Children's Committee
February 20, 2025
Public Hearing on H.B. 6951 An Act Concerning Children's Behavioral Health Services

Good afternoon, my name is Dr. Jeffrey Vanderploeg, and I am the President and CEO of the Child Health and Development Institute of Connecticut (CHDI). I am writing in support of House Bill 6951 with additional suggestions for strengthening the Bill in a manner that ensures promotion of equitable access, quality, and outcomes of behavioral health services for Connecticut's youth and families.

Section 1: Study of the Continuum of Crisis Services

I strongly support legislative action that strengthens our state's continuum of crisis services: 9-8-8, 2-1-1, Mobile Crisis Intervention Services (MCIS), Urgent Crisis Centers (UCC), Subacute Crisis Stabilization Centers (SAC), and hospital emergency departments (EDs). This best practice continuum of services has taken years to establish; however, these services are at risk of being severely diminished or closing altogether if sufficient and sustainable funding is not appropriated this session. In that scenario, *some services recommended for further study in HB 6951 will not exist to be studied, because providers will need to close them*. For example, soon-to-expire federal ARPA funds are currently supporting over $8 million annually for MCIS (which is addressed in Sections 3 and 4 of this Bill). UCCs currently receive ARPA funded grants totaling approximately $13.6 million annually to operate four UCCs. The Governor's budget calls for an appropriation of ~$7.6 million in the DSS budget for UCCs, which is insufficient to sustain these services and will limit services to only those enrolled in Medicaid. One solution is to maintain the proposed Medicaid funding and add grant funding. Blended financing will allow UCCs to continue serving all children, regardless of insurance type.

I support the study called for in Section 1 of the Bill, and I encourage the legislature to first examine existing data reports and refine the questions underlying these recommended studies so they can more squarely focus on gaps in our existing data. For example, DCF funds CHDI to produce data reports for MCIS and UCCs. We are reporting in detail historical utilization patterns, socio-demographic and clinical characteristics of youth served, outreach and marketing efforts, referral sources, and allocations of state and other funds. Furthermore, The CT Behavioral Health Partnership funds Carelon to produce extensive data reports on the use of hospital EDs among youth enrolled in Medicaid, and the CT Hospital Association reports similar data on EDs across payers. Numerous studies have examined ED use and have made data-driven recommendations for how Connecticut can address overutilization of EDs among youth with behavioral health conditions. I believe by pulling from existing research we may be able to address many of the existing questions and focus the recommended studies only on the gaps in our knowledge.

Section 2: Study of School Based Health Centers

I strongly support further study of the existing data collection practices of SBHCs. Standardized and publicly reported data for all funded SBHCs could significantly add to our understanding of the contributions SBHCs are making to the behavioral health and well-being of Connecticut's youth.

Sections 3 and 4: Appropriations for Mobile Crisis

I strongly support the $8.6 million annual appropriation to DCF in FY26 and FY27 for youth Mobile Crisis. Connecticut's Mobile Crisis service is a national best practice and among the most effective services in Connecticut's continuum.

Sincerely,

Jeffrey Vanderploeg, PhD
President and CEO
Child Health and Development Institute (CHDI)