Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee
Legislative Office Building Room 3000, Hartford, CT 06106
(860) 240-0346 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/ph/BHPOC

Co-Chairs: Steve Girelli & Jeff Vanderploeg
Meeting Summary
Wednesday, December 18, 2019
2:00 – 4:00 p.m.

Next Committee Meeting Date: Wednesday, January 15, 2020 at 2:00 PM at Beacon Health Options in the Hartford Conference Room (Third (3rd) Floor in Rocky Hill, CT

Attendees: *Dr. Steve Girelli (Co-Chair), Dr. Jeff Vanderploeg (Co-Chair), Dr. Lois Berkowitz (DCF), Peter Brown (CSSD), Carrie Bourdon (Beacon), Melissa Deasy, Bet Gailor, Elizabeth Garrigan (Beacon), Joshanda Guerrier (DCF), Irvin Jennings, Elaina King, Beth Klink, Pat Nunez (CSSD), Maureen O'Neill-Davis, Donyale Pina (DSS), Tara Scrivano, Erika Sharillo (Beacon), Dr. Stephney Springer (DCF), and John Torello (Jud), Call-ins- Kathy Schiessl, Janessa Stawitz (Jud), and Valerie Wyzykowski (OHA)*

Introductions

Co-Chair Jeff Vanderploeg convened the meeting at 2:04 PM. Participants, including those calling in, introduced themselves.

Comments and Discussion from the November Meeting

Co-Chair Jeff Vanderploeg asked for comments from the last meeting. There was no follow-up discussion from the last meeting. Co-Chair Steve Girelli acknowledged and thanked Jeff for the excellent minutes from that meeting.

Judicial Branch Update on Behavioral Health Services-Peter Brown (Clinical Coordinator- Jud), Patricia Nunez (Program Manager-CSSD), and John Torello (Program Manager -Jud)

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Patricia Nunez (Program Manager II/CSSD PREA Coordinator- CT Judicial Branch, Court Support Services Division, Juvenile Clinical, Educational and Residential Services), John Torello (Program Manager- CT Judicial Branch, Programs and Service), and Peter Brown (Clinical Coordinator) presented Judicial Branch updates regarding children's behavioral health services. The presentation opened with a reminder that
CSSD's overarching goal is to reduce recidivism. It is not primarily a mental health agency, though it does provide some mental health services.

John Torello indicated that the only way to access CSSD mental health services is to have been arrested. However, youth in the judicial system are not prohibited from getting services elsewhere, and many do. Referrals for mental health services through CSSD have been decreasing over time from 15k in 2004/2005 to 8k in 2018/2019. (Slide 3) Most CSSD services are available only after adjudication, though some youth receive services elsewhere before adjudication. Within the judicial system the Probation Officer functions as case manager and performs among other things a risk assessment for recidivism. If recidivism risk is assessed to be low, the youth is likely to be connected to community services.

CSSD services range from Mentoring to Intermediate Residential and fall into three broad levels of care: Community Based Programs, Family/Home Based Programs, and Residential Services. (Slide 4) Mentoring is 4-5 hours per month to 4-5 hours per week. Linking Youth to Natural Communities (LYNC) and Adolescent Sexual Behavior Treatment and Education (ASBTEP) are two other Community Based Programs. LYNC offers case management and groups. Of note, under a new statute in some cases prosecution may be delayed while youth receive services in this program. The program's goal is to get kids involved in community treatment service and/or prosocial activity. Two providers offer ASBTEP, which is available at two levels: treatment and education. Vocational and Employment Services has been rebid with a goal of that process having been completed in the spring.

The next higher level of intervention is Family/Home Based Programs. Multi-Systemic Therapy (MST) and Multi-Systemic Therapy for Emerging Adults (MST-EA), both of which are Family/Home Based Programs, have been historically underutilized, while DCF and community referrals have exceeded capacity. CSSD had developed increased program capacity in preparation for the transfer from DCF to CSSD and had excess capacity as a result. In response, CSSD would like to provide these services to DCF referrals using DCF funding. There would then be a single system rather than over utilization in one system and under in the other. MST-EA and Multi-Systemic Therapy-Family Integrated Transitions (MST FIT) were both recently awarded and will now be statewide. MST-FIT is provided to youth who are in residential services and continues with them through the transition into the community. Finally, Therapeutic Foster Care-Oregon (TFCO) has 10 slots available and targets New Britain and Hartford. The program is currently underutilized, so referrals are being accepted from other parts of the state. Finally, Functional Family Therapy (FFT) was recently procured, and the goal is for services to begin in July.

There are currently three program types under Residential Services. At the lower end of that continuum is Hamilton, a program offered by Boys and Girls Village. Connecticut Junior Republic (CJR) operates both the TRAC program and the Boys' Intermediate Residential Program, while North American Family Institute (NAFI) operates the Girls' Intermediate Residential Program. Typical length of stay is four to five months, and both Intermediate Residential Programs use Dialectical Behavior Therapy (DBT). The programs emphasize a warm hand-off to lower levels of care.

These are all the services offered through CSSD but their kids can access a wide array of other systems. This year's goal is to right size services.

A concern was raised about predetermined treatment time limits and whether there is flexibility around this. Some of treatment duration depends on the length of the sentence through court; however, CSSD is now allowing kids to stay longer than the probation period. Part of the issue is that the system is designed primarily to reduce recidivism and get/keep kids in the community and secondarily to address mental health issues.
An observation was made that prosecutors and probation staff work extremely hard to get the kids whatever services they need, but that we need to be careful to avoid prosecution for the sake of creating access to mental health services. It is important that community providers adequately engage kids so that we're not relying on the juvenile justice system to have the teeth to keep kids in treatment.

A question was raised about the trauma proficiency at the higher levels of care in the system for kids with preverbal trauma. Family based levels of care have trauma services built in or have access to community providers with this skill but are there services that can be provided to a youth whose trauma is severe enough that treatment away from family is warranted. This would not be available within the CSSD system but would be addressed through referral to the behavioral health system.

Peter Brown shared that all courts have licensed clinicians in the courthouses, who serve as independent (i.e., neither on the defense nor prosecution team) clinical advisors to the court. (Slide 5) These personnel see youth with more presentations. Both parties need to agree to clinical consultation or it must be court ordered. They assess both the individual and family issues and while trained in both the clinical and forensic domains, their reports are forensic, not clinical, in nature. Among these staff forensic clinical psychologists are available for particularly complex cases and contribute to the audits of the practices of the court.

Post-adjudication forensic clinical interviews are used in determining placement level need based on risk and clinical needs. (Slide 7) These include a violence risk assessment that drives placement decision, augmented by 1) history of violence, 2) public safety risk (future violence), 3) history of unauthorized absences (i.e., AWOL), 4) history of poor compliance or no progress made in least restrictive settings/interventions, and 5) treatment amenability.

An observation was shared that a judge has often needed to authorize release of clinical information to schools that need the information. It is often an uphill battle for the school to get access to information that might inform its work with the student and make unnecessary the school repeating essentially the same evaluations.

Patricia Nunes described three sets of residential options: per diem beds; staff secure beds, and hardware secure. (Slide 9) All residential programs have 24-hour awake staff. With regard to per diem beds, CSSD contracts for specialized services as needed. Examples include beds provided at Susan Wayne and Waterford Country School. With regard to staff secure residential options for boys, there are 12 beds at the TRAC program at Boys and Girls Village in Milford and 8 beds through CJR in Waterbury. Currently the highest level of residential beds for boys is the hardware secure REGIONS (Re-Entry, Goal-oriented, Individualized, Opportunity to Nurture Success) residential in the Bridgeport and Hartford detention centers of 12 beds each. Girls are placed in the hardware secure Journey House, program of Natchaug Hospital, provides a girls'

hardware secure residential program. CSSD has entered into a contract with Community Partners in Action for a 12-bed hardware secure program to open in Hamden for boys. It is not clear yet whether this will meet the need or additional procurement will be necessary.

An observation was made that while DCF is moving away from congregate care, CSSD is increasing reliance on congregate care. There has been debate about the merits of placing youth with family members as opposed to congregate care. How have our values and assumptions evolved? How do we balance the needs of the child and the needs of the family and the rest of the family, school, and community? We must be careful not to judge families based on the presentation of the child. We look to schools to accomplish tremendous things with totally inadequate funding. Are we recognizing the value that the parents can bring to the assessment process? How do we incorporate the opinion of the parents into the assessment, including the placement decision regarding congregate care?

Within CSSD there is a single statewide residential gatekeeper, who reviews all of the information relevant to placement and matches to appropriate level of residential care or, rarely, recommends to the probation officer against residential placement. (Slide 10) The gatekeeper functions as a liaison between the court and service provider and facilitates the transition into the residential placement. Probation Officers can go back to the court to change placement if warranted.

Detention admissions over the past 10 years peaked in 2012 -2014, roughly corresponding with raise the age legislation. (Slide 11) There has since been a steady decline. There have been roughly 1000 in 2019 year-to-date. In 2017, legislatively required risk screens for detention placement began. Currently a judge's order is needed to sign a youth into detention, and only the highest risk kids who need secure confinement are now sent to detention.

Yale Behavioral Health has a contract for pre-trial detention mental health services. The provide a cadre of clinical staff on-site at each of the detention centers that conducts on-site mental health intake and assessment, suicide safety assessment and planning, crisis intervention, special needs communication plans, Motivational Intervention Cognitive Behavioral Therapy (MICBT), referrals for inpatient hospitalization and/or PECs, consultation to detention staff, 24 hour on-call coverage, medication management, and psychiatric consultation.

The REGIONS residential programs are designed to reduce recidivism risk. Lengths of stay vary from 3 to 6 months. They provide a trauma-informed, therapeutic, and nurturing environment that is supportive and collaborative and utilizes Positive Youth Development. The programs build skills to self-regulate, cultivate prosocial thinking, and develop healthy and supportive relationships with adults and peers and prepare youth to step down to a lower level of care. The REGIONS programs all use DBT for mental health, substance abuse, and anti-social behavior, MST-FIT for family distress, and a variety of strategies for academic disengagement.
Robust CQI that includes third-party audits, model fidelity review, CQI meetings, performance enhancement process;

In response to a question about tracking outcomes from providers, the system that looks at key process measures and outcomes including connection to care and follow up post connection.

Update from Consumer and Family Advisory Council (CFAC): Deferred, as no CFAC member was available to provide the report.

New Business and Adjournment

Co-Chair Jeff Vanderploeg thanked everyone for the presentations. A reminder was provided that the next meeting will be Wednesday, January 15, 2020, 2:00 – 4:00 PM, Beacon Health Options, Hartford Conference Room, Third Floor, Rocky Hill, CT. Jeff then asked for any new business and hearing none, he wished everyone a good holiday season, and adjourned the meeting at 3:55 PM.

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