behavioral health in children is important

Gizmo's Pawesome Guide to Mental Health© is a social-emotional learning curriculum that gives kids the tools to manage their mental health.
The Guide and Curriculum help kids learn:

- Mental health is as important as physical health.
- How to identify when mental health needs attention.
- Daily activities and healthy coping strategies that support mental health.
- How to identify and connect with trusted adults.

The Guide was printed with funding from the NCSP and the CT Children's Mental Health Block Grant under DCF. The NCSP grant is co-directed by DMHAS, DCF, and DPH.

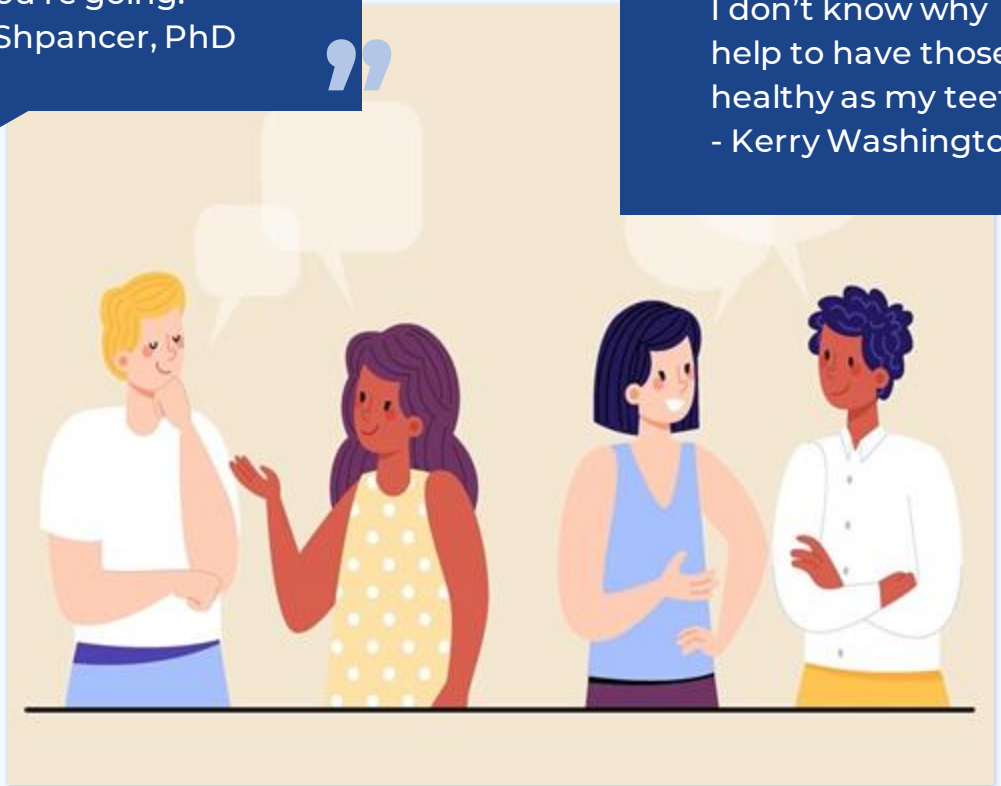
Young children cannot raise themselves...



Destigmatizing mental health...

"Mental health...is not a destination, but a process. It's about how you drive, not where you're going."
- Noam Shpancer, PhD

"I think it's really important to take the stigma away from mental health... My brain and my heart are really important to me. I don't know why I wouldn't seek help to have those things be as healthy as my teeth."
- Kerry Washington



Mental health relates to all of us...
We all have it!

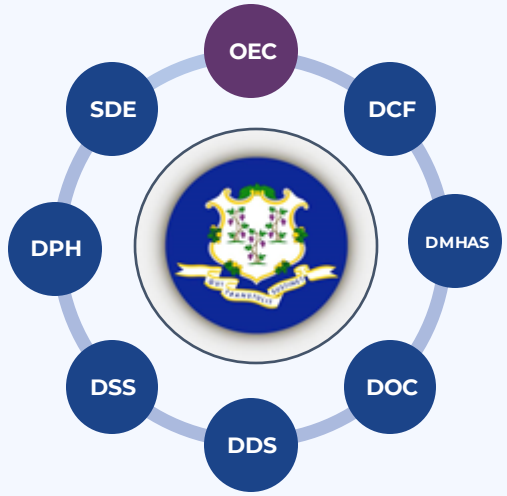
How "healthy" one is, however, is subjective. The more we talk about it, the less stigmatizing the subject matter is.

What can we do?

The ties that bind...

Attending to mental and behavioral health is a lifelong developmental process that continues well after children age out of OEC services.

Recognizing the value in a well-established continuum of care, it is important to proactively expand partnerships with our sister agencies...



DCF Behavioral Health Supports for Young Children and Their Families

- DCF works collaboratively with OEC on initiatives pertaining to the well being of young children
- Interventions for young children are provided in the context of the relationship between the child and their caregivers
- Although many families come to the attention of DCF via the Department's Child Welfare mandate, DCF's Behavioral Health supports are available to families regardless of other DCF involvement.

Early Childhood Consultation Program

- The Early Childhood Consultation Partnership (ECCP®) is a statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. The program builds the capacity of caregivers at an individual, family, classroom, or center-wide level. It provides support, education, and consultation to caregivers in order to promote enduring and optimal outcomes for young children.
- The three tiers are identified as **Level 1: Triage and Referral**; **Level 2: Phone Consultation; Level 3: Child Intervention; and Level 3: Center Wide Intervention.** All callers begin at Levels 1: Triage and Referral and may either be completed at this level or move into the next two levels depending on the needs of the caller. The caller could be referred to other services at that point of contact, be referred to Level 2: Phone Consultation, or referred to Level 3 Service type.
- DCF contracts with Advanced Behavioral Health (ABH) who then subcontracts with community providers across the state.

Therapeutic Child Care

- Utilizes the Center for Social Policy's Strengthening Families Approach and Protective Factors Framework as well as the Attachment, Self-Regulation and Competency (ARC) treatment framework
- The Childcare settings take a family-centered approach in which families and professionals collaborate to improve outcomes for children, and in particular, facilitate children's transition to a less intensive early/care environment.

Geographic Region	Provider	Annual Capacity
Bridgeport	Alliance for Community Empowerment	30
New Britain	Wheeler Clinic	12

Parenting Support Services

- Parenting Support Services (PSS) is a service for families with children 0-18 years-of-age to support and enhance positive family functioning. Families receive one or more of the PSS interventions along with case management services using the Wraparound philosophy and process. PSS offers the evidenced-based model, Level 4 Triple P (Positive Parenting Program®) and the Circle of Security Parenting© intervention.
- Triple P helps parents become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths.
- Circle of Security Parenting (COS) is designed to build, support, and strengthen parents' relationship capabilities so they are better equipped to provide a quality of relationship that is more supportive of secure attachment.
- If needed, families may receive more than one PSS intervention.

Geographic Region	Agency	Annual Capacity
Brdgeport / Norwalk	Boys & Girls Village	210
Meriden	Catholic Charities Archdiocese of Hartford	255
Norwich	Community Health Resources	120
Manchester / Enfield	Community Health Resources	195
Danbury	Community Mental Health Affiliates	90
Waterbury	Community Mental Health Affiliates	120
New Haven	Family Centered Services	165
Torrington	McCall Foundation	75
Middletown	Middlesex Hospital	120
Hartford	St. Francis Hospital	330
Willimantic Area	United Services	165

Family Based Recovery (FBR)

- FBR is an intensive, in-home clinical treatment program for families with children (birth to 5 years old inclusive) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance use. The team provides individual, couple and family therapy; promotes positive parent-child interaction for secure attachment; works to increase a parent's awareness and understanding of child development; provides case management services and conducts weekly relapse prevention and parenting groups.

Geographic Region	Provider	Annual Capacity
New Haven / Milford	Yale Child Study Center	24
Hartford / Manchester	The Village for Families and Children	72
Norwich / Willimantic / Middletown	United Community and Family Services	24
Norwich / Willimantic / Middletown	Community Health Resources	48
Waterbuy / Torrington / Danbury	Community Mental Health Affiliates	12
Meriden / New Britain	Community Mental Health Affiliates	24
New Haven / Milford	Family Centered Services	24

Child First

- Child First is a national, evidence-based, two-generation model that works with very challenged young children and families, providing intensive, mental-health, home-visiting services

Geographic Region	Provider	Annual Capacity
Bridgeport	Bridgeport Hospital	120
Torrington	Charlotte Hungerford Hospital	24
New Haven	Clifford Beers Guidance Clinic	48
Stamford	Child Guidance Center of Southern CT	48
Middletown	Middlesex Hospital	48
Norwalk	Mid-Fairfield Child Guidance Center	48
New London / Willimantic	United Community & Family Services	120
Hartford	Village for Families & Children	48
Waterbury	Wellmore	48
New Britain	Wheeler Clinic	48

CT Association for Infant Mental Health (CT-AIMH)

- CT-AIMH works to promote, support and strengthen nurturing, quality relationships for infants, young children and their caregivers, within the context of family, community and culture, through education, advocacy, and professional development.
- CT-AIMH holds an annual 8 topic training series co sponsored by the Department of Children and Families and the Office of Early Childhood with the goal of expanding knowledge around infant mental health, healthy attachment, and the relationship between infants/toddler and their caregivers.
- DCF has the capacity to send 100 individuals annually to this training and send a variety of stakeholders such as Community Partners, Clinicians, and DCF Social Work staff.

Child First is an intensive, evidence-based, two-generation, home-based intervention that serves young children and families experiencing trauma and adversity.

Child First Model Overview

- Families experiencing trauma and adversity
- Children with behavioral/mental health problems, prenatal to age 6 years
- Intensive in-home services: Two-generation treatment, 1 or more X per week
- Team approach with licensed Mental Health Clinician and Care Coordinator
- Trauma-informed Child-Parent Psychotherapy (CPP)
- Comprehensive care coordination, focused on SDoH, ACEs
- Mental Health Consultation in all childcare settings
- Evidence-based – Reviews by multiple clearinghouses
- Rigorous training, supervision, data collection

- Strong consistent outcomes for both caregivers and children, over a period of 12 years
- Cost effective

Target Population: Two-Generations

Children:

Prenatal to age 6 years

- Emotional/behavioral problems
- Trauma
- Abuse and neglect
- Developmental disabilities

Parents/Caregivers:

- Child protective services
- Depression, anxiety, PTSD
- Substance use
- Domestic violence
- Homelessness
- Extreme poverty

Demographics - 2022

Age ranges:

- Prenatal=2%
- Birth to 3=26%
- 3 to 6=72%

Race:

- Black/African American/ Multiracial=30%
- White=72%
- Other=2%

Ethnicity:

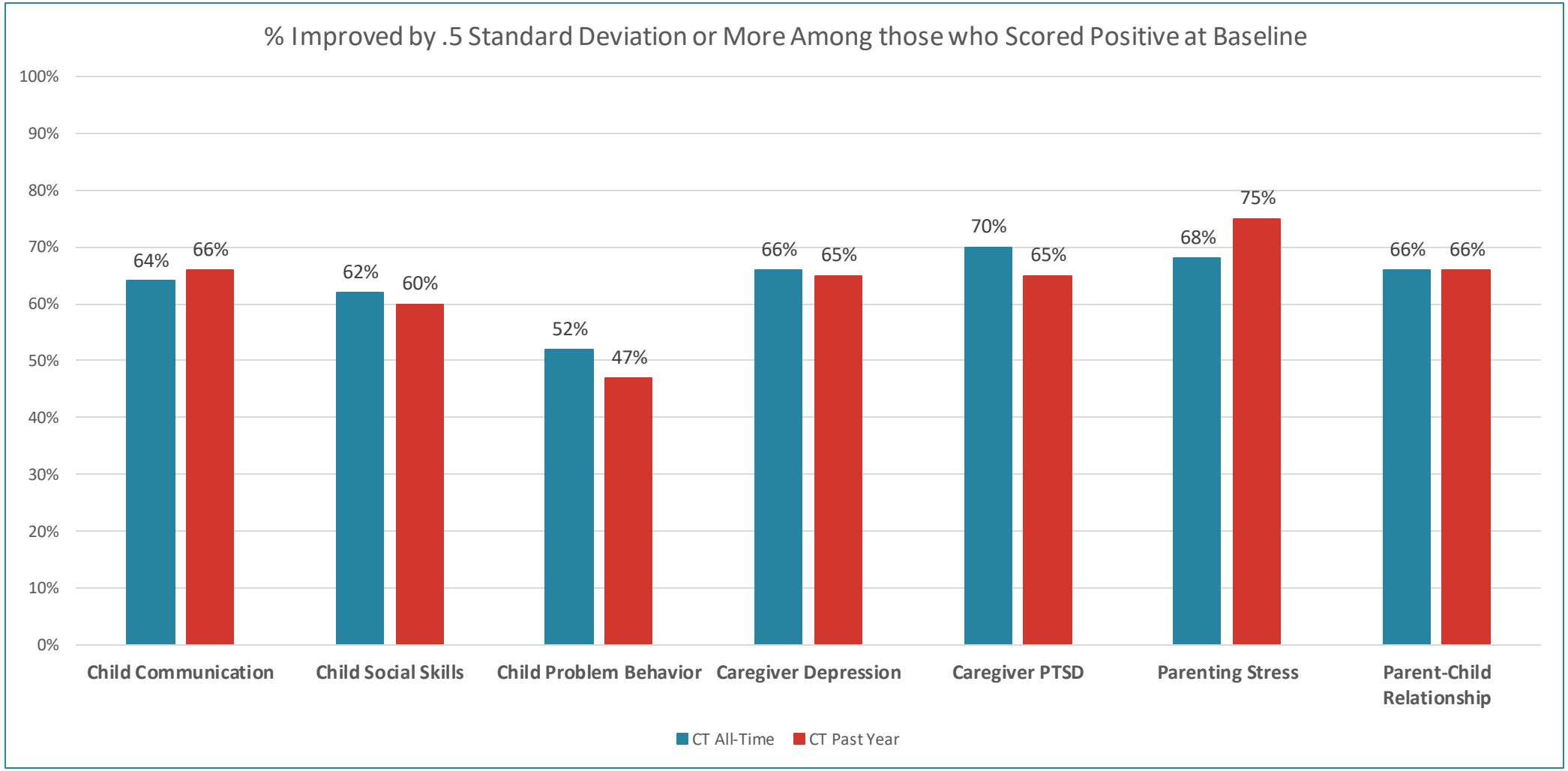
- Latinex=43%
- Non-Latinex= 57%

Prevalence of Problems upon Entry - 2022

- Trauma – Caregiver = 99%
- Trauma – Child = 82%
- Child behavior problems = 62%
- Child language delay = 34%
- Caregiver-child relationship disturbance = 63%
- Caregiver depression = 35%
- Parenting stress = 41%
- Children with past or current DCF involvement = 75%

Percent Improvement in Outcomes - Connecticut

Comparison by Domain among Outcomes 2010-2022 (All-Time) and January-December 2022 (Past Year)



Child First Capacity / Waitlists

- Child First began at Bridgeport Hospital in 2001, began replicating in 2010, and had coverage in all regions of the state by 2021.
- **Current capacity** has decreased markedly, with the end of funding through **ARPA.**
  - **Number of agencies: 15 ⟹ 11**
  - **Number of teams: 57 ⟹ 36**
  - **Capacity to serve children and families: 1,368 ⟹ 864 families**
- Existing agencies are trying to cover the entire state. Saw 950 families in 2022.
- Current waitlist across CT is over 200 children and families
  - This does not reflect the much higher need for services in CT, as DCF Enhanced Service Coordinators often do not refer unless there is an upcoming opening.
  - Single affiliate agency with a waitlist of 74 families.

Current Decrease in Capacity:

- **4 agencies**
- **21 teams**
- **504 children and families**

Funding Streams

Current (without ARPA funds):

- DCF: Funds 11 affiliate agencies with 25 teams
  - TANF funding – Past, current?
- OEC: Funds 9 teams
  - Both State and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding from HRSA
- VOCA (Victim of Crime Act) funds 1 team
- Philanthropy funds 1 team
- **TOTAL: 36 teams**

Future possible funding:

- Medicaid / EPSDT
  - Child First has been certified by DCF and DSS for Medicaid reimbursement
- MIECHV - $1.4 million to CT in new federal funds
- Family First (Title IV-E)
  - Child First is "Supported" and conducting 2nd RCT.
- TANF
- IDEA
- CAPTA
- State funding
- Block grants

Cost Savings

- Child First implementation cost per family = $9,000 (both child and parent)
- Cost-Benefit:
  - Child-Parent Psychotherapy (CPP): Child First MH clinicians are all trained and rostered in CPP. CPP returns $13.82 for every $1 spent to deliver the service.
  - Child First RCT showed: Decrease in child maltreatment: At 1 year = 40% decrease, at 3 years = 33% decrease. Cost of substantiation = $34,000.
    Lifetime cost per victim of non-fatal maltreatment = $210,000.
  - Of those children admitted to Child First "at risk for removal," 75% remained in their homes. Cost to DCF for one child in foster care = $81,232/year.
  - Cost of residential treatment for one child = $96,000/4 months
  - Cost of special education in CT for one child = $28,548/year.
  - Societal cost of untreated maternal depression and anxiety = $32,000.
  - Also cost savings in other mental health, healthcare, and education services, and in juvenile/criminal justice.

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Early & chronic exposures to stressors related to poverty cause vulnerabilities including:

- **physiological disruptions**
- **changes in brain architecture and reflective functioning**
- **each…… resulting in lifelong physical and mental health consequences**
- **(Ellison & Fallon, 2021)**

- Infancy is the age at which a person is most likely to become homeless in the US

- Approximately half of the children staying in HUD shelters are under the age of six

(SchoolHouse Connection, 2020)

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Children Experiencing Homelessness Experience:

- Lower birth rates
- Inadequate nutrition
- Disturbances of sleep
- Higher levels of childhood illnesses
- Delayed development
- Poor educational outcomes
- Toxic stress and complex trauma
- Significant behavioral and mental health issues
- Child welfare involvement
- CASE STUDY

(Zero to Three)

Homelessness from a Developmental Perspective

Infants, Toddlers & Preschoolers are particularly vulnerable to the impacts of trauma-

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Impact of Homelessness on Pregnancy

- Homelessness interferes with establishing the positive prenatal characteristics that promote optimal development for the newborn, including:
  - adequate prenatal care
  - mentally preparing for parenthood
  - logistically preparing for the birth
  - forming impressions of the new baby
  - visualizing where the baby will “be”
  - ***the formation of positive, secure attachment patterns***

Impact of Homelessness on Infants

- Primary developmental task of infancy is to establish security & trust—parents' task is to support the infant through responsive and consistent caregiving.

- Homelessness works against this primary developmental task due to:
  - unpredictable & inadequate physical environments
  - inability to meet basic needs
  - exposure to extreme temperatures
  - overcrowded & over stimulating living conditions

Impact of Homelessness on Toddlers

- Primary developmental task of toddlers is to develop a sense of independence & identity—parents' task is to support the toddler through scaffolding for regulation and the provision of a safe, secure environment.

- Homelessness works against this primary developmental task due to:

  - poorly maintained & unsafe environments
  - restrictions to toddler's opportunity for free exploration
    - pressure on parents to manage behavioral outbursts & power struggles
    - absence of developmentally appropriate materials & activities
  - feeling of parenting under a "microscope"—leads to embarrassment

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Impact of Homelessness on Preschoolers

- Primary developmental tasks of preschoolers are to develop a recognition of emotional states of others, separating from parents, and to develop social competence with peers & adults—parents' task is to provide the preschooler with external support in understanding social situations and facilitating relationship building with peers & adults.

- Homelessness works against these primary developmental tasks due to:
  - inability to provide a structured, organized environment: or the toys, books & activities that promote development
  - unruly behavior in children as they get older may cause eviction resulting in additional stress
  - parents under stress may themselves model poor interpersonal skills with others

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In summary:

- The most significant protective factor for young children facing adversity is having the support of *at least one* stable and committed relationship with a trusted parent, caregiver or other adult.

Case Study sharing

How we support families…..

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Supports & Resources for Families

- Connect with local housing support providers
- Connect with your local school district McKinney Vento Liaisons
- Learn about local early care & education providers- especially Head Start, School Readiness, and other federally & state funded programs
- ***ASK*** about younger children in the home!
- Screen children in shelters, visit shelters

Challenges, Gaps, and Recommendations

1) **Challenge**: There are not sufficient services for young children and families who need mental health intervention, especially Intermediate level (clinic-based) and Intensive Home-Based Treatment.

- Result will be increased intensity of their mental health problems, with more extensive services, residential treatment, and hospitalization utilized, at **very high costs**.
- Lost opportunity to prevent unnecessary pain and suffering for both child and family.
- **Current crisis around departure of 21 Child First teams serving almost 500 families.**

- **Recommendations:** Increase funding for those young children and their families who have experienced trauma and adversity.
  - Add Intermediate level services for young children and families.
  - Utilize outpatient settings for young children by ensuring Medicaid reimbursement (< 4 yrs) and providing additional training to workforce in early childhood mental health.
  - Respond to current need for Child First services (and retain highly trained teams) through Medicaid reimbursement.

2) **Challenge:** Web-based Service Inventories are very confusing for both parents and professionals, and rarely include services for young children.

- **Recommendations:** Revise web-based mental health inventories from the perspective of parents and caregivers, so that they are able to find services for their young children.

Challenges, Gaps, and Recommendations - continued

3) Challenge: A comprehensive continuum of care for young children with social-emotional/mental health difficulties and their families is needed.

- **Recommendations:** Create an Early Childhood Mental Health Workgroup that is part of TBC and the Children's Behavioral Health Plan Implementation Advisory Council.
  - Examine all early childhood and family prevention and mental health services, located in or funded by CT Departments (OEC, DCF, DSS, DPH, DMHAS), with the goal of creating a coordinated early childhood system of care.
  - Track all young children identified with any social-emotional/behavioral needs in a systematic way to look at services received, outcomes, and cost.

4) Challenge: Multiple federal funding streams (and commercial insurance) are not being well utilized for early childhood mental health.

- **Recommendations:** Leverage all possible federal funding streams for future mental health services for young children and families.
  - Include: Medicaid/EPSDT, Family First (Title IV-E), MIECHV, TANF, IDEA, CAPTA, and State Block Grants.
  - After Medicaid is established, access Commercial insurance.

Challenges, Gaps, and Recommendations - continued

5) Challenge: Pediatric Primary Care is not well utilized as a valuable source of both primary prevention, early intervention, identification, and referral.

- **Recommendations:** Research, evaluate, and implement strategies used nationally and in Connecticut.
  - Train and support pediatric providers in order to integrate early childhood mental health into Pediatric Primary Care.
  - Provide mental health consultation to pediatric providers.
    - Utilize Access Mental Health, CTAIMH Pediatric pilot, and other strategies

6) Challenge: There is need for greater focus on the Social Determinants of Health (SDoH) and their impact on the emotional, mental, and relational health of young children.

- **Recommendations:** Integrate the Social Determinants of Health into prevention, identification, and intervention efforts.
  - Access funding for Care Coordinators, Community Health Workers, Health Navigators, and Doulas.

ADDENDUM

Landscape of Early Childhood Emotional/Mental Health Services in CT

- Provider Training:
  - CT AIMH trainings and Endorsement
- Promotion:
  - Home visiting – PAT
- Prevention:
  - Home visiting – HFA, NFP
  - Early care and education – Pyramid Model, Therapeutic Childcare
- Early Identification/Screening/Assessment:
  - Sparkler (Ages and Stages)
  - MLDA (CT AIMH pilot)
  - Referral: 211 Child Development InfoLine - Help Me Grow
- Early Intervention:
  - Birth to Three
  - Mind Over Mood
  - ACCESS Mental Health for Youth
  - Early Childhood Consultation Partnership

Landscape of Early Childhood Services in CT - continued

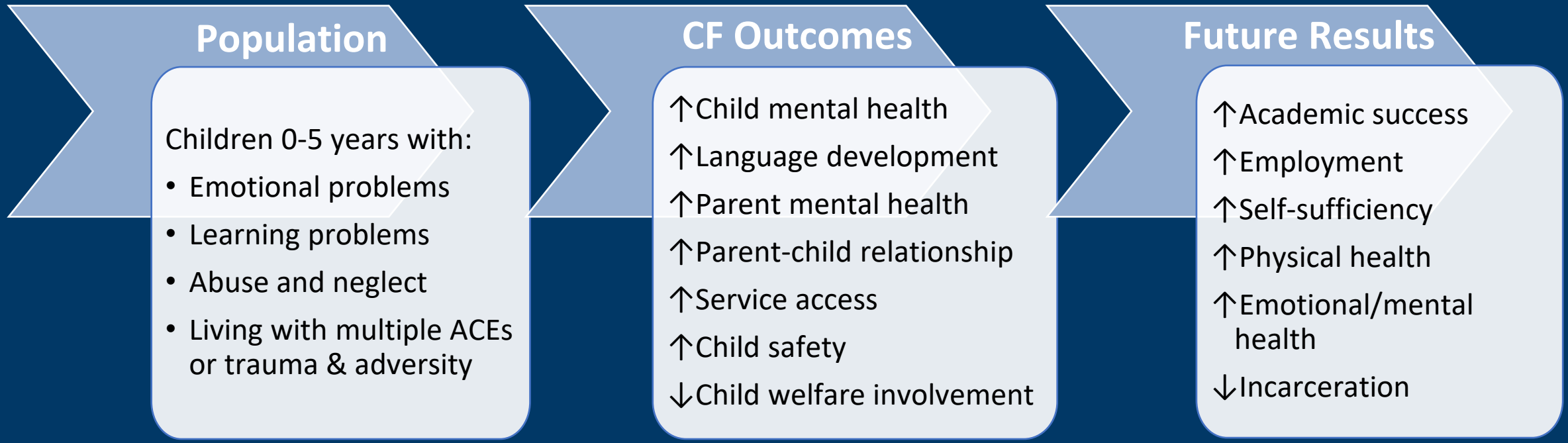
- Intermediate Level Services:
  - Child Guidance Centers, FQHCs, and Training Clinics
    - Triple P
    - Circle of Security
    - CPP and ARC trained clinicians
- Intensive Home-Based Treatment:
  - Child First
  - Family-Based Recovery
  - Safe Baby Court

➢Strong Promotion, Prevention, Referral, and Early Intervention

➢Major gaps exist for all Intermediate and Intensive Treatment Services

➢Extremely difficult to find any early childhood services in the existing Mental Health web-based inventories in CT.

Trajectory of Children Served by Child First



Child First Randomized Controlled Trial

[*Child Development,* January/February 2011]

- **Ethnicity/Race:**

  59% Latino, 30% Black, 7% Caucasian

- **Family Challenges:**

  94% public assistance

  67% unmarried

  64% unemployed

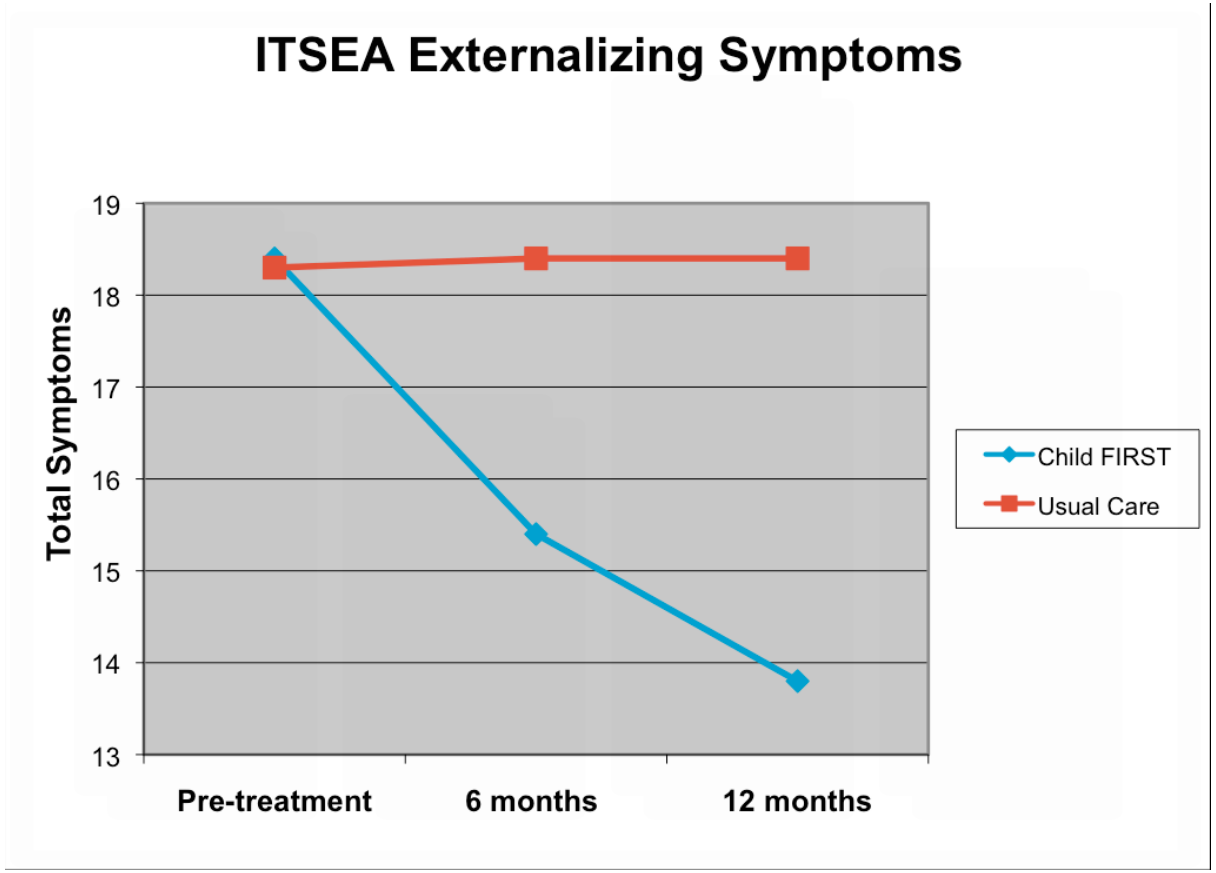
  54% depression

  53% did not complete high school

  44% history of substance abuse

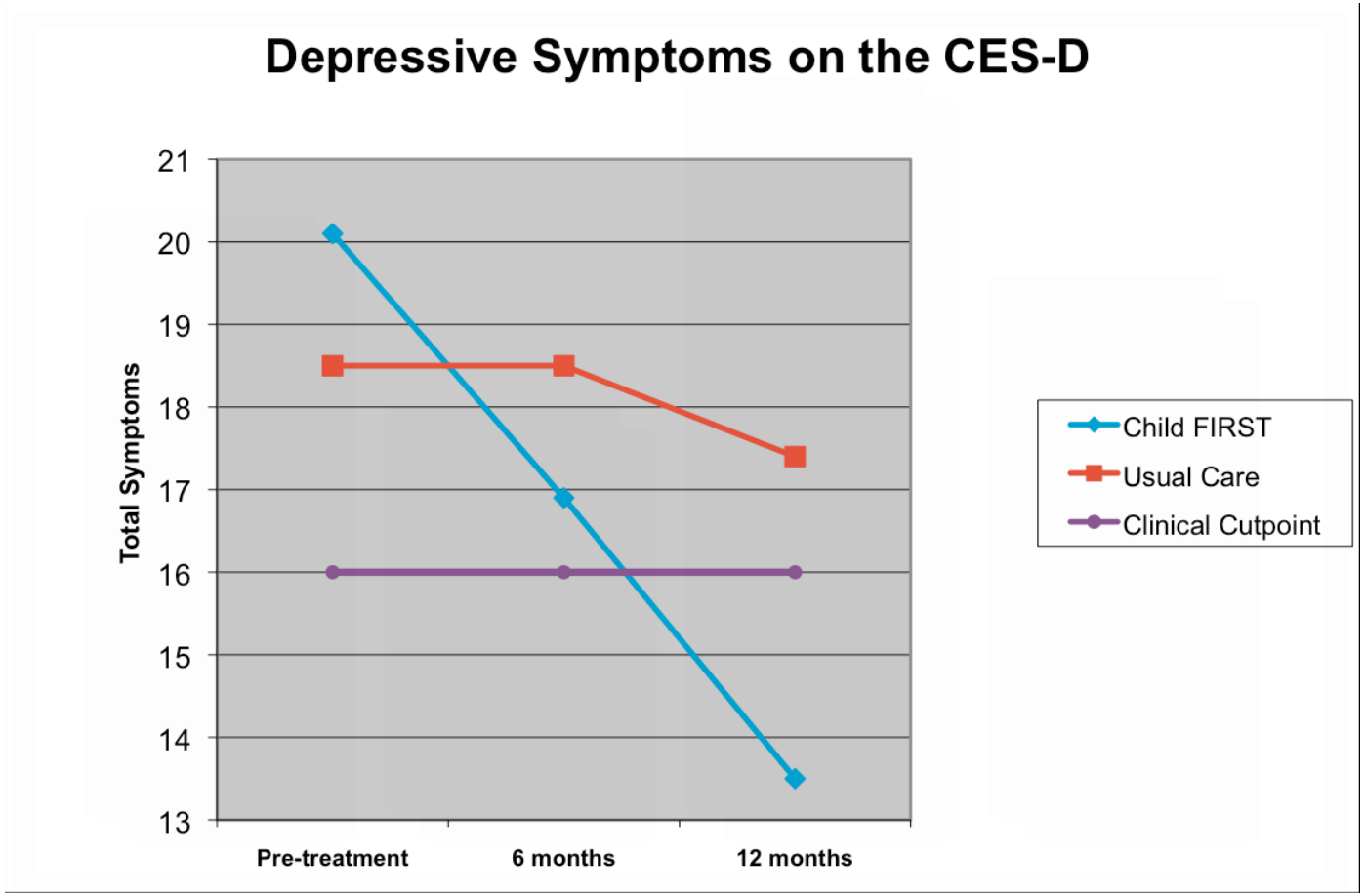
  25% history of homelessness

Child Mental Health Problems



42% decrease in aggression, defiance, impulsiveness

Maternal Depression



64% less likely to have depression or mental health problems

Child First Results of RCT: 12 Month Follow-up

- Child FIRST children were significantly less likely to have **aggressive and defiant behaviors**. (Odds ratio = 4.8)
- Child FIRST children were significantly less likely to have **language problems.** (Odds ratio = 4.2)
- Child FIRST mothers had significantly lower levels of **depression and mental health problems.** (Odds ratio = 4.1)
- Child FIRST families were significantly less likely to be involved with **child protective services** by parent report. (Odds ratio = 4.1)
- Child FIRST families had markedly increased access to **community-based services** (91% vs. 33%).
- Child FIRST families had very high **parent satisfaction**. (Mean of 4.6 of 5)

National Demographics/Population/Need

Maternal Depression	52% of mothers in Early Head Start *https://eclkc.ohs.acf.hhs.gov/mental-health/article/five-action-steps-address-maternal-depression-head-start-programs*
Substance Use Disorder	20.4 million/year 18 or older (2019) 8.3 million had a past year illicit drug use disorder 2.4 million had both an alcohol use disorder and an illicit drug use disorder *https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm*
Domestic Violence	10 million/year Huecker MR, King KC, Jordan GA, et al. Domestic Violence. [Updated 2021 Apr 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK499891/*
Homelessness	180,413 people in families with children (2018) The National Alliance to End Homelessness (NAEH) released its annual report, ***The State of Homelessness in America***, using data from HUD's **annual Point-in-Time Count**. https://*endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2020/*