



STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

Public Hearing Testimony
Human Services Committee
March 12, 2013



S.B. No. 1085 AN ACT CONCERNING A PILOT PROGRAM FOR THE PROVISION OF EMOTIONAL AND BEHAVIORAL HEALTH SERVICES TO YOUTH

The Department of Children and Families (DCF) offers the following comments regarding S.B. No. 1085, An Act Concerning A Pilot Program For The Provision Of Emotional And Behavioral Health Services To Youth.

This bill would establish a pilot program to offer an integrated emotional and behavioral health program for up to 500 youth in Hartford and New Haven counties by July 1, 2014. DCF is **deeply concerned** that this legislation, as drafted, usurps the authority of the Department regarding the provision of mental health services for children; and in fact, makes no reference at all to DCF collaborating in the proposed pilot program. The bill would also establish a working group that includes mental health professionals who serve clients between thirteen and eighteen years of age; mental health clients and other youth between thirteen and eighteen years of age; parents of such youth; and scholars who have studied the needs of this population, but again, excludes DCF from participation.

Since 1975, DCF has been statutorily charged with the responsibility to provide for children's mental health services. The Department operates two facilities that serve adolescents in need of residential behavioral health services, the Albert J. Solnit Psychiatric Center - South and North Campuses (formerly Riverview Hospital for Children and Youth and the Connecticut Children's Place). Through Connecticut Community KidCare, the department also provides funding for a broad array of clinical and other services in the community, including Child Guidance Clinics, Extended Day Treatment Programs, Emergency Mobile Psychiatric Services, Respite Care, Family Advocacy and Intensive Case Management.

Children and families can access state-operated or state-funded community services directly or through referrals from providers in the mental health system. Services are provided on a sliding fee scale, and the majority of service providers are affiliated with a variety of health insurance plans.

Over the past two years, Commissioner Katz and her team have worked to remove the "silos" from the vast array of children's services under the purview of the Department of Children and Families (*see overview of DCF behavioral health services below*). The Department is committed to continuing to enhance community-based behavioral health services and is working collaboratively with our sister state agencies in improving the transition of youth into the adult

service system. We believe that this legislation would only fragment the delivery of mental health services for children.

We welcome the opportunity to educate members of the Human Services Committee regarding our recent initiatives and our plans moving forward.

* * * * *

Overview of DCF Behavioral Health Services

DCF Community Behavioral Health and Substance Abuse Services

Service	Episodes
Psychiatric Outpatient Clinics for Children	22,000+
Emergency Mobile Psychiatric Crisis Service (EMPS)	13,000+
Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)	2,000

Numerous Federal grants and research partnerships

- \$3.2 million Trauma Services in Child Welfare grant (Federal ACF)
- 2 National Institute on Drug Abuse (NIDA) funded research projects on effectiveness of adaptations of evidence-based models (MST and MDT).
- 2 federal SAMHSA Service to Science Awards in collaboration with Yale and CHDI
- \$5 million, 5-year ACF funded Supportive Housing grant

DCF Voluntary Services

- The Voluntary Services Program (VSP) is a DCF operated program for children and youth with serious emotional disturbances, mental illnesses and/or substance dependency.
- The VSP emphasizes a community-based approach and coordinates service delivery across multiple agencies.
- Parents and families are critical participants in this program and are required to participate in the planning and delivery of services for their child or youth.
- The VSP is designed for children and youth who have behavioral health needs and who are in need of services that they do not otherwise have access to. Parents do not have to relinquish custody or guardianship under this program.
- 1,569 families (unduplicated count) were served in FY 2012.

In-Home/Community-Based Behavioral Health Services

Outpatient Psychiatric Clinics for Children

- A multi-disciplinary team of psychiatrists, psychologists, APRNs, clinicians and case managers at 26 contracted outpatient clinics provide psychosocial assessments,

psychiatric evaluations/medication management, and clinical treatment through individual, family and group therapies

- In FY 2012, the outpatient clinics served 22,402 children and their caregivers.

Emergency Mobile Psychiatric Services (EMPS)

- EMPS Crisis Intervention Service is Connecticut's crisis intervention service for children and their families. More than 90% of children are seen at their home, at school or in the community - 85% are seen within 45 minutes of receipt of the crisis call.
- More than 13,814 calls were made to the EMPS system in FY 2012, which developed into 10,560 episodes of care.

Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)

- A 6-month home-based intervention addressing psychiatric disorders of the child, problematic parenting and other family challenges that affect the child's and family's ability to function. Teams of professionals average 4 to 6 hours per week of intervention with the child and caregivers to prevent hospitalization or to return the child to community based outpatient care.
- Serves approximately 2,000 families annually.

Care coordination

- Care coordination uses an evidenced-based child and family wraparound team meeting process to develop a plan of care that uses both the formal and informal network of care to meet the identified needs of the child and family.
- Serves about 1,200 families annually.

Family advocacy

- Family advocates provide support and assistance to the parent/caregiver of a child with a serious mental or behavioral health need. The family advocate works with the care coordinator (above) in the child and family wraparound team meeting process and focuses on providing support to the parent/caregiver.
- Capacity to serve more than 400 families annually.

Extended day treatment

- A multi-disciplinary team of psychiatrists, APRNs, clinicians and direct care staff at 19 program sites deliver an array of integrated behavioral health treatment through individual/family/group therapies, therapeutic recreation, and rehabilitative support services, for a minimum of 3 hours per day/5 days per week through a milieu-based model of care.
- In FY 2012, this program served 1,134 children/youth and their caregivers.

Community Bridge

- Youths and families receive intensive in-home therapeutic support on a 24/7 basis from a clinical team of licensed clinicians and paraprofessional mental health support workers. The clinical team engages with family members and provides necessary

support to the youth in all aspects of community functioning for up to 2 years. Youth without adequate family resources are served in foster homes. The community based service is supplemented by the availability of brief residential placement for purposes of assessment and behavior stabilization.

- This prototype, run by the Village for Children and Families in Hartford, has provided clinical interventions to 20 youth and families in its first five months of operation.

Respite care

- Respite care is a non-clinical intervention, which provides stress relief to parents of children and youth who have serious mental or behavioral health needs. Community or home-based respite is provided for up to 4 hours per week for 12 weeks.
- Annual capacity: 250 children

Functional family therapy

- An empirically grounded, family-based intervention to improve family communication and supportiveness while decreasing negativity.
- 519 youth and their caregivers received services in FY 2012.

Multi-dimensional family therapy (MDFT), including “special population”

- Family-based intensive in-home treatment for adolescents with significant behavioral health needs and either alcohol or drug related problems, or who are at risk of substance use. Provides individual, caregiver and family therapy, and case management.
- 713 families received services in FY 2012.

Multi-systemic therapy (MST)

- Intensive family- and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders -- their homes and families, schools and teachers, neighborhoods and friends.
- 215 families received services in FY 2012.

Multi-systemic therapy (MST) for special populations

- Special populations include problem sexual behavior, transition age youth, and parole youth re-entering the community.
- 112 youth and families received services in FY 2012.

Multi-systemic therapy (MST) “Building Stronger Families”

- Intensive in-home treatment for families with maltreatment and substance abuse issues.
- 24 families received services in FY2012.

Re-entry and family treatment

- MDFT for parole youth with substance abuse treatment needs.
- An estimated 75 youths received services in FY 2012.

- **Recovery case management for families with substance abuse**
 - Intensive recovery support services for families with children at risk for removal or at the point of removal.
 - Annual capacity: 330 families

- **Family-based recovery**
 - Intensive in-home family treatment combining evidence-based substance abuse treatment with a preferred practice to enhance parenting and parent-child attachment.
 - Annual capacity: 144 families

- **Juveniles Opting To Learn Appropriate Behaviors (JOTLAB)**
 - Rehabilitative treatment for youth with problem sexual behaviors that provides comprehensive clinical evaluation, individual psychotherapy, family counseling, psycho-educational therapy groups, and social skills building groups.
 - In FY 2012, 99 children and their caregivers received services.

- **Integrated family violence program**
 - In-home and clinic-based services for families where domestic violence has been identified. Core services include safety planning for survivor and child, trauma focused work with children, interventions focused on repairing and healing relationships, and batterer interventions.
 - Annual capacity: 360 families

- **Adolescent substance abuse outpatient**
 - Substance abuse screening/evaluation, individual, group and family therapeutic interventions in a clinic based setting.
 - 358 adolescents received services in FY2012.

H.B. No. 6606 AN ACT CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES
--

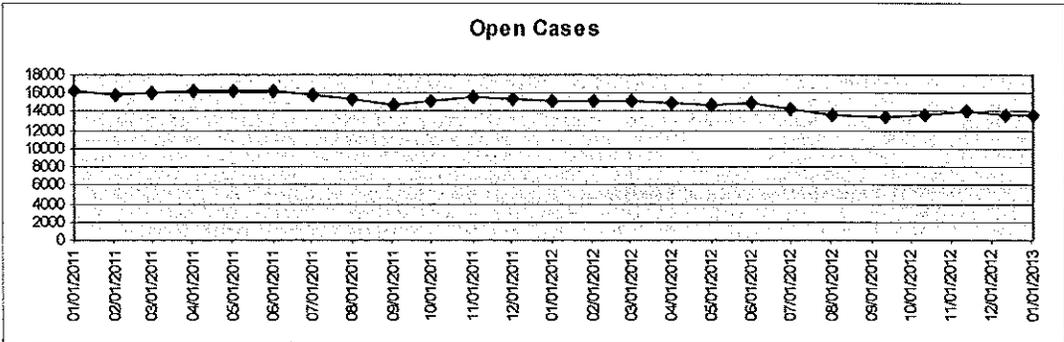
The Department of Children and Families (DCF) offers the following comments regarding H.B. No. 6606, An Act Concerning the Department of Children and Families.

This bill would have the Commissioner of Social Services, in consultation with the Commissioner of the Department of Children and Families, conduct a study of programs for children and families offered by DCF. While we recognize that this is probably drafted as a "dummy bill" for potential future legislative action, we question why the language has one executive branch agency assessing the programs of another sister agency.

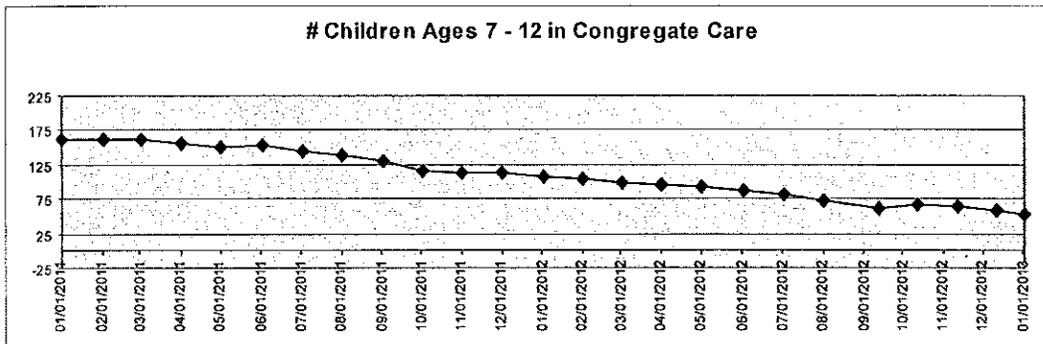
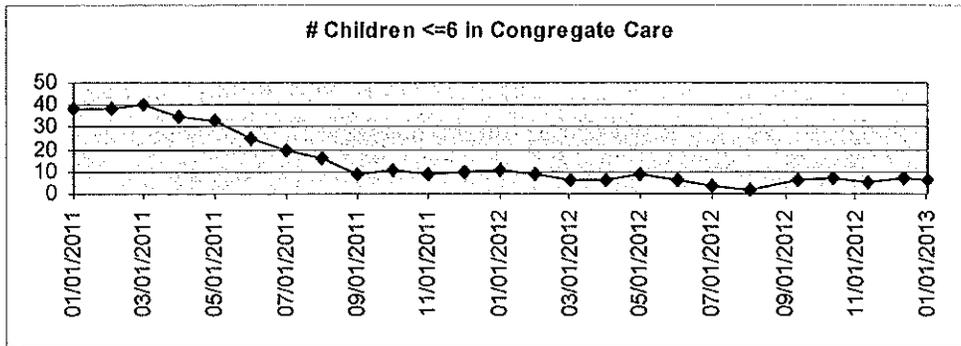
We welcome to opportunity to work with the Human Services Committee and would like to share information regarding our goals to improve services to our children and families so as to achieve better outcomes. We are proud that the Department has made great progress and would like to update the Committee on our efforts in these areas.

Our first major initiative was implementation of the principals of the Strengthening Families Practice Model. This model is one of greater family support and involvement through practices such as family engagement, purposeful visits, family centered assessments, and child and family teaming - enabling families to take control and responsibility of their own treatment and their own lives. The Department has trained over 2,000 agency staff in this approach, with statewide implementation beginning earlier this year.

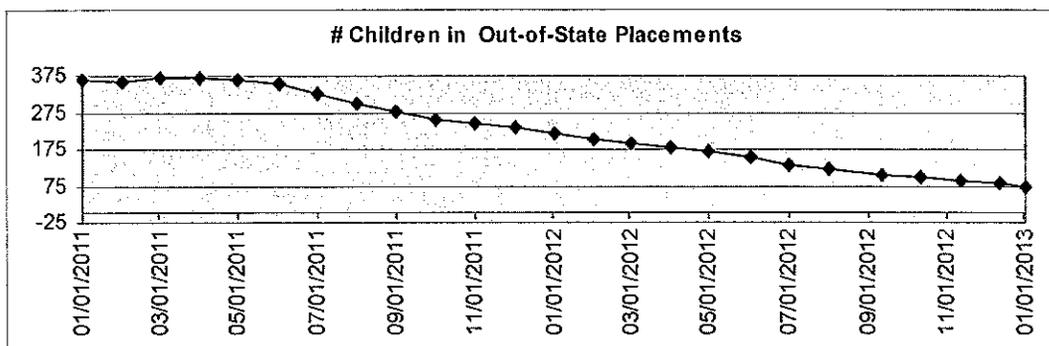
As part of the Strengthening Families Model, the Department launched the use of the Differential Response System (DRS), a component of the Strengthening Families Practice Model. DCF had been working towards this goal for several years and began implementation on March 5, 2012. DRS has given the Department the ability to treat reports differently based on the level of risk. Implementation studies indicate lower rates of removals and repeat maltreatment and greater family satisfaction, with no decrease in safety. Families are classified in a dual-track system that allows DCF to respond and provide assistance with the prevalent issues of neglect and poverty in a less adversarial manner. This gives families the assistance they need and meets the greater goal of keeping kids in their homes with their families. Since implementation of the DRS model, the Department's caseload has been reduced by 9%.



The Department has made great progress in reducing the use of congregate care settings for children under the age of 12. The use of congregate care should only be reserved for treatment, not as a general placement. Additionally our youngest children should be placed in family settings whenever possible. The percentage of children in congregate care on January 1, 2013 declined to 23.5%, compared to 29.8% of all children in care in January 2011. The number of children under the age of 6 in congregate settings in January 2011 was 38. In January 2013 the number was 6. Similarly, the number of children ages 12 and under was 201 in January 2011 and had declined to 60 in January 2013.



The Department has made its greatest progress in the use of out-of-state residential treatment placements. In January 2011, 364 children were in out-of-state placements and in January 2013 this number had been reduced to only 70 children, an 81% decrease. Children being served in-state have lengths of stay that are less than half of those of children in out-of-state placements. While in in-state placements, families are allowed to be engaged in the child's treatment and are given the tools and support they need to bring their child back home.



These results have been achieved by providing community-based service options in place of congregate care and when a congregate placement is required, these options allow children to return to a family setting more quickly.

The changes in DCF's service approach are important to the budget process because it has allowed the Department to save millions of dollars while maintaining service quality.

Although we have made great progress, we feel there are further improvements to be made and many more opportunities to support the children and families that we serve. To that end, the Department will be implementing new initiatives that will continue to move forward the family centered approach along with trauma informed practices, application of neuroscience, development of community partnerships, while working towards achieving all the Juan F. Exit Plan outcomes.