

STRENGTHENING THE FOUNDATION:

Analysis of Connecticut's Outpatient Mental Health System for Children

A report prepared for the Connecticut Department of Children and Families

Developed by the Connecticut Center for Effective Practice of the
Child Health and Development Institute of Connecticut

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EXECUTIVE SUMMARY

The current report presents findings from a study of the strengths and needs of routine outpatient mental health treatment and provides recommendations for system improvements. In this report, routine outpatient mental health treatment is defined as services provided to children and families, primarily in office-based settings, using individual, family, and group therapy techniques, and including case management and other supporting services. Important characteristics of outpatient services in Connecticut, including characteristics of providers, clients, and services provided, are not well understood. In addition, there has been limited work conducted to identify and prioritize needs for service improvements. The current study was designed to begin to address these issues.

The Department of Children and Families (DCF) commissioned and paid for this study through a Personal Service Agreement with the Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute (CHDI), with additional funding and support from the Children's Fund of Connecticut and the Connecticut Health Foundation. The decision to examine outpatient treatment was based in part on a recommendation from the CCEP Advisory Board, which comprises state agency administrators, mental health service providers, researchers, and family advocates. The target audience for this report includes all parties who are interested in routine outpatient mental health treatment for children, including but not limited to the following stakeholders: DCF, outpatient treatment providers, children and families, family advocates, and funders. The findings and recommendations from this report can contribute to a collaborative process among these stakeholders to identify and prioritize areas for statewide service improvements in routine outpatient treatment and to plan for how these services improvements will be implemented.

Children with mental health needs in Connecticut require a comprehensive array of services and supports. Routine outpatient mental health treatment is one of the most fundamental programs in a comprehensive service array, serving more children with mental health needs each year than any other mental health service. Statewide efforts to reduce reliance on more restrictive levels of mental health care (e.g., residential treatment, inpatient hospitalization) and increase community-based treatment options have expanded, particularly since implementation of KidCare in 2005. It is unclear, however, whether expansion of the routine outpatient treatment system has been sufficient to meet the demand for services. Increased attention to routine outpatient treatment would help establish a strong foundation for Connecticut's community-based children's mental health treatment system, and prepare this system to meet the current and future needs of Connecticut's children and families.

The study sought input from a number of stakeholders in outpatient treatment including representatives from the following: parents and family members; the Connecticut Community Providers Association; Department of Children and Families (DCF) Central Office, Area Office, and Area Resource Group (ARG) staff; Child Guidance Clinic (CGC) and other routine outpatient program clinicians and administrators; and ValueOptions Intensive Care Managers. Input from a diverse group is intended to bring together the best thinking and experience related to outpatient treatment. Survey data were collected from 32 agencies across the state and site visits were conducted with nine agencies. Participating agencies served the top ten most populated communities in Connecticut; thus, the sample referenced in this report is representative of the largest segment of children and families receiving mental health services from community-based providers in the state.

Study methods included interviews, focus groups, and online surveys. Key practice areas and characteristics were examined and findings are summarized below in each area, including:

1. Characteristics of clinicians and agencies
2. Characteristics of children and families served
3. Indicators of client and case complexity
4. Screening and assessment practices
5. Service delivery practices
6. Staffing and workforce development
7. Data collection, analysis, and application

One of the goals of this report was to examine quantitative data on characteristics of clients and service delivery practices. The data infrastructure and internal reporting processes at each outpatient clinic varied a great deal, with some providers producing extensive reports on their data and other providers relying on the summary reports provided by the Connecticut Behavioral Health Partnership (CT BHP) or a statewide data reporting system. Furthermore, some providers have access to data from the past month, the past quarter, or the past year, and these time frames differ among providers. One challenge in this report was to find a common way to summarize quantitative data given these constraints. In this study, we asked for a level of data that all providers were able to produce, often in the form of percentages. When summarizing percentages, we chose to analyze these data descriptively by providing medians and ranges.

Summary of Findings

The Role of Outpatient Mental Health Treatment in Connecticut's System of Care

Routine outpatient treatment was recognized as a critically important program in the system of care. Outpatient treatment facilities see a diverse range of clients and often serve children waiting for entry into, or stepping down from, higher levels of care. As data collection and reporting systems reach full implementation, the data on outpatient enrollment trends should be interpreted cautiously. Network-level BHDS submissions from CGCs in Fiscal Year (FY) 2009 indicate the following:

- An average of 2,309 children were admitted to CGCs each quarter
- An average of 1,641 children were discharged from CGCs each quarter
- Median length of stay in CGCs was 11.6 months; mean length of stay was 17.2 months

Furthermore, data submissions to the Programs and Services Data Collection and Reporting System (PSDCRS) during the first three quarters of FY 2010 indicate the following:

- An average of 2,731 children were admitted to CGCs each quarter
- An average of 1,889 children were discharged from CGCs each quarter
- Median length of stay in CGCs in Quarter 3 was 6.9 months; mean length of stay in Quarter 3 was 12.4 months

The data summarized above indicate that outpatient treatment is a widely used and vital part of the mental health services array for children and families in Connecticut. Despite concerns about data quality, the number of children remaining in outpatient care appears to be rising. Planning for a possible increase in demand will be helpful for ensuring that the existing outpatient service system is prepared to meet the needs of children and families seeking routine outpatient services. Attending to the issues that are facing the outpatient system, and planning for service improvements, will help ensure that children and families have access to high quality care that will result in positive outcomes.

Characteristics of Clinicians, Administrators, Agencies, and Clients Served

Responses to two versions of an online survey (Agency Survey completed by Directors, Clinician Survey completed by clinicians) were used to estimate socio-demographic and employment characteristics of the professionals providing and managing the delivery of outpatient treatment, as well as the children and families they serve. Although 32 agency administrators responded to at least part of the Agency Survey, approximately 18 administrators responded to most or all of the survey. Respondents to the Agency Survey revealed the following characteristics among outpatient administrators; most of the administrators were:

- Over the age of 40
- Caucasian
- Female
- Hold an advanced degree in psychology or social work
- Licensed by the state to provide clinical services

The following characteristics applied to most of the clinicians who responded to the Clinician Survey:

- Under 40 years old
- Caucasian

- Employed full time
- Hold at least a Master's Degree in psychology, social work, or a related field
- Endorsed a cognitive-behavioral theoretical orientation
- Had been employed for less than ten years
- Few spoke fluent Spanish

There was a wide range in the number of clinical staff at outpatient clinics, with some very large and some very small clinics represented. There were approximately 23 agency administrators that responded to most items to describe outpatient clinics. Findings include:

- The average total number of clinical full time equivalents (FTEs) was 7.8 (s.d.=5.7) with a range of 0.60 to 26.0
- The number of psychiatry hours provided to children varied from 2 to 500 hours per month, with a median of 46 hours
- The outpatient clinics that were surveyed reported few exclusionary criteria for outpatient treatment; however, when they did so, outpatient providers were most likely to exclude from outpatient services children with substance abuse disorders and significant mental retardation or developmental disabilities.
- Exclusionary criteria point to potential gaps in the system of care and highlight the importance of ensuring that treatment options are available to these youth

Agency administrators also reported the characteristics of children and families served in their outpatient clinics. Because administrators reported their data in percentages, summary data that is provided on the participating agencies is reported using median percentages as the best indicator of central tendency. The full report summarizes these characteristics with median percentages and ranges of reported percentages. Among the surveyed clinics, the following characteristics were found:

- The median reported percentage of adolescents (13 to 17 years old) served by responding outpatient clinics was 39.5% and the median reported percentage of younger children (4 to 7 years old) served was 17.5%.
- Across agencies, the median reported percentage of children that speak English was 84% and the median reported percentage of youth that speak Spanish only was 5%
- The median reported percentage of Hispanic youth served was 20.5%. In addition, the median reported percentages of Caucasian and African-American youth were 50% and 14.5%, respectively.
- The median reported percentage of children living with their biological parents at intake was 71%
- The median reported percentage of children covered by Medicaid was 70%
- The median reported percentage of children involved with DCF was 43.5%
- In terms of referral source, the highest median reported percentage was for children referred by parents (38%)

Because median reported percentage data is an overall estimate of characteristics across agencies, the data from the Agency Survey differ slightly from recent Behavioral Health Data

System (BHDS) data; however, it is largely consistent. BHDS findings indicate more children in the 4 to 7 year old age range, fewer in the 13 to 17 year old age range, more children of Hispanic ethnicity, and fewer with DCF involvement. In terms of socio-demographic information, clinicians and children served differ in terms of gender, race/ethnicity, and Spanish language proficiency. This underscores the importance of ensuring a culturally diverse and culturally competent outpatient workforce.

Treatment Capacity and Access

All stakeholders that were part of this study are interested in improving treatment capacity and access and improving attendance, as well as increasing outpatient clinic revenues. Trend data on CGC enrollment suggests that the number of children remaining in care could be increasing. Furthermore, the average caseload among full-time clinicians responding to this survey was 29 clients, with variability among other types of clinical staff such as supervising clinicians, psychiatrists, and interns. Our results suggest that at least some clients are not seen weekly, which allows clinicians to see a larger caseload, thereby increasing access for new clients. Among the clinics surveyed, the average number of monthly referrals, scheduled intakes, and completed intakes was 49.7, 40.1, and 34.0, respectively. Some agencies advocate a long-term treatment episode of care whereas others emphasize brief episodes of care. Length of treatment can have an effect on treatment capacity and access.

Quantitative and qualitative data suggest potential concerns about treatment engagement, defined as attending six or more treatment sessions. Existing research suggests that less than one-half of all children that are referred for outpatient treatment engage in treatment for six or more sessions. This is a possible area for improvement in Connecticut. Although the Enhanced Care Clinic (ECC) initiative has significantly reduced the length of time from referral to intake, there remain concerns on the part of some stakeholders about the length of time from referral to treatment. Addressing treatment barriers also could improve attendance and treatment engagement rates. All stakeholders are concerned about treatment attendance and no-show rates as it pertains to maintaining productivity and financial viability. Increased family engagement and enhanced business practices can help address financial concerns and enhance treatment capacity to meet the demand for services.

Case Complexity, Case Management, and Family Engagement

The theme of increasing client complexity in outpatient treatment was relatively consistent across all stakeholder groups we encountered. The agencies that were part of this study reported that their clients were more likely to present to outpatient clinics with significant case management needs. The top five most identified indicators of case complexity included:

- Treatment requires parent/family involvement
- Treatment requires communication with other agencies
- Child has co-morbid conditions
- Family is experiencing significant poverty

- Parent has a mental health diagnosis

In addition to these issues, a significant portion of children and families seeking outpatient treatment have substance use issues, maltreatment history, and DCF involvement. These conditions often require significant case management and there are substantial limitations to reimbursing some case management services under current Medicaid regulations. Furthermore, there are concerns among providers that Medicaid regulations are not well articulated and integrated across systems. Currently, there is limited use of standardized screening and assessment instruments to assess indicators of case complexity and treatment need in order to determine level of need and guide treatment planning.

Given these circumstances, the families and other stakeholders we surveyed described the need for more case management for families in outpatient treatment. Balancing mental health business practices with a commitment to maintaining high quality of care is a challenge, particularly during difficult economic times. Case management in children's mental health is a large and often hidden cost to agencies and some of these activities can be difficult to reimburse. Despite this, some of the outpatient clinics that were part of this study have increased their case management to clients, particularly for off-site case management (e.g., at schools). Consistent attention to and monitoring of case management activities and standards would help assess the need. Within existing rules and guidelines, creativity in seeking reimbursement for case management activities would help enhance this important aspect of outpatient treatment.

There was no disagreement among stakeholders on the importance of family engagement as a particularly important aspect of case management. Clinicians highlighted several indicators related to family engagement when asked to report the most important factors contributing to positive outcomes. Other stakeholders, including parents, also reported that there is a need for enhanced focus on family engagement. A comprehensive statewide initiative on family engagement in outpatient treatment could have important effects on treatment attendance, outcomes, and outpatient revenue.

Screening, Assessment, and Service Delivery Practices

Intake procedures were relatively consistent across clinics that were part of the study, although some used intake coordinators and others required clinicians to conduct their own intakes. Intake protocols were common, most were conducted in one or two sessions, and most followed a bio-psycho-social approach. Our findings suggested that 80% of surveyed clinicians reported using screening and assessment instruments during the intake process. Our interviews indicated that the Ohio Scales are commonly used because DCF requires this measure for outpatient treatment; however, the use of other screening and assessment measures to identify treatment needs and guide treatment planning was variable. Parents requested more efficient sharing of intake data within and across programs and services in order to reduce redundancy. Further ECC initiatives will focus on enhancing the capacity of clinics to assess and meet the needs of youth with co-occurring psychiatric and substance abuse conditions.

Stakeholders reported limited access to assessment and treatment for children with substance abuse, mental retardation and developmental disorders, and autism spectrum disorders. Currently, there is limited availability of treatment specializations in outpatient clinics, which will be an upcoming focus for ECCs. Families requested increased access to alternative interventions in the community besides office-based therapy and described the importance of early discharge planning to ensure that children remain in their natural surroundings with a sustainable network of services and supports. In terms of time allocation, clinicians reported that they spent most of their time in individual therapy and family therapy, case management, and completing clinical paperwork.

Across all system stakeholders, the importance of good intake assessment procedures was acknowledged. Many stakeholders believed that in addition to a bio-psycho-social intake process there would be tangible benefits to using standardized instruments to assess and track level of treatment need, identify strengths, and use that information to guide the treatment process. Furthermore, many stakeholders expressed the importance of ensuring that intake and assessment information is transferable across clinics and can follow cases regardless of their point of access in the mental health service system.

Evidence-Based Treatments

Evidence-based practices and treatments (EBTs) have become an important part of the service array in Connecticut and across the nation; yet several implementation barriers remain. The penetration of EBTs in routine outpatient settings lags behind intensive in-home settings, although by the end of FY 2010, sixteen outpatient clinics will have received comprehensive year-long training in the DCF-funded Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model. With the exception of TF-CBT, reported practice of EBTs in outpatient settings remains relatively low. Some outpatient administrators noted the challenge of identifying appropriate EBTs for the outpatient setting; however, most reported that they recognized the importance of EBTs and the emphasis on outcome driven practice.

Our findings suggest that implementation barriers exist at the individual, agency and system levels, and these barriers tend to be conceptual and logistical in nature. In the area of conceptual barriers, some providers reported the perception that manualized EBTs do not have sufficient flexibility to meet the complex needs of their clients. In the area of logistical barriers, providers and administrators report that it is difficult to obtain the necessary training and ongoing supervision for staff, as well as the necessary quality assurance to maintain treatment fidelity. Some providers reported concerns that EBTs are more expensive to implement than usual practices because of the increased need for supervision, meeting time, collateral contact and planning. Several outpatient providers, however, report that their use of EBTs contributes to increased productivity and client outcomes. Providers also reported a need for enhanced capacity to collect and analyze outcome data in order to support the successful implementation of EBTs. In order for EBTs to be successful, agency staff acknowledged that buy-in and support from every level within the agency was vital. Outpatient providers that were part of this study indicated that EBTs were an important part of the future, but indicated that implementation supports were necessary to ensure their successful integration into routine outpatient settings. The use of Learning Collaborative

methodology to disseminate and sustain EBTs could be an important part of future implementation efforts.

Staffing and Workforce Development Issues

Outpatient clinicians are the most important resource within the outpatient treatment system. All system stakeholders we interviewed agreed that outpatient clinicians are hard-working and dedicated to the children and families they serve. All stakeholders also agreed with the need to hire and retain a cadre of well-trained outpatient clinicians that have strong incentives to remain employed in outpatient treatment settings. Clinicians and administrators we interviewed reported that low pay, burnout, and limited opportunities for training, professional development, and career advancement were the primary factors related to staff turnover. In the face of staff turnover and budget constraints, outpatient programs hire interns and practicum students to round out their clinical workforce. Some system stakeholders reported that a few providers rely excessively on interns for service delivery. Because interns generally leave after one year of employment, clinics that utilize interns as service providers are more likely to face the challenges associated with increased treatment disruptions. The importance of adequately preparing graduate students for clinical work was highlighted, as was the importance of hiring a culturally and linguistically diverse and competent workforce. Outpatient administrators reported that clinician retention and job satisfaction were supported by intensive in-service training opportunities, support and stability of agency leadership, clear and reasonable expectations, and competitive compensation and benefits.

Data Collection, Analysis, and Application

Data collection is a part of everyday clinical practice for most outpatient programs, as evidenced by DCF and CT BHP requirements to collect and report basic demographic information as well as Ohio Scales outcomes data. Monthly and quarterly reports from CT BHP are provided for clinics designated as an ECC. Wide variability exists among clinics in their *application* of data. All stakeholders reported that data has not been extensively utilized to monitor treatment outcomes, inform outpatient treatment practices, or guide treatment decision-making. Clinicians' perceptions about outcomes data suggested that they are least likely to have data shared with them which can compromise the ability to use data to inform treatment. Historically, the causes behind problems with data collection and application have been cyclical in nature. Outpatient program administrators that were surveyed reported that, although much data has been collected, relatively little data has been reported back to sites. On the other hand, DCF indicates that the quality of the provider data submissions has been variable, which significantly limits the usefulness of these data for analysis and reporting. The recent implementation of the Program and Services Data Collection and Reporting System (PSDCRS) has significant implications and potential for outpatient treatment, as does continued use of CT BHP utilization reports for ECCs. Many system stakeholders noted a need for enhanced use of data to guide continuous quality improvement, outcomes evaluation, and advocacy. Several indicators, besides Ohio Scales outcomes, were suggested as potentially useful indicators of service quality and client outcomes. Indicators included stability of the child's living situation, maltreatment rates, progression to higher levels of care, and rates of closing cases due to lowered risk and improved functioning.

Systems-Level Issues

Gaps in other areas of the mental health service system can create strain on outpatient departments. System stakeholders reported that routine outpatient treatment often is used for children that are waiting for, or stepping down from, higher levels of care. In addition, many children often present for multiple episodes of outpatient treatment. Parents and clinicians reported that access to other services in the mental health service array was important. They reported a shortage of non-therapeutic, natural supports and services in the community, such as school- and community-based recreational programs and activities, as well as housing, legal, and financial services. Residential treatment and psychological testing also were reported as least accessible in the broader service system.

Although it is clearly not the case for all clinics and all DCF Area Offices, several stakeholders interviewed reported long-standing tensions between DCF Area Offices and the CGCs in their catchment areas. In addition, the landscape of DCF Area Offices has changed significantly, resulting, in some cases, in disrupted relationships. Further, outpatient providers note that managing the requirements and expectations of multiple licensing and funding bodies can create fragmentation and inefficiencies in business and clinical practices. Systems issues could be eased through enhanced collaboration and coordination between DCF and outpatient providers as well as alignment of licensing and funding requirements.

Recommendations

The outpatient mental health system serves more children than any other program, and the number of children served appears to be growing. Outpatient clinicians and administrators are dedicated and hard-working professionals that often face significant challenges to service delivery. In addition, DCF's role can be challenging due to the variability among providers in their service delivery practices and their overall service quality. In order to support this vital service in the children's mental health service array, focused attention devoted to service improvements in several key areas would be beneficial.

It is recognized that in these difficult economic times, sufficient funding will not be available to support all of these recommendations; however, many system and practice level improvements can be accomplished by utilizing existing resources in innovative ways. DCF and all other outpatient stakeholders should work together to articulate shared concerns and goals, identify priority recommendations from this report, and develop and implement plans for improvements. Specific recommendations in key practice areas are summarized below.

1. Enhance Collaboration to Support Outpatient Treatment

- a. As the outpatient service contractor, it is recommended that DCF convene regular Child Guidance Clinic meetings with managers from all contracted providers, and include in these meetings a diverse group of stakeholders that includes youth and families.

- i It would be beneficial for this group to consolidate goals from all outpatient initiatives, align goals with one another, and identify a common vision for program improvement.
- b. An annual improvement plan can be developed to identify priorities, establish a timeline with goals and objectives, and develop an implementation strategy for the outpatient treatment system.
 - i Workgroups and subgroups can be helpful for implementing strategies on specific aspects of outpatient funding and service delivery.

2. Treatment Capacity and Access

- a. Development of a quality assurance database would help facilitate collecting, analyzing, and reporting case flow indicators such as number of referrals, number of scheduled and completed intakes, length of stay in treatment, number of attended sessions, and others. This database could be used to create benchmarks for these indicators and develop initiatives to monitor and improve service delivery efficiency. These data then can be reported back to sites on a monthly and quarterly basis.
- b. Clinical decisions regarding treatment planning, discharge and future recommendations should be informed by ongoing data collection on treatment response and outcomes. This can help address service delivery inconsistencies and inefficiencies.
- c. Promoting enhanced business strategies across all CGCs would be beneficial to improving the quality of service delivery as well as generating additional revenue. This revenue could then be used to address existing financial gaps reported by outpatient providers.
- d. Access to services can be improved by closely monitoring and reducing the amount of time from referral to the beginning of treatment, using strategies similar to the ECC initiative.

3. Case Complexity and Case Management

- a. With the reported increase in case complexity, enhanced case management becomes a vital component of service delivery. Funding for case management services can be explored by further leveraging Medicaid dollars and seeking additional external funding through grant support and fundraising.
- b. Paraprofessionals, parents, and interns can be utilized as additional resources to assist in case management. Peer specialists at CT BHP have been well received by parents and have resulted in improved satisfaction with services and similar approaches could work in outpatient departments. Interns can be used for case management to enhance their training and preparation for the workforce.
- c. Explore opportunities for outpatient clinics to receive training on Medicaid regulations and learn about strategies to maximize reimbursement for case management. These training opportunities should also focus on better articulation and integration of Medicaid regulations across systems.
- d. It is recommended that outpatient stakeholders increase monitoring and quality assurance focused on case management activities; an important element of high quality outpatient treatment.

- e. Incorporating treatment planning and case management activities into the treatment session, when possible, can enhance family-driven care and full family participation in treatment decision-making. This is consistent with best- and evidence-based practice in children's mental health.
- f. In general, enhanced business practices in outpatient clinics are highly recommended.

4. Family Engagement

- a. Initial and sustained family engagement in service planning and delivery consistently was identified as an important part of outpatient treatment. One way to promote family engagement is to involve outpatient providers and family members in a statewide initiative, similar to the recent learning community that DCF implemented with Extended Day Treatment programs.
- b. By enhancing case management strategies through peer specialists, family members, and possibly interns, barriers to family engagement and treatment attendance can be reduced.
- c. Service planning and delivery that focuses on child and family needs is essential to high quality outpatient care. By taking lessons learned from the current Mental Health Transformation State Incentive Grant Wraparound Initiative, the state can work with all stakeholders to disseminate the Wraparound approach in order to enhance family-driven treatment.
- d. By tracking and monitoring family engagement as an indicator of treatment quality, family engagement practices can be enhanced. Many stakeholders believed that cases were closed too quickly after a few missed appointments, without sufficient attention to identifying and addressing treatment barriers.

5. Screening, Assessment, and Service Delivery Practices

- a. Increase the use of standardized screening and assessment tools that will facilitate consistent assessment of child and family functioning, ongoing treatment need, treatment response, and treatment decision-making.
- b. Include in all screening and assessment practices an enhanced focus on identifying child and family strengths and incorporating them into treatment and discharge planning.
- c. Identify and promote policies that facilitate sharing of screening and assessment data within and between programs and agencies to minimize the redundancies experienced by children and families.
- d. Use screening and assessment data to inform the identification and delivery of evidence-based and best-practice treatments. For example, the identification of trauma, depression, or anxiety can be used to further identify needs and select evidence-based treatments to meet those needs.

6. Evidence-Based Treatments

- a. Providers, DCF, CT BHP, and other stakeholders can work together to identify, adopt, and disseminate a range of outpatient evidence-based practices and treatments to meet identified needs within the system of care. For example, exploring the adoption of EBTs for children with autism, children with internalizing behavior disorders, young children, and children with oppositional behaviors whose parents

- require behavior management training is one way to enhance the current service array.
- b. Identify the needs of provider organizations and work together to meet those needs in order to successfully implement and sustain evidence-based practices within outpatient services.
 - c. Include in all EBT dissemination efforts a focus on quality assurance and evaluation and support ongoing outcome data collection and analysis.
 - d. When possible, utilize comprehensive and systematic approaches to implementation, such as the Learning Collaborative methodology, to disseminate EBTs. Lessons learned from the TF-CBT initiative that was successfully implemented in outpatient departments can be applied to adopting and disseminating new EBTs.
 - e. Training and supervision of EBTs should be comprehensive, include training at multiple levels within the provider organization, and promote organizational change to support the sustainability of the EBT.
 - f. Address logistical barriers such as the amount of time and financial support required to train and supervise EBTs.
 - g. Creatively explore ways to fund EBTs and ensure that they can be sustained after grant funding ends, using lessons learned from the implementation of other EBTs in Connecticut. Explore special incentives or enhanced reimbursement rates for agencies that implement EBTs and achieve improved outcomes.
 - h. Develop and promote EBTs in specialty areas that meet the identified needs of the outpatient population.
 - i. Promote access to EBTs in a variety of specialty areas across the state of Connecticut so that children in each region will have access to appropriate care.
 - j. To promote the likelihood of successful implementation of EBTs, integrate family engagement strategies whenever possible. Consider a statewide family engagement initiative similar to those implemented by EDT programs.
 - k. Identify sustainable mechanisms and strategies for promoting and sustaining EBTs across the state. Other states, such as Washington, support a statewide center for EBTs that provides ongoing technical assistance, quality assurance, and support.
7. Staffing and Workforce Development
- a. To promote cultural competency, agencies should continue to recruit and retain bilingual and bicultural staff and ensure that sufficient training in cultural competency is provided.
 - b. Examine compensation for outpatient treatment providers. Salaries for outpatient are reported to be lower than other programs and services in CGCs. Stakeholders can consider innovative strategies to promote performance and productivity and use this extra revenue to provide incentives to clinicians. In addition to increasing clinician compensation this could improve treatment capacity and access.
 - c. Whenever possible, provide training and professional development opportunities for outpatient staff. Increased training can promote the competency of clinicians and lead to improved productivity and better outcomes for children and families. As one option, consider contracting with an outside entity responsible for developing and implementing a comprehensive training curriculum specific to the needs and interests of outpatient providers and consumers.

- d. Examine the use of students and interns who provide outpatient care. Promote agency policies that help ensure that students and interns are receiving adequate supervision and not treating cases that exceed their competency or that require long-term care.
 - e. Closely monitor the results of the MHT-SIG workforce development project as it relates to the employment of individuals with experience in the field, including experience with EBTs, and efforts to work with high schools, community colleges, undergraduate, and graduate institutions to prepare the behavioral health workforce. Consider this project for statewide replication.
 - f. Promote clinician credentialing for specialty treatment areas.
 - g. Enhance use of Peer Specialists in outpatient clinics when possible. Peer Specialists can be helpful in case management, family engagement, and community outreach.
8. Data Collection and Reporting
- a. Provider capacity for data collection and reporting can be enhanced by investing in infrastructure development and technical support, which is particularly important as PSDCRS reaches full implementation.
 - b. All stakeholders will benefit from efforts to develop a culture in which data is viewed as part of the service, not as a separate activity. Such an approach can help promote a shared responsibility for outcomes improvement.
 - c. Providers, DCF, CT BHP, and other stakeholders can work together to identify a set of performance and outcome indicators that can be collected, analyzed, and reported on a regular basis. Results should be analyzed at the aggregate level and for each individual provider. Incorporate benchmarking, control chart methodology, and continuous quality improvement methodologies.
 - d. Examine utilization patterns across multiple episodes of outpatient care to better understand service need and long-term outcomes.
9. Systems-Level Issues
- a. Clearly define routine outpatient treatment within the system of care, including its services, roles, and expected outcomes.
 - b. Engage outpatient treatment providers in a statewide learning community designed to identify salient issues, challenges, needs, and areas of opportunity for the outpatient system of care. Work collaboratively to develop proactive strategies for addressing these issues across the statewide outpatient system.
 - c. Recognize and promote the importance of behavioral health for children across DCF's mandates, including child welfare. Work to further integrate behavioral health and child welfare across the state.
 - d. DCF, CT BHP, and provider organizations can work collaboratively to attend to treatment gaps for children with particular diagnoses or treatment needs including children with substance abuse, mental retardation and developmental disorders, autism, and other conditions. The focus of this work would be to ensure that these youth receive needed services and are not disproportionately placed in inpatient and residential treatment programs.
 - e. Continue to examine service utilization across levels of care. If appropriate, expand access to intermediate levels of care and other intensive community-based programs and services, including intensive in-home services, Extended Day Treatment, and

- Partial Hospitalization Programs in order to ease the burden on outpatient care.
- f. Whenever possible, provide expanded access to natural, community-based, and non-traditional services and supports other than office-based treatment. Such programs are an important part of discharge planning and can be helpful in ensuring that children with behavioral health needs remain in their homes and communities.

10. Further Research into Outpatient Needs and Strengths

- a. As part of a comprehensive research agenda, build upon these initial findings to systematically and regularly examine needs and outcomes within the outpatient treatment system. Further analyze the role of outpatient services in the mental health delivery system and ensure that appropriate resources are dedicated to meet identified needs.
- b. Promote a culture in which data is used to better understand the needs of children and families. The PSDCRS, CT BHP data, and other data collection mechanisms can be used to continuously examine outcomes and promote service quality. Enable providers to access and utilize data to better understand and identify needs.
- c. Promote and create mechanisms for ongoing continuous quality improvement across the outpatient system of care.
- d. Collect and analyze follow-up data to determine how these findings apply to urban, suburban, and rural areas of the state. The current study provides aggregated findings from across the state, including outpatient clinics in geographic areas that are very different from one another.

Conclusions and Next Steps

Outpatient treatment is a critical aspect of the mental health service array for children and families. Continued growth in outpatient enrollment could have important implications and efforts to plan service improvements now could have future benefits. Findings are highlighted in the areas of treatment capacity and access; client and case complexity; case management and family engagement; screening and assessment; service delivery; evidence-based practices; staffing and workforce development; and data collection and application. Few studies have been undertaken to address the goals that prompted this study. Although the findings can be useful for planning, they are not believed to be exhaustive. Continued research could help to further clarify issues, needs, and areas for service improvements. The findings and recommendations from this report could best be used within the context of all available data and information on outpatient treatment, and as a resource and catalyst for continued discussion among key stakeholders in outpatient services.

During difficult economic times, there will not be sufficient resources to implement all recommendations from this report. Report findings could serve as an additional tool for planning and implementing service improvements over time. Through interagency collaboration and cooperation, existing resources can be utilized and/or realigned to implement some of these recommendations. A collaborative workgroup including leaders from state agencies, outpatient providers, CT BHP, juvenile justice, child welfare, community representatives, and family members could come together to examine the results of this study, identify priorities and resources, and plan strategies for system improvement.

INTRODUCTION

Overview and Goals

This study was commissioned and paid for by the Department of Children and Families (DCF) through a multi-year Personal Service Agreement with the Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute, with additional funding from the Children's Fund and the Connecticut Health Foundation. The CCEP Advisory Board, comprised of researchers, state agencies, providers, and family advocates, identified the outpatient mental health system as a strategic priority in the children's mental health system. CCEP investigators designed the current study, with consultation from DCF and the Connecticut Community Providers Association (CCPA). The study is intended to contribute to planning and decision-making for service improvements to the statewide outpatient mental health treatment system for children.

For the purposes of this report, routine outpatient mental health treatment is defined as ambulatory services provided to children and families, primarily in office-based settings, using individual, family, and group therapy techniques, and including case management and other supporting services that contribute to treatment delivery. Many entities, or stakeholders, have an interest in outpatient treatment implementation and in planning service improvements. These stakeholders are referred to throughout this report, and include, but are not limited to: DCF, outpatient providers, children and families, family advocates, and outpatient funders. We anticipate that the findings and recommendations described in this report will contribute to a collaborative planning and decision-making process among all stakeholders in children's outpatient treatment.

The goals of this study were to:

1. Better understand the characteristics of the providers, clients, and existing services in routine outpatient mental health treatment
2. Identify and prioritize existing needs in multiple areas of routine outpatient treatment, according to stakeholder input
3. Provide recommendations for improving services and outcomes

Background

It has been estimated that as many as one in every three children will meet criteria for a psychiatric disorder sometime between the ages of nine and sixteen.¹ Despite this high prevalence, only a small percentage of children with mental health needs will ever receive the treatment they need.² Among those that do receive treatment, many are not provided with the best available treatments that have scientific support of effectiveness. The high prevalence of mental health needs is evident in Connecticut as well. For example, recent estimates suggest that as many as 76,000 Connecticut children have a serious emotional disturbance and another 100,000 have a psychiatric disturbance requiring treatment.³

For many years, there has been a national movement calling for improvements to the mental health delivery and financing system, in order to ensure that all children have access to a comprehensive and effective system of mental health treatments. The goal of comprehensive mental health services and supports is to ensure that children with mental health needs are able to thrive in their homes, schools, and communities and become productive adults. The Report of the President's New Freedom Commission on Mental Health articulated several goals for improving mental health services across the country.⁴ The Commission's goals and recommendations were intended to provide a blueprint for the Federal government, state governments, local agencies, and public and private health care providers. Six primary and interwoven goals from this Commission included:

1. Americans understand that mental health is essential to overall health
2. Mental health care is consumer and family driven
3. Disparities in mental health services are eliminated
4. Early mental health screening, assessment, and referral services are common practice
5. Excellent mental health care is delivered and research is accelerated
6. Technology is used to access mental health care and information

The call for improvements to the mental health service system has reached Connecticut as well. Recent reports in Connecticut highlight the pressing need for an enhanced service delivery system. A 2000 report prepared by the Child Health and Development Institute reported that 70% of annual spending on behavioral health services was directed toward the most restrictive treatment settings that served only 19% of the state's children.⁵ These findings and others became the basis for restructuring the behavioral health system to support an enhancement of community-based services. The System of Care framework was adopted when *Connecticut Community KidCare* (KidCare) took effect in 2002.⁶

The original report outlining the KidCare plan, and the KidCare legislation, emphasized a number of values and principles of behavioral health care that are implemented by DCF in collaboration with an integrated partnership of child-serving agencies. KidCare principles include:

- Services are provided in children's homes and communities whenever possible
- Parents and families are an integral part of planning, treatment, and decision-making
- Culturally and linguistically competent services are available and accessible
- Treatment, support and care are locally coordinated and provided in a context that meets the child's psychosocial, developmental, and educational needs.³

The Connecticut Behavioral Health Partnership (CT BHP), a key element of the KidCare plan, is a collaborative partnership between the Department of Children and Families and the Department of Social Services. The primary role of the CT BHP is to manage the funding and delivery of behavioral health services to children covered under Husky A and B and selected DCF behavioral health grant funding. ValueOptions serves as the administrative services organization for the CT BHP. The primary goals of CT BHP include reducing hospital emergency department overcrowding, unnecessary inpatient admissions, and lengths

of stay in hospitals and residential treatment settings, and promoting alternative treatments such as community-based and outpatient services.

Two important entities in the outpatient treatment system are DCF and the outpatient treatment providers. Both entities engage in activities to strengthen the outpatient system, providing context to the current report findings and recommendations. Each entity is described below.

Department of Children and Families

The Department of Children and Families (DCF) is one of the nation's few comprehensive, consolidated agencies serving children under age 18 and their families. Connecticut was the first state in the nation to legislate the structure for a consolidated agency for services for children and their families. The overarching principle of DCF is to work toward the safety, permanency and well-being of all children and families. Five guiding principles are oriented toward achieving the overarching principle:

1. Families as Allies
2. Cultural Competence
3. Partnerships
4. Organizational Commitment
5. Workforce Development

Guided by these organizational principles and the consolidated agency structure, DCF provides a spectrum of services in the areas of behavioral health, child protection and family services, juvenile justice, substance abuse, education and prevention. DCF also is the entity that licenses, monitors, and evaluates certain services provided by private and community providers including outpatient psychiatric services, extended day treatment, foster homes and group homes.

DCF's Bureau of Behavioral Health and Medicine is charged with planning, administering, and evaluating a comprehensive array of behavioral health services to meet the needs of children with complex emotional and behavioral disorders. The System of Care framework and KidCare legislation resulted in the establishment of 25 local Community Collaboratives that work closely with 15 DCF Area Offices to implement behavioral health care for children who may or may not be involved with DCF. In addition to direct management and oversight of these programs and services, DCF also is charged with participating in a number of workgroups and committees to address the need for continuous attention to system integration and improvements in service quality. Their work is organized along several priority areas that provide a framework for system as well as individual program improvements.³ Examples of DCF's priority areas include:

- Promoting family outreach, engagement and retention
- Improving the quality of care through early identification and comprehensive assessment
- Disseminating and sustaining evidence-based practices

- Addressing the needs of traumatized children, adolescents and their parents/caregivers
- Enhancing the knowledge, skills and competencies of the workforce
- Improving data collection, analysis and reporting systems
- Integrating plans of care across multiple systems
- Enhancing the role of families and other caregivers in all aspects of system design, planning, monitoring and evaluation

DCF's current five-year strategic plan also includes goals and activities for agency practice across each of the Department's divisions, including behavioral health.³ Key behavioral health activities in the strategic plan include:

- Establish a needs assessment methodology to project needs for community-based behavioral health services and guide provider network development and expansion
- Provide training for targeted providers that promote utilization of evidence-based practices
- Develop and oversee the implementation of valid, reliable assessment instruments to screen for behavioral health and developmental factors among child welfare cases

The *Community Mental Health Services Block Grant for Fiscal Year 2010* provides additional context for the current report. In this document, DCF has outlined seven interrelated key areas that will serve as a common framework to guide its efforts to administer and improve the delivery of behavioral health services.³ System improvements will require focused and coordinated attention to each area rather than isolated efforts within one or a few. The seven categories are:

- **Access and Service Capacity:** Children and families need to easily access the type of treatment they need at the time they need it. The overall capacity for service delivery must meet the overall need for services.
- **Service Effectiveness and Quality:** Children and families will receive effective services that meet their needs and preferences, supported by screening and assessment, evidence-based and best practices, workforce development, technology, and data to support quality improvement.
- **Child and Family Involvement:** The system will be driven and informed by multiple stakeholders, particularly the children and families that receive care.
- **Management of Services and Systems:** The coordination of care across providers and service systems is critically important to the overall success of the system.
- **Cultural Competence:** The system will be knowledgeable of, informed by, and responsive to the variety of individuals served according to multiple indicators of diversity and culture.
- **Public Awareness and Policy:** Awareness of the behavioral health system will be enhanced, and efforts will be made to reduce and eliminate stigma and discrimination based on the presence of a psychiatric disorder.
- **Funding and Revenue Maximization:** Multiple funding sources (e.g., federal, state, local, private insurance, philanthropic organizations, school districts, individuals, families) will be aligned and "braided" in order to improve access to care.

Connecticut's Outpatient Mental Health Treatment Providers

A network of programs within community-based agencies and hospitals provides routine outpatient mental health treatment for children under 18 years old who experience a psychiatric disorder. Facilities operating routine outpatient programs are designated in the state as Child Guidance Clinics (CGCs) or Outpatient Psychiatric Clinics for Children (OPCCs). CGCs are licensed by the state and also receive funding from the state legislature to provide mental health services and supports to children, adolescents, and families. OPCCs are licensed by the state to provide mental health services to children, adolescents and their families but do not receive state funding. Within CGCs and OPCCs, the clinical staff is comprised of a multidisciplinary team of psychiatrists, psychologists, Master's level clinicians, and other behavioral health professionals.

As of December 2009, the Connecticut Behavioral Health Partnership (CT BHP) has designated 35 child and adolescent outpatient clinics, with over 75 primary and secondary sites, as Enhanced Care Clinics (ECCs). The ECC designation makes a site eligible to receive reimbursement rates for services that are, on average, 25% higher than standard rates. In exchange for this enhanced rate, ECCs are required to comply with certain special initiatives that are being phased in over time. These special requirements are categorized within five domains with associated sub-domains, and include:

- Treatment Access (emergency screening; emergent, urgent, and routine assessment and follow-up)
- Coordination of Care (with primary care physicians)
- Member Services and Supports (welcoming and engagement, peer support groups, consumer education, member evaluation and feedback)
- Quality of Care (evidence-based practice, co-occurring treatment, clinic specialization)
- Cultural Competence (services that are oriented toward meeting the needs of a culturally and linguistically diverse population)

The Connecticut Community Providers Association (CCPA) represents the interests of the mental health provider community as well as children and families and is organized into three divisions: Adult Behavioral Health, Children's Mental Health and Substance Abuse, and Developmental Disabilities. CCPA is involved in advocacy, policy-making and service improvement and serves as a statewide resource for providers, policy makers and researchers. CCEP worked in collaboration with CCPA members in the design and methodology of this study. In addition, several members of CCPA reviewed a full draft of the report and provided comments and feedback prior to public release (see Acknowledgements).

METHODS

Outpatient treatment is a core element of most mental health care systems and more children are served there than in any other program or service. The routine outpatient mental health treatment system is, therefore, a reasonable point of entry for efforts to assess needs and strengths and recommend service improvements. There are a number of data sources that can be used to inform the identification of needs and strengths of the outpatient system and the development of practice recommendations. Although outpatient data are routinely collected and reported to DCF and to CT BHP, these data reporting mechanisms were not primarily designed to identify needs and gaps in services or to collect recommendations for service improvements from a broad group of stakeholders. Needs assessment is appropriate for collecting and summarizing quantitative and qualitative data and to synthesize systems-level information provided by a broad group of stakeholders.⁷⁻⁸

The children's mental health system is complex and multifaceted, and requires consideration of multiple perspectives in formulating recommendations for service improvements.⁹ The current study gathered the input of a diverse group of stakeholders that included state administrators, service providers, families, referrers, and funders of outpatient services. Survey data were collected from 32 agencies across the state and site visits were conducted with nine agencies. Participating agencies served the top ten most populated communities in Connecticut; thus, the sample referenced in this report is representative of the largest segment of children and families receiving mental health services in the state. To reflect the varying aspects related to outpatient care, seven areas of inquiry were established for this study, including:

1. Characteristics of clinicians and agencies
2. Characteristics of children and families served
3. Indicators of client and case complexity
4. Screening and assessment practices
5. Service delivery practices
6. Staffing and workforce development
7. Data collection, analysis, and application

Institutional Review and Informed Consent

The Institutional Review Board at Connecticut DCF approved all study methods. Survey and focus group participants completed consent forms for participation that explained the purpose and rationale of the study, assured confidentiality of responses, and explained that results would be reported in aggregated form (See Appendices 1 and 2).

Data Sources

Investigators used a multi-method, multi-informant data collection approach to enhance reliability and inform appropriate recommendations. Three primary data sources contribute to this report, including:

- Online surveys administered to outpatient directors and clinicians
- Outpatient clinic site visits
- Key stakeholder focus groups

A fourth data source, Department of Social Services (DSS) data on claims for outpatient services, originally was proposed for this study. We were not able to gain access to these data due to state regulations that restrict their release only to state agencies or to non-state agencies with data sharing agreements. In the future, efforts to supplement and validate the findings and recommendations from this report will be supplemented and strengthened by a comprehensive analysis of DSS outpatient claims data.

Additional data collection and analysis challenges common to statewide needs assessment analysis were encountered in the course of this study. We found that providers differed in their internal capacity to produce data reports corresponding to the areas of inquiry for this study. In collecting the quantitative data for this report, some sites had immediate access to internal data sources allowing them to respond to survey and focus group questions. Other sites relied primarily on data provided to them by the Connecticut Behavioral Health Partnership (CT BHP) or DCF, usually in the form of data summaries at the aggregate level of analysis. In addition, the time frames for which these data were available (e.g., monthly, quarterly, annually) differed among providers. There was a need to develop a common way in which providers could report their data, given these differences. For many variables, we found that the common way in which providers could report data was in the form of percentages. There are limited ways in which to provide a descriptive analysis of a group of reported percentages. For many variables included in this study, we chose to report median percentages for the sample along with the range of reported percentages. The variability in capacity for data analysis and reporting encountered during this study is related to the findings and recommendations found in the section on Data Collection, Analysis, and Application.

Data Collection Procedures

Online surveys. CCEP investigators developed an online survey, with parallel versions developed for clinicians (Clinician Survey) and agency administrators (Agency Survey). The Clinician and Agency Surveys can be found in Appendices 6 and 7, respectively. The Agency Survey invited Executive Directors or Outpatient Directors to answer questions about broad areas of service delivery such as overall client demographics, clinic policies and procedures, and perceptions of systems-level issues. The Clinician Survey asked full-time and part-time clinicians, interns, nurses, and psychiatrists to share their perceptions and experiences about providing direct clinical care. Survey data were collected using Survey Gizmo, a web-based survey data collection service.

After stakeholder input was received on the web-based surveys, CCEP investigators contacted agency Executive Directors and Outpatient Directors to invite their participation. Like many survey-based studies, we encountered difficulties obtaining completed surveys from many outpatient directors and clinicians. Investigators attempted to contact all CGCs and OPCCs; however, not all agency directors responded after multiple attempts, emails, and

voicemails. For those agency directors that did agree to participate, a link to the Agency Survey was emailed to them. During the initial phone contact, and again when the Agency Survey link was emailed, directors were asked to nominate clinical staff members to complete the Clinician Survey. Upon receipt of clinician email addresses, a link to the Clinician Survey was emailed inviting participation. Response rates initially were low; thus, the Agency and Clinician Surveys remained open for completion for approximately six months, during which time CCEP investigators tracked responses, answered questions, and followed-up with providers. Numerous calls were made to providers to solicit their participation, links to the survey were re-sent, and all efforts were made to identify and remediate barriers to survey completion.

Site Visits. During the planning phase, CCPA recommended ten agencies for site visits. CCPA had previously established this list of ten sites as representative of their network of community-based agencies with respect to their geographical location and the size of the agency. Eight of the ten sites responded to our request for a site visit. Two sites did not respond after several attempts to contact them to schedule a site visit. An additional ninth site was added to the list after they expressed an interest in participating in the needs assessment project.

Upon arriving for site visits, CCEP investigators asked prospective participants to read and review the consent form and the facilitators answered questions about the study and its purpose. After all questions were answered, signed consent was obtained from the participants. Study investigators developed a protocol to guide the site visit discussion (see Appendix 3). The site visits lasted for approximately ninety minutes and consisted of group interviews, discussion, and review of applicable data. The following agencies participated in site visits:

- Child Guidance Center of Greater Bridgeport (Bridgeport)
- Clifford Beers Guidance Clinic (New Haven)
- Community Health Resources (Windsor)
- Family and Children's Aid (Danbury)
- Klingberg Comprehensive Family Services (New Britain)
- Lower Naugatuck Valley Parent Child Resource Center (Derby)
- United Community and Family Services (Norwich)
- Wellpath (Waterbury)
- Wheeler Clinic (Plainville)

Focus groups. Agencies or committees that were the subject of a focus group included the following:

- ValueOptions (Administrative Services Organization for the CT BHP)
- DCF Area Office Directors
- DCF Behavioral Health Directors
- DCF Area Resource Group (ARG) staff
- Parent members of the Connecticut Behavioral Health Advisory Committee (CBHAC)

Prior to initiating focus groups, prospective participants were asked to read and review the consent form, then the focus group facilitators answered questions about the study and its purpose. Signed consent was obtained from all participants. Study investigators developed protocols for each focus group audience to facilitate discussion (see Appendix 4). Detailed notes were taken to capture focus group discussion and themes. Focus groups lasted for 60 to 90 minutes at each site.

RESULTS

The Role of Outpatient Services in Connecticut's System of Care

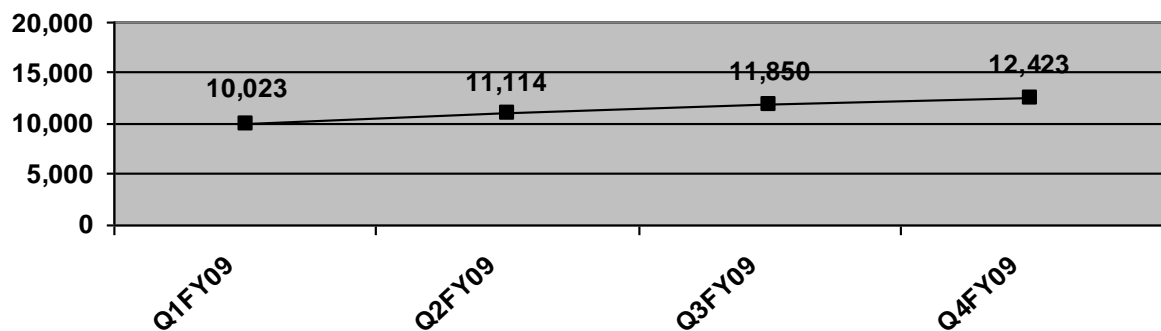
Nationally, as well as in Connecticut, the majority of children and adolescents who become involved with the behavioral health service system are seen in routine outpatient treatment settings. Nationally, increases in utilization of routine outpatient treatment and medication management have helped reduce reliance on inpatient and residential treatment.¹⁰ In Connecticut, the Behavioral Health Data System (BHDS) and the Program and Services Data Collection and Reporting System (PSDCRS) have been used most recently to track admissions, discharges, enrollment levels, length of stay in treatment, and other indicators for the network of CGCs. Historically, both DCF and the outpatient provider community have had concerns about data quality and reliability. Although recent efforts have been directed toward improvement in these areas, the data should be interpreted cautiously and further data should be collected to determine trends.

Network-level BHDS submissions from CGCs through the 4th Quarter of Fiscal Year (FY) 2009 (July 2008 through June 2009) underscore the important role of outpatient treatment in the state, and highlight sustained demand for services within this level of care.¹¹ BHDS submissions during this time indicate the following:

- An average of 2,309 children were admitted to CGCs each quarter
- An average of 1,641 children were discharged from CGCs each quarter
- Median length of stay in CGCs was 11.6 months; mean length of stay was 17.2 months
- The longest observed length of stay in a CGC was 89.5 months as of the 4th Quarter of FY 2009

Figure 1 displays BHDS data on the total number of children remaining in care for each quarter of FY 2009.

**Figure 1: Children Remaining in Child Guidance Clinic Care:
FY 2009 BHDS Submissions**

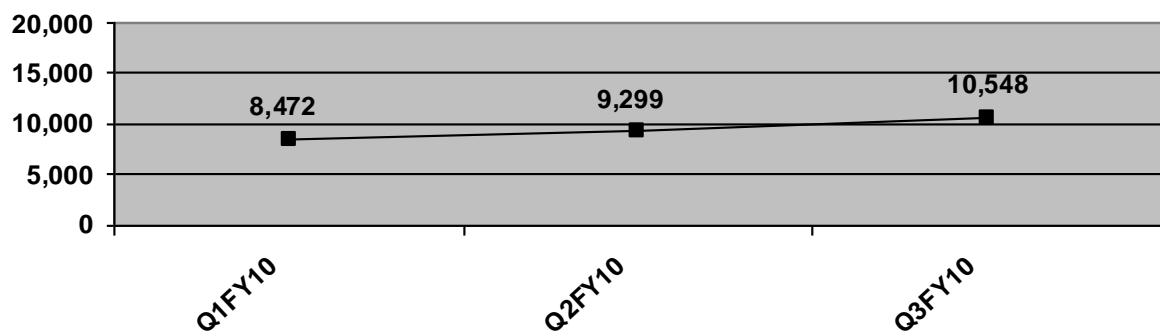


In FY 2010, DCF began using the PSDCRS to track enrollment indicators. DCF indicates that not all providers are consistently reporting data to PSDCRS and that the system continues to build toward full implementation. Nevertheless, PSDCRS data from the first three quarters of FY 2010 indicate the following:

- An average of 2,731 children were admitted to CGCs each quarter
- An average of 1,889 children were discharged from CGCs each quarter
- Median length of stay in CGCs in Quarter 3 was 6.9 months; mean length of stay in Quarter 3 was 12.4 months
- The longest observed length of stay in a CGC was 157.2 months.

Figure 2 displays PSDCRS data on the total number of children remaining in care for the first three quarters of FY 2010.

**Figure 2: Children Remaining in Child Guidance Clinic Care:
FY 2010 PSDCRS Submissions**



Given their limitations, it is not appropriate to use these data alone to reliably establish trends or project future enrollment. However, both BHDS and PSDCRS data indicate that outpatient treatment in CGCs is a highly utilized component of the mental health treatment system that serves many children and families. Furthermore, the data suggest that enrollment in CGCs could be growing. As PSDCRS builds toward full implementation, outpatient stakeholders will be able to monitor trends in enrollment, admissions, discharges, and length of stay with increased confidence and use these data to support planning and decision-making.

The possible growth in outpatient services during FY 2009 and FY 2010 is consistent with the goals of KidCare and this level of growth, if accurate and sustained over time, could have important policy and practice implications. Some outpatient providers expressed serious concerns as to whether the outpatient treatment system had the capacity to accommodate a high level of growth. If significant growth in enrollment does occur, meeting the treatment needs of many more children and families in the next few years would require recruiting, hiring, retaining, and training more outpatient clinicians. It is unclear from these data alone whether the current capacity of the outpatient mental health system would be sufficient to meet a large increase in demand. It is possible that further strains on capacity due to growth

in enrollment without a sufficient infusion of additional resources could lead to compromises in treatment access, quality of care, and compliance with licensing, accreditation, and documentation requirements. Outpatient enrollment growth and related issues of treatment capacity require continued analysis and planning.

In the current study, all stakeholders confirmed the important role played by outpatient mental health clinics. Routine outpatient care settings serve children and families in the community as an alternative to hospitalization or residential treatment and many outpatient clinics practice an “open door policy” whereby children and families who need treatment are not denied services. The agency administrators we spoke with described outpatient mental health services as serving an important function within the behavioral health system, describing routine outpatient as “the golden thread,” a “safety net,” a “default option,” a “catch-all” and a “touchstone” within the system of care. These terms were used to describe the way in which families, schools, medical care providers, and higher-level psychiatric facilities refer clients to outpatient services because other services have limited access or capacity and outpatient treatment has the flexibility to meet multiple and varying client needs. DCF Area Office Directors and Behavioral Health Directors agreed that outpatient treatment is viewed as a “catch all” and noted that this could be due to limited access to other programs and services in the behavioral health service array. ValueOptions Intensive Care Managers reported that they use outpatient as a step-down service for children coming out of higher levels of care. One DCF Area Office Director reported that they have referred many children who require medication management to CGCs over the years because they have few alternative options available for these youth. Thus, outpatient treatment is seen as a critically important, valued, and highly utilized program within the service continuum.

Many stakeholders recognized that there is limited capacity in intermediate forms of treatment such as Partial Hospitalization (PHP), Extended Day Treatment (EDT), and Intensive Outpatient Programs (IOP). Often, when youth have completed a course of treatment in EDT, PHP or IOP, these programs will not accept them back from outpatient providers for another course of treatment. In addition, the rise of managed care has resulted in fewer private insurers providing adequate coverage of mental health treatment, shifting more responsibility to the public sector. Furthermore, inpatient hospitalization stays have become increasingly brief over the last several years and residential treatment slots are limited. These conditions place increasing stress on routine outpatient care settings to fill existing gaps in the broader mental health service continuum.

Stakeholders described numerous strengths inherent in Connecticut’s outpatient treatment system and its network of clinics and clinicians. Clinics are described as being clean and safe environments for children with locations in the communities of greatest need, which enhances access to treatment. Most clinics were described as offering a comprehensive range of services. The ECC initiative has greatly reduced the amount of time between referral and initial intake appointment. Some local CGCs have an increasing presence of evidence-based treatments (EBTs). Many stakeholders described outpatient clinicians as “responsive,” “collaborative,” “dedicated,” and “hard working.” Outpatient clinics see a wide variety of clients, and many reported that DCF Area Offices have good relationships with their local outpatient clinics.

Description of Survey Participants

Agency Survey

Quantitative results from the Agency Survey were used to provide a description of administrators that manage outpatient services as well as characteristics of the agencies themselves. Thirty-two administrators representing community mental health centers across Connecticut completed the Agency Version of the online survey. Most of the 32 administrators reported personal demographic and some basic agency characteristics but approximately 14 administrators did not report extensively on other survey areas. The 18 agency administrators that completed the majority of the survey represented agencies of varying sizes and geographic locations. The sample size is sufficient for group analysis, but the findings should not be considered the only source of information for determining needs and informing practice recommendations.

Figure 3 summarizes the self-described job titles of the 32 administrators that submitted demographic information.

Figure 3: Agency Survey Respondents

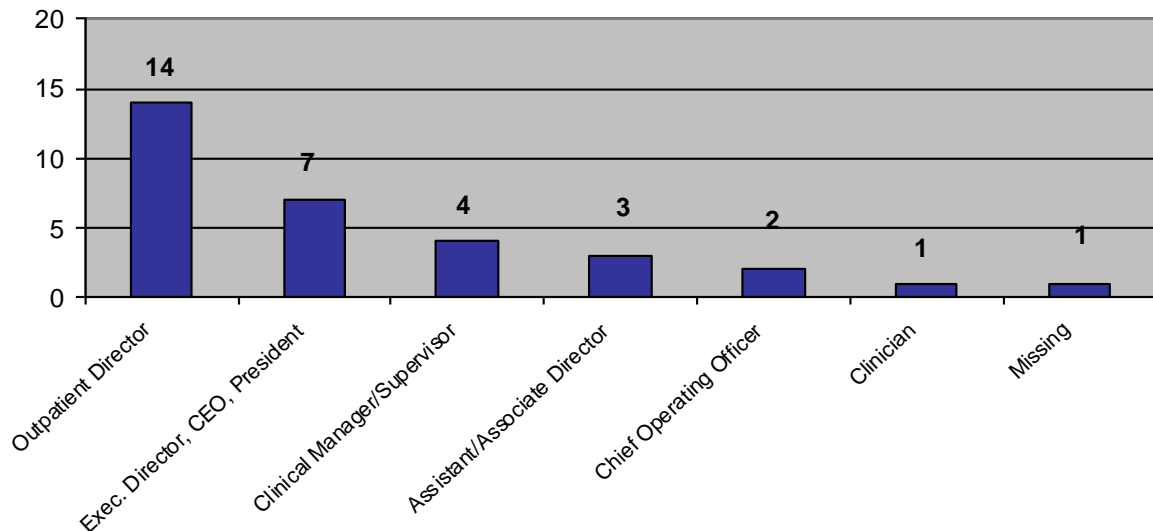


Figure 3 indicates that not every respondent to the Agency Survey was the primary administrator responsible for managing routine outpatient treatment, and not all outpatient administrators in the state are represented; thus, the findings do not fully generalize to all individuals managing outpatient services. Approximately 63% of surveyed administrators were women and 72% were between the age of 41 and 60 years old. Regarding racial/ethnic identification, 91% of surveyed administrators self-identified as Caucasian and 9% self-identified as Latino. Regarding educational background, 9% had a Bachelor's Degree, 72%

had a Master's Degree, and 19% had a Doctoral degree. Most (84%) surveyed administrators were licensed by the State of Connecticut to provide psychological treatment and services.

Clinician Survey

The Clinician Survey was used to describe clinicians that provide outpatient services and to gather their perceptions regarding important aspects of outpatient treatment delivery. Seventy-two clinicians completed basic demographic information only, and of those, 54 clinicians completed most or all of the survey items. The sample size is sufficient for group analysis, but the findings should not be considered the only source of information for determining needs and informing practice recommendations.

Of the 72 respondents that reported their title or position, 63% were clinicians, 26% were in clinical-administrative positions (e.g., Program Director, Clinical Supervisor), 3% were psychiatrists or Advanced Practice Registered Nurses (APRNs), and 8% of respondents were students or interns. Clinician age was evenly distributed with 39% of respondents in the 31 to 40 year old age group. The majority (82%) of respondents were women and 87% were Caucasian. Thirteen percent of respondents were from racial/ethnic minority backgrounds. Eighty-nine percent of respondents spoke English only. Clinician demographic characteristics are presented in Table 1.

Table 1. Clinician Socio-Demographic Characteristics

Characteristic	Frequency	Percentage
Age (n=72)		
18-25 years	4	6%
26-30 years	13	18%
31-40 years	28	39%
41-50 years	9	13%
51-60 years	14	19%
61 years and older	4	6%
Gender (n=72)		
Male	13	18%
Female	59	82%
Racial/Ethnic Background (n=71)		
Caucasian	62	87%
African-American	2	3%
Latino/Latina	3	4%
Asian/Pacific Islander	1	1%
Biracial/Multiracial	1	1%
Other	2	3%
Primary Language Spoken (n=71)		
English only	63	89%
Spanish only	0	0%
Both English and Spanish	4	6%
English and another language (not Spanish)	4	6%

With regard to clinician employment characteristics, more than half (57%) of responding clinicians were licensed in Connecticut to provide mental health services and 83% of responding clinicians were employed full time. Clinical work experience ranged from less than one year to over 21 years, with over one-third (34%) of respondents reporting one to five years of experience. The median and modal reported salary range was between \$40,000 and \$49,999. Clinicians were allowed to endorse one or more response options to describe their theoretical orientation. The most commonly endorsed option was cognitive-behavioral (81%) followed by family systems (75%), integrated/eclectic (47%), behavioral (40%), cognitive (32%), interpersonal process (32%), and dynamic/analytic (29%). Another 22% reported “other” theoretical orientations. Clinician employment characteristics are presented in Table 2.

Table 2. Clinician Employment Characteristics

Characteristic	Frequency	Percentage
Highest Degree Achieved (n=71)		
Bachelor's Degree	2	3%
Master's Degree	61	86%
Advanced Practice Registered Nurse (APRN)	2	3%
Doctoral or Medical Degree	6	8%
Years of Experience (n=71)		
Less than 1 year	1	1%
1 to 5 years	24	34%
6 to 10 years	15	21%
11 to 15 years	13	18%
16 to 20 years	8	11%
21 or more years	10	14%
Employment Status (n=71)		
Full-Time	59	83%
Part-Time	4	6%
Fee for Service	2	3%
Unpaid Clinical Trainee	3	4%
Paid Clinical Trainee	3	4%
Salary (n=70)		
None	3	4%
\$1 to \$9,999	3	4%
\$10,000 to \$19,999	0	0%
\$20,000 to \$29,999	5	7%
\$30,000 to \$39,999	10	14%
\$40,000 to \$49,999	26	37%
\$50,000 to \$59,999	8	11%
\$60,000 to \$69,999	10	14%
\$70,000 to \$79,999	2	3%
\$80,000 or more	3	4%
Theoretical Orientation (n=71) ^a		
Cognitive-Behavioral	58	82%
Family Systems	54	76%
Integrated/eclectic	34	48%
Behavioral	29	41%
Cognitive	23	32%
Interpersonal process	23	32%
Dynamic/analytic	21	30%
Other	16	23%

^a Respondents were allowed to endorse more than one theoretical orientation.

Summary of Survey Participant Characteristics

The majority of respondents to the Agency Survey were Executive Directors or Directors of Outpatient Services, women, Caucasian, and over the age of 40. Most held at least a Master's Degree and were licensed to provide clinical services. Respondents to the Clinician Survey typically were clinicians or clinician-administrators (supervising clinicians), employed full time, held at least a Master's Degree, and had been employed for less than ten years. Two-thirds were less than 40 years old, the majority were Caucasian, and few spoke fluent Spanish. More than three-quarters endorsed a cognitive-behavioral theoretical orientation. It is difficult to ascertain the degree to which this sample is reflective of the total population of outpatient administrators and clinicians. We are not aware of other studies that have reported the characteristics of Connecticut outpatient agencies and clinicians to which these results might be compared. DCF does not have data on the total number of clinicians in outpatient agencies across the state.

Characteristics of Agency Structures and Practices

Study stakeholders were interested in describing basic characteristics of agencies and outpatient departments serving children, adolescents, and families. The Agency Survey asked administrators to report basic characteristics of the agencies in which they work. Twelve administrators (38%) reported that their agency is licensed by DCF but does not receive funding and 18 administrators (56%) reported that their clinic is licensed and funded by DCF (i.e., CGCs). Two surveys (6%) were missing data on this variable. Administrators were allowed to choose more than one type of region served (i.e., urban, suburban, rural). These results indicate that 66% of clinics serve clients who live in urban areas, 63% serve clients who live in suburban areas, and 22% of clinics serve clients who live in rural areas.

Staffing complement. Agency administrators were asked to report staffing characteristics including the number of clinician, psychiatrist, volunteer, intern, and fee for service full time equivalents (FTEs) as well as the number of hours of psychiatric services provided per month. These findings are displayed in Table 3. The mean number of clinician FTEs, reported by 23 administrators, was 7.8 (s.d.=5.7), with a median of 7.0 and a range of 0.60 to 26.0. The distribution can be further described by examining the range of reported FTEs in thirds. The bottom third of the distribution of reported FTEs included outpatient clinics with 0.6 to 3.5 FTEs, the middle third included clinics with 7.0 to 10.0 FTEs, and the top third included clinics with 10.0 to 26.0 FTEs. The mean number of psychiatry FTEs, reported by 23 administrators, was 1.0 (s.d.=0.9), with a median of 1.0, and a range of 0 to 3.5. The mean number of psychiatry hours, reported by 20 administrators, was 103.8 hours (s.d.=122.4), with a median of 46 hours, and a range from 1.96 to 500 hours. Administrators reported a mean of 2.4 FTEs provided by students and interns and 1.6 FTEs provided by fee for service clinicians. Agency administrators reported few volunteer clinical staff. Eight of eighteen (44%) responding administrators reported that they employed a clinician who was designated to coordinate and conduct all intake assessments.

Table 3. Staffing Characteristics

Staff Member	n	Mean (s.d.)	Median	Range
Clinician FTEs	23	7.8 (5.7)	7.0	0.6 – 26.0
Psychiatrist FTEs	23	1.0 (0.9)	1.0	0 – 3.5
Volunteer FTEs	19	0.5 (0.2)	0	0 - 1
Intern FTEs	23	2.4 (2.2)	2	0 - 10
Fee For Service FTEs	18	1.6 (3.0)	0.2	0 - 12
Psychiatry Hours	20	103.8 (122.4)	46	1.96 - 500

Exclusionary criteria. Twenty administrators responded to the item asking whether certain diagnoses or circumstances excluded children from receiving outpatient services at their clinic. Sixteen of twenty administrators (80%) responded affirmatively to the item, indicating that they do have exclusionary criteria; however, only 13 of these 16 respondents described the exclusionary diagnoses or circumstances. The most commonly reported diagnostic condition excluding children from outpatient services was that the child or adolescent had a primary substance abuse disorder (reported by 4 clinics). Three other clinics reported that children with mental retardation diagnoses were excluded from outpatient services. The list of exclusionary criteria submitted by administrators is presented below.

- Primary substance abuse disorder (4 clinics)
- Severe mental retardation/developmental disorder (3 clinics)
- Severe autism (1 clinic)
- Eating disorder (1 clinic)
- Safety risk (e.g., suicide, homicide, violence) (1 clinic)
- Needs higher level of care (1 clinic)
- Sexual offender (1 clinic)
- GAF under 40 (1 clinic)
- Has commercial insurance (1 clinic)
- Young child with medication needs (1 clinic)

This survey did not ask administrators to report how or where youth receive treatment when they are ineligible for their routine outpatient services. Follow-up questions with DCF administrators suggested that youth with substance abuse disorders can be treated in intensive in-home treatment programs or one of three DCF-funded outpatient substance abuse treatment clinics. Follow-up questions with providers suggested that many youth with mental retardation or developmental disabilities receive services through school systems.

Summary of Agency Characteristics

Respondents generally represented agencies that were licensed and funded by DCF (i.e., CGCs) with some that were licensed but not funded by DCF (i.e., OPCCs). Thus, the Agency and Clinician Survey findings speak to broad issues in the outpatient treatment system and have particular relevance to CGCs. There was a wide range in staffing, with some very large

and some very small clinics represented. Respondents to the Agency Survey typically were Outpatient Directors and Executive Directors. The mean number of clinical full time equivalents (FTEs), reported by 23 administrators, was 7.8 (s.d. = 5.7) with a median of 7.0 and a range of 0.6 to 26.0. There was wide variability in the presence of psychiatric services among responding clinics. Outpatient clinics see a very wide range of clients with few agencies reporting extensive exclusions; however, among the clinics we surveyed, the groups of children most likely to be ineligible for routine outpatient services include those with substance abuse disorders and significant mental retardation or developmental disabilities. Youth with substance abuse needs can be referred to an intensive in-home program or to one of three DCF-funded specialty outpatient clinics and youth with mental retardation or developmental disabilities can be treated through local school systems.

Client Socio-Demographic Characteristics

Information about clients served at the outpatient level of care was drawn from the Agency Survey, Clinician Survey, and site visits; thus, the information obtained was based on administrator and clinician report, not on child or parent self-report. Agency administrators and clinicians were asked to use the best available data to describe characteristics of the children and families they serve; however, internal capacity to collect, analyze, and report data varied among providers. Nearly all providers had access to aggregate data, typically reported in percentages. Because the data we collected was in the form of percentages, medians were reported as a measure of central tendency and ranges were reported to provide information on variability.

Table 4 summarizes administrators' reports of the demographic characteristics of the outpatient population they serve. Medians and ranges of reported percentages are reported. The median percentage of adolescents served by responding outpatient clinics was nearly 40% and the median reported percentage of boys served was just over half. The median reported percentage of clients that speak English only was more than 75%. The median percentage of Caucasian clients was approximately 50% and the median percentage of clients of Hispanic ethnicity was 21%. The ranges of reported percentages indicate that, for nearly all variables, there is a great deal of variability among responding outpatient agencies.

The survey response data and BHDS data reported by all CGCs do not match precisely, which is due to different sampling characteristics and response options.¹¹ BHDS summarizes responses from all CGCs whereas the current survey includes a smaller number of CGCs as well as some OPCCs. According to BHDS data, 3% of clients are under four years old, there are more youth served in the 4 to 7 and 8 to 12 year old age groups, and fewer youth served in the 13 to 17 year old age group. The breakdown according to gender is similar across the two data sources. Regarding race/ethnicity, BHDS findings indicate fewer White youth served and more Hispanic youth served. The figures on Black/African-American and Other race/ethnic groups are similar across both data sources. Primary language is not reported on the BHDS. Table 4 summarizes survey and BHDS findings on client characteristics.

Table 4. Demographic Characteristics of Clients Served: Survey and BHDS Data

Client Socio-Demographic Characteristic	Survey: Number of Responding Administrators	Survey: Median Percentage	Survey: Ranges of Percentages	BHDS Data ^a
Age				
0-3 years old	Not reported	Not reported	Not reported	3%
4-7 years old	24	17.5%	0% - 35%	25%
8-12 years old	25	34%	5% - 70%	39%
13-17 years old	26	39.5%	15% - 100%	33%
Gender				
Boys	25	51%	40% - 80%	58%
Girls	25	49%	20% - 60%	42%
Primary Language				
English only	23	84%	5% - 100%	Not reported
Spanish only	20	5%	0% - 50%	Not reported
English and Spanish	21	10%	0% - 80%	Not reported
Other	13	0%	0% - 10%	Not reported
Race/Ethnicity				
White/Caucasian	24	50%	5% - 92%	40%
Hispanic	24	20.5%	3% - 85%	34%
Black/African-American	24	14.5%	1% - 40%	15%
Native American	14	0%	0% - 3%	Not reported
Asian/Pacific Islander	17	1%	0% - 4%	Not reported
Biracial/multiracial	23	5%		Not reported
Other	Not reported	Not reported	Not reported	11%

Note. Response options between this survey and the BHDS do not match exactly. On the current survey, respondents could select more than one category when Hispanic ethnicity is considered in a combine race/ethnicity category.

^a BHDS data reflect percentages of the total population of children served in CGCs according to data submitted for Quarter 3 of FY 2009.

Place of residence at intake. Agency administrators were asked to report the percentage of children that resided in various placements at the time of intake. Table 5 displays medians and ranges of reported percentages. According to reported medians, more children were living with their biological family and fewer were living with a relative or a foster family. Very few children appear to be in adoptive homes or in group homes. Again, the ranges for this variable suggest variability among responding providers.

Table 5. Children's Place of Residence at Intake

Place of Residence	n	Median Percentage	Ranges of Percentages
Biological Family	22	71%	30% - 90%
Adoptive Family	21	5%	0% - 20%
Relatives	22	10%	1% - 48%
Foster Family	21	10%	1% - 30%
Group Home	13	1%	0% - 10%
Other	10	3%	0% - 10%

Referral sources. Agency administrators were asked to report the referral sources of their outpatient clients. Medians and ranges of reported percentages are presented in Table 6. The median reported percentages for referrals sources of parents/caregivers, DCF, and schools were 38%, 20%, and 10%, respectively. Once again, ranges of percentages for this variable suggest variability among clinics.

Table 6. Referral Sources

Referral Source	n	Median Percentage	Range of Percentages
DCF	25	20%	4% - 40%
Schools	23	10%	0% - 25%
Parents	25	38%	5% - 75%
Hospital	23	3%	0% - 39%
Juvenile Justice	21	2%	0% - 30%
Residential	19	2%	0% - 20%
System of Care	20	3%	0% - 25%
Referred Within Agency	22	7%	0% - 25%

Insurance coverage (agency). Agency administrators were asked to report the percentage of cases that have no insurance coverage, Medicaid, private insurance, self-insured, and other insurance. Medians and ranges are presented in Table 7. The median reported percentage of children covered by Medicaid was 70%.

Table 7. Client Insurance Coverage

Insurance Coverage	n	Median Percentage	Range of Percentages
No insurance	17	5%	0% - 30%
Medicaid	24	70%	30% - 98%
Private insurance	24	15%	0% - 70%
Self insured	17	5%	0% - 17%
Other insurance	10	6%	0% - 14%

Children's DCF status at intake. Agency administrators were asked to report the percentage of clients with various types of DCF involvement at intake. Medians and ranges of reported percentages are presented in Table 8. The median reported percentages of children that have no DCF status, Child Protective Service involvement, and DCF Voluntary Service involvement were 56.5%, 12.5%, and 10%, respectively. In addition to these survey data, BHDS data from Quarter 3 of FY 2009 indicates that 32% of all children served by CGCs have some form of DCF-involvement.¹¹

Table 8. Children's DCF Status at Intake

DCF Status	n	Median Percentage	Range of Percentages
No Status	24	56.5%	30% – 95%
Child Protective Services	24	12.5%	1% – 80%
Voluntary Services	21	10%	1% – 37%
Families with Services Needs (FWSN)	18	4.5%	0% – 50%
Juvenile Services	17	5%	0% – 40%
Other DCF Involvement	11	11.4%	0% – 43%

Client diagnoses. Agency administrators were asked to report up to five of the most common diagnoses seen at their outpatient clinics. These data are presented in Table 9. Eighteen clinics reported at least one diagnosis for this variable. All eighteen outpatient clinics reported that Mood Disorders were in the top five most common diagnoses at their clinic. In addition to Mood Disorders, the most commonly reported diagnoses in outpatient clinics were Attention Deficit/Hyperactivity Disorder (ADHD; mentioned by 16 clinics), Adjustment Disorders (mentioned by 15 clinics), and Anxiety Disorders (mentioned by 10 clinics).

Table 9. Most Commonly Reported Diagnoses			
Diagnosis	Number of Identifying Clinics	Median Percentage of Clients with Diagnosis	Range of Percentage of Clients with Diagnosis
Mood Disorders	18	18.5%	10% - 50%
Attention Deficit/Hyperactivity Disorder	16	25%	5% - 70%
Adjustment Disorders	15	15%	5% - 49%
Anxiety Disorders	10	11.5%	6% - 40%
Oppositional Defiant/Conduct Disorder	9	19%	9% - 47%

Other clinical characteristics. Included in Table 10 are data on the presence of substance use, co-morbid psychological conditions, previous hospitalizations, and residential placements. Among the 19 responding clinics, the median percentage of youth with a substance abuse disorder was 5%. As stated earlier, some clinics reported that substance abuse was an exclusionary factor for admission to outpatient clinics, which would reduce the reported rates for this study. Interviews with DCF administrators reported that some youth are treated in one of three DCF-funded outpatient substance abuse clinics or in one of the intensive in-home treatment models (e.g., Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), Brief Strategic Family Therapy (BSFT)). Currently, there is an initiative underway to articulate and implement requirements for ECCs to identify and ensure treatment of youth with co-occurring psychiatric and substance abuse disorders. In terms of co-morbid conditions, among the 17 responding clinics, the median reported percentage of youth with co-morbid conditions was 50%, with a range of 5% to 80%. Eighteen clinics reported on the percentage of youth with a previous hospitalization; the median reported percentage was 15% with a range of 3% to 80%. Finally, 18 clinics reported on previous residential placements; the median reported percentage was 5%, with a range of 1% to 20%. Collectively, these data suggest the possibility that youth treated in outpatient clinics present with complex clinical characteristics and treatment needs.

Table 10. Other Clinical Characteristics

Clinical Characteristics	n	Median Percentage	Range of Percentages
Substance abuse	19	5%	0% – 27%
Co-morbid psychological condition	17	50%	5% – 80%
Previous hospitalization	18	15%	3% – 80%
Residential placement	18	5%	1% – 20%

Perceived trends in outpatient client characteristics. Agency staff members indicated recent increases in referrals of preschool-age children. These young children were reported to present with difficult to manage behavior, and their parents often seek new skills in behavior management or even medication management. Agency staff indicated that these cases often require parenting and family management coaching and support, but specialists in these areas are difficult to find and hire. Many agencies also reported an increase in referrals for children with Mental Retardation, Pervasive Developmental Disorders, Autism Spectrum Disorders, Bipolar Disorder and Reactive Attachment Disorder. Trauma-related concerns also were reported to be increasingly referred and identified. Despite increased referrals for treatment of these conditions, sites reported that the percentage of cases meeting diagnostic criteria remains relatively low. When asked about these trends, many providers described their perception that increased media attention to particular conditions is likely to lead parents to seek support or treatment for their children.

Summary of Client Socio-Demographic Characteristics

Responding agency administrators reported that many children served in outpatient clinics are adolescents (13 to 17 years old) and fewer are younger children (4 to 7 years old). The median reported percentage of youth that speak English only was 84%. The median reported percentage of Hispanic youth was 21% whereas the median reported percentages of Caucasian and African-American youth were 50% and 15%, respectively. The survey numbers differ slightly from 3rd Quarter FY 2009 BHDS data which indicates more children in the 4 to 7 year old age range and fewer in the 13 to 17 year old age range. Furthermore, BHDS reports that more children are of Hispanic ethnicity (34%) and fewer (32%) have some DCF involvement. Survey data also suggest that most children live with one or more biological parents, many children are insured through Medicaid, and referrals are likely to come from parents, schools, and DCF. In addition, the median reported percentage of children with no DCF status was over 50% as was the median reported percentage of children with a co-morbid psychological condition. The median reported percentages of children with substance abuse concerns and a previous inpatient hospitalization were 5% and 15%, respectively.

In terms of socio-demographic information, these survey results highlight the ongoing challenge of hiring a clinical workforce with racial, ethnic, cultural, and linguistic characteristics that are reflective of the community they serve. For example, 87% of

clinicians reported that they were Caucasian whereas the median reported percentage of Caucasian clients on our survey was 53%. Although 82% of clinicians are women, the median reported percentage of boys served in outpatient clinics was over 50%. In terms of client age, our data suggest that many outpatient clients are seven years old or younger and it can be difficult to hire clinicians with training and experience working with very young children and their parents. An encouraging finding was that 6% of clinicians reported that they provide services in Spanish and the median reported percentage of clients that speak Spanish only was 5%. The percentage of Spanish-speaking children and families seeking treatment might be greater than the percentage of Spanish-speaking clinicians in some areas of the state. This idea was validated during site visits when agency administrators and staff described difficulties recruiting and retaining Spanish-speaking clinicians to meet the demand in their communities. In addition to highlighting the importance of a diverse workforce, these findings suggest the importance of ensuring a culturally competent workforce that can adequately understand the cultural and linguistic needs and preferences of the population they serve and incorporate these into treatment.

Treatment Capacity and Access

Treatment Capacity

Indicators such as referrals, completed intakes, number of dropouts, and waitlists for treatment have important implications for the outpatient treatment system. All stakeholders in the outpatient system are interested in improving treatment attendance and promoting strategies to improve quality of care, increase consistent attendance, and increase outpatient revenue. The research literature demonstrates that these issues are a significant concern for mental health treatment systems, not just in Connecticut, but across the country. Reported dropout rates in routine mental health treatment settings vary widely depending on the operational definition of dropout and characteristics of the study sample, but they typically range from 25% to 75%.¹²⁻¹⁴ Estimates of referrals, completed intakes, and waitlists are described below for our study sample.

Administrators, clinicians, and other stakeholders were asked to report on indicators related to case flow and treatment access; for example, the number of referrals per month, number of scheduled and completed intakes per month, and the percentage of clients completing a certain number of treatment sessions. In the survey, referrals were defined as “all clients that seek outpatient services, whether initiated by the child, parent, or other sources.” An intake was defined as “one or more initial assessment appointments.” A treatment session was defined as “an intervention session such as psychotherapy.” Successful completion was defined as “a jointly planned and agreed upon termination of services with symptom reduction and/or completion of treatment goals.” Administrators used these definitions to answer questions about treatment attendance and completion rates among discharged clients.

Number of referrals and intakes. The average number of monthly referrals reported by administrators was 49.7 (s.d. = 44.4). Of those referrals, the average number of intakes

scheduled each month was 40.1 (s.d. = 33.1) and the average number of completed intakes per month was 34.0 (s.d.=29.2). These data are presented in Table 11.

Table 11. Number of Referrals and Intakes

Referral Indicator	n	Mean (s.d.)	Range
Number of Clients Referred	15	49.7 (44.4)	4 – 140
Number of Clients Scheduled for Intake	17	40.1 (33.1)	2 – 100
Number of Clients Who Complete Intake	16	34.0 (29.2)	2 – 100

For each reporting agency, these data were used to calculate three additional indicators. First, the number of scheduled intakes was divided by the number of referrals. Second, the number of completed intakes was divided by the number of referrals. Third, the number of completed intakes was divided by the number of scheduled intakes. Means then were calculated for each of these three variables (presented in Table 12). On average, among the responding clinics, 71% of referrals have an intake scheduled, and 59% of referrals complete the intake. Conversely, of the monthly referrals reported by these sites, on average, approximately 41% of referrals did not complete the intake process. Among the responding clinics, 84% of scheduled intakes are completed. Data were not collected to reflect the reasons for not scheduling or completing an intake.

Table 12. Proportions of Scheduled and Completed Intakes

Referral Indicator	n	Mean (s.d.)	Range
Scheduled Intakes / Referrals	14	71% (24%)	20% - 100%
Completed Intakes / Referrals	14	59% (20%)	16% - 90%
Completed Intakes / Scheduled Intakes	16	84% (12%)	61% - 100%

Waitlists. Some administrators reported their waitlist in terms of number of weeks and others in terms of number of clients. Seven of 18 administrators left this field blank, which suggests either missing data or that these clinics do not have a waitlist for outpatient services. For the seven administrators that reported their waitlist in weeks, the average waitlist was 1.9 weeks (s.d.=1.0) with a range of zero to three weeks. For the three administrators reporting in terms of number of clients, the average was 12.7 clients (s.d.=17.8) with a range of 0 to 33 clients. The BHDS system also tracks data on waitlists for outpatient treatment, for CGCs only. The findings indicate that the median number of days between referral date and start date (intake date) is 11 days. Eighty-nine percent of the responding CGCs had median waitlists of less than 20 days.

The Agency Survey quantitative findings suggest that waitlists are not much of a problem; however, our focus groups with other system stakeholders suggest that waitlists continue to be present in the outpatient treatment system. The discrepancy appears to be related to a distinction between the waitlist to receive an intake assessment and the waitlist to receive ongoing treatment. Parents, DCF ARG staff members and DCF Area Office Behavioral Health Directors all reported that the ECC initiative has reduced the time from referral to intake, but additional attention must be given to reducing the amount of time

between referral and the beginning of treatment. A future initiative of the CT BHP will focus on ensuring that ECC-designated outpatient providers schedule a follow-up visit within 14 days of the initial assessment, but to date this standard has not yet been fully implemented.

Discharge characteristics. Administrators were asked to report the total number of clients that were discharged from outpatient services in an average month. Fourteen agencies reported this indicator, and the average number of discharges per month was 20.4 (s.d.=18.6) with a range of 2 to 60 discharged clients in an average month.

Caseload size. The Clinician Survey was used to examine average caseload size. In terms of caseload size, clinicians reported an average of 24.1 active clients with a range of 0 to 90 clients; however, caseload size differed significantly according to title/position. The average number of clients on the caseload for clinicians, clinician-administrators, psychiatrists/APRNs, and interns, respectively, was: 29.0, 16.3, 45.6, and 6.8.

Some stakeholders in the outpatient treatment system reported that outpatient clinicians tend to see some clients less than weekly in order to: 1) meet ECC access standards and 2) increase capacity for treatment. DCF and ValueOptions staff members noted that some clinics tend to see clients on a once per week model of outpatient therapy, and some can be reluctant to see clients more frequently. The Clinician Survey asked clinicians to report the percentage of their clients that they see about weekly, about bi-weekly, and about monthly. Medians and ranges of reported percentages are presented in Table 13. The results indicate that among those responding to this survey, the median reported percentage of clients seen weekly among clinicians, clinician/administrators, psychiatrists/APRNs, and interns was: 64%, 67%, 26%, and 100%, respectively.

Table 13. Caseload Information

Type of Outpatient Clinician	Median Percentage	Range of Percentages
Clinicians (n=36)		
Percentage seen weekly	64%	16% – 100%
Percentage seen bi-weekly	31%	0% – 100%
Percentage seen monthly	10%	0% – 100%
Clinicians/Administrators (n=15)		
Percentage seen weekly	67%	35% – 100%
Percentage seen bi-weekly	25%	6% – 100%
Percentage seen monthly	0%	0% – 100%
Psychiatrists/APRNs (n=2)		
Percentage seen weekly	26%	6% – 45%
Percentage seen bi-weekly	17%	6% – 27%
Percentage seen monthly	57%	27% – 88%
Interns (n=6)		
Percentage seen weekly	100%	68% – 100%
Percentage seen bi-weekly	9%	0% – 18%
Percentage seen monthly	7%	0% – 14%

A two-tailed Pearson's correlation was performed using only the data from those who identified as clinicians (n=36) to examine the relationship between number of clients seen per week and the reported percentage of clients seen weekly. The results indicate a significant negative relationship between the two variables ($r = -.46, p < .01$). This suggests that, among responding clinicians, having a relatively larger caseload is related to seeing a smaller proportions of clients weekly.

Length of stay in outpatient treatment. Each agency administrator was asked to report the average number of treatment sessions attended during the course of treatment among discharged cases (defined as cases that completed the intake process and began treatment sessions). Administrators were asked to report the percentage of discharged clients who attended no treatment session; 1 to 5 treatment sessions; and 6 or more treatment sessions. These findings are presented in Table 14.

Table 14. Average Treatment Sessions

Average Treatment Sessions	n	Median Percentage	Range of Percentages
0 treatment sessions	8	4%	0% - 16%
1-5 treatment sessions	9	23%	2% - 38%
6 or more treatment sessions	10	70%	45% - 100%
Completed treatment	10	65%	12% - 80%

As reported in Table 14, the median reported percentage of cases that complete six or more sessions was 70%. Thus, many of the cases that complete the intake process go on to complete six or more treatment sessions; however, this does not take into account the percentage of clients that are referred for outpatient treatment but do not complete the intake. Our data show that the median reported percentage of cases that complete the intake process is 59% (see Table 12). Recent research suggests that approximately one half of children, on average, complete enough treatment sessions to be considered “engaged in treatment.”¹²⁻¹⁴ Longitudinal research with a large sample of Connecticut children and families seeking outpatient treatment would be needed to inform stronger conclusions on issues of case flow and rates of treatment engagement.

Length of stay in outpatient is a primary indicator reported in the Behavioral Health Data System (BHDS) as well. The BHDS does not, however, report the number of *treatment* sessions during a treatment episode, only the length of time from case opening until discharge (or the end of the quarter for those still in care). According to 3rd Quarter BHDS data, the median length of stay among cases still in care is 12.2 months for boys and 11.3 months for girls. This suggests relatively long treatment duration among children served in CGCs.¹¹

We asked agency directors to discuss issues of caseload and length of stay as they relate to perceptions about service quality among other system stakeholders. With outpatient services increasingly being delivered to children with complex needs who might be appropriate for higher levels of care, clinics vary in their views of what constitutes an

appropriate length of stay. Some agency administrators supported keeping cases open for relatively long episodes of care and reported that their perception was that many families prefer a long-term connection to an agency as opposed to episodic treatment. Other agency administrators maintained a treatment philosophy focused on relatively brief treatment episodes with a higher tolerance for multiple re-admissions, as needed.

Agency administrators that supported relatively longer treatment durations reported their belief that this approach is unfairly associated with the perception that they provide poorer quality services. System stakeholders such as DCF Area Office Directors and Behavioral Health Directors acknowledged that this bias can exist. Specifically, these stakeholders reported their belief that providers with longer than average treatment durations tend to offer “poorer quality services,” “keep cases open indefinitely,” “have long waitlists,” and “have difficulty articulating treatment goals.”

Administrators espousing a treatment philosophy that supports brief treatment episodes with multiple re-admissions, as needed, described this model as more clinically appropriate and more efficient because it allows them to serve a larger number of clients over time and meet access standards. One director stated:

“It’s not normal for kids to be in therapy, they should be out in the community doing kid things and they’re gonna have bumps along the way where they will come back in and get some support and get some therapy. But what we do in our clinics is therapy, it’s not being your friend or being your mentor, and that was a real line that we drew.”

Our interviews with DCF Central and Area Office staff indicate that long treatment durations are not expected to be supported as a sustainable treatment model. DCF leaders indicated their long-term intention to prioritize shorter outpatient treatment episodes using relatively brief, evidence-based treatments. DCF leaders reported a perception that shorter treatment episodes will help increase treatment capacity and timely access to services for new clients. Outpatient agency administrators, on the other hand, report a perception that treatment length should be driven by treatment need and response. As will be discussed later in this report, there is variable capacity across the outpatient network to collect standardized, reliable assessment and outcome measures throughout treatment and to measure treatment response. The ability to measure and track treatment response would be necessary to determine an appropriate length of stay in treatment.

Advocates of both approaches note difficulties in accurately assessing the quality of their outpatient clinics. Clinics with many long-term open cases can be susceptible to underestimation of the preventive and cost benefits of longer-term treatment. On the other hand, clinics with many brief episodes can be criticized for poor long-term outcomes if a significant proportion of their cases experience treatment re-admissions. DCF staff reported wide variability across sites in their treatment philosophies as it relates to case flow, length of stay in treatment, and overall service quality. Generally speaking, agency administrators suggested further analysis of the effectiveness of outpatient treatment within the context of differing treatment philosophies in order to better understand the complexity of outpatient

treatment effects. Furthermore, agency administrators opposed an arbitrary determination of a maximum length of stay, reporting that length of stay should be driven by child and family need and treatment response.

This study did not collect the data necessary to respond to the question of whether treatment duration is, in fact, related to treatment quality. Rather, this study summarizes general perceptions on the issue as articulated by various stakeholders. The treatment literature is inconclusive as to whether total number of treatment sessions is related to children's outcomes. At least three studies demonstrate no relationship between the number of attended sessions and outcomes; however, many of these studies examined a simple relationship between number of sessions and outcomes on single indicators.¹⁵⁻¹⁷ At least one study has reported a reverse-dose-response relationship whereby fewer sessions were related to better outcomes.¹⁸ Another study found a positive dose-response relationship linking more sessions to better outcomes.¹⁹ Finally, a recent study of 125 children randomly assigned to a public county-wide system of care examined dose-response relationships using multiple standardized outcome measures.²⁰ In each of the analyses examining the impact of total number of sessions on various measures of treatment outcome, there were no significant dose-response relationships discovered. As becomes clear from the literature and from the perspectives summarized in this study, the issue is complex and requires further study in order to inform policy.

Enhanced business practices were described by some agency administrators as a primary means by which they deal with issues of treatment capacity. For example, some clinics offer financial incentives to clinicians to see additional cases, beyond the number of cases that generate the revenue to support their salary and benefits. A portion of additional revenue can be used for incentives and a portion can be used to facilitate hiring additional clinicians. Practices such as these are an important way to manage caseloads, reduce waitlists, increase revenue, and enhance capacity. However, some outpatient treatment providers caution that good business practices are necessary, but not sufficient, for raising the overall quality of care in outpatient treatment. In general, providers agreed that good business practices and fiscal management are important to the outpatient system, particularly in difficult economic times, but they must be coupled by an appropriate level of financial support and infrastructure development to meet the needs of children and families.

Treatment Access

As noted previously in this report, a long-standing issue nationally and in Connecticut is that the need for mental health treatment outstrips system capacity. This is a function of the prevalence of mental health treatment needs among children as well as a history of investment in inpatient and residential as opposed to community-based treatment options. Among the stated priority areas for DCF is a focus on increasing capacity in the children's mental health system to meet the need and ensuring timely access to treatment primarily through expanding the presence of community-based treatment options and achieving significant improvements in system efficiency. A major initiative related to improving capacity and access is the ECC initiative, which has focused on identifying and meeting the

needs of children with emergent, urgent, and routine mental health concerns (see Appendix 5 for a summary of ECC requirements).

Clinic administrators agreed that the ECC initiative has successfully lowered the amount of time between referral and intake appointments. During site visits, outpatient administrators almost invariably reported their clinics are meeting ECC access standards. Many agency administrators also reported improved access to treatment, shorter waitlists, significant decreases in client no-shows, and increased agency attention to overall efficiency. Several challenges were reported related to meeting ECC standards. The primary challenge, described by six agencies, is the need to hire additional staff to meet access standards, which could include assigning more clinical staff to intake positions to ensure that capacity meets the demand for services. Some administrators describe ECC standards as a “burden,” even though many of these administrators acknowledged that the initiative has resulted in numerous service delivery improvements. Many agencies have contracted externally for information technology (IT) support in order to automate intake and appointment scheduling and meet access standards. Most administrators reported that these costs were not covered by the average 25% rate increase for outpatient services implemented under the ECC initiative.

A primary concern is the need to increase not only access to timely intake following referral, but also access to outpatient *treatment* services. Despite the acknowledged success of the ECC initiative for increasing access to intakes, it is less clear that the ECC initiative has affected the amount of time from referral to treatment. It is important to note that this was an initial priority of the ECC initiative, but limited resources necessitated an initial focus on access to timely intake appointments. Parents, DCF leadership, and ValueOptions staff all noted their continued concerns about flexibility of hours once treatment sessions begin. Specifically, parents reported difficulty obtaining treatment appointment times during non-school hours. They noted that it was problematic for working parents and for teachers to release a child from school for therapy appointments, as is frequently requested by outpatient clinicians. DCF Area Office Directors described similar concerns with the limited availability of appointments after 5:00 p.m., although there was disagreement among Area Office Directors regarding the extent to which the ECC initiative has helped with opening up more evening appointment slots. DCF ARG and ValueOptions staff members also noted that outpatient clinics tended to have mostly daytime (8am to 5pm) appointments that made it difficult for families to consistently engage in treatment. Increased responsiveness, flexibility, and customer service were suggested as ways to improve treatment engagement and client outcomes.

Parents and some system stakeholders also reported that some clinics have increasingly terminated services if more than three appointments were missed. It is possible that this is an unintended consequence of the ECC initiative as clinics strive to meet access requirements, improve case flow, and meet productivity standards. Outpatient providers cited a need to improve efficiency and productivity, resulting in increased “gate keeping” that allows efficient distribution of limited outpatient resources (i.e., treatment slots). Parents noted that when this occurs, there often is little consideration of contextual factors, such as lack of transportation. Rather than working with the family to address barriers to treatment, parents reported that their cases too often are closed with little discussion, explanation, or attempts to

address barriers. DCF Area Office Directors and Behavioral Health Directors reported the same concern with closing cases due to a relatively small number of missed appointments, as opposed to addressing existing treatment barriers.

These Directors recommended promoting strategies that increase treatment engagement, especially for families with highly complex needs, and those that have demonstrated past difficulties engaging in treatment. Family advocates recommended that outpatient providers engage in practices that promote full family involvement in decision-making, including case termination. Family advocates recommended that providers develop procedures to ensure that families are made aware at the outset of treatment about their policies concerning missed appointments and discontinuing services, and that clinicians be required to meet with families to discuss and address reasons for missed appointments prior to closing a case.

Summary of Treatment Capacity and Access

It is difficult to underestimate the importance of issues of treatment capacity, access, case flow, and length of stay. The efficiency and effectiveness of the outpatient system relies heavily on these issues, and the data suggests that more work can be done in these areas. Our results suggest that even though the ECC initiative has significantly reduced the length of time from referral to intake, there remain concerns about the length of time from referral to treatment. Consistent monitoring of both types of waitlists and initiatives to address these access issues is required.

In order to meet the demand for services, outpatient stakeholders should work together to identify ways to deliver care more efficiently, ways to increase capacity and access, and ultimately, could consider ways to open more outpatient clinics and hire more clinicians. Some clinics have implemented innovative business practices and believe this is the best way to motivate and compensate clinicians, see more clients, reduce waitlists, and generate revenue. The increased revenue then has been used to hire more clinicians to meet the demand for services. More attention to the business side of mental health could benefit the outpatient mental health system, however, good business practices are necessary, but not always sufficient, to support outpatient treatment. A few innovative business practices were described by participants in this study, and many more are likely to exist statewide. It appears that these innovative practices are not widely known among outpatient stakeholders, making it difficult to identify and disseminate promising practices. Further examination of best practices occurring in the state could be helpful for the outpatient system as a whole if these practices were operationalized and disseminated across the state.

An additional concern is differing treatment philosophies across agencies regarding length of stay, with some advocating long-term episodes of care and others emphasizing brief episodes of care with multiple re-admissions as needed. DCF has expressed concern with long lengths of stay in outpatient treatment and believes this is closely related to capacity and access issues; thus, they have expressed an intention to support shorter lengths of stay in outpatient treatment using evidence-based treatments. It is generally recommended that length of stay be driven by treatment need, which necessitates the use of reliable assessment

measures throughout treatment and analysis of treatment response to guide discharge recommendations.

Client and Case Complexity

Outpatient administrators and clinicians, DCF leadership, and ValueOptions staff all agreed that children and families seeking outpatient treatment present with highly complex needs. For example, one clinic director reported that in the last ten years, the clinic has gone from six hours a week of contracted psychiatric consultation to a current level of over 30 hours a week. Many clinic administrators and clinicians also reported their perception that the level of acuity of children in outpatient treatment has increased in the last several years. During our site visits, administrators and clinicians described that the families in outpatient treatment have significant histories of poverty, parental substance abuse and psychiatric difficulties, ethnic minority and/or immigration status, language barriers, trauma histories, transportation limitations, and lack of familiarity with the broader mental health service system. Survey data from agency directors also supports the contention that outpatient clients present with highly complex needs. Median percentages reported by the administrators we surveyed suggested that many children served in routine outpatient treatment have previous inpatient hospitalizations, have been or are involved with DCF, and have a co-morbid psychological condition.

To address the issue of client and case complexity, clinicians were asked to describe the clients they serve on a number of indicators. Clinicians completed 19 survey items assessing the approximate proportion of their caseload that had certain needs known to contribute to the overall complexity of a case. Respondents answered each item on a 5-point scale from 1 (“none of my clients”) to 5 (“all of my clients”). Higher average scores reflect that the particular indicator of complexity is highly prevalent among outpatient cases. The five most prevalent issues, with mean scores above 3.0, included:

- Treatment requires parent/family involvement
- Treatment requires communication with other agencies
- Child has co-morbid conditions
- Family is experiencing significant poverty
- Parent has a mental health diagnosis

A number of indicators of case complexity were related to issues of family engagement. In addition to family engagement, clinicians identified the need for collateral contact with other systems and providers. Co-morbid conditions also were identified, suggesting that many children have complex needs requiring multiple interventions and strategies. Finally, the systemic problem of family poverty was identified as affecting a large proportion of the outpatient population.

Other prevalent concerns included parents with a mental health diagnosis who might also be taking psychotropic medication(s), siblings with a mental health diagnosis, DCF involvement, and lack of transportation. Results for each indicator of case complexity are presented in Table 15.

Table 15. Factors Contributing to Case Complexity

Item	Mean Score
Requires parent and family involvement in treatment	3.95
Child's treatment requires communication with other agencies	3.79
Co-morbid conditions	3.27
Significant poverty	3.13
Parent has a mental health diagnosis	3.08
More than one psychotropic medication	2.98
DCF involvement	2.92
Sibling has a mental health diagnosis	2.60
Lacks transportation	2.59
Parent currently in mental health treatment	2.43
Sibling currently in mental health treatment	2.43
Currently in foster care	2.35
Would be in intensive treatment setting if not in outpatient	2.32
Child and/or family not motivated for treatment	2.32
Past history of placement in intensive treatment setting	2.27
Committed to DCF care	2.21
Juvenile justice involvement	2.17
On the waitlist for a more intensive treatment setting	1.92
Mandated to attend treatment	1.92

Other stakeholders in the outpatient treatment system also recognized the complexity of outpatient cases. Most Area Office Directors agreed that the complexity of cases is very high. Our focus group with DCF ARG staff members revealed general consensus that the needs of the outpatient population were “highly complex” and “extremely challenging.” Most DCF Area Office staff members agreed that the complexity of cases they refer to outpatient treatment has increased over the past several years. Some DCF Behavioral Health Directors believed that the complexity of needs is now so high that a traditional model of outpatient treatment involving one hour of weekly face-to-face therapy makes it very difficult to meet the needs of the clients they refer for outpatient treatment.

A potential reason for increasing complexity relates to the role of outpatient treatment programs within the service continuum, as described earlier in this report. Specifically, outpatient administrators report that routine outpatient treatment programs regularly provide care for children who are on the waitlist for higher levels of care, such as Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) program, Partial Hospital Programs, and Extended Day Treatment programs, or even inpatient and residential treatment. Parents attending the Connecticut Behavioral Health Advisory Council (CBHAC) focus group identified the need for outpatient programs to provide step-down services and suggested that outpatient plays a pivotal role for children with complex needs that have been, or are at-risk for, involvement in higher levels of care. In addition, to serving as a “holder” for children on waitlists for higher levels of care, outpatient treatment also is regularly used for children

transitioning out of these programs. We found that other treatment programs often incorporate recommendations for outpatient treatment into clients' discharge plans. Reliance on outpatient treatment as both a "holding place" for children waiting for higher levels of care, and a "step-down" for children discharged from higher levels of care could contribute to a high rate of growth in enrollment in the future. Furthermore, a prevailing perception among outpatient administrators and clinicians is that they are currently serving clients that would have been considered, just a few years ago, to have a level of treatment need that was too high for outpatient services. Issues of increasing case complexity create a "drain" on system resources and can present quality of care issues if the needs of cases exceed the resources and capacity of the outpatient treatment system.

Summary of Case Complexity

The theme of increasing client complexity in outpatient treatment was a relatively consistent one across all stakeholder groups we encountered. Case complexity, in the form of issues such as co-morbid conditions, parental psychiatric impairment and substance issues, poverty, maltreatment, and DCF involvement, translates to a need for increased case management and care coordination. These needs place strain on the outpatient system, on clinicians, and on the ability of outpatient clinics to remain financially viable while still providing high quality care. Policy- and systems-level issues could be part of the reason for increasing case complexity. The implementation of KidCare has placed increasing emphasis on maintaining children in their homes and communities instead of higher-end treatment such as residential programs and inpatient hospitalization. As this has occurred, children with complex needs who would have been placed in these more intensive treatment settings several years ago are instead more likely to be in lower levels of care, including outpatient treatment. If lower levels of care are not adequately equipped to manage the influx of children into their programs, then increasing strain will be placed on providers to provide treatment to a population of children and families with highly complex needs. This issue has implications in many areas, one of which is screening and assessment.

A potential solution is for system-wide implementation of a standardized assessment instrument for all children entering outpatient treatment. This would provide a standardized way to assess and compare acuity levels across the state, track outcomes, and achieve more efficient resource utilization. The current perception among providers is that state agencies and legislators are unaware of the level of acuity in outpatient services and could make better-informed decisions about funding and resources if there was a better way to systematically assess and track acuity across the state. Furthermore, many sites reported a pressing need for best- and evidence-based practices and treatments for young children, parenting skills training, and related service coordination. DCF Area Office Directors highlighted the need to provide support for increased case management. In general, use of standardized assessment of needs and risk, linkage to appropriate case management, and increasing use of evidence-based treatments would have important benefits for children and family in routine outpatient treatment settings and would enhance efficiencies and outcomes within the outpatient treatment system.

Case Management and Family Engagement

Given the increasing complexity of outpatient clients, it is clear that many children and families in outpatient treatment are in need of significant time, resources, and care coordination. Outpatient clinicians are called on to provide not only treatment but also case management services for a large caseload of clients and families. Clinics must navigate a delicate balance between the need for case management as an important aspect of high quality clinical care and the need to generate sufficient revenue to remain in business. Furthermore, much of case management relates to family engagement. Issues of treatment capacity and access, client and case complexity, case management, and family engagement each are closely related to one another.

Case Management

Agency directors described the pressing need for case management among children and families seeking outpatient treatment. Nearly all agency administrators held the perspective that high quality children's mental health treatment requires coordination between parents, schools, pediatricians, mental health providers, and sometimes many others; however, agency directors also report that reimbursement rates for case management are insufficient to meet that need. A review of the literature for studies that compare reimbursement rates across states did not yield meaningful published data on how Connecticut's rates compare to other states. Our site visits findings and data from agency administrators indicated that a significant portion of the case management that is requested, expected, or required is not reimbursable. The most common examples of non-reimbursed case management included off-site case management activities; for example, Individualized Education Plan (IEP) meetings at schools and attendance at court proceedings for youth with juvenile justice involvement. Case management activities that are difficult to reimburse strain the resources of many outpatient programs. Other system stakeholders such as DCF and ValueOptions reported that the amount of case management that takes place in outpatient departments varies from clinic to clinic, but in general, the amount of case management that takes place, particularly outside of the office, is minimal.

We were interested in determining the extent to which case management is required and carried out by clinicians. On the Clinician Survey, we defined collateral contacts as "family members, teachers, physicians, probation officers, or others that are interested in the treatment and well-being of children in outpatient services." Clinicians were asked to report the number of collateral contacts, on average, for each child on their caseload and the average number of hours each week spent contacting collaterals. The results indicated that an average case involves contact with 3.8 collaterals, however, results differed by type of clinician. Therefore, the results were stratified and reported in Table 16. For full-time clinicians, the average reported number of collateral contacts was 3.4, and for clinicians in an administrative position, the average number of collateral contacts was 5.1. Using the data for full-time clinicians, the average caseload (29.0) multiplied by the average number of collaterals per case (3.4) suggests that an average full-time clinician is in contact with 99 individuals at any given point during the year. Full-time clinicians report that, on average, 3.6 hours are spent each week communicating with collateral contacts.

Table 16. Collateral Contacts

Collateral Contacts	Overall (N=62)	Clinicians (n=39)	Clinician/ Admin. (n=15)	Psychiatrists and APRNs (n=2)	Students/ Interns (n=6)
Average caseload	24.1	29.0 cases	16.3 cases	45.6 cases	6.8 cases
Average number of collateral contacts for each case	3.8 contacts (s.d.=3.9)	3.4 contacts (s.d.=3.7)	5.1 contacts (s.d.=5.2)	3.5 contacts (s.d.=0.7)	3.7 contacts (s.d. =0.8)
Average number of hours contacting collaterals each week	3.2 hours (s.d.=2.1)	3.6 hours (s.d.=2.4)	2.6 hours (s.d.=1.4)	1.5 hours (s.d.=0.7)	2.3 hours (s.d.=1.0)

These data suggest a great need for case management yet agency administrators and clinicians report difficulties meeting that need. Other system stakeholders expressed a perspective that collateral contacts need to be increased. Some DCF Area Office Directors believed that outpatient clinicians should be obligated to attend more collateral meetings in the community such as school IEP meetings or court sessions; however, other Area Office Directors recognized the difficulty of expecting that clinicians could attend these meetings and still meet expectations for office-based therapy appointments. The issue of case complexity and the need for case management is a challenging one. Some case management conducted off-site is not reimbursable under certain Medicaid regulations, which adversely impacts clinician's ability to attend meetings at schools, hospitals, and other non-office settings. Recent changes in Medicaid reimbursement regulations under the clinic option allow for reimbursement of targeted case management provided in schools, which represents a significant advancement toward increased quality of care and maximization of revenue. Many providers highlighted the need for better articulation and integration of Medicaid regulations in conjunction with receiving additional training for maximizing reimbursement for case management activities. Some also noted that clinicians spend a great deal of time completing documentation related to meeting various regulatory requirements which detracts from time that could be spent providing direct services and case management. Providers commented that this includes the time spent by psychiatrists to document provision of medical oversight to clinical services which can take away from their ability to provide direct services to children and youth. In general, providers expressed concern that financial requirements and procedures are not always aligned with the optimum delivery of outpatient services.

Case management, collateral contacts, and off-site meetings have a direct impact on productivity. Due to the financial constraints and tight budgets managed by CGCs, all of the agencies that received site visits for this study reported that they require clinicians to meet certain standards for billable hours in order to remain financially viable. In the Agency

Survey, 16 of 17 administrators (94%) reported that their agency had productivity requirements. We found that an average outpatient department requires clinical staff to bill for 60% of their work hours, or 24 billable hours in a 40-hour work week. To account for high no-shows, clinicians often must schedule many more than 24 clients each week in order to meet this standard.

Competing demands for increased quality of care through increased case management coupled with pressures to meet productivity requirements creates a difficult-to-resolve dilemma for service providers. To provide high quality care, case management services must be provided; however, case management often is not reimbursable or is reimbursed at too low a rate, creating a disincentive. Many clinicians and outpatient agencies reported a commitment to providing many hours of non-reimbursable case management services knowing they are compromising productivity for themselves and their clinic. The degree to which outpatient programs are able or willing to provide non-billable case management services varies by site. What is clear is that every agency has to manage on a daily basis the tension between quality of care (i.e., case management) and the business of mental health (i.e., productivity requirements). This dilemma requires much more attention.

Agency administrators offered many potential solutions to address the need for increased case management. One important solution is to make treatment planning and some case management activities part of the treatment session. This recommendation is based on lessons learned from the implementation of evidence-based treatments and is consistent with acknowledged best practices promoting family-driven care and full family participation in treatment decision-making. Incorporating at least some case management into treatment sessions has distinct advantages. First, it reduces demand for a clinician's time outside of treatment sessions. Second, it can model for parents and caregivers appropriate advocacy, promote skill development, and enhance families' ability to navigate multiple and complicated systems such as mental health, child protection, schools, juvenile justice, and primary care medical settings.

Many outpatient sites have hired or consider hiring paraprofessional staff, parents with experience in the mental health system, or undergraduate students to provide case management. Some agencies have supplemented CGC funding with external grant support to do so. This allows for primary clinicians to spend more of their time providing direct, billable services and is consistent with DCF's stated priority to increase opportunities for families to participate in their child's treatment as well as in the service delivery process as paid employees and consultants. Increasing the presence of parents and paraprofessionals in outpatient clinics has numerous benefits and the potential to reduce burden on full-time clinicians. To date, the state has had limited resources to implement this vision, and from the perspective of agency leadership, the amount of time and resources required to hire and train these staff can adversely impact productivity. Many agency administrators expressed a desire for the state to provide grant funding to support at least 1.0 FTE of case management, though the current funding climate makes this unlikely.

Clinics have taken numerous other approaches to address this issue. Some agencies provide clinicians with financial incentives each month for meeting or exceeding

productivity standards. We are aware of at least two outpatient clinics that recently lowered their productivity expectations to allow for more case management, due to their concerns about a drift in quality of care. Several administrators are advocating for further changes to Medicaid reimbursement policies relating to case management, including better alignment of Medicaid regulations across systems. Several agency administrators felt strongly that allowing reimbursement for targeted case management services provided *off-site* (as has been accomplished in allowing for reimbursement of case management in the schools under the clinic option) would significantly reduce the tension between productivity and quality of care. Another system stakeholder suggested that clinics engage in fundraising activities that will allow them to loosen productivity requirements, lower case loads, hire additional staff, or provide more case management. Given the complexity of Medicaid regulations, local and statewide solutions have promise for helping to manage this tension.

Client and Family Engagement

Family engagement is related to issues of treatment access and duration. Even though the literature has been equivocal on the issue of treatment duration and its relationship to outcomes,¹⁵⁻²⁰ best practices in children's mental health support the importance of client and family involvement and engagement in treatment.⁶ Some outpatient departments report pressure to close cases after consecutive missed appointments because it provides them with greater flexibility to meet access standards and efficiently manage the demand for services. In that sense, strict access standards can be a deterrent to family engagement, unless equally strong expectations for family engagement are put into place as a counterbalance.

This study examined clinicians' beliefs about the factors that are most closely related to positive client outcomes. The Clinician Survey invited clinicians to rate the importance of 19 factors, with response options ranging from 1 ("not at all effective") to 5 ("extremely effective"). Fifty-four clinicians responded to these items; findings are presented in Table 17.

Table 17. Clinician Perceptions of Factors Contributing to Improved Outcomes

Item	Mean Score (n=54)
Therapeutic alliance	4.63
Client's engagement in treatment	4.61
Client's level of motivation for treatment	4.52
Parent/family participation in treatment	4.43
High consistency in treatment (i.e., attended sessions relative to missed sessions)	4.43
Client access to psychiatric assessment and medication, as needed	4.24
Culturally competent treatment	4.20
High frequency of treatment	4.07
Staff training and professional development activities	4.07
Clinical supervision	4.07
Comprehensive assessment and diagnosis	4.04
Peer support from colleagues and administrators	4.02
Access to a comprehensive service array	4.02
Case management	3.96
Treatment planning (e.g., identifying goals and strategies, tracking progress)	3.91
Discharge planning	3.81
Use of evidence-based treatments	3.57
Use of assessment measures to assess progress in treatment	3.40
Long duration of treatment (total number of sessions over a long period of time)	3.38

There was a tendency for clinicians to agree that all factors were important to promoting positive client outcomes. All indicators were rated above 3.0 which suggests that each activity was viewed as at least “moderately effective.” Despite this response tendency, the top five clinician-rated activities supporting good clinical outcomes appear to be closely related to one another, and can be described as falling under the general category of client and family engagement in treatment. The top five factors included:

- Therapeutic alliance
- Client's engagement in treatment
- Client's level of motivation for treatment
- Parent/family participation in treatment
- High consistency in treatment (attended sessions relative to missed sessions)

Recent BHDS data supports this theme as well. The BHDS asks CGCs to report reasons for discontinuation of services among all discharged cases.¹¹ Providers are allowed to identify one or more reasons, as appropriate for each case. In Quarter 3 of FY 2009, three of

the top five most frequently identified reasons for discontinuation of outpatient services could be construed as being related to client and family engagement. The rank order of reasons (from most to least commonly identified) included:

1. Child/family chose to discontinue services
2. Child/family did not participate in treatment
3. Completed treatment goals, symptoms abated
4. Unable to follow-up with child/family
5. Presenting problem resolved, client stable
6. Services to be provided by another agency
7. Child requires higher level of care
8. Child/family moved
9. Other reasons
10. Agency initiated discontinuation of services

As demonstrated by the above findings, clinician self-report and agency-level BHDS data underscore the importance of client and family engagement in outpatient treatment. In addition, parents at the CBHAC focus group also identified family-oriented treatment as a significant gap in outpatient service delivery. Some parents expressed the perception that they are “not listened to” and not fully integrated into treatment planning and treatment delivery. Many parents reported that they believe treatment sessions should include parents and even siblings. The general perception was that this would result in a more family-driven approach to treatment. Some parents believed that more time should be dedicated to ensuring a good match between clinician and family. Furthermore, parents felt strongly that there should be more options for supporting families that have a child with complex and serious emotional or behavioral needs due to the stress that this places on the family unit. Parents identified CT BHP’s use of peer specialists as very well received in the parent community, and a potential model for treatment programs and services. The take-home message from their input was that families should have more involvement in outpatient treatment.

DCF ARG and DCF Area Office Behavioral Health Directors echoed their belief in the importance of family engagement. DCF Area Office Directors consistently reported the need for increased attention to issues of family engagement and retention as a primary means to increasing capacity for treatment and improving outcomes. Many DCF Behavioral Health Directors stated that issues of client and family engagement, outreach, and retention in treatment were the primary issues that must be addressed in outpatient treatment settings. They also mentioned challenges in engaging foster parents and reported that outreach to this population is critical due to high rates of behavioral health needs and the relation of behavioral problems to foster care placement disruption. An important consideration regarding client and family engagement is that not all children served at the outpatient level of care are living with a biological parent or legal guardian; nearly one-third of children currently live in relative’s homes, foster care, or group homes (see Table 5). ValueOptions staff members described the importance of good customer service (e.g., flexible treatment hours) as an important means of promoting client and family engagement and improving the overall quality of outpatient treatment. In sum, outreach to parents and consistent attention to family engagement is likely to have important effects on improving treatment attendance,

enhancing outcomes, and improving overall consumer satisfaction with outpatient treatment services, and should be a priority for improving overall service quality.

We found little disagreement with the shared goal across stakeholders of increasing family engagement in treatment. Increased family engagement increases the quality and outcomes of treatment, makes families a center point in treatment, and increases revenues; thus, it is desirable for all stakeholders. An ongoing question that remains unanswered is “to what *end* is client and family engagement important?” Some stakeholders appeared to highlight the importance of family engagements as an end unto itself, whereas other stakeholders emphasized the importance of client and family engagement as a necessary first step toward implementing an effective treatment strategy. This issue appears to be reflective of differences in treatment philosophies and approaches, and perhaps, theoretical orientations. Regardless of the approach taken to enhance client and family engagement, all such efforts must take into consideration existing treatment barriers (including poverty, transportation issues, availability of culturally and linguistically appropriate services) as important reasons for case terminations.

Summary of Case Management and Family Engagement

Case management in children’s mental health is a large and often hidden cost to agencies requiring hard work from outpatient clinicians and support staff. Outpatient clinics must struggle with balancing the business of mental health with the commitment to maintaining high standards for quality of care. The fact that many case management activities are not reimbursable creates disincentives for this work. It is important to highlight the often vastly conflicting perspectives between providers and other stakeholders on the issue of case management. Providers report extensive case management activities and difficulties with reimbursement, whereas families and DCF report limited case management, particularly in off-site locations such as schools. Some, but not all outpatient clinics have found innovative ways to manage this tension. To help ease this tension, consistent attention to and monitoring of case management activities could be applied. Furthermore, outpatient providers could engage in seeking additional grant opportunities and community fundraising to increase revenues and provide funding for case management. Innovative business practices adopted by some agencies could be widely disseminated. Full caseloads could generate additional revenue allowing outpatient departments to hire additional staff and meet the demand in their local community. The state, providers, and the CT BHP should work together to identify additional ways to reimburse for case management, perhaps under the Medicaid rehabilitation option. One way to address the concerns raised by provider organizations is to ensure that outpatient clinicians are regularly educated about Medicaid regulations on case management reimbursement. In addition, there appeared to be consensus that Medicaid regulations across systems should be aligned to maximize revenue while also providing high quality treatment. This process could also help make stakeholders’ broader goals more compatible with financing and reimbursement requirements.

An important aspect of case management is family engagement, which directly impacts treatment access and duration. Analysis of the reported data on treatment referrals, intakes, completed intakes, and treatment sessions suggests the possibility that perhaps more than half

of all referrals to outpatient treatment are not ultimately engaged in treatment; a figure that is consistent with existing research. Family engagement appears to have a central role in outpatient treatment and was repeatedly mentioned as a potential area for further work in the outpatient treatment system. Efforts to engage families must include attention to the many treatment barriers that stand in the way of consistent treatment attendance. Furthermore, system stakeholders must attend to the issue of why treatment engagement is important; that is, whether treatment engagement is effective treatment, or whether treatment engagement is a necessary pre-condition that supports the delivery of effective treatment.

Screening, Assessment, and Service Delivery Practices

Intake Procedures

The intake and diagnostic evaluation process is critical to the treatment process. It is during this time that children, family members, and clinicians develop an initial relationship that will guide the remainder of the treatment process, identify the needs of the child and family, and develop a treatment plan targeted to meet those needs. Multi-informant interviews, assessment measures, observation, psychological testing, and other strategies can be used during the intake process to accomplish these goals.

Although there is some variability between outpatient providers in the specific approaches to conducting intake assessments, they have many of the same elements. All nine agencies that received site visits reported that they had a standardized intake procedure, and 82% of clinicians reported that they use an intake protocol as part of their routine intake procedure. On average, clinicians rated their intake procedures as “moderately helpful” to “very helpful.” All visited sites reported that they include an initial telephone contact with a parent or guardian and schedule an initial in-person appointment at the clinic to complete insurance and registration paperwork. Sites generally conduct thorough bio-psycho-social assessments and the duration of the intake assessment phase ranges from two to four weeks. Detailed information is collected regarding the presenting problem, previous treatment history, and medical needs. The first intake sessions typically are used to begin formulating a treatment plan.

There are minor areas of variability in intake assessment approaches. One area of difference is the type of clinician(s) involved in the assessment process, with some clinics utilizing an intake coordinator or team, some relying solely on a primary clinician from intake through treatment, and various levels of involvement of psychiatrists and Advanced Practice Registered Nurses (APRNs) to assess the need for medication at the time of intake. One agency reported that they have experienced some success in reducing no-show rates using a group orientation process prior to scheduling a full intake.

Assessment Instruments

Results of the Clinician Survey indicated that 80% of respondents use screening or assessment instruments during the intake process. Our site visits revealed that agencies generally collect the Ohio Scales during the intake process; however, some sites report that

their completion of this measure has become less consistent over time. When queried further, these sites reported that the Ohio Scales data have not been reported back to them in the past and they see little value in collecting these data. When asked on the Clinician Survey about the perceived relation of various activities to facilitating positive outcomes, “use of assessment measures to assess progress in treatment” was rated as second from last in terms of relative importance (see Table 17). A few sites reported that they analyze Ohio Scales data internally. Six agencies specifically mentioned that they incorporate trauma screenings into their intake assessment. The Trauma-Focused CBT Learning Collaborative project has increased the use of trauma screening tools across the state.

Parents expressed some concern with the intake assessment and diagnosis process. Many parents at the CBHAC focus group expressed their concerns with “over-assessment” described as having to repeatedly share their story with multiple providers within the same agency or across several agencies. Further discussions with parents revealed their desire that assessments not be repeated unnecessarily and that assessment findings be shared within an agency and across agencies in the event of a transfer of services. Providers described the importance that each clinician conducts an assessment in order to build rapport and formulate their own clinical conceptualization. Parents viewed their experiences with assessment as being somewhat “deficit-based.” In addition, parents noted the lack of availability of psychological testing as part of the assessment process, particularly access to neuropsychological testing. Providers noted that a primary reason psychological testing is limited is due to Medicaid and licensing regulations that make it difficult to reimburse for psychological testing conducted by anyone besides a licensed clinical psychologist. Because many providers have historically used psychology interns or trainees under supervision to provide psychological testing and because access to licensed psychologists is limited, these regulations significantly limit access to testing services. DCF Area Office Directors did not appear to share parents’ concerns with the intake assessment process. Most viewed the process from initial contact to the beginning of treatment as relatively standardized across outpatient clinics with relatively few problematic issues or quality concerns. On the other hand, ValueOptions staff noted that there is a lack of standardization of intake and assessment procedures, and standardization would facilitate an improvement in quality and continuity of care that would benefit the statewide outpatient system.

These conflicting reports about intake and assessment procedures require further exploration, particularly the issue of having a more standardized intake process. Across all system stakeholders, the importance of good intake assessment procedures was acknowledged. System stakeholders generally consider a bio-psycho-social intake assessment approach to be standardized across clinics and reflective of best practices. Many stakeholders, however, believed that in addition to a bio-psycho-social intake process, there would be tangible benefits to using standardized instruments to assess and track level of treatment need, identify strengths, and use that information to guide the treatment process. DCF Area Office Behavioral Health Directors and ValueOptions staff members reported that there is a need for better, more standardized assessment instruments and procedures that are transferable across clinics and can follow cases regardless of their point of access in the mental health service system.

Clinician Time Allocation

Clinicians were asked to report the percentage of work hours spent in various activities during a typical week. The findings were stratified by type of clinician and reported in Table 18. Clinicians and students/interns reported spending the most time in direct service delivery including individual and family therapy. The median reported percentages of time spent on individual therapy and family therapy were 25% and 15%, respectively. In addition, the median reported percentage of time spent on case management and clinical paperwork was 10% for both activities. Median reported percentages of less than 5% were reported for the following activities: prescribing medication, training, consultation, preparation, doing billing paperwork, prevention and outreach, and other activities. The data presented in Table 18 include medians of reported percentages that were 5% or higher with ranges in parentheses.

Table 18. Proportion of Work Week Spent in Outpatient Activities

	Overall (n=61)	Clinicians (n=37)	Clinician/ Admin. (n=16)	Psychiatrists/ APRNs (n=2)	Students/ Interns (n=6)
Direct individual therapy	25% (0%-85%)	25% (1%-85%)	15% (5%-65%)	15% (0%-30%)	38% (10%-40%)
Direct family therapy	15% (0%-75%)	20% (0%-75%)	12% (3%-40%)	3% (0%-5%)	5% (0%-10%)
Case management	10% (0%-25%)	10% (2%-25%)	8% (3%-23%)	5% (0%-10%)	13% (10%-20%)
Meetings at clinic	5% (0%-20%)	5% (0%-15%)	5% (3%-20%)	8% (5%-10%)	13% (5%-20%)
Meetings outside clinic	5% (0%-15%)	4% (0%-10%)	5% (0%-15%)	4% (2%-5%)	8% (5%-10%)
Clinical supervision	5% (0%-40%)	4% (1%-19%)	13% (0%-40%)	9% (8%-10%)	15% (5%-30%)
Doing clinical paperwork	10% (1%-30%)	10% (1%-30%)	10% (1%-20%)	10% (10%-10%)	10% (10%-20%)

Note. Data represents median of reported percentages with the range of reported percentages in parentheses.

CGCs also report data to BHDS that has relevance to our analysis of service delivery and generally is consistent with the findings reported above.¹¹ Respondents were asked to report via BHDS whether each of ten services was provided to each of the clients on their caseload in Quarter 3 of FY 2009. Nearly three-quarters of clients receive individual therapy, nearly three-quarters receive family therapy, and over one-quarter receive medication management. The top six most commonly reported services provided to outpatient cases included:

- Initial assessment or diagnostic evaluation (77% of clients)
- Family therapy (73% of clients)
- Individual therapy (71% of clients)
- Psychiatric evaluation or assessment (26% of clients)
- Medication management by an M.D. (26% of clients)
- Parent guidance (26% of clients)

Gaps in Service Options and Access for Certain Diagnoses

Limited access for certain diagnoses. There was consistency among stakeholders on the types of children and families for whom relatively few treatment options exist in the current outpatient treatment system, particularly according to certain diagnoses or presenting problems. Agency administrators overwhelmingly endorsed a need for treatment options for early childhood oppositionality, parenting skills training, Pervasive Developmental Disorders and Autism Spectrum disorders. DCF Area Office Directors also identified gaps in treatment options for Autism-Spectrum disorders, Pervasive Developmental Disorders, very young children, and adolescents with sexual acting out or sexual offending behavior. Mental retardation, according to CBHAC parents, “falls through the cracks” when it comes to the provision of appropriate services. The populations of children that have limited access to treatment were fairly consistent among administrators, providers, parents, and other system stakeholders.

Substance abuse treatment. DCF Area Office Directors identified substance abuse treatment services as a gap in outpatient treatment, and many stakeholders agreed that there currently is not enough capacity in the outpatient system to meet the needs of children and adolescents with substance abuse problems. Some outpatient clinics exclude youth with primary substance abuse disorders from routine outpatient services, and instead refer them to intensive in-home services or one of three DCF-funded outpatient substance abuse treatment clinics. At the time of this report, an ECC initiative is underway to define and implement a plan to address the needs of youth with co-occurring psychiatric and substance abuse concerns. The initiative will require ECCs to provide integrated screening, and in some cases, brief interventions for adolescents with co-occurring substance abuse disorders. The initiative calls for enhanced use of standardized mental health and substance abuse screening instruments, protocols for identifying and referring youth with elevated risk, linkage to appropriate assessment and treatment services, and optional consideration for outpatient clinics and substance abuse clinics to seek licensing in both areas of expertise. Such an initiative appears to be a great need based on study findings and statements of needs and gaps from multiple stakeholders. Some agency administrators recalled past efforts to obtain dual licensure in substance abuse and mental health as complicated and ultimately unsuccessful. Future efforts to expand the expertise of CGCs to enhance access to youth with substance abuse concerns can consider working closely with the provider community to ensure that licensing and accreditation issues are understood and addressed.

Psychiatric consultation and medication management. Parents at the CBHAC meeting also recognized the importance of psychiatric assessment and medication management in outpatient services. Even though psychiatric assessment and medication management was rated as highly accessible by clinicians (see above), parents reported that they experience limited access to psychiatric assessment and long waitlists. BHDS data from the 3rd Quarter of FY 2009 indicates that approximately 26% of youth in outpatient treatment are provided with psychiatric evaluation or assessment. Parents’ experience with psychiatric services was that there often is not enough time during psychiatric appointments to understand the medications being prescribed and to have their questions answered. In addition to short appointment times, parents also reported that use of medical jargon can impede full

understanding of their treatment. Other stakeholders including parents, DCF Behavioral Health Directors, and ValueOptions noted limited availability of medication management. These findings suggest an overarching perspective within the outpatient system that the availability of psychiatric services and medication management for children has not yet met the need for such services. Some providers noted that salaries for psychiatrists working in community settings lag far behind private practice and DCF salaries, making it difficult to attract psychiatrists to full-time employment in CGCs.

Treatment specialization. Outpatient treatment providers and parents identified insufficient specialization in outpatient services as a service delivery gap, an issue that is closely related to the diagnostic conditions for which few treatment options exist (e.g., autism, substance abuse, mental retardation). Many of the suggested strategies for enhancing specialization included building capacity at the clinic-level. One administrator suggested creating specialty clinics or “centers of excellence” to provide assessment, treatment, and case management for children and adolescents diagnosed with autism-spectrum disorders. Under the ECC initiative, clinics will be expected to develop specialty areas. Future implementation of this requirement should strongly consider working with outpatient clinics to ensure that their specialties match the gaps in access related to particular conditions, and that specialty areas do not overlap with one another within geographic regions.

Need for alternative treatment options. Parents identified the need for increased access to non-traditional and alternative therapies as well. One parent noted that not all children need traditional therapy or to become “little patients,” but rather, many children become overburdened and over-pathologized when referred for too many services. One Area Office Director recommended an analysis of how DCF offices spend flex funds as one way of determining service needs that go unmet in outpatient clinics.

Discharge planning. Parents at the CBHAC focus group expressed some ideas about the discharge planning process. One parent stated, “there should be an exit plan from the time you enter treatment” and others reported a desire for regular progress reviews to determine appropriate timing for discharge. When it comes time to discharge a child or family from services, parents expressed their desire for stronger aftercare plans that would allow them to transition from mostly center-based care to a network of formal and informal community-based services and supports. These suggestions generally reflect best practices in clinical care in which discharge planning starts at the beginning of the treatment episode and is guided by data on treatment response.

Summary of Screening, Assessment, and Service Delivery Practices

There was relatively little variability among outpatient clinics in the elements of the intake process, although some clinics used intake coordinators who were dedicated to conducting all intakes and others asked clinicians to conduct their own intakes. Intake protocols were common and most followed a bio-psycho-social approach. The Ohio Scales were used during the assessment phase, although clinics varied in the consistency with which they were collected citing lack of useful information. Some clinics used trauma screeners as well, many of whom were current or past participants in the TF-CBT initiative. Parents

expressed concern with having to explain “their story” to too many clinicians and expressed their interest in more efficient sharing of assessment data within and across programs and services; however, providers appropriately noted the importance that clinicians develop their own case conceptualizations. One notable gap in the assessment process is related to the use of standardized instruments to consistently assess child and family functioning, determine level of ongoing treatment need, and inform treatment response, treatment duration, and timing of discharge.

Several system stakeholders noted limited access for children with substance abuse, mental retardation and developmental disorders, and autism spectrum disorders. Further ECC initiatives are likely to enhance the capacity of clinics to meet the needs of youth with co-occurring psychiatric and substance abuse conditions. All system stakeholders should work together to enhance the presence of treatment specializations in outpatient clinics and ensure that these specializations are planned and coordinated to minimize overlap within the same geographic regions. The long-term vision of specialization is that outpatient clinics will have multiple specialization areas, enhancing access to clients with a wide variety of treatment needs. Finally, families would benefit from increased presence of alternative interventions in the community to supplement office-based therapy and aid in discharge planning. Stakeholders should work together to identify and implement a best practices discharge planning process that includes an emphasis on identifying natural supports in the community to sustain children upon the conclusion of formal office-based interventions.

Evidence-Based Treatments

A number of survey items and focus group questions addressed the issue of evidence-based treatments (EBTs). EBTs are interventions that have significant research support for positive outcomes, usually evidenced by one or more randomized controlled trials. EBTs are very well described treatments with numerous required practice supports to promote effective implementation. Recent reports have identified the importance of “implementation drivers” that underlie effective service delivery and bridge the gap between research findings and implementation of those findings in community settings.²¹ This research identifies core implementation components, including:

- Staff selection
- Pre-service and in-service training
- Ongoing coaching and consultation
- Staff evaluation
- Decision-support data systems
- Facilitative administrative support
- Systems intervention

There are now a number of effective and widely used EBTs available for specific mental health disorders, though the children’s mental health field requires additional work to develop treatment models that address all clinical presentations, take into account important contextual factors, are culturally responsive, sufficiently address implementation barriers, and are appropriate for office-based therapy. EBTs continue to emerge as a significant aspect

of mental health care in the United States and in Connecticut. In fact, Connecticut now has one of the most comprehensive arrays of EBTs of any state, though many that have been implemented to date are designed as intensive in-home services. Despite the promise of EBTs for children's mental health care, there remain significant concerns among all system stakeholders about the appropriateness and the practicality of EBT implementation, as well as the resources required for ongoing sustainability of such services.

Agency administrators and clinicians reported awareness that EBTs are likely to become an increasing part of routine clinical practice. DCF has specified its intention to address the recognized discrepancy between the number of evidence-based intensive in-home treatment models and the lack of EBTs currently available in office-based (e.g., outpatient) settings.³ It is clear that EBT implementation is enhanced when individual clinicians and agency administrators are part of the implementation process and when dissemination efforts address agency culture and broader systems (e.g., state government, policies, funding entities).²¹ Efforts to adopt and implement EBTs in outpatient treatment would be enhanced if providers, families, and the state work together to ensure that all needed implementation supports exist; however, this level of efforts often requires a significant infusion of resources.

Existing EBT Models in Outpatient Treatment

According to agency administrators, EBTs have achieved some penetration within the outpatient level of care with many sites reporting that they currently implement one or more EBTs. The level of integration of EBTs varies across settings with some agencies indicating that they are fully integrated into their agency's mission and strategic plan, and others indicating difficulty building the infrastructure and the support necessary for implementation. On the Agency Survey, several administrators reported that their agency currently implements one or more EBTs; however, only 50% of administrators (8 of 16) reported that EBTs were available for children of all ages that present for outpatient services.

The Trauma-Focused CBT initiative is one example of an EBT that has been disseminated at many outpatient departments across the state. Trauma-Focused CBT is among the most widely supported EBTs for children exposed to trauma and violence. To date, 16 agencies have participated in the Trauma-Focused CBT initiative, which has used a Learning Collaborative approach to disseminate and sustain the practice. The Learning Collaborative approach focuses on effecting changes to clinical practice as well as organizational change that will facilitate sustainability of the practice beyond the training year. Evaluation data from the initiative suggests that TF-CBT results in positive organizational changes as well as reductions in children's symptoms of depression and PTSD. Learning Collaborative methods to disseminate EBTs have promise for other similar initiatives to disseminate EBTs in the children's routine outpatient mental health system.

Although some treatment providers reported the presence of many EBTs, what remains unclear is the extent to which these EBTs are supported by the practice elements and implementation drivers described above that are known to underlie effective treatments. EBTs that do not have the necessary training, supervision, fidelity monitoring, outcomes evaluation, and other implementation requirements are likely to experience "model drift," a

process by which implementation fidelity diminishes to the point that the treatment no longer adheres to the original design. To implement EBTs in outpatient departments, stakeholders should consider all the supports that are related to successful implementation, fidelity, effectiveness, and sustainability.

Priority Groups for EBT Implementation

The penetration of EBTs into clinical practice was variable across the provider network and there was recognition that EBTs still were needed for specific groups of children and families. When asked which age groups were most in need of EBTs we found no clear patterns. In terms of the diagnostic groups most in need of EBTs:

- 44% of administrators identified children with Post-Traumatic Stress Disorder
- 22% identified children with Mood Disorders (e.g., Depression, Bipolar Disorder)
- 22% identified children with Behavior Disorders (Oppositional Defiant Disorder, Conduct Disorder, Disruptive Behavior Disorder)
- 17% identified Anxiety Disorders (e.g., Generalized Anxiety Disorder, Obsessive Compulsive Disorder, phobias)

In terms of treatment modalities for EBTs, providers reported the following:

- 39% identified individual treatment
- 28% identified group therapy
- 28% identified family therapy EBTs

It was somewhat surprising, given the importance that all system stakeholders place on family-oriented care, that clinicians reported individual treatments to be the most important modality for EBTs. There appears to be a growing awareness of the prevalence of trauma and the importance of trauma-informed care which could explain the interest in EBTs for PTSD. Familiarity with the TF-CBT initiative could also explain the interest in PTSD treatments.

Perceived Facilitators of EBT Implementation

Very few sites suggested that EBTs are inconsistent with their service delivery vision; however, there was strong indication that support from senior agency leadership is a critical element for achieving buy-in for EBTs. Not surprisingly, we found during our site visits that agency leaders who question the role or the importance of EBTs in clinical practice also reported limited EBT penetration in their outpatient clinics. Leaders that view EBTs as an emerging and critical aspect of clinical practice and believe that EBTs add value to clinical services were most likely to have EBTs in their treatment repertoire and were more likely to seek opportunities to integrate EBTs into everyday clinical practice. Examples of administration efforts to promote the adoption and implementation of EBTs include:

- Actively promoting EBTs during clinical and administrative meetings
- Investing in clinician training

- Adjusting productivity requirements to accommodate the need for increased training, supervision, and smaller caseloads
- Seeking supplemental funding from local, state, and federal sources
- Providing ongoing supervision and support to implement and sustain EBTs

Perceived Barriers to EBT Implementation

There was general agreement that EBTs are an emerging part of clinical practice, but clinicians and administrators identified several barriers to full integration of EBTs into routine care practices. On their respective surveys, 44% of administrators and 49% of clinicians reported that they perceive significant barriers to using EBTs in their outpatient clinics. In site visits, the most commonly identified barrier to implementing and sustaining EBTs was insufficient funding for training, supervision, and sustainability particularly in the context of productivity standards and tight operating budgets. All agency administrators indicated that EBT implementation requires the addition of several key elements to their everyday practice, including training, supervision, information technology, data collection and reporting procedures, and fidelity monitoring. One agency administrator stated:

“One of the consequences of evidence-based practices is that it is accompanied by extra documentation, extra research, extra data collection, which often times is not accompanied with any extra funding. So, it’s overtaxing already overtaxed organizations that often times have no choice but to accept the evidence-based model if they want to expand services. But yet, they have to contribute out of pocket for all the necessary infrastructure supports to make that happen.”

Consistent with the above quote, our findings pertaining to EBTs indicate that many, if not most, administrators report *practical* or *logistical* barriers to adopting and implementing EBTs, even the administrators that support the expansion of EBTs. The most commonly identified logistical barriers were insufficient time and funding to support training, supervision, and sustainability.

Findings from the Clinician Survey were consistent with the perceptions of agency administrators described above, in the sense that they also see barriers to EBT implementation. Clinicians’ concerns, however, tended to group around *conceptual* issues related to EBT implementation rather than logistical concerns. The most commonly endorsed barrier was the statement “I have doubts that manualized EBTs are sufficiently flexible for my client’s needs.” Another item that received frequent endorsement was “EBTs are not appropriate to my client’s needs.” When given the opportunity to expand their viewpoints using an additional write-in category for “other barriers,” many clinicians reported that EBTs do not take into consideration the complex needs of children and families, and that families do not respond well to manualized treatment approaches. These three responses can be viewed as representing a similar theme for clinicians; that EBTs do not address the complexity of their real world cases and that EBTs can be viewed as inflexible and ineffective. Additionally, clinicians reported that insufficient training (a logistical barrier) was the second most significant barrier to EBT implementation.

The findings related to EBT suggest that addressing logistical barriers to EBTs are critical to building overall agency-level support of such initiatives. Given sufficient resources to support effective implementation, administrator buy-in and support could result in increased buy-in from front-line clinical staff. In addition, demonstrating positive effects of EBTs through quality assurance and evaluation methodologies could help address conceptual concerns with EBTs related to their effectiveness in real-world settings. The problem is one of sufficient funding for EBT implementation. Without an infusion of significant resources and support to outpatient clinics, adoption and implementation of EBTs is unlikely to be successful. System stakeholders such as DCF Area Office Directors noted that outpatient clinics would find it very difficult to incorporate EBTs into routine practice due to the demands placed on staff for increased training and supervision and the fact that these activities typically are non-billable.

Suggestions for Integration of EBTs into Routine Outpatient Treatment Settings

Our discussions reveal that Connecticut's initial forays into comprehensive EBT implementation has reinforced to some state agencies and outpatient providers that given sufficient funding and support and statewide commitment and collaboration, an EBT can be disseminated and sustained in outpatient settings. There are continued concerns about the likelihood that additional EBTs will have the level of funding and support to ensure success. Providers offered several ideas for further supporting EBT implementation. There are some agencies in the state that have successfully integrated comprehensive EBTs into their everyday clinical practice and their organizational vision. Many viewed the money spent to build the infrastructure to support EBTs as a wise investment in their agency and in children and families, as the presence of EBTs was believed to support better clinical outcomes as well as a positive image among statewide stakeholders regarding the overall quality of their service delivery practices. Furthermore, agencies with a strong presence of EBTs believed that training in EBTs was stimulating and challenging for their clinicians and actually promoted retention and job satisfaction. Several suggestions for supporting EBTs were offered:

- Some outpatient providers with strong EBT penetration rates reported that they have invested in the infrastructure necessary for their implementation, at their own cost, but with a long-term view toward EBTs as the “wave of the future” in clinical practice.
- Several clinics indicate a need for start-up funds that can be used to build the infrastructure for EBTs. This would include the need for information technology development, payment for training time, and funding treatment coordinator positions.
- Providers commonly requested that the state or other funding sources provide incentives or special reimbursement rates for agencies that adhere to evidence-based treatment models and whose outcomes represent best practices. It is important to note that the ECC initiative added an average 25% increase in reimbursement rates in order to provide support for just such an endeavor; though some agency administrators believed this was insufficient to support EBT implementation.
- One site argued for higher reimbursement rates for cases served using an EBT because these cases generally are more complex, the treatment itself is more

demanding, caseloads for EBTs generally are smaller, and outcomes on the whole are better.

- Providers and DCF stakeholders viewed the use of a Learning Collaborative approach for EBT dissemination and sustainability very positively. Learning Collaborative methodology should be considered for future EBT dissemination efforts.
- In order to help balance the competing demands of EBT sustainability and productivity, program managers and supervisors can specialize in a limited number of EBT models and oversee cases in which the presenting problem matches their area of expertise.
- In order to address the potential increased cost for delivering EBTs (supervision, team meeting, case preparation, training), the state can work to establish enhanced reimbursement rates for such services funded by Medicaid.

Medicaid rules will need to be examined and realigned in order to support evidence-based and best practice treatments. Through a Medicaid Rehabilitation Waiver the CT BHP is considering funding a range of home- and community-based services that in the past could not be fully funded under Medicaid. The pending DCF and Department of Social Services (DSS) Certification Regulation would allow departments to selectively certify evidence-based and promising practices for Medicaid reimbursement, thus shaping the service system towards effective treatment approaches; however, current statewide financial constraints could delay this process. Although this represents encouraging progress, these reimbursement changes apply primarily to evidence-based treatments delivered in the home and the community. To date, TF-CBT is one of few efforts to support evidence-based treatments that can be easily delivered in office-based settings. Providers and CT BHP will benefit from continued partnership in efforts to fund additional EBTs along with the supports for these treatment models.

Summary of Evidence-Based Treatments

There is a growing understanding of the importance of EBTs, yet several barriers remain. First, the penetration of EBTs in routine outpatient settings lags behind intensive in-home settings. Second, there are numerous barriers evident at the levels of individuals, agencies, and the broader system of care, both practical and logistical. Third, although many clinics report an increasing presence of EBTs, what remains unclear is the quality with which these EBTs are being practiced and whether the necessary supports and infrastructure are present to ensure adherence to model specifications. Of primary concern was the need for a comprehensive strategy to support EBTs that does not result in excessive cost shifting to outpatient providers. Important facilitators of EBT included strong agency leadership and buy-in for EBTs, and enhancements in this area could be pursued to build wider support for EBTs. A significant commitment of time and resources will be required in order to continue to expand EBTs into Connecticut's outpatient mental health treatment system; however, the investment is likely to be worthwhile for children and families, as EBTs hold significant promise for improving service quality and outcomes.

Staffing and Workforce Development

Across the board, agency leaders believed strongly in the talents, work ethic, and persistence of their outpatient clinicians and their dedication to the well being of children and families. Stakeholders in the system also recognized the hard work and dedication of outpatient clinicians. Embedded within much of the discussion of staffing and workforce development was the need for a broader commitment to hiring, retaining, training, and competitively compensating these professionals in a way that acknowledges their central importance in the mental health delivery system. Maintaining a stable outpatient workforce should be a top priority for the system as a whole, and such a commitment is likely to have numerous benefits.

All sites discussed the importance of hiring and retaining a qualified clinical workforce. Several agency directors discussed a broader issue of limited training and mastery of basic clinical skills among general clinical staff, to the point that clinicians with exceptional qualifications are attractive to many potential employers, including DCF. Agency leaders cite a high level of competition for qualified staff among agencies, state employers, and hospitals, given the relatively small size of the state. One director even noted:

“I think the single biggest barrier to quality treatment is the lack of credentialed staff...the best thing that ever happened to us is that the state declared a hiring freeze.”

ARG staff reported a need for an increased volume of outpatient clinicians to meet the demand for services. Beyond hiring more clinicians, a primary issue is hiring highly trained clinicians that are able to meet the complex needs of the outpatient population, and making all necessary efforts to keep them employed in outpatient clinics. Furthermore, many administrators also reported a shortage of full-time child psychiatrists.

The shortage of qualified clinicians described to us is at least partially related to high turnover. DCF Area Office Directors, ARG staff, and parents in the CBHAC focus group noted that staff turnover is a significant problem. Administrators and clinicians that participated in our site visits noted that some of the best outpatient clinicians leave the outpatient department in order to work in better paying treatment programs such as intensive in-home services, or even to work for DCF. Interestingly, there was some degree of disconnect between the data we collected from outpatient sites and data from parents, DCF staff, and ValueOptions. The majority of clinic administrators reported relatively low turnover rates for outpatient staff and consistency in these rates over time. Other parties interviewed for this report indicated that staff turnover is a significant problem.

Use of Trainees in Outpatient Programs

In order to address the need for a skilled workforce that can provide direct clinical services to children and families, many agencies have turned to interns and student trainees in psychology, social work, marriage and family therapy, and nursing. Many agencies have a strong commitment to training and mentoring the emerging mental health workforce and have long-standing relationships with academic institutions that ultimately benefit the

statewide mental health system, and these relationships and commitments should be encouraged. Some clients are reported to prefer interns to more seasoned clinicians based on the perception that they receive *“better and more connected service because interns have more time to spend on each of their cases...and are more invested in it.”* Providers also acknowledge that interns and trainees help manage caseloads and are cost effective in the context of ever-present budget constraints. They describe insufficient funding to hire additional full-time clinical staff members.

Agency administrators are forthright in noting the practical and financial benefits of training students and interns in their outpatient clinics. However, other system stakeholders viewed the use of students and interns as presenting some potential concerns. We discovered four interrelated concerns when it comes to the use of clinical trainees for service delivery:

- Excessive reliance on trainees to staff outpatient departments
- Insufficient supervision of trainees
- The clinical implications of yearly training cycles and turnover
- Trainees with poor preparation for direct service delivery

There is a perception among some system stakeholders that some outpatient clinics rely too heavily on interns as a disproportionate segment of their total clinical FTEs. The Agency Survey indicates that across all respondents, the average number of clinical FTEs is 7.8 and the average number of student/intern FTEs is 2.4. Students and interns, therefore, are a significant staffing presence in outpatient treatment settings. DCF Area Office Directors discussed excessive use of interns as a significant problem in outpatient services, particularly if students or trainees are not well supervised. They reported that when students and interns are relatively well trained and competent, then the potential negative impact is minimized. Interns lack extensive experience in direct service delivery, so the importance of good supervision is critical to avoid quality of care concerns. In contrast, 17 of 17 agency administrators reported that adequate supervision exists to support all their clinicians.

There is some research guidance on the issue of how clinical experience relates to quality and outcomes. The empirical literature suggests that years of experience, as a marker of clinician expertise, has little relationship to psychotherapy outcomes, which suggests that years of experience could be a poor indicator of overall clinician experience.²²⁻²⁵ A recent study suggests that therapists that see patients with similar presenting problems in rapid succession to one another typically achieve the best clinical outcomes.²⁴ This conceptualization of therapist experience suggests that client outcomes will be best among clinicians who are highly trained in a specific area of practice. This conceptualization is consistent with efforts to promote specialization areas and to train clinicians in specialized skills such as EBTs for specific conditions.

For the significant proportion of interns and trainees that either move on to a new practicum experience or are not hired as full time employees, yearly turnover of clinical staff can create quality of care concerns or introduce treatment disruptions that can adversely impact treatment outcomes and client trust. Several system stakeholders described this situation as potentially detrimental to children with a history of significant disruptions in

caregivers and living arrangements. Given the temporary nature of many intern and practicum placements, it is likely that turnover is much higher in these positions than among full-time salaried outpatient clinicians. For families, losing a clinician to turnover is problematic whether that clinician is a full-time employee or a part-term intern.

Agency directors believe that clinical internship training programs provide critical experience as clinicians prepare for careers in direct service delivery—experience that cannot be gathered from academic training alone. They also acknowledge that students and trainees often do not come to their placements well prepared for direct service delivery. On the Agency Survey, only 4 of 17 (24%) administrators believed that graduate training programs had adequately prepared clinicians for the work that they are required to do. According to one agency leader:

“I think that there continues to be nationwide, a disconnect between graduate school training and the reality of what we need in terms of our new hires. And the burden gets shifted to programs like ours to do a lot of the professional training that really should be started in their professional schools, which really impacts on productivity and resource allocation and everything else. What you’re hearing is really a shift, in some ways, in responsibility, and if we really had an even playing field and the schools are really preparing people for what the skills are that the marketplace demands of them, then there would be less that we would have to do in terms of retraining or training people. So the expectation is that people are coming in without any knowledge of evidence-based practices prior to this and we really have to start from scratch.”

Many agencies reported their desire for hiring interns and trainees that have exposure and training in EBTs. The Mental Health Transformation State Improvement Grant (MHT-SIG) links evidence-based practices and treatments closely with the need for enhanced training and workforce development. As part of the MHT-SIG workforce development project, students in graduate social work programs are receiving intensive training in specific home-based evidence-based treatments such as Multisystemic Therapy, Functional Family Therapy, and Multidimensional Family Therapy. Graduates who have participated in these courses are selected for placements in clinical sites that implement these treatments, which often can lead to employment opportunities upon graduation. This is an important demonstration of a model approach to enhancing the availability of a highly-trained workforce with skills in implementing evidence-based treatments. Results of this project could be monitored and considered for further replication.

Difficulty Recruiting and Retaining Bilingual and Bicultural Clinicians

All agency administrators reported that there is limited availability of bilingual clinical and receptionist staff and that this is a significant quality of care issue within the entire child mental health system, not just outpatient programs. DCF Area Office Directors and Behavioral Health Directors agreed with this assessment. Bilingual clinicians in particular are difficult to recruit and retain because there is high demand and competition for their services and because they often leave outpatient programs or “burn out” due to the size and

complexity of their caseloads. Clinicians and administrators at one outpatient clinic described a situation in which a bilingual clinician was not able to provide services in their area of interest and expertise (substance abuse) because of the need to treat the high volume of Spanish speaking clients regardless of presenting problems.

In some clinics with limited bilingual clinicians, Spanish-speaking children and families can experience longer waitlists and limited access to services. One clinic described that a local inpatient hospital unit increasingly referred clients directly from inpatient to their outpatient department rather than IICAPS, Intensive Outpatient Programs, or other intermediate levels of treatment, primarily because the outpatient department had bilingual and bicultural clinicians on staff. Another clinic described clients having to remain in higher levels of care such as inpatient settings due to the outpatient clinic's lack of bilingual clinical staff. As the client population across the state continues to become more diverse, the need for Spanish speaking clinicians is likely to continue to exceed capacity. Solutions need to be systemic in nature, including recruiting bilingual college and graduate students to enter the mental health service field, thereby increasing the supply to address the demand. Some administrators have attempted to attract higher numbers of clinicians from racial/ethnic minority backgrounds by hiring recruiters and providing financial incentives for "special expertise" such as minority status or language skills.

Clinician Retention Strategies

The Agency Survey asked administrators to offer their top three reasons for staff retention. The most commonly identified reason among participating agency administrators was salary and benefits (identified 10 times). This was followed by the availability of training and supervision (7 times), professional development opportunities (7 times), relationships with other staff members (6 times), and interest in serving clients (4 times). The Agency Survey also asked respondents to identify their top three reasons for turnover. The most commonly identified reasons were high workload and productivity demands (endorsed 11 times) and low pay (identified 8 times).

Prior research has found that salary is related to turnover in the social work field, but these effects are likely to diminish in strength or disappear when other factors are included in multivariate models.²⁵⁻²⁶ Other studies have found that younger clinicians, large caseloads, and caseloads with highly complex presenting problems each are related to high turnover.²⁷⁻²⁸ On the other hand, opportunities for advanced training and professional development, career advancement, peer support, and positive organizational culture are consistently related to job satisfaction and retention.²⁹⁻³¹

Our site visit interviews revealed several factors and strategies related to staff retention, including:

- Intensive in-service training opportunities
- Support and stability of agency leadership
- Clear and reasonable expectations for clinicians
- Respectful treatment as "valued and connected" team members

- Competitive compensation and benefits
- Financial incentives for consistently meeting productivity requirements
- Effective conflict-resolution procedures
- Financial support for pursuing continued education, training, and credentialing

Additional efforts to improve job satisfaction and retention included implementing a four-day work week, increased salary upon achieving professional licensure, a student loan forgiveness program, and increased opportunities for professional development and career advancement. Several agencies reported requiring new hires to commit to the agency for a minimum length of time as a condition of their employment.

Training Needs

On the agency administrator survey, respondents were asked to identify clinicians' top three needs for additional training. The most commonly identified training needs among surveyed administrators included: trauma and PTSD (identified 7 times); early childhood interventions (6 times); and autism spectrum disorders (4 times). In addition, client family engagement strategies and motivational interviewing (an evidence-based approach to client/family engagement) each were identified four times.

During site visits, we asked clinicians to describe their training in cultural competence. Outpatient administrators and clinicians reported that culturally competent service delivery was part of their routine in-service training program. Given the data presented earlier on clinician and client characteristics in terms of race, ethnicity, and gender, cultural competence is an area of significant importance. Coordinated, statewide training and staff development in cultural competence is highly recommended.

Summary of Staffing and Workforce Development

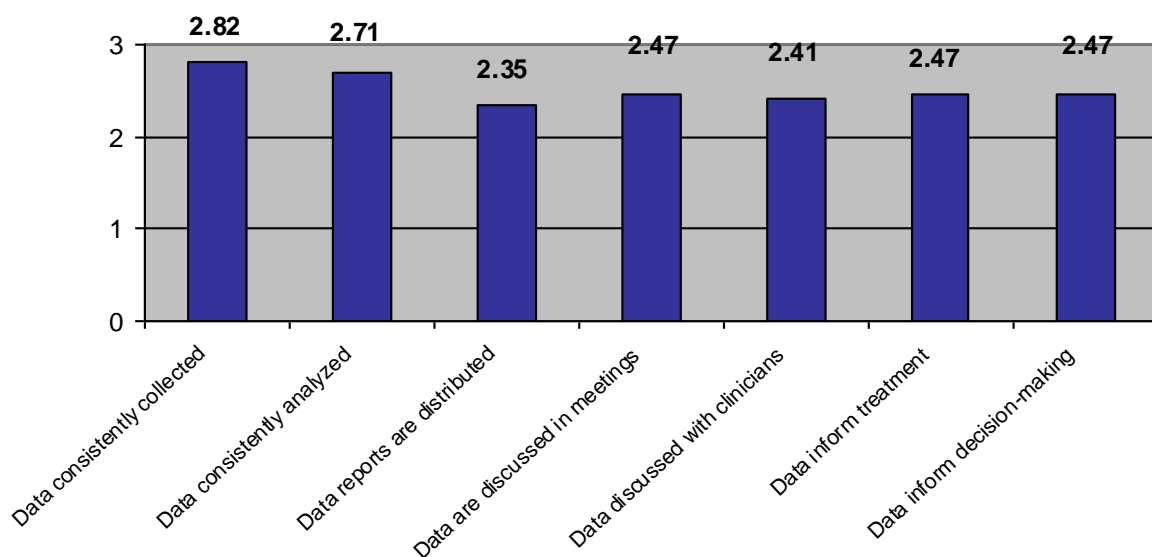
It is generally the case that outpatient departments are the core program in any mental health service system, and thus, outpatient clinicians are extraordinarily important to the overall functioning of the system. There is a tremendous need for increased attention to hiring and retaining a cadre of well-trained outpatient clinicians that have strong incentives to remain in outpatient treatment. Agency administrators report that low pay, burnout, and limited opportunities for training, professional development, and career advancement are the primary issues related to staff turnover. In the face of staff turnover, outpatient programs have increasingly turned to interns and practicum students to help fill out their outpatient clinical staffing complement. Well supervised and competent interns are an important part of the workforce; however, excessive reliance on interns and practicum students as a disproportionate segment of total FTEs is a concern for parents, DCF, and other system stakeholders. There is a need to hire and retain bilingual clinicians in CGCs. Best practices in clinician retention should be explored and considered for dissemination across the state. A comprehensive training curriculum for all outpatient clinicians would enhance their skill set and could potentially contribute to lower turnover. Best practice models for ensuring competitive compensation and opportunities for career advancement also should be strongly considered for dissemination.

Data Collection, Analysis, and Application

In general, outpatient clinicians and administrators report that they value data and are interested in using data to inform and improve service delivery and outcomes. The Behavioral Health Data System (BDHS) was the required data collection system for CGCs until the recent implementation of the Program and Services Data Collection and Reporting System (PSDCRS). In addition, the CT BHP collects data on characteristics of clients served by ECCs, along with information on utilization and outcomes. These data are reported on a monthly and quarterly basis. Finally, some clinics analyze and report data internally. Many clinics reported using Ohio Scales and Global Assessment of Functioning (GAF) scores to measure child functioning, consistent with these DCF and CT BHP reporting mechanisms. Despite this work, challenges remain in the extent to which all outpatient departments and agencies routinely use data to inform clinical practice. There is a need in Connecticut for all stakeholders to view data collection as part of the clinical intervention and not as a separate enterprise.

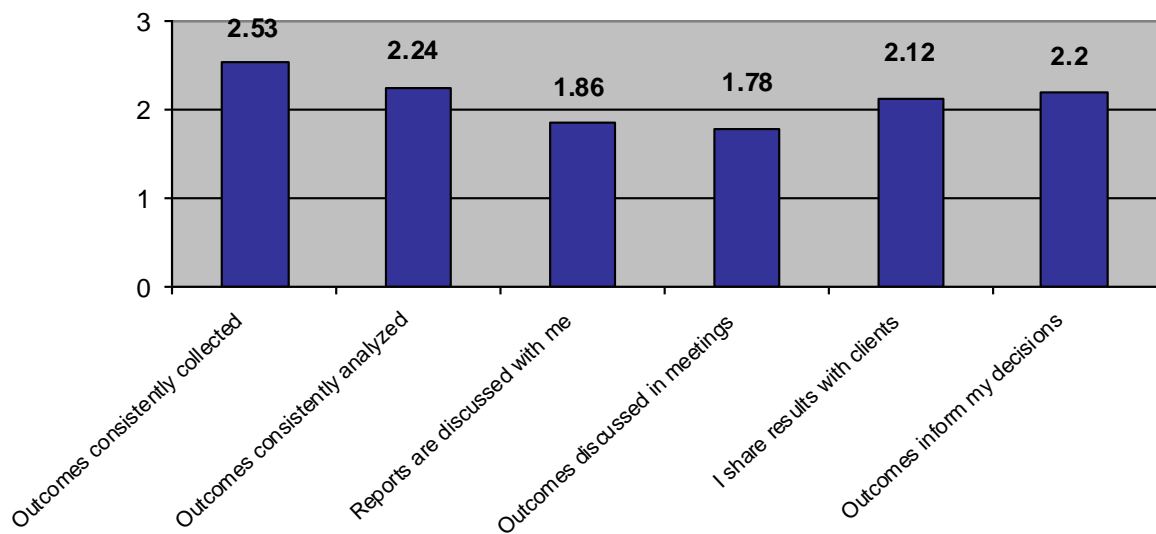
On the Agency Survey, 17 administrators responded to seven items regarding the frequency with which they engage in activities related to the collection and application of data (Figure 4). Response choices were from 1 (“Never”) to 3 (“Often”). All items suggested that agency administrators integrate data into their everyday practice. For example, respondents were most likely to agree with the statement “data are consistently collected at my agency” (mean=2.82). On the other hand, administrators were least likely to agree with the statement “data reports or summaries are distributed to my clinical staff” (mean = 2.35), although the high mean score still reflects that administrators generally considered this to be a routine part of their everyday practice.

Figure 4: Administrator Perceptions Toward Data (n=17)



A similar set of questions were administered to clinicians, with slight variations on items reflecting collection and application of outcomes data to treatment. Fifty-one clinicians responded to these items; results are presented in Figure 5. These clinicians tended to report that outcomes data were a part of their routine clinical practice. According to clinicians, they are least likely to have reports or summaries of outcomes data shared with them during team meetings or to have supervisors or administrators share these data with them. This suggests that, among the responding clinicians, sharing and application of collected outcomes data is a relative need for outpatient treatment.

Figure 5: Clinician Perceptions Toward Data (n= 51)



On the agency administrator survey, 16 administrators reported on four items reflecting their perceptions of DCF outcomes data collection. Response options were from “Strongly Agree” (1) to “Strongly Disagree” (4). Respondents tended to disagree most with DCF’s role in ensuring that data are used to make treatment decisions. Respondents tended to agree most with DCF’s role in ensuring that data are collected in a timely manner. Respondents neither agreed nor disagreed with DCF’s role in ensuring that data are analyzed or reported back to sites. Results of these items are presented in Table 19 (note that higher mean scores in Table 19 indicate higher level of *disagreement* with the statement).

Table 19. Perceptions of DCF Outcomes Data Collection and Application

Item	Mean Score (n=16)
DCF ensures that I collect data in a timely manner	1.88
DCF ensures that the data I collect are analyzed	2.60
DCF ensures that the data I collect are reported back to me, or my agency	2.50
DCF ensures that the data I collect are used to help me make treatment decisions	3.06

Note. Higher scores indicate higher degree of disagreement with the item.

There is a consistently held perception among agency administrators and clinicians that significant barriers exist when it comes to required data collection and how these data are analyzed, reported, and used. Some clinicians and administrators have broader concerns about the state's right to collect data related to service delivery balanced against the child and family's right to confidentiality. Some families have similar concerns about releasing data to providers or to the state. In addition, clinicians and administrators believe in the importance of reporting data back to sites so they can share in the results and apply them to clinical practice and organizational decision-making. Providers report that, in the past, there has not been enough attention to building capacity at the provider-level in the forms of training and technical assistance, data reporting, and use of data for quality improvement. As one agency director stated,

"I think there is a general frustration with sending in gobs of data to the state and it's a black hole, such a waste of time, and a waste of money. What we get back in terms of program operations is not meaningful."

A "vicious cycle" has existed in the past involving data quality, data analysis and reporting, and lack of commitment to data collection as an important part of practice. Poor data quality results in diminished incentive to analyze and report, and vice versa. It is not productive to attempt to assign blame or understand where the cycle begins and ends. Rather, it is important for all outpatient stakeholders to understand that the process is cyclical, ineffective, and not in the best of interest of the state, outpatient providers, or consumers of outpatient services. Data collection that produces reliable information and is reported back to sites to inform practice can be a powerful tool in improving practice. The PSDCRS has important implications in this respect.

Some clinics report making an investment in their own information technology infrastructure, and describe this as an "absorbed cost" given the priority they place on collecting and analyzing data for their own needs and to improve service delivery. Often, they have the same perception as other clinics regarding the insufficient resources devoted to quality assurance, continuous quality improvement, and evaluation. They have responded proactively to these concerns and taken on significant expenses with the belief that this

ultimately will benefit service delivery, improve their reputation, and make them more competitive for future funding and other initiatives.

DCF Area Office Directors noted that one area that has been lacking with regard to data collection is on indicators of the quality of outpatient clinics themselves. Directors noted that these quality assurance data elements are virtually non-existent in the DCF and CT BHP data systems, but they should be incorporated to monitor service quality. When asked whether DCF had any “teeth” with which to enforce quality standards for service delivery, one Area Office Director noted, “they can only chew at them with their gums.” This Area Director appeared to be addressing the perception that DCF has difficulty enforcing standards for clinic quality among CGCs.

Suggestions for Data Reporting and Application

Several recommendations were provided based on existing best practices among outpatient clinics in the state. A few agencies have managed to identify funding streams to fund quality assurance staff that monitor agency-wide data. For example, agencies describe utilizing a Central Access Department or Service Effectiveness Coordinator position funded by the clinic or by external grant funding. Some sites employ high school or college interns to collect, enter, analyze, and report data on service delivery and client outcomes. Other sites suggested collaboration with local colleges and universities as a way to provide cost-efficient services while offering training opportunities for students who are interested in quantitative data analysis. Agencies with their own data collection processes and procedures described them as “very beneficial” in that the data is available for immediate feedback and discussion with families regarding diagnosis and barriers to treatment. Many of the same providers note that the Ohio Scales are limited in this regard. Other sites that do require additional resources for building capacity for data reporting and analysis suggest that DCF or CCPA provide funds for data managers and suggest that these individuals can be shared among multiple clinics.

Area Directors suggested several data elements that could be used to assess quality of service delivery, although the suggestions varied in the degree to which terms were operationalized and the degree to which suggestions applied specifically to children with DCF involvement. Suggestions included:

- Stability of child’s living situation
- Parent/guardian’s responsiveness to child’s needs
- DCF staff ratings of satisfaction with outpatient clinic services
- Creativity in meeting families needs
- Participation of outpatient clinics in cross-system collaboration
- Reentry to treatment services and foster care
- Rates of substantiated maltreatment
- Rates of placement disruption (for children in foster care)
- Progression from higher levels of care into community-based services and supports

- Rates of closed DCF cases due to sufficiently lowered risk and improved functioning

An additional suggestion for improving consistency in collecting and tracking data over time is to implement electronic medical records systems. Two agencies that received site visits reported that they currently are in the process of transitioning to electronic medical records, and others already have done so. Other interested agencies report a need for funding and support for similar efforts, such as start-up grant funding or state incentives. Electronic records are suggested as a means for:

- Improving service delivery
- Facilitating coordination within and between agencies and levels of care
- Managing documentation standards imposed by multiple licensing bodies
- Improving staff morale by creating more efficient documentation procedures

As mentioned previously, DCF currently is in the process of implementing the Program and Service Data Collection and Reporting System (PSDCRS). Although it is early in the implementation of PSDCRS, this web-based data collection system has tremendous potential to address the concerns raised by stakeholders in the outpatient treatment system. Early indications are that PSDCRS has the potential to greatly increase system capacity for entering, analyzing, reporting, and applying data to service delivery. Throughout PSDCRS implementation, many providers have had the opportunity to obtain training and technical assistance from system developers.

Of paramount importance in the implementation of PSDCRS is that these data are used efficiently. Sufficient training and technical assistance in data collection, entry, and application would help avoid past concerns with unused and poor quality data. Data analysis of outpatient services could focus on trends in the characteristics of the population served, service quality indicators, and outcomes at the level of the CGC network and for each individual provider. These findings can be used to design and implement performance improvement initiatives to strengthen service delivery and improve child and family outcomes. Numerous approaches can be taken to accomplish this. One example is to hire consultants who are independent of DCF or providers who can be responsible for analyzing and reporting PSDCRS data for all state-funded outpatient programs; however, regardless of the approach to analyzing and reporting CGC data, all outpatient stakeholders should work together to ensure that PSDCRS is used to its full potential.

Summary of Data Collection, Analysis, and Application

Best practices in children's mental health support the use of data to guide clinical decision-making and to evaluate the effectiveness of services.²⁰ Past or current data collection and reporting efforts include BHDS, data submissions to CT BHP, and some internal agency data collection and reporting. Monthly and quarterly reports from CT BHP to ECCs are one of few examples of standardized analysis and reporting provided to a network of outpatient providers. All stakeholders agreed that outpatient treatment programs have not made full use of data to inform service delivery, to guide service delivery, or to monitor

treatment outcomes. The causes for this are varied, and they are cyclical in nature. Very little data has been reported back to sites in recent years through BHDS and providers' data quality and adherence has been inconsistent, contributing to disincentives for robust data analysis and reporting. Long-standing concerns persist regarding the state's right to obtain data on families served balanced against a family's right to confidentiality. Rather than attempting to determine cause and assign blame, all stakeholders should work together to identify meaningful uses of data to inform service delivery using the newly implemented PSDCRS. This web-based data collection system should be used to guide continuous quality improvement initiatives and outcomes evaluation for each outpatient provider. PSDCRS data also can be used by providers and family advocates to seek additional infusions of funding and resources to support routine outpatient care.

Systems Level Issues

There were three primary systems-level issues addressed repeatedly by many stakeholders in outpatient treatment:

- Limited access to other programs and services
- Insufficient collaboration and cooperation between some agencies and some DCF Area Offices
- Desire for improved coordination among licensing and funding bodies that oversee outpatient treatment

Access to Other Programs and Services

There were perceived gaps relating to the accessibility of other treatment programs and services, and the "ripple effect" this can have on outpatient treatment. The Clinician Survey asked respondents to rate the level of accessibility of specific programs and services in the broader mental health service system (Table 20). Respondents were asked to describe how easy or difficult it is to access a particular service *when a child needs that service*. Responses were provided on a 4-point scale (1 = "very easy to access," 4 = "very difficult to access"). Fifty-four clinicians responded to these items. Results are presented in Table 20 and are listed in order from most accessible (lower scores) to least accessible (higher scores).

The programs and services that outpatient clinicians rated as most accessible included:

- 24-hour emergency support (e.g., Emergency Mobile Psychiatric Services)
- Psychiatric assessment and medication management
- Medical services
- Mental health treatment for parents
- Therapeutic support services

The programs and services that outpatient clinicians rated as least accessible included:

- Residential treatment
- Psychological testing

- Non-traditional services (e.g., art, music, drama)
- Housing services
- Legal services
- Financial services

It is particularly notable that clinicians rated psychiatric assessment and medication management as the second most accessible treatment. This is likely due to most clinics having psychiatric consultation available on-site, and therefore having a relationship with a prescriber. Despite the rating, parents and other system stakeholders believe that psychiatric consultation is a gap in the system. Based on the inconsistencies in reports, it is likely that there is wide variability across clinics and regions regarding the available amount and quality of psychiatric consultation and medication management services.

Table 20. Clinician Perceptions of Access to Mental Health Services and Supports

Item	Mean Score (n=54)
24-hour emergency support	1.81
Psychiatric assessment and medication management	1.96
Medical services	1.98
Mental health treatment for parents	2.37
Therapeutic support services	2.40
Parent support, education, and coaching	2.44
Case management	2.49
Intermediate-level treatment (EDT, PHP, IOP)	2.58
In-home treatment models	2.69
Substance abuse services	2.71
Inpatient hospitalization	2.71
After-school programs	2.75
Transportation services	2.75
Educational supports and services	2.88
Financial services	3.04
Legal services	3.04
Housing services	3.04
Non-traditional services (e.g., art, music, drama)	3.10
Psychological testing	3.18
Residential treatment	3.49

Note. Low scores indicate *most* accessible services and high scores indicate *least* accessible services.

Collaboration and Cooperation

Within a system of outpatient care, various entities must work together to meet the needs of children and families. Although all entities share the overarching goal of reducing child and family symptoms and improving child and family functioning, there can be disagreement on the best strategies and approaches for achieving those goals. Tensions inevitably emerge between entities, and sometimes those tensions can negatively impact cooperation and

collaboration. For example, several stakeholders addressed the sometimes-conflicted relationships that exist between some DCF Area Offices and their local outpatient clinics.

Currently, a high level of variability exists in terms of the quality of these relationships and expectations for collaboration. Several dynamics contribute to this perspective, most of which have existed for many years. One lasting dynamic is one in which outpatient clinics and DCF are called on to share responsibility for determining treatment strategies and expectations for ensuring good outcomes. Related to this is a relationship dynamic in which providers and DCF administrators fail to recognize the demands and mandates faced by their counterparts. In addition, there is a difference between DCF Area Office staff and outpatient clinics in the scope of their mandate for apportioning limited behavioral health resources. DCF Area Office staff members are asked to ensure that behavioral health services are available to clients with DCF involvement whereas outpatient clinics have a broader mandate to ensure that behavioral health services are available for all children in their community. There also is a long-held belief that behavioral health divisions within DCF tend to not be well integrated into the broader mission of DCF and that such fragmentation negatively impacts system effectiveness. In addition to behavioral health, DCF's child protection and juvenile justice mandates also are supported by outpatient (and other behavioral health) resources, and DCF leaders acknowledged that there can be competition within DCF for access to these resources. As one agency administrator stated, *"Until their relationship is fixed, it's our problem. The power is within the system to change."* In addition, there is a perception that frequent reorganization and restructuring of DCF can have negative impacts on relationships between area offices and the local provider community.

In some areas of the state, tensions such as these have compromised the presence of a consistently positive and collaborative relationship that can be important for working toward shared goals and responsibilities. It is, however, important to note that some outpatient clinics have excellent relationships with their local DCF Area Offices. These kinds of ongoing, established, positive relationships are important and valuable.

Enacting positive change in the mental health system is a collaborative endeavor that would be greatly benefited by shared responsibility among all stakeholders in the outpatient treatment system. Across the board, it would be beneficial to providers, DCF, and children and families to identify and address ongoing problems in the degree and consistency of communication and collaboration between DCF Central Office, DCF Area Offices, and outpatient providers. Issues of relationship building, collaboration, and coordination of care do not exist solely between DCF Area Offices and local providers. Community collaboratives, care coordinators, CT BHP, and family advocates all share in the responsibility for monitoring and improving outpatient treatment locally and statewide. Although ongoing work and progress is evident in this area, continued attention to improving communication and collaboration will be beneficial for all system stakeholders, and ultimately, for children and families.

Coordination among Licensing and Funding Bodies

Agency directors perceive “silos” or fragmentation among key systems-level stakeholders (e.g., DCF, CT BHP, DSS, Medicaid, the Department of Mental Health and Addiction Services (DMHAS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Connecticut state licensing board, schools) as an important barrier to providing the highest quality outpatient mental health services for children. The perceived lack of coordination, collaboration, communication, and consistency across funding streams, licensing agencies, and policy makers was discussed as a significant and longstanding concern by each of the participating agency directors. In addition, agency directors reported that the amount of funding provided to support their mandates and regulations is insufficient, and there is limited flexibility to use funds in a manner that is most “responsive” to children and their families. One director stated:

The silos between education, DCF, juvenile justice, all the funding streams...I think those barriers and, again, that silo mentality that ‘This is my set of funding, this is our set of funders, we can’t blend streams, we can’t blend positions, we can’t have those co-operations,’ just makes it very difficult and limiting.

Licensing and accreditation boards were viewed as having “good intentions” but as being disconnected from the actual needs of children and families and the resources needed to provide high quality care. Agency directors feel particularly burdened when attempting to balance the requirements of licensing standards and Medicaid documentation standards, citing the extreme amounts of time and energy required to maintain compliance across various mandates, which in turn can take away from direct services and case management activities. Some directors viewed the oversight as a “necessary evil” that prevents some providers from “drift” in service quality and standards. In general, however, there is a need to align the requirements of various licensing and funding bodies so that more time is spent on delivering high-quality mental health services and not on meeting diverse accreditation and licensing requirements. Shared responsibility between DCF and outpatient providers in this regard would be beneficial. For example, much good work has been done in the IICAPS and EMPS programs to develop care plans that integrate the expectations of various licensing and funding entities. In these programs, DCF, providers, funders, and other interested parties meet regularly to align paperwork, meet licensing and accreditation requirements, and reduce burdens when possible. These lessons can be applied to outpatient departments as well.

Summary of Systems-Level Issues

Behavioral health services are in high demand in outpatient clinics. Gaps in other areas of the mental health service system result in additional strain on outpatient departments. Enhancing access to intermediate levels of care and alternative services and supports would have benefits for the entire system, including outpatient treatment. Although it is clearly not the case for all clinics and all DCF Area Offices, there are reports of tensions between some DCF Area Offices and some CGCs. Enhanced relationships among all system stakeholders, including CT BHP, CCPA, providers, family advocates, and community collaboratives would have important benefits for continuity of care and a sense of shared responsibility for

performance improvement. Efforts should be made to standardize expectations coming from multiple licensing and funding bodies. Fragmentation in this area creates system inefficiencies and can compromise quality of care.

RECOMMENDATIONS

The following recommendations draw upon the findings of this study and the broader context of Connecticut's mental health service delivery and financing system. When appropriate, recommendations addressing separate sections of the report above are combined in order to consolidate similar recommendations and reduce redundancies.

1. Enhance Collaboration to Support Outpatient Treatment

- i As the outpatient service contractor, it is recommended that DCF convene regular Child Guidance Clinic meetings with managers from all contracted providers, and include in these meetings a diverse group of stakeholders that includes youth and families.
- ii It would be beneficial for this group to consolidate goals from all outpatient initiatives, align goals with one another, and identify a common vision for program improvement.
- b. An annual improvement plan can be developed to identify priorities, establish a timeline with goals and objectives, and develop an implementation strategy for the outpatient treatment system.
 - i Workgroups and subgroups can be helpful for implementing strategies on specific aspects of outpatient funding and service delivery.

2. Treatment Capacity and Access

Existing data indicates that the number of children needing mental health treatment in Connecticut is likely to continue to increase. There are several past, current, and future CT BHP initiatives that focus on reducing reliance on inpatient and residential treatment options and increasing reliance on community-based treatment options, including outpatient treatment. Without a significant expansion of community-based treatment capacity, demand is likely to outstrip capacity in all community-based services including outpatient. Recent data suggests that CGCs are serving more children and families, yet it is unclear that this expansion is sufficient to meet the need. Issues of capacity and access should continue to be a paramount concern for all system stakeholders. Recommendations include the following:

- a. Development of a quality assurance database would help facilitate collecting, analyzing, and reporting case flow indicators such as number of referrals, number of scheduled and completed intakes, length of stay in treatment, number of attended sessions, and others. This database could be used to create benchmarks for these indicators and develop initiatives to monitor and improve service delivery efficiency. These data then can be reported back to sites on a monthly and quarterly basis.
- b. Clinical decisions regarding treatment planning, discharge and future recommendations should be informed by ongoing data collection on treatment response and outcomes. This can help address service delivery inconsistencies and inefficiencies.
- c. Promoting enhanced business strategies across all CGCs would be beneficial to improving the quality of service delivery as well as generating additional revenue.

This revenue could then be used to address existing financial gaps reported by outpatient providers.

- d. Access to services can be improved by closely monitoring and reducing the amount of time from referral to the beginning of treatment, using strategies similar to the ECC initiative.

3. Case Complexity and Case Management

Our results indicate that outpatient cases are increasingly difficult and present with complex needs that require significant amounts of case management, particularly as KidCare and system of care principles lead more children to community-based services. It is clear that high quality care relies on effective case management, care coordination, and effective treatment approaches. There is a gap between client and family needs and available resources that underscores the need for a broader societal investment in the well-being of children and families. Although recent changes to Medicaid reimbursement have allowed providers to bill for case management provided in schools, there are still reimbursement barriers that serve as a disincentive for providers to provide more case management services. Stakeholders must work together to identify and implement innovative strategies for increasing case management. Recommendations include:

- a. With the reported increase in case complexity, enhanced case management becomes a vital component of service delivery. Funding for case management services can be explored by further leveraging Medicaid dollars and seeking additional external funding through grant support and fundraising.
- b. Paraprofessionals, parents, and interns can be utilized as additional resources to assist in case management. Peer specialists at CT BHP have been well received by parents and have resulted in improved satisfaction with services and similar approaches could work in outpatient departments. Interns can be used for case management to enhance their training and preparation for the workforce.
- c. Explore opportunities for outpatient clinics to receive training on Medicaid regulations and learn about strategies to maximize reimbursement for case management. These training opportunities should also focus on better articulation and integration of Medicaid regulations across systems.
- d. It is recommended that outpatient stakeholders increase monitoring and quality assurance focused on case management activities; an important element of high quality outpatient treatment.
- e. Incorporating treatment planning and case management activities into the treatment session, when possible, can enhance family-driven care and full family participation in treatment decision-making. This is consistent with best- and evidence-based practice in children's mental health.
- f. In general, enhanced business practices in outpatient clinics are highly recommended.

4. Family Engagement

Among the most consistently identified issues in this assessment was the need for enhanced family engagement, which is closely related to the issues of treatment access and

capacity described above. A comprehensive family engagement initiative is likely to ease access barriers, increase treatment attendance and retention, improve case flow, and increase clinic revenues, all of which should be shared goals for all stakeholders. Recommendations in this area include:

- a. Initial and sustained family engagement in service planning and delivery consistently was identified as an important part of outpatient treatment. One way to promote family engagement is to involve outpatient providers and family members in a statewide initiative, similar to the recent learning community that DCF implemented with Extended Day Treatment programs.
- b. By enhancing case management strategies through peer specialists, family members, and possibly interns, barriers to family engagement and treatment attendance can be reduced.
- c. Service planning and delivery that focuses on child and family needs is essential to high quality outpatient care. By taking lessons learned from the current Mental Health Transformation State Incentive Grant Wraparound Initiative, the state can work with all stakeholders to disseminate the Wraparound approach in order to enhance family-driven treatment.
- d. By tracking and monitoring family engagement as an indicator of treatment quality, family engagement practices can be enhanced. Many stakeholders believed that cases were closed too quickly after a few missed appointments, without sufficient attention to identifying and addressing treatment barriers.

5. Screening, Assessment, and Service Delivery Practices

Use of standardized assessment measures is a common element of high quality care. Although intake processes are relatively consistent across sites, the use of standardized screening and assessment instruments is inconsistent. Enhanced screening and assessment is important for consistently tracking treatment needs and family goals, monitoring treatment response and outcomes, and guiding treatment decision-making. Recommendations in this area include:

- a. Increase the use of standardized screening and assessment tools that will facilitate consistent assessment of child and family functioning, ongoing treatment need, treatment response, and treatment decision-making.
- b. Include in all screening and assessment practices an enhanced focus on identifying child and family strengths and incorporating them into treatment and discharge planning.
- c. Identify and promote policies that facilitate sharing of screening and assessment data within and between programs and agencies to minimize the redundancies experienced by children and families.
- d. Use screening and assessment data to inform the identification and delivery of evidence-based and best-practice treatments. For example, the identification of trauma, depression, or anxiety can be used to further identify needs and select evidence-based treatments to meet those needs.

6. Evidence-Based Treatments

Although nearly all stakeholders recognize the growing influence and presence of evidence-based treatments in Connecticut and nationwide, their presence at the outpatient level of care lags behind other programs and services such as intensive in-home treatments. All stakeholders recognize that barriers to EBT implementation exist at the clinician, administrator, agency, and systems level, and must be addressed; however, some agencies have successfully confronted these barriers to create a culture that is supportive of evidence-based treatments. Recommendations in this area include:

- a. Providers, DCF, CT BHP, and other stakeholders can work together to identify, adopt, and disseminate a range of outpatient evidence-based practices and treatments to meet identified needs within the system of care. For example, exploring the adoption of EBTs for children with autism, children with internalizing behavior disorders, young children, and children with oppositional behaviors whose parents require behavior management training is one way to enhance the current service array.
- b. Identify the needs of provider organizations and work together to meet those needs in order to successfully implement and sustain evidence-based practices within outpatient services.
- c. Include in all EBT dissemination efforts a focus on quality assurance and evaluation and support ongoing outcome data collection and analysis.
- d. When possible, utilize comprehensive and systematic approaches to implementation, such as the Learning Collaborative methodology, to disseminate EBTs. Lessons learned from the TF-CBT initiative that was successfully implemented in outpatient departments can be applied to adopting and disseminating new EBTs.
- e. Training and supervision of EBTs should be comprehensive, include training at multiple levels within the provider organization, and promote organizational change to support the sustainability of the EBT.
- f. Address logistical barriers such as the amount of time and financial support required to train and supervise EBTs.
- g. Creatively explore ways to fund EBTs and ensure that they can be sustained after grant funding ends, using lessons learned from the implementation of other EBTs in Connecticut. Explore special incentives or enhanced reimbursement rates for agencies that implement EBTs and achieve improved outcomes.
- h. Develop and promote EBTs in specialty areas that meet the identified needs of the outpatient population.
- i. Promote access to EBTs in a variety of specialty areas across the state of Connecticut so that children in each region will have access to appropriate care.
- j. To promote the likelihood of successful implementation of EBTs, integrate family engagement strategies whenever possible. Consider a statewide family engagement initiative similar to those implemented by EDT programs.
- k. Identify sustainable mechanisms and strategies for promoting and sustaining EBTs across the state. Other states, such as Washington, support a statewide center for EBTs that provides ongoing technical assistance, quality assurance, and support.

7. Staffing and Workforce Development

The most significant resource available to the outpatient system is its workforce, composed of dedicated and hard-working professionals who are committed to the well-being of children and families. Recruiting and retaining a highly trained, motivated, and satisfied workforce is essential to promoting positive child and family outcomes. Many stakeholders identified clinician turnover as a significant problem. Like most other programs and services in Connecticut, the lack of sufficient numbers of bi-lingual and bi-cultural staff was noted as an important limitation. Currently, there is not a comprehensive and standardized training and workforce development plan to guide outpatient treatment across the state.

Recommendations in this area include:

- a. To promote cultural competency, agencies should continue to recruit and retain bilingual and bicultural staff and ensure that sufficient training in cultural competency is provided.
- b. Examine compensation for outpatient treatment providers. Salaries for outpatient are reported to be lower than other programs and services in CGCs. Stakeholders can consider innovative strategies to promote performance and productivity and use this extra revenue to provide incentives to clinicians. In addition to increasing clinician compensation this could improve treatment capacity and access.
- c. Whenever possible, provide training and professional development opportunities for outpatient staff. Increased training can promote the competency of clinicians and lead to improved productivity and better outcomes for children and families. As one option, consider contracting with an outside entity responsible for developing and implementing a comprehensive training curriculum specific to the needs and interests of outpatient providers and consumers.
- d. Examine the use of students and interns who provide outpatient care. Promote agency policies that help ensure that students and interns are receiving adequate supervision and not treating cases that exceed their competency or that require long-term care.
- e. Closely monitor the results of the MHT-SIG workforce development project as it relates to the employment of individuals with experience in the field, including experience with EBTs, and efforts to work with high schools, community colleges, undergraduate, and graduate institutions to prepare the behavioral health workforce. Consider this project for statewide replication.
- f. Promote clinician credentialing for specialty treatment areas.
- g. Enhance use of Peer Specialists in outpatient clinics when possible. Peer Specialists can be helpful in case management, family engagement, and community outreach.

8. Data Collection and Reporting

A consistently identified limitation of the outpatient treatment system is that data collection and reporting has been insufficient to date. Best- and evidence-based practices in children's mental health include a strong emphasis on quality assurance, continuous quality improvement, and program evaluation. With the exception of CT BHP reports on ECCs, these methodologies are not uniformly applied to outpatient treatment. In collecting the quantitative data for this study from providers, it was clear that they varied in the degree to

which they were able to collect, analyze, and report data internally. Enhancing data collection and reporting has the potential to drive system improvements in a number of areas. Recommendations in this area include:

- a. Provider capacity for data collection and reporting can be enhanced by investing in infrastructure development and technical support, which is particularly important as PSDCRS reaches full implementation.
- b. All stakeholders will benefit from efforts to develop a culture in which data is viewed as part of the service, not as a separate activity. Such an approach can help promote a shared responsibility for outcomes improvement.
- c. Providers, DCF, CT BHP, and other stakeholders can work together to identify a set of performance and outcome indicators that can be collected, analyzed, and reported on a regular basis. Results should be analyzed at the aggregate level and for each individual provider. Incorporate benchmarking, control chart methodology, and continuous quality improvement methodologies.
- d. Examine utilization patterns across multiple episodes of outpatient care to better understand service need and long-term outcomes.

9. Systems-Level Issues

Routine outpatient treatment affects, and is affected by, other programs and services within the service array. Attempts to enact changes to the outpatient treatment system must be considered in the context of the broader service system. Efforts should be made to align the priorities of outpatient treatment with those of other programs and services in order to promote continuity and capitalize on shared goals and values. Recommendations include:

- a. Clearly define routine outpatient treatment within the system of care, including its services, roles, and expected outcomes.
- b. Engage outpatient treatment providers in a statewide learning community designed to identify salient issues, challenges, needs, and areas of opportunity for the outpatient system of care. Work collaboratively to develop proactive strategies for addressing these issues across the statewide outpatient system.
- c. Recognize and promote the importance of behavioral health for children across DCF's mandates, including child welfare. Work to further integrate behavioral health and child welfare across the state.
- d. DCF, CT BHP, and provider organizations can work collaboratively to attend to treatment gaps for children with particular diagnoses or treatment needs including children with substance abuse, mental retardation and developmental disorders, autism, and other conditions. The focus of this work would be to ensure that these youth receive needed services and are not disproportionately placed in inpatient and residential treatment programs.
- e. Continue to examine service utilization across levels of care. If appropriate, expand access to intermediate levels of care and other intensive community-based programs and services, including intensive in-home services, Extended Day Treatment, and Partial Hospitalization Programs in order to ease the burden on outpatient care.
- f. Whenever possible, provide expanded access to natural, community-based, and non-

traditional services and supports other than office-based treatment. Such programs are an important part of discharge planning and can be helpful in ensuring that children with behavioral health needs remain in their homes and communities.

10. Further Research into Outpatient Needs and Strengths

The current findings provide guidance regarding the perceived needs and strengths of outpatient treatment; however, the study is not exhaustive. Recommendations include:

- a. As part of a comprehensive research agenda, build upon these initial findings to systematically and regularly examine needs and outcomes within the outpatient treatment system. Further analyze the role of outpatient services in the mental health delivery system and ensure that appropriate resources are dedicated to meet identified needs.
- b. Promote a culture in which data is used to better understand the needs of children and families. The PSDCRS, CT BHP data, and other data collection mechanisms can be used to continuously examine outcomes and promote service quality. Enable providers to access and utilize data to better understand and identify needs.
- c. Promote and create mechanisms for ongoing continuous quality improvement across the outpatient system of care.
- d. Collect and analyze follow-up data to determine how these findings apply to urban, suburban, and rural areas of the state. The current study provides aggregated findings from across the state, including outpatient clinics in geographic areas that are very different from one another.

CONCLUSIONS AND NEXT STEPS

Conclusions

The outpatient mental health system serves more children than any other program, and the number of enrolled children appears to be growing. Outpatient clinicians and administrators are dedicated and hard-working professionals that often face significant challenges to service delivery. In addition, DCF's role can be challenging due to the variability among providers in their service delivery practices and their overall service quality. In order to support this vital service in the children's mental health service array, focused attention to service improvements in several key areas would be beneficial.

Recent efforts to improve treatment access through the ECC initiative have had important benefits. Our findings suggest that, given the evidence that enrollment could be growing, increased focus on building capacity could help prepare for the future. Our findings suggest that the typical child and family seeking outpatient treatment has complex needs. To address this complexity, case management, and particularly family engagement, was highlighted as a critical aspect of service delivery, and focused attention in this area could have important benefits for improving treatment attendance, improving outcomes, and generating revenue to support the outpatient treatment system. In terms of service delivery, the intake assessment process is relatively standardized across outpatient clinics; however, the use of standardized screening and assessment measures is variable. Enhanced use of screening and assessment instruments could help identify important treatment needs, guide treatment planning, ensure that families receive the services and supports they need, and improve outcomes. EBTs are increasingly important in many areas of children's mental health treatment, but the penetration of EBTs in outpatient treatment has been inconsistent across the state. In order to implement EBTs into outpatient settings, conceptual and logistical barriers need to be addressed, and appropriate implementation supports should be identified and put into place to support fidelity and sustainability of these practices. Outpatient clinicians are an important resource in the treatment system. In difficult economic times, some outpatient clinics can rely on interns to round out their workforce and this practice can have benefits and drawbacks. Recruiting and retaining a cadre of well-trained and culturally competent clinicians continues to be a critical aspect of the outpatient system. Finally, although data collection is part of routine outpatient treatment, use of data to monitor outcomes and to guide clinical decision-making is variable across the state. Use of the PSDCRS and CT BHP data collection and reporting mechanisms to monitor outcomes and contribute to continuous quality improvement processes would help guide and support outpatient treatment in the future.

The current study sought to gather and synthesize information from multiple sources; however, the study was not exhaustive. The findings and recommendations can be considered an additional tool and resource and considered in the context of all available information on outpatient treatment. Further research would help to clarify these findings. During difficult economic times, sufficient funding will not be available to support all of the recommendations in this report; however, many system and practice level improvements can be accomplished by utilizing existing resources in innovative ways. Ideally, these findings will contribute to a planning process by which priorities and available resources are

identified and long-term implementation steps are articulated. It is important that all system stakeholders work together to identify shared concerns and goals, establish priorities, and develop and implement plans for improvements.

Next Steps

The results of this study can be used as a catalyst for continued discussion among key stakeholders in outpatient services. During difficult economic times, there will not be sufficient resources to implement all of the recommendations from this report; rather, the report findings could serve as an additional tool and a roadmap for planning and implementing service improvements over a sustained period of time. Through interagency collaboration and cooperation, existing resources can be utilized and/or realigned to implement many of the recommendations described in this report. Early planning can have important benefits for implementing service improvements; thus, a collaborative workgroup could come together to examine the results of this study, identify priorities and available resources, and plan strategies for system improvement. This workgroup could include leaders from state agencies, CT BHP, juvenile justice, child welfare, outpatient providers, community representatives, and families.

REFERENCES

- ¹ Costello, E.J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, 60, 837-844.
- ² Satcher, D. (2001). U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.
- ³ Community Mental Health Services Block Grant for FY 2010. Connecticut Department of Children and Families and the Department of Mental Health & Addiction Services.
- ⁴ New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS pub no SMA-03-3832. Rockville MD, Department of Health and Human Services, 2003. Available at www.mentalhealthcommission.gov/reports/finalreport/fullreport-02.htm
- ⁵ Child Health and Development Institute of Connecticut (2000). Delivering and Financing Behavioral Health Services for Children in Connecticut. Report available for download at <http://www.chdi.org/publications>
- ⁶ Stroul, B.A. & Friedman, R.M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center.
- ⁷ Engstrom, M., Lee, R., Ross, R., Harrison, M., McVeigh, K., Josephson, L., Plapinger, J., Herman, D., King, C., & Sederer, L. (2003). *Children's Mental Health Needs Assessment in the Bronx*. New York: New York City Department of Health and Mental Hygiene, Division of Mental Hygiene, Bureau of Planning Evaluation and Quality Improvement.
- ⁸ Zima, B.T., Hurlburt, M.S., Knapp, P., Ladd, H., Tang, L., Duan, N., Wallace, P., Rosenblatt, A., Landsverk, J., & Wells, K.B. (2005). Quality of publicly-funded outpatient specialty mental health care for common childhood psychiatric disorders in California. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44, 130-144.
- ⁹ Mordock, J.B. (1993). Hidden costs of children's outpatient mental health services: Lessons from New York State. *Administration and Policy in Mental Health*, 20, 215-229.
- ¹⁰ Martin, A. & Leslie, D. (2003). Psychiatric inpatient, outpatient, and medication utilization and costs among privately insured youths, 1997-2000. *American Journal of Psychiatry*, 160, 757-764.
- ¹¹ Behavioral Health Data System. *Child Guidance Clinic Activity Accounting Report: Quarter 4, Fiscal Year 2009*. Data reports submitted to the Department of Children and Families.

- ¹² Luk, E.S., Staiger, P.K., Mathai, J., Wong, L., Birlleson, P., & Adler, R. (2001). Children with persistent conduct problems who dropout of treatment. *European Child & Adolescent Psychiatry*, 10, 28-36.
- ¹³ Kazdin, A.E., Marurick, J.L., & Siegel, T.C. (1994). Treatment outcome among children with externalizing disorder who terminate prematurely versus those who complete psychotherapy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 549-557.
- ¹⁴ Wang, J. (2007). Mental health treatment dropout and its correlates in a general population sample. *Medical Care*, 45, 224-229.
- ¹⁵ Casey, R.J. & Berman, J.S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin*, 98, 388-400.
- ¹⁶ Andrade, A., Lambert, E.W., & Bickman, L. (2000). Dose effect in child psychotherapy: Outcomes associated with negligible treatment. *Journal of the American Academy of Child and Adolescent Psychotherapy*, 39, 161-168.
- ¹⁷ Salzer, M.S., Bickman, L., & Lambert, E.W. (1999). Dose-effect relationship in children's psychotherapy services. *Journal of Clinical and Consulting Psychology*, 66, 270-279.
- ¹⁸ Schneider, B.H. & Byrne, B.M. (1985). Children's social skills training: A meta-analysis. In K.B.H. Schneider, K.R. Rubin, & J.E. Ledingham (Eds.), *Children's peer relations: Issues in assessment and intervention* (pp. 175-192). New York: Springer.
- ¹⁹ Angold, A., Costello, J., Burns, B.J., Erklani, A., & Farmer, E.M.Z. (2000). Effectiveness of nonresidential specialty mental health services for children and adolescents in the "real world." *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 154-160.
- ²⁰ Bickman, L., Andrade, A.R., & Lambert, E.W. (2002). Dose response in child and adolescent mental health services. *Mental Health Services Research*, 4, 57-70.
- ²¹ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation Research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
<http://nirn.fmhi.usf.edu/resources/publications/Monograph/index.cfm>
- ²² Smith, M.L. & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32, 752-760.
- ²³ Shapiro, D.A. & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin*, 92, 581-604.

- ²⁴ Leon, S.C., Martinovich, Z., Lutz, W., & Lyons, J.S. (2005). The effect of therapist experience on psychotherapy outcomes. *Clinical Psychology and Psychotherapy*, 12, 417-426.
- ²⁵ Weaver, D., Chang, J., & Gil de Gibaja, M. (2006). *The retention of public child welfare workers*. Berkeley, CA: University of California at Berkeley, California Social Work Education Center.
- ²⁶ Glisson, C. & Durick, M. (1988). Predictors of job satisfaction and organizational commitment in human service organizations. *Administrative Science Quarterly*, 33, 61-81.
- ²⁷ Mor Barak, M.E., Nissly, J.A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research?: A review and meta-analysis. *Social Service Review*, 75, 625-661.
- ²⁸ Jex, S.M. (1998). *Stress and job performance: Theory, research, and implications for managerial practice*. Thousand Oaks, CA: Sage Publications, Inc.
- ²⁹ Acker, G.M. (1999). The impact of clients' mental illness on social workers' job satisfaction and burnout. *Health and Social Work*, 24, 112-119.
- ³⁰ Tracy, E.M., Bean, N., Gwatkin, S., & Hill, B. (1992). Family preservation workers: Sources of job satisfaction and job stress. *Research on Social Work Practice*, 2, 465-478.
- ³¹ Ellett, A.J. (2001). *Organizational culture and intent to remain employed in child welfare: A two-state study*. Dallas, TX: Council on Social Work Education Annual Program Meeting.

Appendix 1

GLOSSARY OF ACRONYMS

ADHD	Attention Deficit/Hyperactivity Disorder
ARG	Area Resource Group
BHDS	Behavioral Health Data System
BSFT	Brief Strategic Family Therapy
CBHAC	Connecticut Behavioral Health Advisory Committee
CCEP	Connecticut Center for Effective Practice
CGC	Child Guidance Clinic
CHDI	Child Health and Development Institute
CT BHP	Connecticut Behavioral Health Partnership
DCF	Department of Children and Families
DSS	Department of Social Services
EBT	Evidence-Based Treatment/Practice
EDT	Extended Day Treatment
FTE	Full Time Equivalent
FWSN	Families with Service Needs
FY	Fiscal Year
IEP	Individualized Education Plan
IICAPS	Intensive In-Home Child & Adolescent Psychiatric Services
IOP	Intensive Outpatient Program
MDFT	Multidimensional Family Therapy
MST	Multisystemic Therapy
OPCC	Outpatient Psychiatric Clinic for Children
PHP	Partial Hospitalization Program
PSDCRS	Program and Services Data Collection and Reporting System

Appendix 2

CONSENT FORM FOR INTERVIEWS AND FOCUS GROUPS

Outpatient Needs Assessment Interview or Focus Group

You have been invited to participate in a needs assessment of outpatient clinics for children and adolescents in the state of Connecticut. The primary purpose of this needs assessment is to help clinicians, agencies, and Connecticut DCF to better understand how outpatient services currently are delivered and to identify areas for program improvement in order to better serve children, youth, and their families.

If you agree to participate in this needs assessment, an experienced interviewer from the Connecticut Center for Effective Practice, the agency that is conducting this needs assessment, will conduct the interview. The interview will take approximately 1 hour of your time and will consist of questions about your perspectives in providing treatment to children and youth in an outpatient setting.

The primary risk to you of participating in this research is breach of confidentiality. However, your privacy will be protected to the extent possible, and the research records will be kept confidential to the extent of the law. The information that you provide is protected under specific federal and state laws except for certain situations. The only exception to confidentiality laws is that the proper authorities must be contacted in cases of reported child abuse and/or neglect or if you are a danger to yourself or others.

Please note that you do not have to participate in this interview or focus group if you do not wish to. If you do agree to participate, every effort will be made to ensure that there is no way you could be identified in the report. Your responses will be combined with those of other participants in order to generate overall results and themes. Your particular answers will not be discussed with others. In addition, if at any time you do not wish to answer a particular question, or if you wish to discontinue your participation once we've begun, please let the interviewer know. If at any time after beginning the interview or focus group you wish to discontinue your participation, you may do so with no negative consequences.

As described above, the primary risk of participation is breach of confidentiality, and due to the protections in place, we consider this risk to be minimal. The benefits to you from participating in this interview and focus group include the opportunity to have your ideas and opinions heard, to highlight the strengths and challenges in providing outpatient services to children and adolescents, and to suggest changes to outpatient services that would benefit participating families in Connecticut in the future.

If you have further questions or concerns about the review, please contact the Principal Investigator, Robert P. Franks, Ph.D. at 860-679-1519.

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I understand what is being asked of me and agree to participate in this needs assessment interview or focus group to discuss outpatient services for children and adolescents. I have been given the opportunity to ask questions about the interview or focus group and any questions I had have been answered to my satisfaction. I also understand that it is my right to get further information by contacting Dr. Robert Franks at 860-679-1519. I understand that I may refuse to answer any questions during the interview or focus group and that my refusal to participate or to discontinue participation will not influence my present or future association with my employer or participating agencies in any way.

Signed:_____

Please print name:_____

Date:_____

Appendix 3

CONSENT FORM FOR ONLINE SURVEYS

You have been invited to participate in a needs assessment of outpatient clinics for children and adolescents in the state of Connecticut. The primary purpose of this needs assessment is to help clinicians, agencies, and Connecticut DCF to better understand how outpatient services currently are delivered and to identify areas for program improvement in order to better serve children, youth, and their families. Your responses will be used as part of a research study to accomplish these purposes.

If you agree to participate in this study, you will complete an online survey developed by investigators from the Connecticut Center for Effective Practice, the agency that is conducting this needs assessment. The survey will take approximately 30-45 minutes of your time and will consist of questions about your demographic characteristics and training, as well as your perspectives about providing treatment to children and youth in an outpatient setting.

The primary risk to you of participating in this research is breach of confidentiality. However, your privacy will be protected to the extent possible, and the privacy of the research records will be kept confidential to the extent of the law. The information that you provide is protected under specific federal and state laws except for certain situations. The only exception to confidentiality laws is that the proper authorities must be contacted in cases of reported child abuse and/or neglect or if you are a danger to yourself or others.

Please note that you do not have to participate in this online survey if you do not wish to. If you do agree to participate, every effort will be made to ensure that there is no way you could be identified in the report. We will not ask for your name on this survey, but instead we will assign an identification number to your survey. Your responses will be combined with those of other participants in order to generate overall results and themes. Your specific answers will not be discussed with others. In addition, if at any time you do not wish to answer a particular question, or if you wish to discontinue your participation once we've begun, you may do so with no negative consequences.

The only foreseeable risk to participating in this study is breach of confidentiality. However, your privacy and the privacy of the research records will be kept confidential to the extent of the law, thus, we consider this risk to be minimal. The benefits to you from participating in this survey include the opportunity to have your ideas and opinions heard, to highlight the strengths and challenges in providing outpatient services to children and adolescents, and to suggest changes to outpatient services that would benefit participating families in Connecticut in the future.

If you have further questions or concerns about the research, your rights as a participant, or anything else, please contact the Principal Investigator, Robert P. Franks, Ph.D. at 860-679-1519.

.....

I understand what is being asked of me and agree to participate in this needs assessment survey to discuss outpatient services for children and adolescents. I have been given the opportunity to ask questions about the needs assessment and any questions I have asked have been answered to my satisfaction. I also understand that it is my right to obtain further information by contacting Dr. Robert Franks at 860-679-1519. I understand that I may refuse to answer any questions during the survey and that my refusal to participate or to discontinue completion of the survey will not influence my present or future association with my employer or participating agencies in any way.

Signed:_____

Please print name:_____

Date:_____

Appendix 4

SITE VISIT PROTOCOL

Characteristics of Client Population

- What are the characteristics of the children and families served by your outpatient clinic?
 - Age, gender, race/ethnicity, diagnosis, referral source, living situation, etc.
- How are clients identified and referred for outpatient services?
- Are children and families seen in outpatient services ‘new’ to your outpatient clinic, or have they been seen previously?

Screening and Assessment

- How have your intake screening and assessment practices changed at your clinic over time?
- What are the strengths of your current intake procedures (what works well)?
- What are the limitations of your current intake procedures (what doesn’t work as well)?
- Is there an intake specialist that conducts all intakes? If no, does each clinician undertake the same methods to conduct intakes, or are there differences among clinicians?

Service Delivery

- What is your general treatment philosophy? What is it that contributes to children and their families “getting better”?
- How would you define a successful outcome of outpatient treatment?
- What are the factors that contribute to a successful outcome (for example, child-level, family-level, contextual, cultural)?
- In what way do evidence-based treatments (EBTs) fit in at your clinic? What is the general culture at your clinic around EBTs?
- What are the strengths and barriers of EBTs?
- What gaps exist in the overall service array for children and youth, and their families? In what way does outpatient treatment aim to address gaps in the system?
- How do you define culturally competent services? In what ways do you ensure that culturally competent services are delivered?

Client and case complexity

- Have children and families referred for outpatient services become more complex, less complex, or about the same over time?
- What are the most significant psychosocial and contextual factors that impact service delivery in your outpatient clinic?
- How does the degree of case complexity impact overall productivity in terms of direct face-to face client contacts?
- Tell us how the degree of case complexity impacts the amount of time that can be spent doing family-centered work?

- Have you noticed trends in presenting problems or diagnoses among those seeking outpatient services? Diagnostically, what types of children are you seeing more of over time? Less of over time?

Staffing and Workforce

- What contributes to maintaining high clinician job satisfaction? What contributes to lower clinician job satisfaction?
- What do clinicians need to further support their work?
- Coming out of graduate school, are clinicians prepared for the work they are asked to do in the field of children's mental health?
- In your experience, have clinicians received the necessary education and training in EBTs during graduate school?
- How do productivity requirements impact the work environment? How does it impact clinicians' day-to-day work?

Data Collection, Analysis, and Application

- What data currently are collected for outpatient services (from clients themselves, from clinicians)?
- What kinds of outcomes are important to measure for outpatient services?
- In addition to DCF mandated data collection, does your clinic require that additional data be collected and reported?
- Would you consider the current level of data collection that is required to be burdensome? Worthwhile?
- How is the data that are collected useful to the clinical services you provide?
- How is the data that are collected not useful to the clinical services you provide?

Other Salient Issues

- Are there other issues related to outpatient that were not covered during our discussion, but are important to consider?
- What issues, unique to your community, affect outpatient services?
- What are the systems-level or policy-related issues that are most problematic when it comes to outpatient services?
- If you could "wave a magic wand" to change anything in the mental health system in order to better serve children and families, what three things would you change?

Appendix 5

FAMILY FOCUS GROUP PROTOCOL

Need for Services:

- What are the most common types of behavioral health needs of children, adolescents and families?
- How well do you think that the treating clinicians understand the behavioral health needs of children, adolescents and families?

Treatment Process:

- What have been your experiences regarding the treatment process?
- What is your understanding of the typical length of treatment?
- What is your understanding of the treatment plan and its uses?
- Are treatment goals generally achieved? If no, what are the barriers?
- What benefits occur as a result of receiving services? (Improved functioning, symptom reduction, improved relationships, ability to solve problems, etc.)

Types of Services Available:

- What types of services are received in outpatient services?
- Do services differ for younger children versus adolescents?
- Are foster families involved in services?
- Are all formats available: individual, group, and family?
- What services do you wish you could receive in outpatient treatment?
- Overall, do you believe that you and your family received the "right" kinds of treatment to meet your needs? If no, what are your recommendations?

Family-Oriented Treatment:

- What efforts are made by clinic staff to involve children, youth and families during the period of services? (At intake, initial treatment planning, during the course of treatment, and at discharge)
- What is the extent of involvement?
- What is your understanding of the parents' role and responsibilities in this process?
- What are the typical patterns of communication? How are parents apprised of their child's progress or lack thereof? How frequently does this occur?
- What feedback is received during the course of treatment? How are families involved?

Cultural Competence:

- Are clinicians in outpatient services often the same race or ethnicity as you and your family?
- Would you prefer it if they were?
- Do clinicians and families speak the same language?
- Are clinicians usually able to provide culturally sensitive treatment?

Access to Services and Coordination of Services:

- Is it easy or difficult to access services?
- In what ways?
- How long do you have to wait to receive an initial (intake) appointment?
- How much time passes between a first phone call to (or from) a clinic and the first face-to-face appointment?
- How much time passes between the first face-to-face (intake) appointment and the first treatment appointment?
- What is the availability of staff? For emergencies? For regular treatment appointments?
- What efforts are made by the clinic staff to coordinate your plan of care with other involved providers such as the school, DCF, etc?

Overall Satisfaction with Services:

- How satisfied are you with the outpatient services provided at community-based clinics?
- Would you return for services if needed?
- Would you refer other family members or friends? Why or why not?
- If you could change three areas to improve services at the clinic, what would they be?
- Overall, what are the most helpful aspects of care at the clinics?
- What are the least helpful?
- What are the areas needing the most improvement?

Appendix 6

ENHANCED CARE CLINIC REQUIREMENTS

The Connecticut Behavioral Health Partnership now has designated approximately 61 child and adolescent outpatient clinics as Enhanced Care Clinics (ECCs), which includes primary and secondary (satellite) sites. The ECC designation makes the site eligible to receive reimbursement rates for services that are 25% higher on average than standard (non-ECC) rates. In exchange for this enhanced rate, ECCs will be required to comply with phased-in special requirements in five domains and their associated sub-domains. These requirements are outlined in Table 1.

Table 1. Enhanced Care Clinic Requirements

Domain	Sub-Domain
1. Access	a. Emergency Screening and Crisis Assessment
	b. Urgent Evaluation
	c. Routine Evaluation
	d. Emergent, Urgent, and Routine Follow-up Visits
	e. Extended Hours of Operation
2. Coordination of Care	a. Coordination with Primary Care Physicians
3. Member Services and Support	Welcoming and engagement, Peer Support Groups, Consumer Education, Member Evaluation and Feedback
4. Quality of Care	a. Evidence-Based Practice
	b. Co-Occurring Treatment
	c. Clinic Specialization
5. Cultural Competence	a. To Be Determined

Appendix 7**NEEDS ASSESSMENT SURVEY: CLINICIAN SURVEY****CONNECTICUT OUTPATIENT SERVICES FOR CHILDREN AND YOUTH**

Rationale: Outpatient services are a vital component of the service array for treating children with emotional and behavioral disturbances, and their families. In fact, the majority of clients that are seen for mental health care across the country are seen in outpatient services. The Connecticut Department of Children and Families and the Connecticut Community Providers Association have worked in collaboration with the Connecticut Center for Effective Practice to develop this needs assessment survey in order to learn more about outpatient services, and determine what can be done to support this vital program in the state.

In this survey, outpatient services are defined as center-based assessment and psychotherapy in individual, family, and group treatment formats, and the activities in which clinicians, directors, supervisors, and families are engaged to support that treatment.

Please read each question carefully, and answer to the best of your knowledge. If you have any questions about this survey, or the project, please contact the Project Coordinator at the Connecticut Center for Effective Practice, Jeffrey Vanderploeg, Ph.D. (860-679-1542)

Part 1: Agency and Clinician Characteristics

Your Position or Title:

Your Gender:

- ☐ Male
☐ Female

Your Age:

- ☐ 18-25
☐ 26-30
☐ 31-40
☐ 41-50
☐ 51-60
☐ 61+

Your Race/Ethnicity (check one):

- ☐ White or Caucasian
☐ Black or African-American
☐ Latino/Latina
☐ Native American
☐ Asian/Pacific Islander
☐ Biracial or Multiracial
☐ Other

Languages with which you can comfortably provide clinical services

- ☐ English and Spanish
☐ English only
☐ Spanish only
☐ English and other languages (please list): _____

Highest degree achieved (check one)

- ☐ High School diploma or GED
- ☐ Bachelor's (e.g., B.A., B.S., B.S.W., or equivalent)
- ☐ Master's (e.g., M.A., M.S., M.S.W., M.F.T., or equivalent)
- ☐ Registered Nurse (R.N.)
- ☐ Advanced Practice Registered Nurse (e.g., APRN)
- ☐ Doctorate (e.g., Ph.D., Psy.D., Ed.D., or equivalent)
- ☐ Medical degree (M.D., D.O., or equivalent)

Are you currently independently licensed to provide mental health services to children and youth in Connecticut?

- ☐ Yes
- ☐ No

How many years of experience do you have in providing mental health services?

- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16-20 years
- ☐ 21 or more years

How would you characterize your theoretical orientation(s) (Check all that apply):

- ☐ Behavioral
- ☐ Cognitive
- ☐ Cognitive-Behavioral
- ☐ Psychoanalytic/dynamic
- ☐ Family Systems
- ☐ Interpersonal Process
- ☐ Integrated/Eclectic
- ☐ Other (please list): _____

Which best describes the nature of your employment?

- ☐ Full time employee
- ☐ Part-time employee
- ☐ Fee-for-service employee
- ☐ Unpaid clinical trainee
- ☐ Paid clinical trainee

Please check the box that most accurately reflects the salary you receive for your work at this outpatient clinic:

- ☐ None
- ☐ \$1 to \$9,999

- ☐ \$10,000 to \$19,999
- ☐ \$20,000 to \$29,999
- ☐ \$30,000 to \$39,999
- ☐ \$40,000 to \$49,999
- ☐ \$50,000 to \$59,999
- ☐ \$60,000 to \$69,999
- ☐ \$70,000 to \$79,999
- ☐ \$80,000 or more

Part 2: Client and Case Complexity

How many active clients (children and youth that have not yet been discharged, regardless of frequency of treatment attendance) are currently on your caseload?

Of the number of active clients listed above, how many do you see about weekly, about every other week, or about monthly? *Note: Total of three responses should equal total number of active clients listed above.*

- About weekly _____
- About every other week _____
- About monthly _____

Think about a typical week for you. What **percentage** of your work hours did you spend on the following activities? "Direct services" are defined as face-to-face clinical contacts. *Please note that the sum of all responses should total 100 percent.*

- | | |
|---------|---|
| _____ % | Direct services: Individual therapy |
| _____ % | Direct services: Group therapy |
| _____ % | Direct services: Family therapy |
| _____ % | Case management |
| _____ % | Meetings with others who are at the outpatient clinic |
| _____ % | Meetings with others who are outside the outpatient clinic (in-person, phone) |
| _____ % | Receiving or providing clinical supervision |
| _____ % | Participating in training |
| _____ % | Providing consultation services |
| _____ % | Preparing for services (including preadmission preparation) |
| _____ % | Completing billing and insurance paperwork, including pre-authorization paperwork |
| _____ % | Completing clinical paperwork (e.g., progress notes, treatment plans) |
| _____ % | Providing prevention and outreach services |
| _____ % | Prescribing medication and providing medication management |
| _____ % | Other activities (please list: _____) |

“Collaterals” are family members, teachers, physicians, probation officers, or others that are interested in the treatment and well-being of children in outpatient services. From initial intake through treatment and discharge, how many collaterals do you contact for each child or youth, on average? _____

About how many hours do you spend each week contacting collaterals?

Clinicians often provide services to children, youth, and families with very complex needs. Please respond to each item below by circling the response that best characterizes the complexity of the needs of clients that you serve, and their families.

	None of my clients	A few of my clients	Several of my clients	Most of my clients	All of my clients
Child/family lacks adequate transportation to consistently attend appointments	1	2	3	4	5
Child/family experiences significant poverty or housing problems	1	2	3	4	5
Child has more than one diagnosed psychological condition	1	2	3	4	5
Child has been prescribed one or more psychotropic medications	1	2	3	4	5
Child has one or more <u>parent</u> with a diagnosed psychological condition (includes substance abuse)	1	2	3	4	5
Child's <u>parent(s)</u> currently is in mental health or substance abuse treatment	1	2	3	4	5
Child has one or more <u>sibling</u> with a diagnosed psychological condition (includes substance abuse)	1	2	3	4	5
Child's <u>sibling(s)</u> currently is involved in mental health or substance abuse treatment	1	2	3	4	5
Child has or had an open DCF investigation	1	2	3	4	5
Child is or has been committed to DCF care	1	2	3	4	5
Child has past or current juvenile justice involvement	1	2	3	4	5
Child is or has been in foster care	1	2	3	4	5
In the past, child has been in a more restrictive or intensive clinical treatment setting than outpatient therapy	1	2	3	4	5
If not for outpatient, child would be in a	1	2	3	4	5

more restrictive or intensive treatment setting					
Child would benefit from more intensive treatment, but can't access it due to waitlist	1	2	3	4	5
Child's treatment requires parent/family involvement in treatment sessions	1	2	3	4	5
Child/family is mandated to attend treatment	1	2	3	4	5
Child/family is not motivated for treatment	1	2	3	4	5
Child's treatment requires communication and linkage with other community agencies (e.g., treatment providers, schools, courts)	1	2	3	4	5

Part 3: Screening and Assessment

To provide initial assessments in outpatient services, clinicians often use a combination of methods to determine the nature and severity of presenting problems, develop a case formulation, and complete a treatment plan. The following questions will ask you about your use of, and opinions about, these screening and assessment methods.

Do you use an intake interview protocol to conduct intake assessments?

- ☐ Yes (name of instrument(s): _____)
- ☐ No

Please rate the degree to which an intake interview protocol is helpful to case formulation, diagnosis, and treatment (circle one):

Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful	Extremely helpful
--------------------	------------------	--------------------	--------------	-------------------

Do you use any screening or assessment instruments to conduct intake assessments?

- ☐ Yes (name of instrument(s): _____)
- ☐ No

Please rate the degree to which using a screening or assessment instrument is helpful to case formulation, diagnosis, and treatment (circle one):

Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful	Extremely helpful
--------------------	------------------	--------------------	--------------	-------------------

Which assessment procedures or instruments (including, but not limited to: interviews, home visits, assessment measures, collateral contacts) do you find to be **most helpful** to case formulation, diagnosis, and treatment? Why?

Which assessment procedures or instruments (including, but not limited to: interviews, home visits, assessment measures, collateral contacts) do you find to be **least helpful** to case formulation, diagnosis, and treatment? Why?

Part 4: Service Delivery

For each of the activities listed below, please rate the **effectiveness** of each element of treatment in **improving clients' outcomes**:

	Not at all Effective	Somewhat Effective	Moderately Effective	Very Effective	Extremely Effective
Comprehensive assessment and diagnosis	1	2	3	4	5
Case management	1	2	3	4	5
Use of evidence-based treatments (EBTs)	1	2	3	4	5
Parent/family participation in treatment	1	2	3	4	5
Client's level of motivation for treatment	1	2	3	4	5
Client's engagement in treatment	1	2	3	4	5
Therapeutic alliance	1	2	3	4	5
Culturally competent services	1	2	3	4	5
High consistency of treatment (attended sessions relative to missed sessions)	1	2	3	4	5
High frequency of treatment (having at least weekly appointments)	1	2	3	4	5
Long duration of treatment (total number of sessions over a long period of time)	1	2	3	4	5

Use of assessment measures to assess progress in treatment	1	2	3	4	5
Staff training and professional development activities	1	2	3	4	5
Treatment planning (e.g., identifying goals and strategies, tracking progress)	1	2	3	4	5
Clinical supervision	1	2	3	4	5
Peer support from colleagues and administrators	1	2	3	4	5
Client access to psychiatric assessment and medication, as needed	1	2	3	4	5
Access to a comprehensive service array	1	2	3	4	5
Discharge planning	1	2	3	4	5

Please list below the **manualized** evidence-based treatments that you have been trained to use in outpatient services. Please include EBTs that you have used in the past, or that you currently use.

Do you experience any barriers to using manualized EBTs in outpatient services?

- ☐ Yes
☐ No

If you answered yes to the previous question, what do you experience as the barriers to using manualized evidence based treatments (EBTs)? Please check all that apply:

- ☐ I don't really understand what makes a treatment "evidence-based"
☐ Sufficient training in EBTs is not available at my agency
☐ My supervisors and agency do not support the use of EBTs
☐ EBTs require too much supervision
☐ I have doubts that manualized EBTs are appropriate to my clients' needs
☐ I have doubts that manualized EBTs are more effective than other treatment approaches
☐ I have doubts that manualized EBTs are sufficiently flexible for my clients' needs
☐ I don't have the time to be trained in a new approach
☐ The non-manualized approaches I use are usually effective for my clients

☐ Other barriers (please list below):

In your opinion, what groups of children and families are most in need of manualized evidence-based treatments?

Question	Your Answer
For what age group?	
For what diagnosis ?	
Using what modality (e.g., individual, family, group)?	
Any other considerations?	

Children and families in outpatient treatment sometimes need additional services, but those **services vary in the degree to which they are accessible to clients and their families**. When clients have needed the following services, how easy or difficult have they been to access?

	Very easy to access	Moderately easy to access	Moderately difficult to access	Very difficult to access
Inpatient hospitalization	1	2	3	4
Residential treatment	1	2	3	4
Intermediate-level treatment (EDT, PHP, IOP)	1	2	3	4
Psychiatric assessment, medication management	1	2	3	4
In-home treatments (MST, IICAPS, MDFT, FFT)	1	2	3	4
24-hour emergency services	1	2	3	4
Therapeutic support services	1	2	3	4
Psychological testing	1	2	3	4
Non-traditional services (art, music, drama, recreation)	1	2	3	4
After-school programs	1	2	3	4
Educational supports and services	1	2	3	4
Case management	1	2	3	4
Parent support, education, coaching	1	2	3	4

Transportation	1	2	3	4
Medical services	1	2	3	4
Financial services	1	2	3	4
Legal services	1	2	3	4
Housing services	1	2	3	4
Substance abuse treatment for children and youth	1	2	3	4
Mental health treatment <u>for parents</u>	1	2	3	4

What are the three most significant **gaps in services** in your community? That is, what services are not currently available or not easily accessible that would help to keep children in their homes and communities instead of in residential or inpatient programs?

1.

2.

3.

What do you consider to be “successful outcomes” of treatment for children and families in outpatient services?

Part 5: Staffing and Workforce Development

Please list 3 or more reasons for clinician **retention** at your outpatient program:

1.

2.

3.

Others:

Please list the top 3 or more reasons for clinician **turnover** at your outpatient program:

1.

2.

3.

Others:

Please list 3 or more areas in which you would like to have additional **training**:

1.

2.

3.

Others:

Did your education and training adequately prepare you for the work you do in outpatient services?

☐ Yes

☐ No

Did your education and training adequately prepare you for delivering evidence-based treatments?

☐ Yes

☐ No

What could have better prepared you for the job you now have?

Have you, or do you now engage in continuing education?

☐ Yes

☐ No

If yes, in what courses or continuing education have you participated?

What types of support do you receive as a clinician that you find **most helpful** to delivering clinical care?

What are the most **significant barriers** that interfere with your ability to provide ideal clinical care to your clients?

Are there productivity requirements at your workplace?

- ☐ Yes
☐ No

If yes, how do productivity requirements **positively** impact the work you do?

If yes, how do productivity requirements **negatively** impact the work you do?

Part 6: Data Collection, Analysis, and Application

Please rate the following questions according to how often each of the following data-related activities occurs:

	Never	Sometimes	Often
Outcome measures are consistently collected at my agency	1	2	3
Outcome measures are consistently analyzed at my agency	1	2	3
Reports or summaries of outcome measures are discussed with me by supervisors or clinic administration	1	2	3
Outcomes measures are discussed in team meetings	1	2	3
I share the results of outcome measures with my clients	1	2	3
I use outcomes measures to guide or inform my clinical decision-making (e.g., need for treatment, type of treatment, discharge from services)	1	2	3

In thinking about assessing client outcomes, which outcomes do you think are most important to measure?

In what ways do you feel DCF-required outcome data could be better utilized to help inform the clinical care you provide?

Thank you for completing this survey. Your ideas and perceptions about outpatient treatment are very important to us.

Appendix 8

NEEDS ASSESSMENT SURVEY: AGENCY SURVEY

CONNECTICUT OUTPATIENT SERVICES FOR CHILDREN AND YOUTH

Agency Identification Number: _____

Rationale: Outpatient services are a vital component of the service array for treating children with emotional and behavioral disturbances, and their families. In fact, the majority of clients that are seen for mental health care across the country are seen in outpatient services. The Connecticut Department of Children and Families and the Connecticut Community Providers Association have worked in collaboration with the Connecticut Center for Effective Practice to develop this needs assessment survey in order to learn more about outpatient services, and determine what can be done to support this vital program in the state.

In this survey, outpatient services are defined as center-based assessment and psychotherapy in individual, family, and group treatment formats, and the activities in which clinicians, directors, supervisors, and families are engaged to support that treatment.

Please read each question carefully, and answer to the best of your knowledge. If you have any questions about this survey, or the project, please contact the Project Coordinator at the Connecticut Center for Effective Practice, Jeffrey Vanderploeg, Ph.D. (860-679-1542)

Part 1: Agency and Director Characteristics

Your Position: _____

Your Gender:

- ☐ Male
- ☐ Female

Your Age:

- ☐ 18-25
- ☐ 26-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61+

Your Race/Ethnicity (check one):

- ☐ Caucasian
- ☐ African-American
- ☐ Latino/Latina
- ☐ Native American
- ☐ Asian/Pacific Islander
- ☐ Biracial or Multiracial
- ☐ Other

Highest degree achieved (check one)

- ☐ High School diploma or GED
- ☐ Bachelor's (e.g., B.A., B.S., B.S.W., or equivalent)
- ☐ Master's (e.g., M.A., M.S., M.S.W., M.F.T., or equivalent)

- ☐ Registered Nurse (R.N.)
- ☐ Advanced Practice Registered Nurse (APRN)
- ☐ Doctorate (e.g., Ph.D., Psy.D., Ed.D., or equivalent)
- ☐ Medical Degree (M.D., D.O., or equivalent)

Are you currently independently licensed to provide mental health services to children and youth in Connecticut?

- ☐ Yes
- ☐ No

Which of the following best describes where the outpatient clinic is located (check one):

- ☐ Community mental health center
- ☐ Hospital

Which of the following best describes the region(s) served by the outpatient clinic (Check all that apply)

- ☐ Urban
- ☐ Suburban
- ☐ Rural

Part 2: Characteristics of Clients Served

The following section asks several questions about the characteristics of the children and youth admitted to your outpatient clinic, and aspects of the clinic's service capacity.

Gender	
_____ %	Male
_____ %	Female

Age	
_____ %	4-7 years
_____ %	8-12 years
_____ %	13-17 years

Race/Ethnicity	
_____ %	Hispanic ethnicity
_____ %	Caucasian (non-Hispanic)
_____ %	Black or African-American
_____ %	Latino/Latina
_____ %	Native-American
_____ %	Asian/Pacific Islander
_____ %	Bi-/Multi-Racial

Child's Primary Language

_____% English only
_____% Spanish only
_____% English and Spanish

Insurance Coverage

_____% No insurance
_____% Medicaid eligible
_____% Private Insurance

_____% Self pay
_____% Other _____

Referral Sources

_____% DCF
_____% Schools
_____% Parents / caregivers
_____% Hospitals
_____% Court / juvenile justice
_____% Inpatient / Residential
_____% System of care/care coordination
_____% Intra-agency referral

DCF Status at Intake

_____% No DCF Involvement
_____% Protective Services
_____% Voluntary Services
_____% FWSN
_____% Juvenile Services

Child Place of Residence at Intake

_____% Biological Family
_____% Adoptive Family
_____% Relatives
_____% Foster Family
_____% Group Home
_____% Other

Child Diagnoses

Please list the five most common diagnoses among children served at your outpatient clinic, along with the percentage of children with each diagnosis.

Please note that due to comorbid diagnoses, the totals might not add up to 100%.

1. _____ %
2. _____ %
3. _____ %
4. _____ %
5. _____ %

What percentage of children has a substance use diagnosis? _____ %

What percentage has comorbid psychological conditions? _____ %

Have you seen any recent increases or decreases in the percentages of children presenting with particular diagnoses?

- ☐ Yes
☐ No

If yes, please describe below.

Are there exclusionary criteria for your outpatient services? Are there certain diagnoses or circumstances in which you will not admit someone for outpatient services?

Child Placement History

Percentage of clients with a prior psychiatric hospitalization? _____ %

Percentage of clients with prior residential placement? _____ %

Part 3: Service Access and Capacity

Clinician full-time equivalent (FTE) _____

Psychiatry full-time equivalent (FTE) _____

How many hours of monthly psychiatry services currently are provided at your outpatient clinic? _____

For the following sections, please note that “referred” clients are all clients that seek services, whether initiated by the child, parent, or other sources. Of the total number of referred clients, some are scheduled for an “intake,” defined as one or more initial assessment appointments. Some clients complete the intake process, and others do not. Of those that complete the intake process, some will attend one or more “treatment sessions” (e.g., an intervention session such as psychotherapy). “Successful completion” is defined as a jointly planned and agreed upon termination of services, with symptom reduction and/or completion of treatment goals.

Total number of clients referred to outpatient services in an average month

Number of clients scheduled for intake in an average month _____

Number of clients that complete the intake process in an average month _____

The following questions are about treatment attendance and completion rates. To answer these questions, please use discharge data that covers a reasonable timeframe, such as the most recently completed quarter or fiscal year.

Number of clients discharged in an average month _____

Percentage of all discharged clients that attended 0 treatment sessions
_____ %

Percentage of all discharged clients that attended 1-5 treatment sessions
_____ %

Percentage of all discharged clients that attended 6 or more treatment sessions
_____ %

Percentage of all discharged clients that successfully completed treatment
_____ %

What is the average length of treatment at your outpatient clinic?

Approximately how long is the current wait list for outpatient services at your clinic?

What efforts have you undertaken, past or present, to increase the access to services at your outpatient clinic?

What efforts have you undertaken, past or present, to increase engagement and retention of clients?

What do you think could or should be done that would help improve clients' access to, and engagement in, outpatient treatment?

Part 4: Screening and Assessment Practices

Do you have an intake specialist at your outpatient clinic (someone who handles the intake procedures for most or all referred clients)?

Please use the space below to describe the intake assessment process and procedures at your outpatient clinic:

If one or more structured intake interviews are used, please list the name of the instrument(s):

If brief screening measures are used, please list the name of the instrument(s):

If other assessment measures are used, please list the name of the instrument(s):

Which assessment procedures or instruments currently in use at your agency do you find to be **most** helpful to assessment, case formulation, and treatment? Why?

Which assessment procedures or instruments currently in use at your agency do you find to be **least** helpful to assessment, case formulation, and treatment? Why?

Part 5: Service Delivery

Please list below all the manualized evidence-based treatments that currently are available to clients at your outpatient clinic.

Do you have available manualized EBTs that are appropriate for children of all ages that present for outpatient services?

- ☐ Yes
- ☐ No

Do you perceive that there are significant barriers to using evidence-based practices and treatments in outpatient services?

- ☐ Yes
- ☐ No

If yes, what are the barriers to using evidence-based treatments (check all that apply)?

- ☐ I don't understand the criteria for establishing an intervention as an EBT
- ☐ Sufficient training in manualized EBTs is not available at my agency
- ☐ Manualized EBTs require too much supervision
- ☐ I have doubts that some manualized EBTs are appropriate to my clients' needs
- ☐ I have doubts that some manualized EBTs are more effective than other treatment approaches
- ☐ I have doubts that some manualized EBTs are sufficiently flexible for my clients' needs

- ☐ Clinicians at my agency do not have the time to be trained in an EBT
- ☐ The non-manualized EBT approaches my clinicians use are sufficiently effective
- ☐ EBTs require more staff and/or resources than are available
- ☐ Other barriers (please list below):

In your opinion, what groups of children and families are most in need of manualized evidence-based treatments?

Question	Your Answer
For what age group?	
For what diagnosis ?	
Using what modality (e.g., individual, family, group)?	
Other considerations?	

Please use the space below to describe the current processes and procedures for discharge planning for children (e.g., aftercare, referrals, follow-up):

Part 6: Staffing and Workforce Development

Please list the top 3 reasons for clinician retention at your outpatient clinic:

1.

2.

3.

Please list the top 3 reasons for clinician turnover at your outpatient clinic:

1.

2.

3.

Please list 3 or more areas in which you would like outpatient clinicians to receive additional training:

1.

2.

3.

Others: _____

In your opinion, are undergraduate and graduate programs adequately preparing outpatient clinicians for the work they currently are required to do?

☐ Yes

☐ No

What must be provided in order to prepare outpatient clinicians for the work they are required to do?

Please list any perceived barriers that can interfere with outpatient clinicians' ability to provide the best quality of care?

Are there productivity requirements at your workplace?

- ☐ Yes
☐ No

If yes, how do productivity requirements **positively** impact the work?

If yes, how do productivity requirements **negatively** impact the work?

Is there sufficient clinical supervision available to outpatient clinicians?

- ☐ Yes
☐ No

Part 7: Data Collection, Analysis, and Application

Please rate the following questions according to how often each occurs:

Activity	Never	Sometimes	Often
Data are consistently collected at my agency	1	2	3
Data are consistently analyzed at my agency	1	2	3
Data reports or summaries are distributed to clinical staff	1	2	3
Data are discussed in team meetings	1	2	3
Data collected from clients are discussed with clinical staff	1	2	3
Data are used to inform clinical treatment	1	2	3
Data are used to guide or inform clinical decision-making (e.g., appropriate treatments, timing of discharge from services)	1	2	3

DCF requires outcome data to be collected from your clients. Please rate how much you agree or disagree with each of the following statements regarding DCF outcome data collection requirements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
--	----------------	-------	----------	-------------------

DCF ensures that I collect data in a timely manner	1	2	3	4
DCF ensures that the data I collect is analyzed	1	2	3	4
DCF ensures that the data I collect is reported back to me, or my agency	1	2	3	4
DCF ensures that the data I collect is used to help me make treatment decisions	1	2	3	4

How do you use the Ohio Scales data? How could DCF support your use of Ohio Scales data in clinical decision-making and treatment?

What kinds of other outcomes data do you collect? In what ways are these outcome measures useful to clinical decision-making and treatment?

Please describe any ongoing evaluation, quality assurance, or continuous quality improvement practices that currently are conducted at your outpatient clinic:

Thank you for completing this survey. Your ideas and perceptions about outpatient treatment are very important to us.