



STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

Testimony of Commissioner Joette Katz
Bipartisan Task Force on
Gun Violence Prevention and Children's Safety
Mental Health Services Working Group



Good morning Senator Harp, Representative Wood and members of the Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety. The unspeakable horror that took twenty young children and six brave adults from their families naturally has spawned a search for answers. While no satisfactory response may emerge, one important part of the discussion has focused on children's mental health. The Department of Children and Families has children's mental health as one of our mandates and, as commissioner, I welcome the attention to this complicated subject -- particularly in light of this incomprehensible tragedy.

As Governor Malloy pointed out last month, the children's mental health system needs continued improvements, and I am committed to implementing reforms. While progress has been made under the current administration -- notably the share of children receiving treatment in congregate settings has declined 26 percent and the number of children sent out of state to receive treatment has declined 81 percent -- much improvement remains necessary. That is why we are initiating a number of further reforms.

Within the next two weeks, the Department of Children and Families expects to launch a new Request for Proposals entitled "The Community Bridge." It is intended to provide intensive community based treatment for youth who are experiencing mental health or behavioral challenges that are of sufficient severity that a residential placement would have historically been the treatment of choice. The Bridge is envisioned as a flexible array of family-based, community, residential and aftercare programs that are closely linked and integrated. Most services will be oriented to an in-home venue and will be rooted in evidenced based practice. Youth referred to community based services will be 11-18 years of age and have complex behavioral, emotional, and physical needs that would likely necessitate out-of-home care if a successful intervention were not implemented.

In certain circumstances, however, a youth may require more intensive individual care to address a particularly difficult pattern of behavior. In such a case, in-patient stabilization may be needed to restore the youth to behavior that is acceptable and manageable within the family setting. The therapeutic focus of such treatment will be on decreasing unsafe and high risk behaviors and increasing pro-social skills, emotional competency, and self-control. This short term stabilization will provide a therapeutic 24-hour living situation with supervision, structure, and multi-disciplinary, multi-modal therapies. Youth at this level of care will have access to consultation from a psychiatrist to monitor the effectiveness of medication. Treatment is less intensive than hospitals and residential levels of care and can be a diversion from initial hospitalization for those clients needing less intensive treatment in a structured residential setting. In the Community Bridge system, intermediate short term stabilization is part of a treatment continuum, not a treatment destination.

For those youth who require a longer term of inpatient treatment, the Albert J. Solnit Children Psychiatric Center remains available. Based on a recent data review, the Solnit Children Center is in the process of change and reorganization to better meet the needs of Connecticut's youth and their families. Upon completion of this conversion, the Solnit Center will be a 118 bed facility treating youth ages 13 through 17. On its North Campus, located in East Windsor, current residential beds will be converted to Psychiatric Residential Treatment Facility (PRTF) beds, allocated to adolescent boys, ages 13 through 17, with complex behavioral health care needs that include but are not limited to: Aggression, self-harm, substance abuse and low-risk problem sexual behavior. There will be a total of 38 treatment beds on this campus along with 2 emergency beds that social workers can access through the Department's Careline. The conversion on the East Windsor campus will be complete by September 1, 2013. Fifty two inpatient psychiatric beds will remain at the Solnit Center's South Campus, located in Middletown Connecticut. These beds will be for both genders ages 13 through 17. The 16 PRTF beds for adolescent girls, 13 through 17 will also remain in operation. Finally, the facility will close two inpatient psychiatric units currently serving very young children and opening them both as PRTFs: one unit will provide care to adolescent girls, 13 through 17, while the other will serve both genders, ages 12 through 15 with complex behavioral health care needs that include but are not limited to: aggression, self-harm, substance abuse and low-risk problem sexual behavior.

Notably, the Department also is making strides in expanding the array of in-state resources for youth on the autistic spectrum. The services will include evidence-informed, community based programming as well as closely linked residential services and family supports. Services will be available for both males and females 9 to 18 years old. Additionally, in February, the Department will open six intensive treatment slots for adolescent girls with trauma histories. These girls have traditionally been served out of state.

Attached to my testimony is a brief description of existing behavioral health programs offered through the Department of Children and Families.

The Department has been working diligently with many community providers, physicians and psychiatrists who have identified service gaps and who have helped to design creative solutions. Children's mental health will need more improvements still, but if there is any good that could possibly come from such extreme horror as befell Newtown and Connecticut, it may very well be a serious and complete discussion of how to improve services for troubled children. I welcome that development.

Thank you for the opportunity to appear before you today. I look forward to the opportunity to continue our dialogue as you move forward with your important work.

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+
IICAPS (Intensive In-home psychiatric services)	2,000

Numerous Federal grants and research partnerships

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

DCF Voluntary Services

- The Voluntary Services program is a DCF operated program for children and youth with serious emotional disturbances, mental illnesses and/or substance dependency.
- The Voluntary Services Program 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 Voluntary Services Program 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 SFY12.

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 SFY 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 and 85% within 45 minutes of receiving the crisis call.
- More than 13,814 calls to the EMPS system SFY2012, 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 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 SFY2012, 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, delivered within the family setting by 4 providers, 5 teams that are grant-funded.
- 519 youth and their caregivers received services in SFY2012.

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 SFY2012.

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 SFY2012.

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 SFY2012.

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

- Intensive in-home treatment for families with maltreatment and substance abuse issues.
- 24 families received services in SFY2012.

Re-entry and family treatment

- MDFT for parole youth with substance abuse treatment needs.
- An estimated 75 youths received services in SFY2012.
- **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 SFY2012, 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 SFY2012.