

Delivering and Financing Children's Behavioral Health Services in Connecticut

A Report to the Connecticut General Assembly

Pursuant to Public Act 99-279, Section 36

From the Connecticut Department of Social Services

Presented by Patricia Wilson-Coker, MSW, JD, Commissioner

in collaboration with the Department of Children and Families, the State Department of Education, the Department of Mental Health and Addiction Services, the Department of Mental Retardation, and the Office of Policy and Management

Prepared for the Department of Social Services by

The Child Health and Development Institute of Connecticut, Inc.

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The Connecticut Department of Social Services

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PREFACE

The Child Health and Development Institute of Connecticut prepared this report under an agreement with the Connecticut Department of Social Services (DSS). The Institute is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive, and social development of children throughout Connecticut. The Institute creates, supports, and facilitates innovative primary and preventive strategies for children, and works to maximize the effectiveness of the institutions and systems that contribute to their well being. The Institute retained F. Carl Valentine & Associates to conduct the study that is the basis of this report.

The analyses and recommendations presented in this report and the accompanying Technical Appendix were developed with DSS and the Department of Children and Families, in consultation with members of the Children's Behavioral Health Task Force established by DSS. The Task Force membership is listed below. The group consisted of representatives of State departments with responsibilities related to children's behavioral health, behavioral health care providers, and consumer parents.

Children's Behavioral Health Task Force Members

David Parrella, Chair	Department of Social Services
Karen Andersson	Department of Children and Families
Lois Berkowitz	Anthem Blue Cross Blue Shield of Connecticut
Gary Blau	Department of Children and Families
Eva Bunnell	Family Representative / Medicaid Managed Care Council
Paul DiLeo	Department of Mental Health and Addiction Services
George Dowaliby	State Department of Education
Tracey Halstead	Connecticut Association of Nonprofits
Dawn Anderson Henschel	Family Representative / No. Central Regional Mental Health Board
Steve Larcen	Natchaug Hospital
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Executive Summary

State policymakers and practitioners are increasingly concerned about children in Connecticut who have serious emotional or behavioral problems, as are the families of these children. Providing appropriate and effective services to meet their needs is a high priority.

The State of Connecticut invests an estimated \$207 million annually in behavioral health services for children, addressing many of their needs. Behavioral health services, however, are administered by more than five state agencies and a myriad of local agencies and the schools. The result is a complex and fragmented system that leaves families confused about where to turn when they recognize that their children need help.

In response to these concerns, the State Legislature requested that the Connecticut Department of Social Services (DSS) conduct a study of the State's behavioral health services for children, specifically services for those enrolled in the state-sponsored health insurance programs for low-income families (HUSKY A and B)¹. Legislators also sought recommendations for improving the quality and integration of these services for Connecticut's children. DSS engaged the Child Health and Development Institute of Connecticut to conduct the study. A task force comprising representatives from the state agencies who fund or provide behavioral health services for children, along with major service providers, consumer parents, and managed care organizations assisted with the study.

¹ HUSKY A is for children enrolled in Medicaid and HUSKY B is for uninsured children in families whose income is above 185% of the federal poverty level.

The study was conducted in the context of national research, documented in a recent report by the U.S. Surgeon General. This report advanced a "system of care" approach in which multiple problems associated with "serious emotional disturbance" are addressed comprehensively.

The good news for Connecticut is that the foundation to implement this approach is already in place. The State has begun to build a network of systems of care under the mandate and principles established by the Legislature in 1997 (P.A. 97-272). These local systems must now be fully supported and replicated on a statewide basis.

The results of the study are presented in two parts: 1) the main report that summarizes the findings and presents the recommendations; and 2) a technical appendix to the report that provides more detailed information, data, and analyses that were the basis for the findings and recommendations.

Children Served by HUSKY

- Approximately 184,000 children are enrolled in HUSKY A and B— about 20% of all children under 21 in the state.
- Approximately 22,300 or 12% of children in HUSKY A used one or more behavioral health services in the twelve-month period studied (April 1998 – March 1999).
- 8,419 children (5%) enrolled in HUSKY A were in the custody of DCF during the year studied.

Behavioral Health Services Delivered and Their Cost

- 70% of all behavioral health dollars are spent for psychiatric hospitals and

residential treatment, serving 19% of all HUSKY children receiving services.

- Acute Care Psychiatric Hospitals, the most intensive and expensive level of service, serve an estimated 1,067 children in a year and cost the state \$41.1 million.
- Residential Treatment and other out of home placements through DCF and the state and local education system (in various settings both in state and out of state) serve an estimated 3,000 children per year and cost \$104.2 million.
- Community-based services serve about 18,200 children with a state investment of \$61.3 million.

Funding Sources for Services

- Connecticut spent approximately \$207 million across the five child-serving systems (DCF, SDE/LEA, DSS, DMHAS, and DMR) included in this study, for behavioral health services in FY 1999 for children enrolled in HUSKY plans.
- A majority of the public investment in behavioral health services (72%) comes from the State's General Fund. The federal government contributes 20%, primarily through Medicaid and Title IV-E foster care funds. Local funds through local education agencies account for the remainder.
- DCF administers 58% of all behavioral health services funds. State and Local Education Agencies fund 23% (through the Special Education program). DSS directly administers 14% of the total funding.
- \$62 million in HUSKY/Medicaid funds flow through five state agencies, with DSS directly administering 48% of these HUSKY/Medicaid funds.

Critical System Issues

The study identified the following critical system issues:

1. There are insufficient mechanisms for effective coordination of care between levels and across systems for children and their families.
2. Community-based resources and treatment alternatives must be better developed to avoid serious bottlenecks in the treatment system.
3. Funding is allocated by program and agency, each with its own requirements and incentive structure. This fragmentation within the system must be reduced.
4. Families must have a greater role in planning services for their own children and in system planning and oversight. Currently there are not adequate supports to enable families to be sufficiently involved in these ways.
5. Current resources may not be sufficient, but a redistribution of existing resources and taking fuller advantage of federal financing mechanisms could go a long way toward supporting a more effective system of behavioral health services for children.

Some study highlights that drive these issues home include the following:

- From July-December 1999, fully 55% of the children in DCF custody enrolled in HUSKY A who were in private psychiatric hospitals were ready for discharge to a less intensive and less expensive setting (residential treatment or home). As of September 1999, almost half of these children had been there for longer than 90 days.
- The State spent \$8 million for reinsurance for a 10-month period in FY 1999 to support stays longer than 15 days in psychiatric hospitals or subacute units. Projections are that reinsurance costs will be \$12 million for FY 2000.

- Residential treatment facilities are at or near capacity, yet many children in residential treatment no longer need this level of care. There are not sufficient community-based services to support their return to the community.
- Placements by parole and juvenile justice authorities through DCF have increased 34% in the last three years (accounting for 432 of the 1,268 children in placements in December 1999).
- Children in DCF custody are 5% of the HUSKY population but account for 60% of behavioral health expenditures.
- There has been a 40% increase in the number of children in out-of-state placements through DCF over the past three years. (347 of the 1,268 children in placement in December 1999 were out of state).
- There is no statewide support organization for families of children with serious emotional and behavioral problems, an important component for supporting family roles in systems of care.

Recommendations

Building on existing models already in place in Connecticut, this Report presents the following recommendations in support of building a system of care to address children's behavioral health:

A. Expand and enhance local systems of care established under P.A. 97-272 as the mechanism for coordinating and delivering behavioral health services for children with severe emotional disturbance and their families.

1. Expand the eligibility criteria for system of care services to include all children meeting functional and diagnostic criteria for serious emotional disturbance and those at high risk, regardless of family income or placement status.

2. Decentralize decisions about individual care planning for eligible children to the local level, where individual care teams can access a flexible funding stream to purchase all services that are part of individual treatment plans.
 3. Support local systems of care efforts to develop a richer array of community-based services for children with severe emotional disturbance and their families as an alternative to long-term residential care.
 4. Actively support the development of a statewide family support network with local chapters to build capacity for family involvement.
- B. Design, develop, and implement a blended funding approach to support these comprehensive, integrated, community based systems of care.**
5. Fund the system of care operation and services by pooling the portion of federal and state dollars currently spent on children with serious emotional disturbances through DSS and DCF.
 6. Carve out behavioral health services funding from the capitation rate for existing HUSKY A and HUSKY B plans for children who meet defined assessment criteria. Develop case rates based on an actuarial analysis of the service needs of the population of children with serious emotional disturbance and for those at high risk for becoming seriously emotionally disturbed.
 7. Explore the feasibility of maximizing federal Medicaid reimbursement to expand resources for children's behavioral health services.
 8. Ensure that sufficient resources remain available through the HUSKY Plans to respond to the behavioral health needs of children not eligible for, or in need of, the extensive systems of care services.

C. Establish a coordinating and administrative structure to direct and implement the expanded system of care model.

9. Establish an administrative structure to implement the expanded system of care under the joint direction of DSS and DCF. The structure would include an Administrative Services Organization (ASO) to administer the system of care funds and up to 10 regional Lead Service Agencies (LSAs) to contract with providers and provide services and administrative support required by local systems of care.
10. Form a state-level Interagency Committee for strategic planning and support for the development and implementation of the expanded system of care, with representation from DSS, DCF, SDE, DMR, DMHAS, the Department of Public Health (DPH), and OPM.
11. Establish an Advisory Committee with representation from consumer families and providers.
12. Develop measurable outcomes against which the state and local systems of care can assess the effectiveness of services.
13. Conduct training for state agency staff, providers, families, and other system participants to support the implementation of the system of care.
14. Develop a case management information system to support service delivery and management and evaluation.
15. Conduct a systematic, comprehensive, independent evaluation of this endeavor, examining the process of design, development, and implementation, and

the outcomes, including impact and cost-effectiveness at multiple levels.

D. Study additional critical issues including: early intervention and prevention for young children, children in transition to adulthood, children with dual diagnoses (mental health and substance abuse, mental health and mental retardation), enhancing cultural competency, and effects on the education system.

Moving Forward

The state should continue to research the most effective mechanisms for implementing the recommendations in this report and address the issues identified for further study, working with the Children's Behavioral Health Task Force. Initial Foundation funding has already been secured for this continuing effort from the Connecticut Health Foundation and the Children's Fund of Connecticut.

The issues needing further study to support implementation of the recommendations include: development of community based service capacity; outcome accountability; contractual arrangements; governance at state and local levels; cross agency systems of care training; and financing mechanisms.

The children and families of Connecticut deserve no less than a collective best effort to build effective systems of care. With the focused attention and increased awareness of so many groups and individuals, the opportunity to take action to improve the way Connecticut delivers services for children with serious emotional and behavioral problems has never been better. The findings and recommendations of this study help point the way.

Delivering and Financing Children's Behavioral Health Services in Connecticut

I. Introduction

The Essence of the Problem

State policymakers and practitioners are increasingly concerned about children in Connecticut who have serious emotional or behavioral problems, as are the families of these children. Providing appropriate and effective services to meet their needs is a high priority.

Approximately 22,000 Connecticut children covered by the state's health insurance program for children (HUSKY) seek some form of behavioral health services over the course of a year. An estimated 4,000 (2%) of these children suffer from emotional disturbance severe enough to seriously impair their daily functioning.

The State of Connecticut invests over \$207 million annually on behavioral health services for children, addressing many of their needs. The majority of services, however, are administered by more than five state agencies and a myriad of local agencies and the schools. The result is a complex, fragmented system that leaves families confused about where to turn when they recognize that their children need help.

The public financing structure complicates the coordination of a child's care across several systems and many providers. As a result, children who need care may not receive care. Left untreated or inadequately treated, their problems become more serious over time. Eventually some children end up in psychiatric hospitals and residential treatment settings -- often far removed from their own homes, schools, and communities, and even in other states. Too often, children

remain in these settings long beyond the time they need to be there, but there is nowhere else for them to go. There may not be specialized programs to treat their problems, or sufficient programs at a less intensive level of care that would provide the treatment and support to allow them to remain safely at home and in school.

Meanwhile, other children, who need hospitalization or residential care, are in detention centers, shelters, and emergency rooms awaiting an open bed. At the community level, treatment is difficult to access, and for those needing services from more than one source, hard to coordinate. There is no single point of accountability for the outcome of interventions at any level.

The backlogs in hospital, residential and community-based placements create difficulties for children and their families, and consume scarce resources that could be better used in more appropriate community-based care and increased early intervention and prevention.

Connecticut is not unique. These are problems with which all states struggle, as documented in the recent Surgeon General's Report on Mental Health. The good news for Connecticut is that the ingredients for a more systemic approach to resolve the problems are in place. The recommendations in this report build on existing resources and models as an excellent foundation from which to start.

The Basis for the Report

In response to the mounting concerns of parents, advocates, providers, and state agencies, the State Legislature requested that the Connecticut Department of Social Services (DSS) conduct a study of the behavioral health services specifically for children enrolled in the state-sponsored health insurance programs for low-income families (HUSKY A and HUSKY B). Legislators were interested in knowing about the services being used and the costs of those services. They also sought recommendations for improving the quality and integration of these services for Connecticut's children.²

DSS engaged the Child Health and Development Institute of Connecticut (CHDI) to conduct the study. A task force comprising representatives from the state agencies who fund or provide behavioral health services for children, along with major service providers, consumer parents, and managed care organizations assisted with the study.

This report summarizes the findings and recommendations. A Technical Appendix with more detailed information about the pattern of service use and expenditures across agencies and at different levels of service has been prepared and is available as a separate document.

The findings are derived from the following sources: state agency data sources; interviews with key providers, advocates, and state agency staff; and the deliberations of the Task Force. The focus of the study is on programs and services provided or financed by the Department of Children and Families (DCF), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), the Department of Mental Retardation (DMR),

² Public Act 99-279, Section 36

the State Department of Education (SDE), and local education agencies.³

This report documents the current commitment of resources for children with behavioral health problems, and identifies systemic issues that reduce the efficiency and effectiveness of the current services. It concludes with a set of recommendations.

If current resources could be used more effectively, building on existing models to fully support and expand their reach, many of the current difficulties could be corrected. Connecticut has the opportunity to forge a system of services that could be a model for the rest of the country. HUSKY could stand for #1 both on and off the basketball court.

As background to understanding behavioral health services for children enrolled in HUSKY, the next sections provides a national perspective on children's mental health and describes the HUSKY program in Connecticut.

A National Perspective on Children's Mental Health: The Surgeon General's Report

Connecticut is not alone in its concern for the mental health of its children. A recent report by the Surgeon General of the United States addressed the issue from a national perspective. This comprehensive document provides a thorough review of the literature and a framework for action. The report emphasizes the application of principles of child development in considering mental illness in children. It includes the following definition of children's mental health:

³ Behavioral health services provided or financed by the Court Support Services Division of the Department of Justice, the Department of Corrections, or other state agencies were beyond the mandated scope of this study.

Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood et al., 1996).⁴

The Surgeon General's major conclusions about children's mental health provide an excellent capsule summary of the nature of mental health and disability in children, and the best approaches for treating behavioral health problems.

The points most relevant to this Connecticut study are summarized below.

- Childhood is a period of rapid development. It is critical to assess the mental health of children in a developmental context that takes into account family, community, and cultural expectations about age-appropriate thoughts, emotions, and behaviors.
- Approximately one in five children experiences the signs and symptoms of a disorder during the course of a year, and five percent experience "extreme functional impairment".
- Children at greatest risk include those with physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.

⁴ Mental Health: A Report of the Surgeon General. (U.S. Department of Health and Human Services, 1999), p. 123.

- Primary care and the schools are major settings for the recognition of mental disorders, yet trained staff are limited, as are options for referral to specialty care.
- Families are essential partners in the delivery of mental health services to children.
- Culturally appropriate services improve access to services, but are not widely available.
- The multiple problems associated with "serious emotional disturbance" are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way. These systems of care lead to positive system outcomes and functional outcomes for children.

What is HUSKY?

HUSKY is Connecticut's comprehensive health insurance plan that covers children. There are approximately 195,500 children receiving publicly financed health coverage of which 184,000 are enrolled in the HUSKY Plans – about 20% of all children under 21 in the state.⁵ There are three programs under the HUSKY umbrella: HUSKY A, HUSKY B, and HUSKY Plus.

- **HUSKY A** is Connecticut's Medicaid managed care program. It includes children in families with income at or below 185% of the federal poverty level (\$30,895 annual income for a family of 4 in 1999). The program, begun in 1995, is administered through DSS.

⁵ There are an additional 11,500 children receiving Medicaid fee-for-service benefits, including children new to the program in the process of joining a health plan, children in hospitals who are not plan members, and children who have disenrolled to participate in the DMR Case Management Program.

The agency contracts with four managed care organizations to provide coverage. HUSKY A covers all “medically necessary” services, including physical and/or behavioral health needs. *There are approximately 179,700 children currently enrolled.*

- **HUSKY B** is a health insurance program for children in families with incomes above 185% of the poverty level who have been without insurance for at least six months and have no other means of accessing insurance. The program is administered similarly to HUSKY A, although its benefits are different, mirroring those available under the State’s Employee Health Plan. *There are about 4,300 children currently enrolled across the state.*
- **HUSKY Plus** is a program begun in 1998 providing supplemental coverage for children enrolled in HUSKY B who have intensive physical and/or behavioral health needs. The Yale Child Study Center administers the behavioral health aspect of the program through

arrangements with twelve HUSKY Centers throughout the State. Only seven children are currently enrolled largely because of the limited eligible population -- those without insurance for at least six months and in families with incomes between 185% and 300% of the poverty level. Also, many children whose disorders are serious enough to qualify them for HUSKY Plus are enrolled in HUSKY A rather than B, or are receiving services through the DCF voluntary services program

The next section of the report summarizes key findings of the study, addressing the following:

- Who are the children enrolled in HUSKY who are using behavioral health services;
- What services are they receiving;
- What are the sources of funds for these services.

II. Major Findings⁶

Who are the Children Using Behavioral Health Services?

Based on the best available health services encounter data from DSS, it appears that *approximately 22,300 or 12% of children in HUSKY A used one or more behavioral health services in the twelve months from 4/1/98-3/31/99* (referred to as the “reporting year” throughout this document). Males were disproportionately represented.

As one might expect given their history, children in the custody of DCF were significant users of behavioral health services. Although only 5% of children enrolled in HUSKY A were in the custody of DCF during the reporting year (8,419 children), they accounted for 60% of all behavioral health expenditures on behalf of HUSKY children.

What Behavioral Health Services Do Children in HUSKY Receive?

Children who have an emotional disturbance require a range of treatments and supports tailored to their diagnoses and personal situations. Behavioral health providers and funders have developed a variety of programs and facilities to address these needs. These programs and facilities generally fall into three categories of care described below. Figure 1 compares the percentage of children served by each category and the funding devoted to each. Over time children may receive services from more than one category.

- **Acute Care Psychiatric Hospitals** - the most intense and expensive level of service, for children who may be suicidal, dangerous to themselves or others, or whose behavior cannot be managed in a less restrictive setting.

- **Residential Treatment and Other Out-of-Home Placements** – treatment for children ages 5-21 who are unable to function in their home, school, and community. Settings include residential treatment facilities, group homes, therapeutic foster homes, and supervised apartments.
- **Community-based services** – a wide range of services for children and families with an array of needs. Services include extended day treatment, outpatient therapy, in-home services, evaluation, case management, emergency services, and family support services.

The majority of children in HUSKY received their behavioral health services in a community-based setting-- only 1,067 were hospitalized (5%), and 3,000 were in

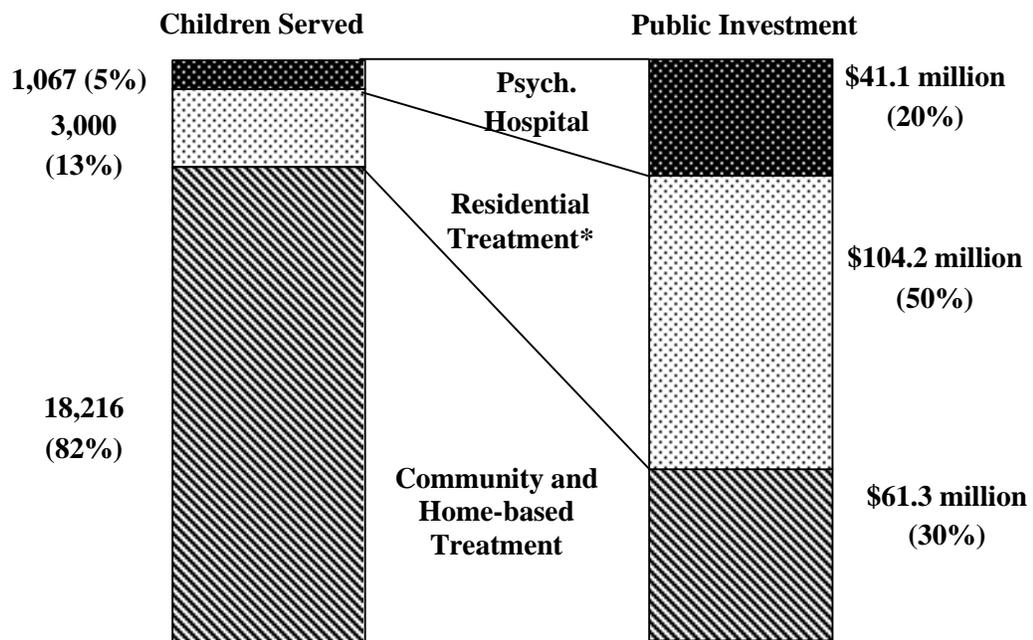
⁶ Much of the quantitative data concerning the HUSKY A population were drawn from encounter data for the period 4/1/98 – 3/31/99. The data were submitted by the HUSKY A MCOs, to Qualidigm, the firm under contract with DSS to perform external quality review for HUSKY. Two MCOs that submitted incomplete data were excluded from the study. Totals were developed based on projections of the data from the 4 MCOs whose submissions were complete.

Expenditures for behavioral health services under HUSKY were based on the application of the Medicaid fee for services schedule, as MCOs provided very little information about their actual costs. DSS believes these rates are sufficiently comparable to those used by the MCOs.

residential care (13%) during the reporting year. Yet, as Figure 1 illustrates, the greatest investment of dollars is for the fewest children in the most intensive level of services: **70% of all behavioral health**

dollars are spent for psychiatric hospitals and residential treatment, serving only 18% of all HUSKY children receiving behavioral health services.

Figure 1: Children Served and Public Investment in Behavioral Health Services, by Level of Treatment' for Children Enrolled in HUSKY Plans, 1998-99



Total Served: 22,283 Total Investment: \$207 million

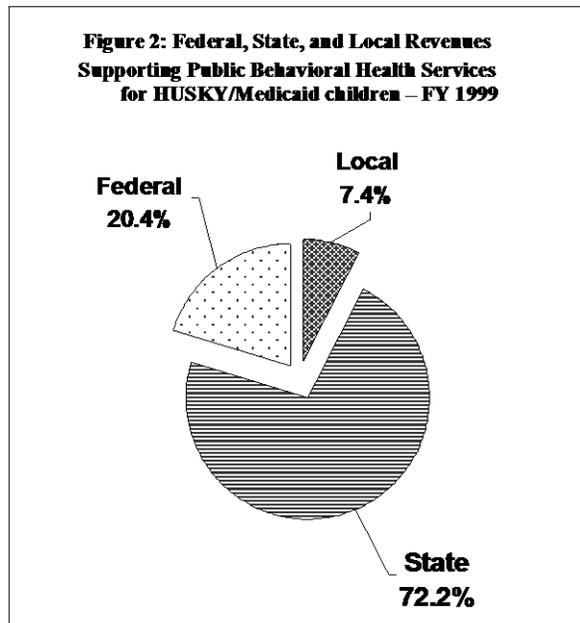
* includes services in residential treatment facilities and other out-of-home placements by DCF and Local Education Agencies, including group homes, therapeutic foster homes, and supervised apartments.

NOTE: Numbers of children include all children accessing that level of service during the year

What are the Sources of Funding for Behavioral Health Services?

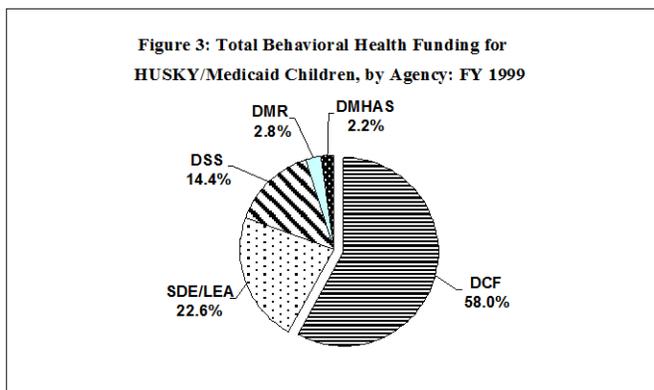
Connecticut spent approximately \$207 million for behavioral health services in FY 1999 for children enrolled in HUSKY plans. This amount includes a combination of federal, state, and local dollars, administered by five state agencies and numerous local agencies. The study examined which state agencies were responsible for administering these funds, and the sources of these revenues, and learned the following:

- *A majority of the public investment in behavioral health services (72.2%) comes from the State's General Fund as direct investment or match for federal funds.* The federal government contributes 20.4% of the total dollars through the Federal Medicaid program (reimbursement of 50% of eligible state Medicaid expenditures), and through Title IV-E that reimburses 50% of room and board costs for children placed in residential treatment facilities through DCF. Local funds, through local school districts, account for the remaining 7.4% (See Figure 2).
- *DCF is clearly the lead agency in this system, administering 58% of the funds spent on behavioral health services.* (See Figure 3.) Children in DCF custody account for 40% of the



expenditures for hospital stays in FY 1999. DCF expenditures of \$82 million account for 79% of all expenditures for residential treatment in FY 1999.

- *State and local education agencies expend 23% of the funds (\$46.8 million),* spent primarily through the Special Education process. About 30% of this amount is for residential treatment. In the 1998-99 school year, 423 HUSKY eligible children with severe behavioral disabilities were placed in residential settings, at a cost of \$14.5 million. 40% of these expenditures came from local school district funding, 56% from state funds, and the remaining 4% from federal funds.
- *A combination of federal and state Medicaid dollars totaling \$62 million flows through a number of state agencies. Federal and State Medicaid dollars are the source of 30% of the dollars spent on behavioral health services for children enrolled in*



HUSKY. Table 1 shows the amount of Medicaid funds for behavioral health services that flows through each agency and the percent these funds comprises of the agency’s total funding for behavioral health services. DSS administers 48% of the Medicaid funds and DCF administers another 26%. Because of its reach, the Medicaid program can serve as a unifying force for a common approach to children requiring behavioral health services.

Table 1: HUSKY/Medicaid as a Proportion of Public Funds Spent on Behavioral Health by Department, FY 1999 (\$\$ in millions)

Agency	Total Funds	Medicaid (Federal and State)	% Medicaid
DCF	119.79	16.36	13.7
SDE/LEA	46.77	8.0	17.1
DSS	29.72	29.72	100.0
DMR	5.75	4.94	85.9
DMHAS	4.60	2.8	60.9
Total	\$206.63	\$61.82	29.9%

Special Concerns for Further Study

In addition to the findings presented above, the study attempted to explore several additional issues of concern and importance, specifically:

- Early identification and prevention services for young children;

- Youth in transition from the child-focused mental health system to the adult system;
- The impact on local schools of serving increasing proportions of children with behavioral health service needs in the community;
- Children with dual diagnoses (mental health and substance abuse; mental health and mental retardation);
- Access to outpatient services;
- Enhancing the cultural competency of the service delivery system in response to the high proportion of children enrolled in HUSKY who are Black or Hispanic.

Each of these topics addresses a serious concern, and is an important component for designing a comprehensive system of mental health treatment for children. However, there were relatively little data available to fully explore these issues. More time than was available for this study is needed to generate the necessary information. (See the Technical Appendix for findings based on what information was available.) Further study of the listed areas is recommended to better inform the design and development of appropriate interventions.

III. Critical Systems Issues

Although an impressive array of resources and capabilities in Connecticut are devoted to children's behavioral health, there are significant problems in the current way services are organized, financed, and delivered. The study pointed to five major problems:

1. There are **insufficient mechanisms for effective coordination of care** between levels of intensity and across service systems for children and their families.
2. Community-based resources and treatment alternatives must be better developed to avoid the **serious bottlenecks in the treatment system**.
3. Funding is allocated by program and agency, each with its own requirements and incentive structure. This **fragmentation within the system** must be reduced.
4. Families must have a greater role in planning services for their own children and in system planning and oversight. Currently there are not adequate supports to enable families to be sufficiently involved in these ways.
5. Current resources may not be sufficient, but a redistribution of resources and taking fuller advantage of federal financing mechanisms could go a long way toward supporting a more effective system of behavioral health services for children.

These concerns were based on the following key findings of the study.

- ***From July-December 1999, 55% of the children in DCF custody who were in private acute care psychiatric hospitals***

were ready for discharge to a less intensive and less expensive setting (residential treatment, therapeutic foster care or home-like setting). Their conditions had stabilized and were less severe, but there was nowhere for them to go. They remained in the hospital but on what is termed "subacute" status, at a lower daily rate.

- ***Almost half the children in these hospitals on subacute status in September 1999 had been there for longer than 90 days.*** The experience of Nayib, a child in DCF custody, illustrates the human and financial toll of this problem. (See box on p. 10).
- ***13% of children discharged from psychiatric hospitals were readmitted within 30 days,*** as compared to a national average of 10%. This suggests problems with discharge planning and follow-up care.
- ***The State spent \$8 million for reinsurance for a 10-month period in FY 1999*** to support hospital stays longer than 15 days. Projections are that reinsurance costs will be \$12 million for FY 2000. The State's reinsurance program was instituted in September 1998 to prevent premature discharges that occurred under managed care when the hospitals were not being reimbursed for extended stays. Through reinsurance, the State's Medicaid program pays a portion of the cost of hospital stays over 15 days, preventing children from being discharged from hospitals prematurely. An unintended consequence has been

to create a financial incentive to keep children in acute or sub-acute care longer than necessary.

- **Residential treatment facilities are at or near capacity, yet many children in residential treatment no longer need this level of care.** There are not sufficient community-based services to support their return to the community.
- **Placements by parole and juvenile justice authorities through DCF have increased 34% in the last three years.** (They accounted for 432 of 1,268 children placed by DCF's central placement team in December 1999).
- **5% of children enrolled in HUSKY are in DCF custody, yet this population accounts for 60% of the behavioral health expenditures.** Although this is not surprising, given the nature of the life experiences of this group, the finding highlights the need for special attention to the financing and delivery of services to this population.
- **There has been a 40% increase in children placed out of state through DCF over the past three years.** In December 1999 there were 347 children in DCF custody who were in out of state facilities (27 % of all children in DCF-funded residential care). There were also 107 HUSKY-eligible children children placed out of state by local school districts in FY 1999. There were also 159 children placed out of state by local school districts in FY 1999. Children in out of state placements are much more likely to have one or more of the following challenging behaviors than children in group or private residential placements in the State: sexually reactive; sexually offending; suicidal,

Nayib (not his real name)

Nayib is a ten-year-old African-American boy who entered the DCF system when he was five years old. He has spent most of the past year in a psychiatric hospital, awaiting an appropriate placement. During part of that time, his mother was in jail. Nayib was hospitalized in January 1999 because he was a danger to himself and others, but he had stabilized within a few weeks and was ready to be discharged. The hospital's discharge recommendation was a therapeutic foster home, but despite repeated attempts, none could be found. After a period of disagreement over discharge recommendations, DCF and the hospital are now trying to find a residential placement for Nayib. Not only has this situation been the wrong placement for Nayib, it has tied up an acute care bed that could have served other children needing that level of care. Eleven months after admission, Nayib still remained hospitalized. At \$400/day and approximately 350 days in the hospital, the state had paid approximately \$140,000 for an intensity of service that, after the first ten days, was not medically indicated.

assaultive, threatening. There are insufficient resources or incentives to care for these children within the state, the causes of which merit further exploration.

- **One in four of the 274 children awaiting placement through DCF's central placement team in December 1999 were classified as having mental retardation.** This is another population for whom appropriate services appear to be a problem.
- **At the community level, \$61 million is spent by the five state agencies reviewed in this study. Each program has its own funding with its own set of rules governing how the money**

can be used. Funding is rarely flexible or comprehensive. A child with serious emotional problems cannot easily have his or her physical, emotional, social, and educational needs met in a coordinated way. Even a seasoned case manager experiences difficulty in coordinating community-based services for children with complex needs. For families it is an even greater challenge.

- ***DMR and DMHAS account for a relatively small portion of the funds spent on behavioral health services.*** DMR spent a total of \$5 million on 64 children with behavioral health needs and in out-of-home placements (out of a total of 3,773 children and their families served through DMR in FY 1999). A review of participants in DMR's Birth-To-Three program identified 4% of the children as receiving behavioral health services (153 of 3,500 children) at a cost of about \$800,000. DMHAS expended \$2.1 million in FY99 to provide residential behavioral health services for young adults age 18 through 20 who could not live at home. The agency spent \$1.8 million on community based mental health services and \$300,000 on substance abuse services for Medicaid eligible children and youth age 18 through 20.
- ***Psychotropic drug costs accounted for 48% of HUSKY-supported non-hospital-related behavioral health costs for individuals enrolled in HUSKY A, in FY 1999.*** This includes use of pharmaceuticals by children in all settings except psychiatric hospitals.
- ***There has not been an active statewide family organization for families of children with emotional, behavioral, or cognitive problems in Connecticut for***

the past five years. Experience in other states indicates that such an organization is crucial to strengthening the capacity of families to participate actively in the care of their own children as well as in the development and implementation of systems of care and state and local policy.

- ***Children who are Black or Hispanic comprise a high proportion of children in HUSKY (62%).*** There were not sufficient data to indicate the proportion of Black and/or Hispanic children among users of behavioral health services. Further attention to documenting their service utilization and services needs will be important to help guide the development of culturally appropriate behavioral health service systems.

Conclusions

The critical issues outlined above, backed by the key findings, identify a clear need to develop more integrated systems of services, supported by an integrated approach to funding, and more supports for family involvement.

The high number of children who remain in psychiatric hospitals and residential treatment settings for increasingly long periods of time, when such care is no longer considered appropriate, is a direct result of the combined lack of care coordination and lack of alternatives in the community. Children remain in these settings because of a lack of "step-down" and other appropriate transitional services that can provide less intensive care when a child's family, the school, or the community are unable to provide adequate support and services for him or her. The current approach to funding services is not conducive to the development of these community-based resources.

This lack of available step-down services not only keeps children in these out-of-home settings for longer periods than is necessary and at high cost, it prevents other children from quickly accessing these services when they need them, leaving children backed up in emergency rooms and in the community awaiting care.

For services to be more responsive, appropriate, and effective, supporting the best possible developmental outcomes for children with behavioral health disorders, reform in the children's behavioral health system must occur. Significant restructuring is needed in the way that services are organized, financed,

and delivered for children with serious and complex behavioral health problems. Though there has been a reduction of 65 hospital beds in Connecticut since 1994, the ability to use current beds only for the child requiring acute care would be a far more cost-effective solution than adding new ones. The solutions must emphasize capacity building at the community level, using community-based, family-centered, culturally-competent, systemic approaches to treatment, rather than a "bricks and mortar" approach through building more institutional settings or adding beds.

IV. The Foundations for a Solution

Building on Existing Models

The good news for Connecticut is that there are resources and know-how to do a far more effective job in taking care of children with behavioral health concerns. Most of the ingredients for success are in place.

Local Systems of Care. Notably, Connecticut has begun to build the “systems of care” recommended in the Surgeon General’s report for children with the most serious and complex problems and recognized nationally as the best practice for delivering responsive behavioral health care. State legislation passed in 1997 (Public Law 97-272) adopted the national system of care approach, identifying a set of core values and guiding principles for Connecticut’s services for children and adolescents with serious emotional disturbances (included in Technical Appendix). The systems approach is already being developed and tested through several initiatives that can serve as models.

DCF has sponsored local systems of care in 19 communities for children who have serious emotional problems and are at risk of, or in, an out-of-home placement for mental health treatment. DCF has developed practice standards for local systems of care and has provided training and technical assistance to the local collaboratives.

Through this initiative, DCF has begun to create an infrastructure that lays the foundation for systems change. The State spent \$590,000 in FY 1999 to fund 16.5 case managers and eight family advocates to work in these local systems. Other DCF funds also paid for the expansion of essential community-based services such as

respite and emergency mobile psychiatric services.

Other promising pilots include the following:

- DCF’s Continuum of Care initiative (through a IV-E Waiver Demonstration) is testing a flexible funding approach in which local collaboratives manage the care of children with serious emotional disturbance within an overall budget cap.
- HUSKY Plus: This is a well-designed model of “wraparound” services (community supportive services that enhance the effectiveness of behavioral health treatments) for children with serious emotional disturbance. It is currently available to only a few children through HUSKY B. A pilot demonstration of its applicability to children in HUSKY A who are enrolled through Anthem-Blue Cross is being tested, with some promising results.

Although the number of children served by these programs remains small, they are being carefully evaluated. Initial findings suggest that cost and health-related outcome data demonstrate success. For these small pilots to be brought to scale, however, significant changes, outlined in the recommendations section of this report, must occur.

Financing the System of Care

The system of care and associated community-based service enhancements can be largely financed over time by reducing unnecessary hospitalizations and

residential placements and reinvesting the savings in new services at the community level, and from increased federal Medicaid reimbursements.

There is an opportunity to increase federal reimbursement by as much as \$14 million through (a) Medicaid supported case management, (b) Medicaid supported rehabilitative services in residential and community based settings, and (c) Title IV-E supported training activities.

As we look to the future, the proposed system of care approach, which relies heavily upon expanded use of case management and community-based services, could be supported in part through the use of the two Medicaid programs -- targeted case management and the rehabilitative services options – and Title IV-E training.

Targeted case management would provide about 40% federal participation for each state dollar invested in enhanced case management by DCF and its local systems of care partners.

Residential placements through DCF and local education agencies for special education are presently financed almost exclusively by state dollars, despite the

availability of Medicaid as a federal reimbursement source. Use of the rehabilitative services option could provide two critical benefits: 1) free up an estimated \$14 million of state investments in residential treatment services (\$11.7 million by DCF and \$2.3 million by SDE/local school districts) for investment in the development of infrastructure necessary for system of care development; 2) support new investments in community-based services. Use of the rehabilitative services option for community-based treatment services would provide about 33% federal participation for each state dollar invested (assuming 67% of the children served will be Medicaid/HUSKY eligible).

Federal Title IV-E funds can be used to support the extensive training needs required for the introduction and ongoing support of the local system of care.

If these funds were reinvested in expanding and improving the system of behavioral health services for children, much could be accomplished without the need for substantial new state dollars beyond some initial transitional funding.

V. Recommendations

Connecticut should implement an expanded, community-based System of Care Model for the management and delivery of behavioral health services to all children with serious emotional disorders, building on the structures established under P.A. 97-272. This system of care should also be charged with assessing and developing responses to the needs of all children requiring behavioral health services from prevention and early intervention to intensive treatment.

The following 15 recommendations would move the existing children's behavioral health system in Connecticut toward an accountable, community-based system of care that incorporates the core values and guiding principles already adopted in statute. The recommendations concern tasks required to implement this expanded system of care in three categories:

- local system and service development
- finance
- coordination and administration

The structural reform recommended would greatly reduce, if not eliminate the major system gaps and barriers described above. The recommendations also address areas for further study, important to informing this work but unable to be completed with existing data within the timeframe available.

The intended results are that children with serious mental health problems will have the opportunity to experience healthy social, emotional, physical, and cognitive development in the context of a nurturing family and community, leading to their ability to succeed in their families, schools, and communities. Better-coordinated, integrated care will help ensure that appropriate

treatment plans are developed and followed. This should result in a significant reduction in length of stay in psychiatric hospitals and residential treatment placements as well as a reduction in out-of-community and out-of-state placements.

The many specific changes in practice and procedure that will be required to implement these recommendations are not addressed in this report. They will need to be developed by state agencies responsible for funding and administration of services, with the help of the further analyses recommended and guidance from key parties in the system.

Through cost savings on placements and expanded federal Medicaid reimbursement, these recommendations should not require substantial new State dollars. This approach, however, will only work if the savings achieved from reduced reliance on costly services are reinvested in building the community-based infrastructure necessary to meet the full needs of children and their families.

A. Expand and enhance local systems of care established under P.A. 97-272 as the mechanism for coordinating and delivering behavioral health services for children with severe emotional disturbance and their families.

- 1. Expand the eligibility criteria for system of care services to include all children meeting functional and diagnostic criteria for serious emotional disturbance and those at high risk, regardless of family income or placement status.**

Currently most systems of care work primarily with children involved with DCF.

Any family or agency should be able to access treatment services for children who meet functional criteria for enrollment, without DCF intermediation, as long as the payor joins in supporting the costs of care.

- 2. Decentralize decisions about individual care planning for eligible children to the local level, where individual care teams can access a flexible funding stream to purchase all services that are part of individual treatment plans.**
- 3. Support local systems of care efforts to develop a richer array of community-based services for children with severe emotional disturbance and their families as an alternative to long-term residential care.**

Under the mandate of P.A. 97-272, DCF has facilitated the development of 19 systems of care covering 151 of the 169 towns in the state. These local systems handled 500 cases in FY 1999. They bring together key providers of services, parents, and other agencies working with children to plan services for individual children as well as to identify gaps in treatment that need to be addressed. Although some of the local systems are more developed than others, the vision and principles that inform their development are an appropriate starting place. These local systems of care can be the foundation for changing the overall approach to the financing and delivery of services.

The bottlenecks in the current system that are causing children like ten year old Nayib to stay in psychiatric hospitals or inappropriate residential treatment facilities unnecessarily can be mitigated by decentralizing the responsibility and funding for care planning to the local case planning and management teams. Under the proposed system, these teams would command the resources to purchase integrated, community-based services as well as hospitalization or residential treatment when necessary.

The study found a shortage of community-based placements offering a range of intensive services that could accommodate many of the children now in expensive hospitals and residential treatment. The short-term emphasis of the systems of care should properly be on improving care coordination and developing new treatment alternatives for those children needing the most intensive services. This is where the most dramatic opportunities for improvement can be seized, building on some of the promising practices and current substantial capacity identified in the study. The long-term value of the system of care lies as well in its role of provoking increased investments in early intervention and prevention activities that can improve children's outcomes and reduce the demand for more intensive services.

A goal of the system of care should be to reverse the trend of placing more children out of state and in other locations that are far from their families and communities. Such placements sever the child's valuable connections to family and community, making his or her return and reintegration more difficult. It is also very difficult for DCF or schools to monitor care at a distance. Clearly the answer lies in the development of additional quality placement resources within the state through investment of system of care funds for services.

- 4. Actively support the development of a statewide family support network with local chapters to build capacity for family involvement essential to the success of a well-functioning system of care.**

Parents play a critical role in the coordination of care for their children and in the development of their Individual Treatment Plans. They also have a role to play in providing valuable feedback for the continued improvement of services and in supporting other parents coming into the

system. Connecticut needs a strong statewide family organization that can be instrumental in building the capacity of parents to participate in developing plans of care for their own children as well as at the state and local systems levels. Parents can and should play important roles in design, development, oversight, and evaluation.

B. Design, develop, and implement a blended funding approach to support these comprehensive, integrated, community based systems of care.

- 5. Fund the system of care operation and services by pooling the portion of federal and state dollars currently spent on children with serious emotional disturbances through DSS and DCF (e.g., HUSKY A, HUSKY B, HUSKY Plus Behavioral funds, Medicaid fee for service, state funds for reinsurance, Title IV-E funds, and DCF state funds).**
- 6. Carve out behavioral health services funding from the capitation rate for existing HUSKY A and HUSKY B plans for children who meet defined assessment criteria. Develop case rates based on an actuarial analysis of the service needs of the population of children with serious emotional disturbance and for those at high risk for becoming seriously emotionally disturbed.**
- 7. Explore the feasibility of maximizing federal Medicaid reimbursement to expand resources for children’s behavioral health services.**
- 8. Ensure that sufficient resources remain available through the HUSKY Plans and through direct contracts to service providers (e.g. child guidance clinics, school-based clinics, and other private providers) to respond to the**

behavioral health needs of children not eligible for, or in need of, the extensive systems of care services.

In the proposed model, behavioral health funds would “follow the child” rather than the categorical requirements of a particular program. Care managers would have access to flexible dollars to design individualized treatment plans that best meet the needs of children. Local systems of care should receive funding on an actuarially determined case rate. The fact that the current systems of care control few if any resources has limited their effectiveness and role. The newly flexible funds would stimulate development of community-based alternative and wrap-around services.

The proposed “carve out” would dedicate a portion of the per member per month capitation rate currently paid to Managed Care Organizations under HUSKY plans to fund treatment for eligible children through the system of care mechanism. These children would continue to receive primary care services under HUSKY.

Those children not needing the extensive behavioral health care services offered through a systems of care approach would continue to receive their behavioral health services through the HUSKY plans as well.

The state should work towards inclusiveness, with the long-term goal of developing services that will draw the participation of the education system and, where appropriate for special populations, the mental retardation and mental health/substance abuse systems.

Additional federal Medicaid funds can also be accessed for this purpose. The study has identified at least \$15 million in behavioral health services costs for HUSKY A participants that could be submitted for federal reimbursement. This number is based on re-categorizing expenditures for DCF

residential treatment, special education residential placements, and Targeted Case Management so that they are eligible for Medicaid reimbursement. This can be done through options available in the state's Medicaid plan, including provisions for funding Targeted Case Management and the rehabilitative services option.

With reference to the need for resources for less intensive services, at least 14,000 children in HUSKY A with less serious conditions accessed behavioral health services through a wide variety of community-based providers. These services play a crucial role in preventing the development of more severe conditions and avoiding the need for expensive residential treatment. DSS, with input from the local systems of care and family support networks, should continue to monitor the policies and practices of the Managed Care Organizations to urge the full implementation of contractual provisions related to behavioral health.

C. Establish a coordinating and administrative structure to direct and implement the expanded system of care model.

9. Establish an administrative structure to implement the expanded system of care under the joint direction of DSS and DCF. The structure would include an Administrative Services Organization (ASO) to administer the system of care funds and up to 10 regional Lead Service Agencies (LSAs) to contract with providers and provide services and administrative support required by local systems of care.

10. Form a state-level Interagency Committee for strategic planning and support for the development and implementation of the expanded system of care, with representation from DSS, DCF, SDE, DMR, DMHAS, DPH, and OPM.

11. Establish an Advisory Committee with representation from consumer families and providers.

Based on their mandates, DSS and DCF are the lead partners in creating the expanded system of care. They should work with the existing Children's Behavioral Task Force in the coming months to develop the governance and administrative structure that will support effective development of the systems of care. An interagency memorandum between DSS and DCF should establish the roles of each agency in administrating and operating the plan. Suggested roles are as follows:

- **DSS Role:** administer pooled funding, handle all Medicaid/HUSKY plan changes, waiver amendments, federal reporting, claims processing and financial management.
- **DCF Role:** set standards, and monitor implementation; develop statewide training on the systems of care approach for providers, families, and other major stakeholders. Develop outcome measures and an evaluation plan.

DSS and DCF would jointly contract with the Administrative Services Organization described below and ensure continued administrative and financial support for an integrated funding stream.

Strategic Planning: An Interagency Committee would be responsible for maintaining the vision, coordinating planning, and work toward expanding the participation of other systems in an integrated funding approach at the state and/or local level. This Committee would be composed of those agencies listed that fund children's behavioral health services. The Committee should be expanded eventually to include representatives from other agencies that fund or provide behavioral health services (e.g., Judicial Services).

A process to involve providers and consumer parents in the work of designing the new system will help ensure its relevance to the needs of children. The Behavioral Health Subcommittee of the DCF Advisory Committee, which currently advises DCF on behavioral health issues, could be charged with advising this effort. It has representatives from providers, consumer parents, and state agencies.

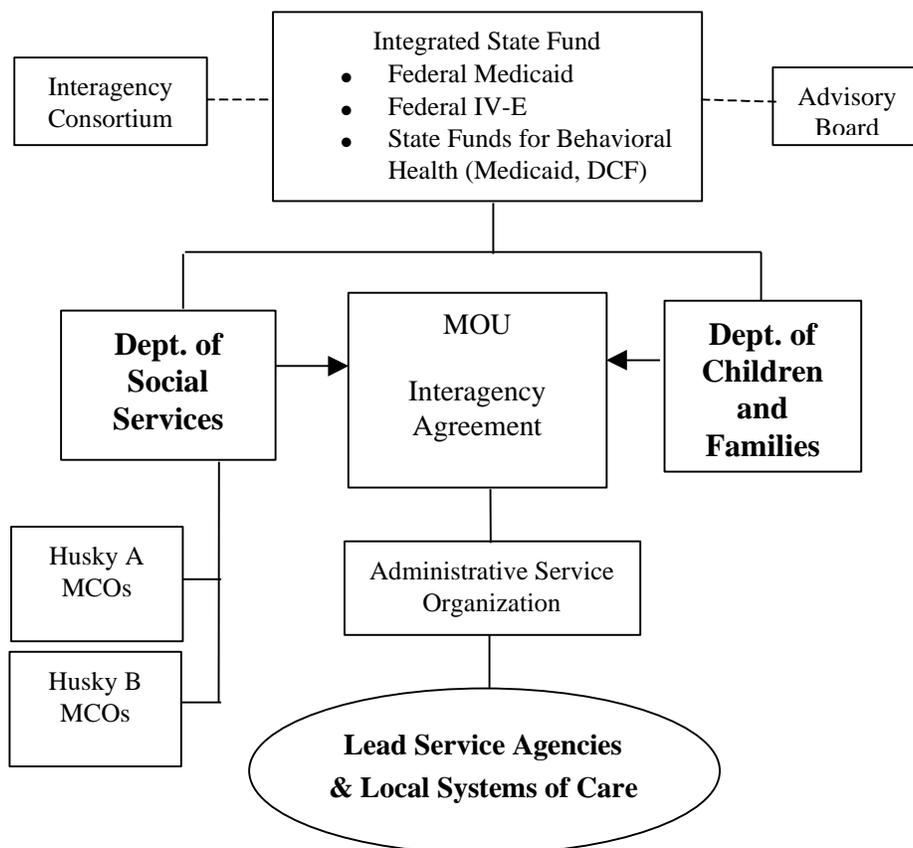
Administration: Based on the experience of other states engaged in similar efforts, the proposed administrative structure has three main components (Figure 4): a statewide Administrative Services Organization, “regionalized” Lead Service Agencies, and local systems of care.

The roles for each of these participants in the system will need further development, but in general terms may encompass the following:

The ASO would provide administrative support for the local systems of care. It would be responsible for maintaining performance and outcome data and providing financial management for reimbursements and reconciliation of funding requirements for the lead service agencies.

The Lead Service Agencies would work with local systems of care to provide a comprehensive array of community-based services and supports. They would be responsible to do the following: authorize and reimburse services delivered under approved individual treatment plans, fund all care required within a case rate, gather and organize all information required for quality management and performance oversight, provide administrative support to the system of care, and ensure that the local systems of care respond to the unique needs of their communities.

Figure 4: System of Care Governance and Administrative Model



The system of care at the local level would be built on the foundation of the 19 systems of care established since the passage of P.A. 97-272.

12. Develop measurable outcomes against which the state and local systems of care can assess the effectiveness of services.

A major concern expressed about the current delivery system for behavioral health services is the difficulty in assessing whether investments result in positive outcomes for children. Joining in a national trend, Connecticut should require all providers to measure and report outcomes against a set of agreed measures. This will move the system toward greater accountability. The results of a study of outcomes in children's behavioral health commissioned by DSS are due this fiscal year, and may help inform this work.

13. Conduct training for state agency staff, providers, families, and other system participants to support the implementation of the system of care.

Additional resources would provide needed support for staff, provider and consumer family training in the provision of services under the system of care model. A system of care approach requires that all participants work collaboratively on behalf of the child, and they need to be able to assess strengths and develop interventions that build on these.

14. Develop a case management information system to support service delivery, program management, and evaluation.

This study highlighted the difficulty of accessing information across systems and across time for individual children. An effective case management information system to track children and services delivered will be required to facilitate operation of and planning for the system of care.

15. Conduct a systematic comprehensive, independent evaluation of this endeavor, examining the process of design, development, and implementation, and the outcomes, including impact and cost-effectiveness at multiple levels.

The evaluation should look at three dimensions: child and family outcomes, process and system development outcomes, and financial outcomes.

D. Study additional critical issues that require attention.

The study uncovered a number of critical areas for which insufficient data was available in the window of time for the study, or that presented dynamics too complex to unravel through this process. The following areas are suggested for further study, and could yield substantial benefits in system improvements and improved outcomes for children.

Early Intervention and Prevention Services for Young Children: Parents, child care providers, health practitioners, teachers, and others in a position to recognize early signs of problems need to be able to access information, referrals, and services easily. As noted in earlier sections, they should have resources readily available to them. Further study should focus on delineating the existing system of services for young children and developing recommendations as to how services can be developed, funded, managed and delivered in a way that best meets the need for prevention, early intervention, and treatment services for this population.

Children in Transition to the Adult System: There are collaborative efforts underway between DMHAS and DCF to ensure that youth who are in transition to the adult system are served appropriately and that smooth transitions occur. Further study

is recommended to help better inform the design and development of appropriate interventions for this special population.

Special Education: Federal and state legislation constrains schools serving children through special education from taking a broader view of the service needs of children in its care. A substantial portion of residential treatment funds is invested through the education system, yet the primary mission of that system is education rather than behavioral health. Further work is needed to understand this issue and to facilitate partnerships that serve children well, preferably through the system of care model.

Children with Dual Diagnoses

Mental Health and Mental Retardation: Children with mental retardation and behavioral problems require an intensive level of services that combines the skills of providers in both the mental retardation and mental health arenas in order to assure good outcomes. Effecting good practice and service delivery without draining resources needed for other children is a system challenge in need of further review.

Mental Health and Substance Abuse: Service providers have stated that youth with both substance abuse and mental health problems are not currently well served. The amount spent on services for them is known, but little is known about whom they are or how to assess whether services are effectively provided. Further study is needed to assess how best to serve these children and youth.

Cultural Competence: There was very little information available for this study about the

demographics of the children receiving services at the various levels of intensity and there was not an opportunity to analyze the cultural competency of the existing services. In order to enhance the cultural competency of the service delivery system in response to the high proportion of children in HUSKY who are Black or Hispanic, further study will be needed.

VI. Moving Forward

DSS and DCF should work with the other state agencies and the Children's Behavioral Health Services Task Force to develop the detailed design and guidelines for implementing the recommendations put forth in this Report. The issues needing further attention include: development of community based service capacity; outcome accountability; contractual arrangements; governance at state and local levels; cross agency systems of care training; financing mechanisms; and the need for legislation.

Initial funding has already been secured to assist with this continuing effort and the further studies needed from the Connecticut Health Foundation and the Children's Fund of Connecticut.

The children and families of Connecticut deserve no less than a collective best effort to build effective systems of care. With the focused attention and increased awareness of so many groups and individuals, the opportunity to take action to improve the way Connecticut delivers services for children with serious emotional and behavioral problems has never been better. The findings and recommendations of this study help point the way.