

CARLOS RODRIGUEZ IS WAITING...

Connecticut's Plan for a Comprehensive,
Community-based Service System for
Children and Adolescents who Experience
Serious Emotional Disturbance and Their
Families

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Carlos Rodriguez is waiting...

A request for an out-of-state placement sits on the desk of the Deputy Commissioner in Connecticut's Department of Children and Youth Services, awaiting approval for Carlos Rodriguez to get help.¹

The report describes a boy who was sexually abused as a young child but who did not receive treatment. It tells of a boy who was retained twice in kindergarten and who was, by third grade, regularly absent from school.

It describes his acts of sexual abuse on other children, his assaultive behavior, and frequent disappearances from home. The report of the inpatient psychiatric evaluation indicates a DSM III-R diagnosis of "Conduct Disorder Solitary Aggressive Type," and recommends an institutional placement.

Workers sent Carlos' referral packet to eight in-state residential treatment providers who rejected it due to concerns over "unmanageability, aggressiveness, lack of self control, does not fit program design, parents may not attend treatment sessions."

There is tragedy here, for Connecticut's mental health, child welfare and special education systems appear to have failed Carlos. His story raises significant questions about the need for early and coordinated community treatment services for children and their families, about the need for intensive community-based alternatives to institutional placement, and about the types of services currently offered by residential and inpatient treatment facilities in the State of Connecticut.

There is also great urgency in addressing these questions, for Carlos does not wait alone. Many other seriously emotionally disturbed children and youth like Carlos pass through childhood waiting for the programs they need to get them on the road to mental health.

Carlos Rodriguez is waiting...and so are Jamal and Keisha, Terry and Beth.

¹Carlos Rodriguez is a real child, but he uses another name.

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INTRODUCTION

About the Plan...

The purpose of this plan is to provide the same attention to the problems of children and adolescents with serious emotional disturbance as other initiatives have brought to Connecticut children who are abused, neglected, handicapped or at risk of school failure.

Development of the Plan, Carlos Rodriguez is Waiting..., represents the collective effort of a broad group of citizen advisors, child advocates, community mental health providers and state agency staff who met and engaged in spirited discussion over several months. Often, questions which were raised could not be answered. Always, they prompted thoughtful analysis. A second purpose of this plan is to obtain and analyze information which can give us the answers we now lack.

It was clear during the planning process that other people need to be a part of future efforts to plan and improve services for children and adolescents who experience serious emotional disturbance. Most important among these people are parents and family members. The planning group has agreed to expand its membership to include better representation among people who use the services and people who provide them, and to continue its deliberative and advocacy process over the next year. The group, to be constituted as a Standing Committee of the department's Statewide and Regional Advisory Councils, also will monitor progress in implementation of this plan.

Members of the planning group and representatives of the general community who reviewed earlier drafts of this work worried that this plan is not directed at improving the mental health of all of Connecticut's children and adolescents. Federal law requires that Connecticut develop a plan to identify and meet the needs of children and youth who are the most impaired, and this plan satisfies that mandate explicitly. Connecticut General Statutes (17-412) require that the Department of Children and Youth Services develop a broad-based children's mental health plan, and the planning group has committed itself to that broader effort over the coming year.

For this effort just completed and for the effort yet to come, the Connecticut Department of Children and Youth Services acknowledges the crucial contributions of the planning group, and welcomes its continued participation. The Department is grateful as well for reviews and comments on earlier drafts by individuals, associations and provider groups, and will continue to welcome their thoughtful participation.

About the New System...

The vision of an enhanced community-based system of services is guided by an evolving understanding about the needs of children and adolescents who experience serious emotional disturbance, and about their families.

Taking a Child-Centered, Family-Focused Approach. The first understanding about children and adolescents with serious emotional disturbance is that they are generally best served in and with their families. For this reason, any effort to enhance services must plan for and implement programs which are child-centered and family-focused. The family-focus is essential because parents need support as they care for their emotionally disturbed children. Parents and families also need to develop the skills and knowledge to advocate for their children, as individuals and as a group. Finally, the plan and programs must be family-focused because problems of the family or the parents such as adult mental illness, mental retardation, or substance abuse contribute to children's dysfunction and often to their placement.

Case Management as a Family Support. A second understanding is that families where a child is seriously emotionally disturbed may experience a series of other problems as well, including poverty, inadequate housing, inadequate nutrition, income problems, poor physical health, substance abuse. To obtain necessary services, these children and families must traverse several complex systems and apply to several different agencies. They require access to family-based, clinically-sensitive case management services which assist them to secure appropriate, coordinated programs and aid them in becoming advocates for themselves and their children. The same case management services act as a valuable resource to providers across human service systems, by identifying gaps in necessary programs and providing for the multi-disciplinary and interagency integration of services.

Intensive Clinically-Appropriate Community Services. A third understanding is that many times the needs of children and adolescents who experience serious emotional disturbance can be met through the availability of intensive, clinically-appropriate, community-based emergency and treatment services. When these are available, the need to place children away from their families in residential or institutional care can be reduced. Necessary community programs include crisis intervention, in-home and outpatient treatment services, respite programs, and special education. When children with serious emotional disturbance cannot live at home, alternative living settings such as treatment foster families, therapeutic group homes and diagnostic shelter facilities can enable them to remain as part of their community.

Assuring the Appropriate Use of Hospital and Residential Services. A fourth understanding is that some children and adolescents who experience the most severe emotional disturbance may require treatment in the most intensive, comprehensive and secure environments, inpatient psychiatric hospitals or residential treatment facilities. It is important that these services be available when children need them, so that successive failures in less appropriate settings do not occur. It is equally important that these services be utilized only when the same treatment outcome cannot result from services which should be available in the child's home and community. When children and adolescents are served in psychiatric hospitals or residential treatment settings, their families need to be involved in treatment planning and delivery, and appropriate less intensive services must be available so that they may return once treatment goals are achieved.

A Public-Private Partnership to Improve Systems. Finally, the vision is premised upon the knowledge that social and economic factors contribute to the significant mental health problems of Connecticut's children and families. No single agency can ameliorate poverty, homelessness, discrimination, substance addition, or family break-up. Acting in concert, however, public and private sector representatives will be able to conduct interagency data analysis, guide policy and program development, and secure the financing required at the community, regional and state level to plan for and implement necessary community service enhancements.

SECTION I

CONNECTICUT'S FRAMEWORK FOR THE DEVELOPMENT OF HUMAN SERVICES AND THE MENTAL HEALTH PLAN

This plan for an enhanced system of services for Connecticut's children and adolescents who experience serious emotional disturbance has its roots in a statewide public policy for children and families and in a significant history of interagency work to address the State's human service priorities.

Connecticut's Public Policy on Children and Families

Connecticut's public policy on children and families was developed in 1988 by the Governor's Child Welfare Reform Policy Advisory Council. Membership in this policy council included the Commissioners of the Departments for Children and Youth Services, Education, Health Services, Human Resources and Income Maintenance with the Secretary of State Office of Policy and Management, the Courts and members of the Legislature.

Following a lengthy period of interagency analysis and discussion, Connecticut's policy for children and families was articulated:

To assure the well-being of all of its children by promoting the ability of their families to protect, nurture, educate and support the development of their children so that their full potential is achieved.

Council members recognized that children and families in Connecticut experience serious risks to their development and healthy functioning, and that any plan to improve the developmental outcomes for children would have to begin to address these risk factors:

Poverty; inadequate nutrition and hunger, inadequate housing and homelessness; inadequate health care, illness, disease and mental or physical handicaps; substance abuse; discrimination; a lack of family stability, nurturing and supervision; abuse, neglect or abandonment; delinquency and criminality; lack of educational opportunity and success, including a lack of English proficiency.

For many of the state's most fragile or troubled children and families, especially those who experience serious emotional disturbance, several of these risk factors seem to converge at the same time.

The Council believed that a comprehensive approach to meeting the needs of children and families experiencing these risks to healthy development and functioning would need to cross interagency boundaries and involve an enhanced degree of public/private partnership. An emphasis will be placed on developing community-based services which are child-centered and family focused, which respect the special time imperative of children as well as their racial, cultural and linguistic heritage, involve parents fully in planning, implementing and evaluating services for themselves and their children, and focus on demonstrable outcomes.

Although the Connecticut's public policy with regard to children and families was first articulated in the context of child welfare reform, the same principles serve as the framework for this first plan for service enhancements for children and adolescents with serious emotional disturbance.

The Commitment to Interagency Effort

The commitment of the Governor's Policy Advisory Council to interagency policy analysis is not unique in Connecticut. The State has a long history of employing innovative interagency and cross-sector efforts to examine human service needs and propose improvements. When faced with federal reductions in the Title XX program in the early 1980's, the Governor's Office of Policy and Management initiated its nationally recognized Negotiated Investment Strategy involving state agencies, the non-profit sector and municipal government leaders in planning and allocation decisions for the newly consolidated federal Social Service Block Grant. This multi-sector approach to planning set the stage for later task force efforts to address the state's employment needs, its housing crisis, and the dramatically increasing problem of drug addiction.

In 1987, the Governor established a formal mechanism for assuring regular, state-level interagency policy deliberation when he convened his Human Services Cabinet composed of the Commissioners of fourteen state human service agencies and chaired by the Secretary of the Office of Policy and Management. The goals of the Cabinet are to advise the Governor on emerging human service issues and to assist in coordinating the development of policies and service delivery. To date, the Cabinet has developed an integrated policy response for the State of Connecticut to the problem of AIDS and has outlined a project to understand and address the problem of poverty in Connecticut.

Interagency efforts also exist to address the needs of children and adolescents. The State Department of Education chairs the interagency Birth to Three Council, directed at piloting case management strategies for young children with handicapping conditions, and the Youth at Risk Task force, which provides a forum for cross-agency information sharing on the needs of adolescents at risk. The Department of Children and Youth Services has just co-chaired, with the Connecticut Association of Boards of Education, an interagency Task Force on Student Truancy and co-chairs, with the State's Attorney General, a focus group to implement recommendations of the Governor's Task Force on Justice for Abused Children.

Taken together, these interagency efforts provide a strong collaborative base within which to address the needs of children, adolescents and their families.

Foundation Partnerships to Effect Systems Improvements

Three significant foundation-related efforts have been undertaken to improve service planning, coordination and delivery for children, adolescents and their families, including those children with mental health problems. The first of these, the Bridgeport Futures Initiative, was developed by the City of Bridgeport along with the State Departments of Children and Youth Services, Education, Human Resources and the Office of Policy and Management. Its purpose was to redesign school and community services for middle school children at risk of truancy, dropping out, pregnancy and eventual unemployment. The effort has resulted in a \$750,000 three-year award from The Annie E. Casey Foundation to implement school-based management programs, a community case management model for children and their families, parent education and support centers for families, special corporate and business initiatives in the schools, and special instruction for middle school youth in decision-making and social competency.

The second foundation-based effort, The Annie E. Casey Children's and Family Reform Initiative, began as a child welfare reform effort including the Departments of Children and Youth Services, Education, Health Services, Human Resources, Income Maintenance and the Office of Policy and Management, the Courts and the Legislature and has expanded to include the adult Departments of Mental Health, Mental Retardation and the Alcohol and Drug Abuse Commission.

This systems reform initiative, developed with the City of New Haven as its first demonstration site, proposes several model program components designed to: support families before problems occur; provide intensive community-based alternatives to the placement of children; pilot a cross-agency integrated community case management service for at risk children and their families; and establish a new legislatively-authorized governance entity to oversee the reform effort. The State of Connecticut has committed \$23,316,709 to the statewide reform effort over five years, while The Annie E. Casey Foundation has committed an additional \$7,500,000 to the initiative.

Finally, the Department of Children and Youth Services in conjunction with the Departments of Education and Income Maintenance, representatives of the City of Hartford and area health, mental health and education agencies developed an application to the Robert Wood Johnson Foundation to develop a model service delivery system for children and adolescents who are seriously emotionally disturbed. While the proposal was not funded, the effort confirmed the need for case management, emergency psychiatric programs, day treatment and family preservation services for these children and their families in the greater Hartford area. It also prepared the city and surrounding municipalities for integrated program development as soon as mental health funding becomes available.

Through these three foundation-related efforts, a significant partnership has been defined between the state and its three major cities in the design and development of a comprehensive system of service for some of Connecticut's most vulnerable children, adolescents and their families.

The Consolidation of Children's and Adolescent Services

Based on an evolving vision of an integrated, non-categorical service system for children and adolescents, Connecticut's Department of Children and Youth Services has developed, since its creation by the General Assembly in 1969, as the single state agency responsible for children's mental health, child welfare, juvenile justice, substance abuse and preventive services.

The department's centralized administrative structure was established in 1969. In 1970, the Department became responsible for juvenile delinquency treatment and prevention programs, including institutional custody at the Long Lane School, direct placement services for delinquent youth at private residential programs, and community parole services. In late 1974 and early 1976, child welfare services were transferred to the Department along with a community-based network of Youth Service Bureaus. Also in 1976, five service regions were established (which would, in 1988, become six) along with a State Advisory Council and five Regional Advisory Councils to serve as professional and citizen advisory resources to the Department. During the same year, children's mental health services, including public institutional services and community-based child guidance clinics, were transferred from the Department of Mental Health. In 1979, the General Assembly added responsibility for court-committed status offenders, called Families with Service Needs, and in 1988, a three year plan was agreed upon to transfer children's substance abuse services from the Alcohol and Drug Abuse Commission.

The Transfer of Children's Mental Health Services

Transfer of children's mental health services was mandated through a special act of the 1974 Connecticut General Assembly. This act set forth the general philosophy of the state concerning the reorganization of children's services, stating that the transfer "will consolidate existing funding and resources and utilize other public and private children and youth service providers toward the most effective delivery of all aspects of care for children and youth".

The legislature created a Commission to plan the transfer of psychiatric and other related services for children to the Department. According to this plan, children's mental health services were transferred in order (a) to insure parity of children's services with other human services in state government, (b) to increase the state's commitment to preventing children's mental health problems, and (c) to increase the quality and effectiveness of children's mental health services by establishing an organizational structure with clear lines of authority and responsibility and eliminating duplication and gaps in services. After two years of planning, children's mental health services were transferred to the Department of Children and Youth Services.

The resulting move toward the integration of children's mental health with child welfare and delinquency seems natural today, but in the mid-seventies the legislation consolidating services within the Department was considered progressive. With the subsequent addition of responsibility for preventive services and substance abuse programs for children and adolescents, the Connecticut Department of Children and Youth Services continues to be viewed as a national model for children's services administration and program development.

Development of the Continuum of Care Model and Program Budget

In 1980, the Department adopted recommendations of a broad-based public-private working committee that children's mental health services be described and developed according to a Continuum of Care model.

In this model, services were described as available through several levels of a continuum of intensity and restrictiveness, beginning with community-based natural family support and prevention programs, moving through an array of community-based in-home, day treatment and outpatient programs, and providing for a range of substitute care programs for children and adolescents who cannot be treated or protected in their own homes or communities. The substitute care services includes foster family care, groups homes and shelters, residential treatment facilities, and inpatient psychiatric hospital services for emergency, intermediate and longer term treatment.

Adoption of the continuum model was important, for it allowed the Department to emphasize the importance of early, preventive services as the foundation for children's mental health while at the same time continuing to identify gaps in crisis intervention and treatment programs.

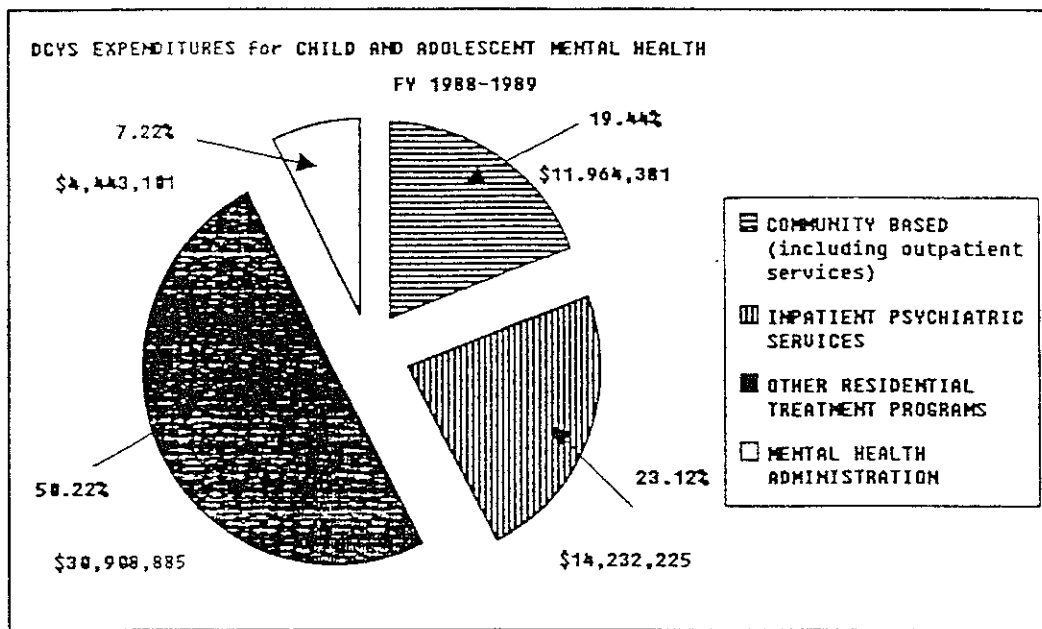
At about the same time, the State of Connecticut initiated the development of program rather than line item budgeting for state agencies, and in 1983-84, the Department developed its first program budget modeled on the service levels described in the continuum of care. This development was significant for it explicitly linked the program and budget planning process.

The table below shows the Department's general fund expenditures from 1983-84 through 1988-89 for each level of the continuum of care serving children and adolescents across the five service mandates: child welfare, mental health, juvenile justice, substance abuse, and preventive services.

Levels of Service	1983	1989	Actual Dollar 5 year Increase
Positive Development - Level I	1,145,410	3,048,246	1,902,836
Support Services - Level II	24,331,684	48,053,250	23,721,566
Placement Services - Level III	45,505,254	81,994,899	36,489,645
Agency Management -	5,694,602	10,354,465	4,659,863
Total	76,676,950	143,450,860	66,773,910

As can be seen from the table on the previous page, the Department received an increase of \$66,733,910 over the five year period from 1983-84 through 1988-89. Importantly, however, when inflation is taken into account, the real gain was \$50,633,412.

Although expenditures are not tracked by mandated service, we have attempted to construct a picture of 1988-89 expenditures for children's mental health services. Of the Department's total general fund budget of \$143,450,860, we estimate that \$61,548,592 was expended to support services for children and adolescents with serious behavioral, emotional or psychiatric problems. As shown below, 19.4% supported community programs, 23.1% supported inpatient psychiatric services, 50.2% funded residential programs, and 7.2% provided for Administration. The graph which follows shows the proportion of 1988-89 funding used to support mental health services for children and youth.



Agency Mission and Operating Principles

During March and April, 1987, the newly re-elected Governor of Connecticut appointed a new Commissioner to head the Department of Children and Youth Services and she appointed two new Deputy Commissioners.

The Commissioners' review of agency operations from the perspective of the children and families who used it revealed a series of programs organized around categorical entry and service criteria and activated most frequently when service needs reached the point of crisis. The focus was on remediating the presenting problem of the child rather than prevention and intervention services which were child-centered and family-focused. Service availability also seemed to be unequal for minority children, with Black and Hispanic children over-represented on the child welfare and delinquency caseloads, but apparently under-represented in mental health services.

Following several months of discussion with advocates, families, agency staff and providers of service, the Commissioner published the Department's first Mission Statement in July 1987:

The Mission of the Department of Children and Youth Services is to join with others to create the conditions within which all children in Connecticut:

- . Develop as healthy, productive and caring persons, free from harm and injury
- . Experience enduring, nurturing relationships as members of permanent families
- . Participate fully in community life
- . Exercise age appropriate opportunities for decision-making
- . Are supported in their transition to adulthood, and
- . Receive services that are respectful of child time, responsive to children's individual and developmental needs, and sensitive to their heritage.

To guide planning, budget development and implementation of the Mission Statement, the Commissioner also issued a set of Operating Principles. These principles follow:

- . Children have a fundamental right to grow up as members of a family. The Department therefore will work to support, enhance and empower individual families to care for their children.
- . Some children live in economic and environmental conditions which do not promote their healthy development. These conditions include poverty, substandard housing, the presence of substance abuse, and the absence of adequate health care. The Department therefore will work with other Connecticut agencies and the private sector to address these public policy issues for Connecticut families.

- . Decision-making on behalf of children works best when it involves the family as well as others serving the family. The Department therefore will develop an inter-disciplinary case planning process which includes and values the input of family members.
- . Services work best when they are planned and delivered close to where people live. The Department therefore will provide for services through a system of regional planning, program administration and funding.
- . The special needs of some children may require time-limited, out-of-home treatment. The Department therefore will plan for, operate or fund an integrated system to meet the particular needs of these children.
- . Children and families are a vital source of information about the quality of services which they receive. The Department therefore will include children, families and citizen advocates in the assessment of services provided.
- . The Department will invest its human and financial resources, to the greatest extent possible, in activities and programs most likely to advance this mission.

Developing a Regional Base for Community Services

Upon appointment, the Commissioner requested and was granted executive and legislative approval to implement a regionally-based management structure for the delivery of community services. Six regions were identified, each headed by a new Regional Director hired between August 1987 through January 1988. All of the Department's facilities, with the exception of the statewide children's and adolescent psychiatric hospitals and the statewide juvenile correctional facility, were assigned as part of the regional structure. Also assigned to the regions were the department's child protection and homefinding operations. Plans are being finalized to strengthen community-based services through transfer of staff in the areas of fiscal and personnel services, grants and contract management of ongoing community services, community development efforts, and training.

Each of the regions is assisted in needs assessment, program planning, policy deliberation and advocacy by a Regional Advisory Council consisting of both consumers and providers. During the 1989-90 state fiscal year, each region will produce its first regional planning document outlining the multi-year integration of children's service programs across child welfare, children's mental health, substance abuse, and eventually juvenile justice and prevention services. The plans will identify program components needed to complete the continuum of care, with special attention to services needed for prevention and early intervention, family preservation, child protection, and for children and adolescents who are seriously emotionally disturbed.

In each of the regions, there are generally at least two population centers or clusters of towns. The planning process initiated in 1988-89 will build upon these subregional networks in developing each region's first plan for integrated services.

Recent Legislative Initiatives

In addition to supporting the Department's request to develop a regional and community-based system of services, members of the Connecticut legislature have directed two recent initiatives concerning services for children and adolescents with serious emotional disturbance.

Legislative Program Review of Inpatient Services. In late 1985 and 1986 the Legislative Program Review Committee conducted a review of the Department's Psychiatric Hospital services for Children and Adolescents. The following are major recommendations from that review and are addressed in this plan. DCYS should develop a comprehensive children's mental health plan and should:

- . Conduct a needs assessment of the target population.
- . Develop the roles of the system components.
- . Conduct statewide planning.
- . Develop a service model based upon needs.
- . Develop a scheme to insure that patients have better access to services.
- . Develop 24-hour emergency service programs, which aid in screening referrals to inpatient programs.
- . Define and implement a referral process for mental health services.

Suicide Prevention Task Force. Over the past two years, the Department of children and youth services took a leadership role in the Connecticut General Assembly's Task Force on Youth Suicide Prevention. In February 1989, the Task Force issued a report that outlined a comprehensive approach to prevent youth suicide. The recommendations in the report provided the framework for four pieces of legislation which were subsequently passed in the 1989 legislative session. One of the bills, Public Act No. 89-191 calls for the establishment of a youth suicide advisory board within the Department of Children and Youth Services. The Department plans to convene the advisory board in October to begin to develop a plan for accomplishing the objectives assigned to the board by the legislature.

Federal Partnerships

CASSP: A DCYS-NIMH Partnership. In the spring of 1989 the Department developed and submitted an application to the National Institute of Mental Health (NIMH) for a "Child and Adolescent Service System Program" State Level Development Grant (CASSP). The mission of CASSP is to develop, coordinate, implement and monitor a comprehensive community-based system of services for children and youth with emotional disturbance. The basic philosophy is to maintain the child in his or her home or the least restrictive and most therapeutic environment indicated by his or her specific needs. Although formal notification of an award has yet to be received, the agency expects to receive a grant of \$180,000 for each of two years.

Much of the work set out in this plan will be accomplished through the resources and funding provided for in the CASSP grant.

Mental Health Needs Assessment. The Yale Child Study Center, with the Department of Children and Youth Services and supported by NIMH, has embarked upon the task of conducting a thorough needs assessment to estimate the mental health requirements of children and adolescents in urban, rural and small town settings. This assessment relies upon extensive, direct interviews with families, teachers, clinicians and members of the child psychiatric community. Its primary focus is to determine the prevalence of emotional disturbance among children in these three environments. It also focuses upon the mental health service utilization patterns, service preferences of the various sub-population of parents and perceived barriers to seeking or using existing mental health services.

SECTION II

THE VISION FOR A COMPREHENSIVE, COMMUNITY-BASED SYSTEM OF SERVICES FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE

Several challenges must be addressed as planning and program development move forward to define, describe and implement a model child-centered, family-focused system for services for children and adolescents with serious emotional disturbance.

Defining the Target Population

Although the national literature on children's mental health acknowledges the absence of universally accepted definitions of "chronic mental illness" or "serious emotional disturbance" among children and adolescents, Connecticut's operational definition of serious emotional disturbance among children and adolescents draws heavily on the work of the National Institute of Mental Health's Toward a Model Plan (1987).

Age. The population of seriously emotionally disturbed children and adolescents includes individuals ages birth through 17 years (and through age 21 where Connecticut state law permits) regardless of where they are currently living or in which system they are being served, ie., juvenile justice, child welfare, substance abuse, or mental retardation.

The population is further defined according to three additional dimensions: (a) disability, (b) duration and (c) multi-service need.

Disability. To be identified as experiencing serious emotional disturbance, a child or adolescent must be assessed by a mental health professional as having:

- . A diagnosis under DSM III-R, and
- . An emotional, behavioral and/or organic impairment resulting in a substantial limitation of function and/or development in two or more major life skills including; (a) self care and life maintenance, (b) perceptive and expressive language (c) learning, (d) self-direction including impulse and behavioral control, (e) the capacity for family and interpersonal relationships, (f) or equivalents to the above about which regional experts agree.

Duration. The disability carries a significant risk that the child or adolescent will experience severely impaired development or functioning for an extended period of time. For adults to be identified as chronically and severely emotionally ill, duration is generally defined as lasting at least one year. For children, however, duration must take into account the child's age and developmental progress; the younger the child, the less significant duration is as a definitional factor.

Multi-Service Need. The child or adolescent will exhibit a degree of disturbance which requires services from at least two state or community agencies or from multiple disciplines within a single agency. These services include (a) health, (b) special education, (c) mental retardation, (c) juvenile justice services, (d) child protective services, (e) substance abuse services.

Enactment in Statute. NIMH planning documents suggest that a state's definition of serious emotional disturbance be enacted as part of the agency's legislative mandate. Connecticut will consider whether this is necessary or appropriate after utilizing the proposed operational definition for at least one year.

Identifying the Incidence of Serious Emotional Disturbance Among Connecticut Children and Adolescents

The absence of an operational definition of serious emotional disturbance results in Connecticut's inability to project, in other than broad numbers, the scope of the problem. However, based on the application of national indicators and the DCYS-Yale Child Study Center Needs Assessment Program, the Department's mental health planning group estimates that:

- Approximately 12% of Connecticut children and adolescents--some 93,000--may experience a need for some level of mental health service.
- Approximately 3% of Connecticut children and adolescents--some 23,000--may experience serious emotional disturbance.
- Approximately .87% of Connecticut children and adolescents--some 6,664--may experience serious emotional disturbance at such a disabling level that inpatient psychiatric hospitalization, residential treatment or intensive community-based treatment will be required.

Comparative Data. Data currently available from several sources suggests that, if the projections above prove accurate, Connecticut does not appear to be identifying and providing treatment for all children and adolescents in need of mental health services.

- . Findings from the DCYS-Yale Children's Mental Health Needs Assessment of children's mental health needs in an urban municipality reveal that 38.6% of children ages 6 through 12 and in school are identified by their parents or their teachers as having mental health needs. Importantly, half of these children screened as at risk of emotional or behavioral problems had not been in contact with the social service system for treatment.

In the same study but using a more restrictive measure of emotional or behavioral problems, 11.7% of the children were identified as at risk of child psychiatric disorders. Preliminary findings from a second DCYS-Yale survey of 170 parents and teachers of 6-11 year olds in a primarily rural planning region indicate that 32% of the children are at risk for emotional disturbance using the same screening indicators as in the urban setting.

- . In 1986-87, the State Department of Education reported that 13,539 students were identified by the public schools as socially emotionally maladjusted, under P.L. 94-142. This represents 2.9% of school enrollment for that year.
- . Also in 1987, some 3,200 children and adolescents were reported as admitted to public and private hospitals for inpatient psychiatric services. If this is an unduplicated count (and that cannot be determined), it represents less than .5% of the child and adolescent population.
- . Community child guidance clinics served 12,654 children and adolescents in 1988, and 13,087 in 1989, approximately 2% of the child population.
- . Private residential treatment facilities served 2,117 children and youth and another 337 were served in day treatment settings, representing .3% of the child/youth population.

Other Findings of the Connecticut Needs Assessment. The most promising data on the prevalence of mental health problems among Connecticut children is being collected as part of the Yale University-DCYS epidemiologic survey of children ages 6 through 12 in New Haven, an urban municipality in south central Connecticut, and in a three county planning region in Eastern Connecticut comprised of rural townships, suburban communities and three small cities. In addition to identifying numbers of children screened as needing mental health services, the data identify what services are reported as utilized and where they are received.

From the New Haven study, we have learned that half of the children screened as being at risk of emotional disturbance had not been in contact with the service system, and that many parents go to the school rather than community mental health providers for service. Lack of knowledge about how to obtain service was the barrier most frequently cited by parents; approximately one in three parents of children screened as at risk report not knowing how to get service for their child. Among the high risk groups identified from the study, single parent mothers were least likely to use services and most likely to report that they did not know how to obtain them. Also, Hispanic mothers who reported that their children needed help were three times less likely to receive help than other parents.

Analyses have also been conducted to identify the needs of children who are identified as at risk of homelessness in the New Haven sample. It was estimated some 515 children of the survey population of 9,448 had lost their homes due to eviction in the year of the survey. These children were significantly more likely to score high on the indicators of psychiatric disturbance than the general sample.

The Need to Develop Valid and Reliable Data Systems. Although the data reported above suggest that seriously emotionally disturbed children and adolescents may be underserved in Connecticut, significant limitations exist in the definition of emotional disturbance, the reliability of informants and of measures, geographic and age restrictions in target populations surveyed, and in the absence of information about treatment efficacy and outcomes. There are also problems of comparability in existing data gathered by agency management information systems. Similar problems concerning data needs, program utilization and outcomes of service exist across all levels of the service continuum.

Defining an Integrated System of Care and Treatment

The most important challenge in this planning effort is to define the model mental health system for children and adolescents with serious emotional disturbance as both complete unto itself yet fully integrated with other service systems for children and families, including:

- . Protection Systems, including child welfare, juvenile justice and adult legal systems
- . Education, Special Education, Vocational Training, Parenting Education and Support Services
- . Health Care and Substance Abuse Treatment
- . Income Support
- . Housing Assistance
- . Recreation
- . Child Care
- . Social, Fraternal, Cultural Supports

The new system must have the capacity to identify the mental health needs of all children who approach the Department of Children and Youth Services (or its funded agents in the community) for mental health service, regardless of whether they enter through the doors of traditional mental health agencies or through the doors of the courts, shelters for homeless families, or through the child protective or substance abuse treatment system.

The integrated mental health system also must have specific linkages with public education so that children and adolescents with serious emotional disturbance identified by school personnel can benefit from Individual Education Plans which are integrated with other community treatment services they may be receiving.

Finally, there must be formal agreements with departments responsible for adult mental health, mental retardation and substance abuse services. Such agreements will ensure the timely transition of older adolescents who require continued treatment and support into the adult systems and will ensure referrals to appropriate home and community-based service for children when it is their parents who experience chronic mental illness, mental retardation or substance abuse.

Core program components of the model service system include:

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| <p>A. Regional Triage Teams</p> <p>B. Regional Crisis Intervention Services</p> <ul style="list-style-type: none">. Intensive Family Preservation. Diagnostic Shelters. Emergency Psychiatric Outpatient Services. Emergency Psychiatric Inpatient Services <p>C. Home and Community Based Treatment and Support Services</p> <ul style="list-style-type: none">. Outpatient Mental Health Programs. Day treatment. Partial Psychiatric Hospitalization Services. Specialized Respite Care. Specialized Parent Aide Services. Specialized Independent Living Programs. Community Outreach Services. Treatment Foster Families. Therapeutic Group Homes <p>D. Integrated Child-Centered Family Focused Case Management</p> <p>E. Residential Treatment and Inpatient Psychiatric Hospitalization</p> <p>F. Operational Support Services</p> <p>G. Parent Advocacy</p> |
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Regional Triage Capacity. The new system must have the capacity to provide easy and timely access to assessment, diagnosis and the identification of needed services when children or adolescents are believed to be experiencing serious emotional disturbance. Such access must be available on both a planned and emergency basis.

To accomplish this will require definition and development of an intake and triage process, staffed through a clinically-appropriate multi-disciplinary team of professionals. The team will be responsible for:

- . Identifying and providing necessary assessments, including developmental, family and specialized mental health evaluations
- . Providing a referral to appropriate community services when a diagnosis of other than serious emotional disturbance is made
- . Providing a triage process to identify appropriate in-home and community-based intensive treatment and support services, or necessary inpatient services
- . Making a referral to publicly-operated or funded inpatient or residential treatment services, as appropriate, and
- . Making a referral for case management services.

The regional triage team(s) will provide system support as well as support for children and their families. Members will assist in specialized training for community and state agency staff, provide consultation in support of case managers dealing with complex child and family situations, and assist community and regional planning staff to assess the aggregate service needs of children and adolescents who experience serious emotional disturbance.

Regional Crises Intervention Services. The integrated system of care and treatment for these children and adolescents also must have a regional capacity for crisis intervention services, available on a 24-hour basis. These services will be available to families in their homes through intensive family preservation programs and in community settings through such programs as emergency foster homes and diagnostic shelters for children and youth, homeless shelters for families, emergency psychiatric outpatient and inpatient services, and emergency child protection programs such as the CARELINE. When crisis intervention services are fully operational there will be a capacity for outreach to other locations where homeless youth may be found.

While crisis intervention services are available on a 24-hour basis, they are generally of short duration and serve to stabilize the crisis, evaluate the safety and treatment needs of the child and family, assist the family to develop appropriate problem-solving behaviors, initiate therapeutic intervention where appropriate, and provide access to information and concrete services such as income support and temporary housing for the family and special education programs for the child or adolescent.

Regionally-based needs assessment will determine which of these emergency services currently exist, and which must be modified or developed. It is an immediate goal of the model system to develop at least one intensive family preservation program in each region, available for children and adolescents at risk of placement. It is also the goal of the model to develop four to six short-term emergency psychiatric inpatient beds in each region for children ages ten and younger, in order that they may receive intensive psychiatric care close to their homes and with the daily participation of their families.

Home and Community Based Treatment and Support Services. A third component of a model system for children, adolescents and their families experiencing serious emotional disturbance involves the ready availability of ongoing home and community-based treatment and support services. These services include outpatient mental health programs such as provided now by Connecticut child guidance clinics and family service agencies, day treatment and partial hospitalization programs which serve as an alternative to extended inpatient care, life skills and independent living, respite care and parent aide services which are available in the family's home.

Other specialized treatment services may need to be developed, based on current needs of families within Connecticut communities; among these necessary specialized treatment services are outreach services for homeless children and youth, post-adoptive services, and additional services for sexually abused children (and their abusers). Also necessary are community programs for children and adolescents who are diagnosed as both seriously emotionally disturbed and mentally retarded or who have significant mental health needs and who have been convicted of juvenile delinquency and/or who have become substance abusers.

Regionally-based needs assessment will identify service gaps, and plans will be developed to request necessary funding.

Treatment Foster Homes and Therapeutic Group Home Services. Some children and adolescents with serious emotional disturbance will be unable to remain with their families, because of their own intensive treatment needs, because their families have seriously abused, neglected or abandoned them, or because their families are unable to protect and care for them due to poverty, lack of housing, or parental mental illness, mental retardation or substance abuse. For many of these children, specially trained and adequately compensated foster families will provide the treatment and nurturance they require; adolescents may receive treatment within either treatment foster families or therapeutic group homes. Though the goal is to return these children to their own families as soon as possible, substantial numbers of children and adolescents with serious emotional disturbance may require long-term care and treatment in these community-based alternate living settings.

Inpatient Psychiatric Hospitalization and Residential Treatment. The fourth core component of a model system lies in the availability of appropriate inpatient psychiatric hospitalization and residential treatment for those children and adolescents who require it. Although not in effect at the present time, access to the state's public psychiatric hospitals for children and adolescents--RiverView Hospital for Children, Altobello Adolescent Hospital and Housatonic Adolescent Hospital--would be accomplished in the model system through the regional office triage teams. Access to publicly-funded residential treatment would continue to be managed by the department's regional offices through the Non-Committed Treatment Program and through various forms of legal custody of children and adolescents granted to the Department.

As part of the model systems development, current residential facilities would work with the Department's new regional administration to develop within each region a strongly linked continuum of improved out-of-home treatment alternatives for children and youth who experience serious emotional disturbance. As a partner in the development of this continuum, residential treatment providers would link with public and private psychiatric hospitals to ensure continuity of treatment for children or adolescents whose specialized needs required a period of continued residence in an intensive and highly structured environment. The availability of a continuum of out-of-home treatment programs would also assure that children and youth have timely access to clinically-appropriate, but less intensive and restrictive community treatment services, including treatment foster families, therapeutic group homes and transitional living settings. In some regions, these programs may be developed and administered as part of the residential treatment center; in other regions, the necessary linkages will be assured through formal interagency agreements and individual case plans. In all cases where a child or adolescent is placed for residential treatment or inpatient psychiatric hospitalization, the facility will encourage family participation, address the specialized treatment needs of each child in the program, provide a therapeutic milieu in which acceptable treatment outcomes can occur within the briefest length of stay, and offer emergency back-up services when the child returns home or to less intensive community services.

Integrated Child-Centered Family Focused Case Management. The center of service delivery for children and adolescents with serious emotional disturbance will be an integrated case management system. Like other components of the new model, case management will be child-centered but family focused. The agency's guiding principles will act as a philosophical base for case management services. Although case managers will need to have a thorough understanding of serious emotional disturbance as well as clinical expertise, case management is not a service designed to "treat" serious emotional disturbance. Rather, case management is a series of functions directed at empowering, coordinating and advocating both for the child and family unit and for the systems within which children and families are served.

Client-specific case management functions include the identification of persons eligible for the services and outreach to them, assessment of child and family strengths and needs, development of a relationship that motivates and enables the child and family to take needed action, service planning and resource identification, assistance to families in arranging for access to needed services, coordination and linking of services for a child and family across multiple providers, monitoring service delivery, evaluating progress in meeting treatment and support goals, and acting as an advocate for the child and family.

Through the case managers, assurance will be provided that the mental health services are responsive to cultural, ethnic and linguistic needs of the seriously emotionally disturbed child and youth and their families. Case managers will also utilize existing laws and other safeguards to assure that patients rights are protected. (See appendix item C)

System-specific case management responsibilities include the identification of service needs across families and gaps in programs available to met those needs, recommendations for the modification of existing programs which do not meet the needs of the people using them, proposals for better coordination of services at the community level, the identification of interagency policy barriers which inhibit service delivery, and advocacy for systems change.

Publicly-supported case management, as proposed in this plan, is an intensive service for the most seriously involved children, adolescents and their families, those where placement of the child is highly likely or has actually occurred. Case managers will carry an average of 20 cases, low enough to ensure that they are available to families as needed to help avert a placement and to assist families to secure the treatment and support services necessary for their children to return to their homes and communities.

For children in inpatient hospitals facilities, the case manager will join the hospital's treatment team as an active member and will visit the child and meet with the team at least weekly. During the beginning and ending phases of hospitalization, the case manager may spend an additional six to eight hours per week assisting the child to attain the treatment goals. In cases when hospitalization occurs, the caseload will need to remain very low.

In addition to the mental health services described above, case managers will assist in securing educational, vocational, recreational services and respite programs, income support and housing when needed, health care and child protective services, and parenting support. Only through comprehensive needs identification followed by the coordination of multiple services can the complex needs of the most fragile and impaired children, adolescents and families be met.

Interagency Policy Planning Functions. For case management to be effective in its "systems change" functions, a formal multi-disciplinary and interagency policy and planning body must be available to receive its observations and recommendations.

At the regional level, Department of Children and Youth Services Regional Directors will invite their management peers from the Departments of Income Maintenance, Human Resources, Mental Retardation and Mental Health to join as members of regional Planning and Policy Councils. Clarification of policy issues will be sought, proposals for program modification will be reviewed, and recommendations for resources enhancements developed.

At the statewide senior staff level, policy and resource issues identified locally will come to the Interagency Operations Team of the Connecticut Children's and Family Reform Initiative, chaired by the Coordinator of the Reform Initiative. Membership includes the Departments of Children and Youth Services, Education, Health Services, Human Resources, Income Maintenance, Mental Health, Mental Retardation, the Alcohol and Drug Abuse Commission and the Governor's Office of Policy and Management.

When Commissioner approval is needed to implement required changes or to seek resource enhancements, the issues will be taken to Commissioners through the Governor's Human Services Cabinet.

Operational Support Services. The success of the new model for an integrated mental health system rests in large part on the availability of appropriate operational supports. These include:

- . The capacity for regional planning and community development services, responsible for needs assessment, service inventories, and program development.
- . A regional and statewide management information system capable of providing an accurate and timely description of children served, outcomes obtained, and characteristics of the programs and the service system.
- . Staffing for the regional triage service, case management and community treatment and residential/inpatient programs appropriate in terms of racial, cultural and linguistic representation, training and experience, and adequate numbers to achieve desired caseload or workload targets.
- . The development of financing strategies and resources which maximize federal and third-party reimbursement and which assure appropriate levels of state funding.
- . A quality assurance system based on treatment standards, demonstrable outcome measures, appropriate and timely feedback to providers, and parent or citizen involvement in program monitoring and reviews.

Significant work is required in each of these operational support areas.

Parent Advocacy. The final core component of the new model system is parent advocacy. Through the availability of CASSP funding, the Department of Children and Youth Services will initiate a statewide parent advocacy effort designed to inform and mobilize parents as advocates for their own children with serious emotional disturbance, as well as for all children and adolescents in their communities with similar problems.

SECTION III

STATUS OF CURRENT EFFORTS IN CHILDREN'S MENTAL HEALTH SERVICE DELIVERY

Development of a Regional Triage Process

In its 1988-89 Budget Request, the Department described the resources necessary to begin to establish a Clinical Support Team in each of its six regional offices. The Clinical Support Team was to include at a minimum: a psychologist knowledgeable in children's mental health needs; a nurse knowledgeable in child development, pediatric nursing, AIDS, and in the health needs of foster children; a psychiatric social worker knowledgeable in residential treatment services and one clerical staff member. This core team of Department staff would be joined by a community child psychiatrist, pediatricians and specialists in other therapies under contract to the Department for assessment, program planning, and training. Together, members of the Clinical Support Team would provide a triage process for children referred to the Department for child protection and mental health services and would assist agency intake and case management staff in assessment and treatment planning for these children and their family members.

Although positions for establishment of these core Clinical Support Teams were appropriated for State Fiscal Year (SFY) 1988-89, insufficient funding in the Department's overall budget for both 1988-89 and 1989-90 prohibited hiring the professionals and establishment of the Teams. Approximately \$850,000 is required to fund these full-time positions.

Crisis Intervention Services

Intensive Family Preservation. Intensive family preservation services are available to families whose children are at imminent risk of placement in three of the Department's six regions, serving the New Haven, Bridgeport and Hartford areas. In 1989-90, an additional program will be developed in each of the remaining three regions, with total statewide funding available in SFY 90 of \$1,535,000.

When fully operational statewide, Intensive Family Preservation Services are expected to serve 500 - 600 families, assisting them to retain their children in their homes in 75% of the cases. Preliminary data available from two of the current programs reveals that of 111 families served in 1989, 92% remained intact at the end of the year.

Although the services now available generally focus on preserving families referred for abuse and neglect of their children, programs will also be available when children or adolescents with serious emotional disturbance are referred for hospital or residential treatment services. Development of intensive family preservation in New Haven as part of The Annie E. Casey Children's and Family Reform Initiative will begin this expansion to children with mental health needs by serving at least 20 such families in its first year.

Diagnostic Shelter Services. In 1988-89, the Department initiated significant program changes in one of its residential facilities, High Meadows, located in the New Haven area. Twelve beds were redesigned as a short-term intensive diagnostic shelter unit. The unit serves children committed to the Department for whom residential treatment is recommended but no current private provider can be identified. During the planned 30 to 60 day stay at the Diagnostic and Emergency Planning and Placement (DEPP) Unit, a review of the placement recommendation is conducted, behavior is stabilized, and children are then either returned to their homes or an appropriate placement is arranged.

In its first ten months of operation through April 1989, the unit served 31 children, with four returning to their homes, two to a foster family, and ten being placed in a residential treatment, and one each placed in day treatment and a group home. The average length of stay for those discharged was 125 days.

The unit fills a critical gap for the department by providing diagnostic emergency care and treatment for children and adolescents unable to return home and generally rejected from a range of private residential and shelter providers. For 1989-90, the Department has initiated a planning process to make additional diagnostic shelter beds available for committed children who are seriously emotionally disturbed.

Community Emergency Psychiatric Services. The Department currently supports the delivery of emergency psychiatric services in each of the six DCYS regions. Eight individual programs were funded at a 1988-89 cost to the agency of \$916,225. In 1988, six of the programs received 998 referrals for service and admitted 585 children and adolescents for service. Data for SFY 89 is not currently available.

Generally child guidance clinics are the initial entry point for these programs. Services include the provision of a continuum of crisis intervention and stabilization services ranging from outpatient and inpatient psychiatric evaluation by multi-disciplinary staff through short-term psychiatric hospitalization. Although availability of a complete array of services is intended, many of the existing programs must rely on available beds in acute care hospitals for short-term hospitalization, and few are designed to include abusers of hard drugs, chronic violent/assaultive patients, or children and adolescents who are profoundly retarded or autistic.

The model available in New Haven provides the complete range of services from an outpatient program to short-term inpatient psychiatric hospitalization. Outpatient services are provided during normal working hours and the remainder of emergency services are available on a 24 hour basis. Children may receive up to 30 days of inpatient services and adolescents may be treated for up to 14 days before being referred to other programs or hospitals. Additionally the programs provide for collaboration with DCYS, shelters and other service agencies to access disposition alternatives.

To plan for meeting the needs of children under the age of ten who require emergency hospitalization, the Department established a public/private special study group. The group has proposed establishment of six to eight emergency psychiatric beds per region, to be funded through the federal Title XIX program. The service would emphasize family involvement, while stabilizing the child in crisis and providing a comprehensive assessment of child and family functioning. Further work on cost models and program design will continue during 1989-90.

Home and Community Treatment and Support Services

Mental Health Outpatient Services. At the present time, most of Connecticut's community-based mental health services are provided by 29 child guidance clinics situated throughout the state and serving all six regions. Staffed by psychiatrists, psychologists, social workers and other professionals and paraprofessionals, the clinics generally provide screening and referral services, evaluation and diagnosis, treatment programs including individual, group and family therapy, emergency crisis intervention and community consultation.

Children are most often referred to the clinics by public schools, their families, the Department of Children and Youth Services, other human services agencies, and health providers. In 1988, the child guidance clinics served 12,654 children and adolescents while, in 1989, 13,087 were served. Average, treatment services were based on seeing the child in the office for bi-weekly hour-long sessions, conducted over a period of about 12 months. The total cost of these services in 1988 was \$18,500,000 of which \$7,916,942 was funded by the Department of Children and Youth Services. Waiting time for admission to treatment services ranges from 0 to 429 days, with a statewide average of 24 days during 1987-88. For 1989-90, the Department has initiated a process of regional dialogue and planning with the child guidance clinics to target certain groups of children and families for priority access for outpatient mental health treatment and support services.

Day Treatment. Day treatment is a mental health service for children who require intensive treatment programming, generally on an extended day basis, but who can return to their families in the evenings. Day treatment offers an alternative to residential treatment programs for some children and may serve as a follow-up to a psychiatric hospitalization or residential treatment for others. Day treatment services include individual, group and family therapy, family support through crisis intervention, outreach, and parent education, access to appropriate educational services, therapeutic recreation and appropriate developmental programs such as the pre-school intervention and vocational services for adolescents.

In 1988-89, Department funded 21 different day treatment programs in the private sector, through a combination of state and federal funds. In addition, the Department operated two day treatment programs with agency staff. Together, these programs funded by the Department have a capacity of 477 pre-school, elementary and adolescent youngsters. The Department's total expenditure for day treatment services was \$3,238,912 in 1988-89.

A review of day treatment resources for children committed to the Department was conducted recently by the Connecticut Association of Child Caring Agencies and DCYS staff. The report, published in September 1988, recommended that the Department adopt a formal definition of day treatment as a mental health service, and review the varied funding mechanisms in light of gaps between rates and actual costs. The analyses conducted as part of the review will provide the basis for program reconciliation and potential expansion during the 1989-90 fiscal year. The sum of \$500,000 has been appropriated to the Department to develop community alternatives to residential treatment during 1989-90. It is anticipated that some portion of these funds may be utilized by the regions to develop or expand day treatment programs.

Respite Services. Respite care is a family support service which enables parents a period of relief from the constant care of their seriously emotionally disturbed or handicapped children for brief periods of time. The service may be available in the family's home or may be available to the children in other settings. Currently, funds are available to purchase limited respite services to foster families serving child protection cases. Additional resource availability is needed to expand this vital service to families with seriously emotionally disturbed children.

Parent Aide Services. Parent aides are paraprofessionals who assist families on the Department's child welfare caseload in the care and protection of their children. Parent aides work in the family's home to model appropriate parenting behaviors and aid parents to develop problem-solving approaches while assisting them in home and child-rearing tasks. For 1988-89, the Department will continue contracts with 20 private agencies for the provision of 62 full-time equivalent parent aides statewide. At present, parent aides are generally assigned to protective service cases; however, future expansion of the service would enable it to serve as a resource for families with seriously emotionally disturbed children.

Specialized Mental Health Community Services. As part of the 1988-89 budget development process, the Department requested additional funding to develop private sector contracts for the following specialized mental health services: \$420,000 (for six months) to treat sexually abused children and youthful offenders; \$467,500 (for six months) to add 30 certified drug and alcohol counselors to existing mental health programs statewide; and \$150,000 (for six months) to purchase post-adoptive services for families where risk of adoption disruption is high. Of these requests, \$90,000 was appropriated to provide for treatment of children and adolescents who have been sexually abused.

Treatment Foster Family Care. This service, provided by specially trained foster parents, functions as an alternative to residential treatment and hospitalization for children and adolescents. Treatment foster parents are viewed as full members of the child's treatment team and are responsible for implementing in-home treatment plans. Treatment foster parents are provided with intensive planning, consultation and support. Nationally, treatment foster care costs \$20,000 per child on an average annual basis.

In 1987-88 the Department contracted for a review of specialized foster family resources within the state. The study, issued in August 1988, recommends that the Department develop definitions, cost models, policy guidelines, a recruitment and training package, and appropriate funding to develop this resource in Connecticut. Initial funding of \$ 869,500 was requested for the 1989-90 year, but not appropriated by the legislature. It is anticipated that some portion of the \$500,000 appropriated for 1989-90 for community alternatives to residential treatment may be utilized to develop a treatment foster care program in at least one region.

Therapeutic Group Homes. Therapeutic group homes provide intensive community living services for adolescents who require both treatment and supervised living but who cannot remain in their own homes. These programs serve as alternatives to institutionalization as well as enabling youth who have been hospitalized or in residential treatment to become increasingly re-integrated into the community. In addition to supervised housing, therapeutic group home programs assure that adolescents receive treatment through individual and group therapy and through therapeutic recreation, education (or special education) through local schools, vocational training and supported employment opportunities, and opportunities for social interaction in the community.

At present, this necessary program is not available to adolescents in Connecticut, although group home and residential treatment providers have expressed interest in modifying existing programs to provide this intensive and comprehensive service. As part of its 1988-89 budget package, the Department requested \$242,517 for a one month start up of 12 six-bed therapeutic group homes, at a daily per diem of \$118 and an annual cost of \$2,910,204 statewide. Funds were not appropriated.

Residential Treatment and Inpatient Hospitalization

Concerned about the adequacy of Connecticut's continuum of residential services, including inpatient psychiatric hospitalization, two public-private work groups recently examined issues with regard to both residential treatment programs and a system for publicly-funded inpatient psychiatric services.

Residential Treatment. The report of the DCYS-private sector Residential Work Group, published in April of 1988, identified gaps in the continuum of care which inhibit the movement of children through the service system. With regard to residential treatment programs, the group identified several underserved populations, including sexual offenders and adolescents with sexual identity problems, firesetters, assaultive and severely acting-out youth, children and adolescents returning from psychiatric hospitalization, substance abusers, children and adolescents with mental retardation and those who are HIV infected. The group also noted a particular need to develop programs for older youth who generally fall outside the age range of most facilities.

Importantly, the Work Group did not propose an expansion of residential treatment beds in order to address these needs, but rather recommended "that current bed capacity in residential treatment programs be used to develop more services for specialized populations." Additionally, the report recommended that residential treatment facilities be "viewed as a 'hub' for the development of other needed services, such as transitional/independent living, specialized group homes... (and) foster care, day treatment, aftercare, home-based treatment and short-term diagnosis and assessment."

During 1987-88, the Department of Children and Youth Services served 1,763 children and adolescents in residential care within Connecticut facilities or out-of-state.

Also in 1987-88, 559 of these placements were provided through the Non-Committed Treatment Program. This program assists families in the cost of residential placement for their seriously emotionally disturbed children without requiring that the child be legally committed to the Department in order to receive the service. The cost to the Department for this program in 1988-89 was \$8,000,000. For 1989-90, a 25% reduction (\$2,000,000) in funding for the statewide Non-Committed Treatment Program (NCTP) resulted from legislative action during the 1989 session. The impact of these lost resources for children and families, as well as for several of the residential facilities serving predominantly NCTP children, will be closely monitored over this year.

Public Inpatient Psychiatric Hospitals. Connecticut's view of inpatient hospitalization was articulated during the fall of 1988 by a joint committee of DCYS psychiatric staff and representatives for the child psychiatric community. The report of the focus group states that "Inpatient intervention is required when the severity and/or complexity of the problems (of seriously emotionally disturbed children or adolescents) make outpatient services inadequate. Examples of severity include disturbances which are life threatening such as severe anorexia nervosa, suicide attempts, firesetting and self-mutilation. Children may also warrant psychiatric hospitalization because they exhibit a vicious cycle of deterioration which cannot be interrupted except by multi-disciplinary, 24-hour/day intervention. These disorders include severe attentional and anxiety disturbances and acute psychotic decompensation." Finally, the report notes that "many children with severe psychiatric disturbances have problems in virtually every sphere of their lives" and that psychiatric hospitalization may be called for when a comprehensive and simultaneous set of psychological, neurological, interpersonal, familial and educational interventions is required."

The report proposes that a system of psychiatric care for such children would have both local emergency and brief inpatient treatment capacity and access to a statewide facility for children who require longer treatment or are dependent upon public rather than private pay services.

The Department of Children and Youth Services currently operates the statewide public sector part of such a system. RiverView Hospital is a 50-bed psychiatric hospital for children ages 5 through 13. Altobello and Housatonic Adolescent Hospitals are public inpatient psychiatric facilities with 35 and 57 beds, respectively, for adolescents ages 14 through 18. In 1988-89, RiverView Hospital for Children served 135 children, while Altobello and Housatonic adolescent hospitals together served 217 youth. Referrals to RiverView Hospital numbered 300, and 590 adolescents were referred to the two adolescent hospitals. The total cost of operating these three psychiatric hospitals was \$14,232,225 in 1988-89; however, \$11,656,114 was returned to the state General Fund through federal reimbursement, private insurance payments and parental contributions for the treatment of their children.

Members of the focus group recommended the development or designation of four to six emergency and brief treatment inpatient psychiatric beds for young children in each of the state's regions where they do not now exist. Work will be undertaken as part of this plan to specify program and cost models for this service.

Private Sector Psychiatric Hospital Beds. At the present time, it is not possible to report on the number of children served in non-public psychiatric beds, or on the total cost of those services. However, it is recognized that private sector psychiatric beds comprise an important component in a comprehensive mental health system for children and adolescents. Work will be initiated within the context of this plan and the CASSP effort during 1989-90 to describe and quantify the availability of these services.

Case Management

Except through protective service social workers responsible for committed children and adolescents in placement and those admitted to the Non-Committed Treatment Program, there is no case management system available to seriously emotionally disturbed children and youth. Present caseloads of protective service workers including those who serve the Non-Committed Treatment Program, are at an average statewide ratio of 1:35, twice the national standard of 1:17-20 in protective services, and nearly twice the desired caseload expressed earlier in this plan.

In conjunction with The Annie E. Casey Children's and Family Reform Initiative, and the DCYS CASSP Initiative, several state agencies will review existing case management programs during the fall, 1989. The Department of Children and Youth Services will prepare a 1991-92 budget option to initiate case management services specifically for children and youth who experience serious emotional disturbance and who are in placement or at high risk of placements. At the present time, budget estimates are not possible.

In addition to developing program and cost models for these case management services, department staff are working with Income Maintenance staff to explore Title XIX coverage of case management services for this target population.

Operational Support Services

In order to satisfy its complex mandate for child welfare, mental health, juvenile justice, substance abuse and preventive services, significant enhancements are required in operational support services.

To enable the regions to plan for, develop and administer community services for children adolescents and their families, each region requires the addition of one program development specialist and one clerk. These positions were requested as part of the 1988-89 budget request, but not funded. Cost of these positions was estimated at \$328,000.

Significant enhancement is also required in the department's automated data system. As part of the 1988-89 budget options package, \$1,618,950 was requested but not approved.

An increase of six positions, plus clerical support, is required within the department's Administrative Case Review process, an essential quality assurance process which reviews all out-of-home placements every six months. In 1988-89, six children's service consultants conducted review of 8,069 cases.

Finally, significant funding is required to assure that going and specialized staff training is provided. A budget option outlining the department's needs and those of community mental health providers will be developed by the Spring of 1990, for the 1991-92 fiscal year.

SECTION IV: GOALS AND OBJECTIVES

GOAL I

With inpatient hospital personnel, residential providers, representatives of the child psychiatric community and provider agencies, and consumers, identify and evaluate the availability, appropriate utilization and quality of psychiatric hospital, and treatment services for children and youth with serious emotional disturbance and plan for necessary improvements - (SFY 90 and 91).

Objective 1: Analysis of Hospital and Residential Placements

Conduct a statewide analysis (SFY 90) of referrals and placements of Connecticut children and youth in public and private psychiatric hospitals and residential facilities, identifying:

- (a) characteristics of children referred, of those accepted, and the expressed rationale for requiring placement
- (b) identify characteristics of the placement experience, including the length of stay, desired and achieved outcomes, descriptions of home and community services provided prior to placement and available upon return, family involvement, costs of placement and funding mechanisms.

Anticipated Outcomes

- . Development of a data base which will allow for accurate description of service utilization, evaluation of system components, and tracking seriously emotionally disturbed children and youth who utilize the various mental health components.
- . A determination of the numbers of clinically inappropriate admissions and re-admissions and the reason for each.

Objective 2: Clinically Appropriate Outcome Measures

With the CASSP State-wide Policy Institute and families of children in treatment, develop a series of specific, clinically appropriate outcome measures which may be applied to hospital and residential programs serving seriously emotionally disturbed children and youth - (by December 1990).

Anticipated Outcomes

- . Identify outcome measures to assist families and agency personnel in planning for and evaluating residential and inpatient treatment services.
- . Application of outcomes measures to treatment and licensing standard.
- . Enhanced parental involvement in planning for and treatment of seriously emotionally disturbed children and adolescents.

Objective 3: Treatment Standards

Modify and develop or adopt (during SFY 91) treatment standards for psychiatric hospitals and residential treatment centers to include at least the following:

- (a) intake criteria
- (b) treatment planning
- (c) clinical and child care staffing patterns
- (d) family involvement in the treatment process
- (e) brief, intermediate and longer term program models
- (f) discharge planning
- (g) follow-up and emergency back-up services
- (h) utilization review processes
- (i) staff training and competencies
- (j) requirements for culturally and linguistically appropriate programs, and
- (h) demonstrated program efficacy.

Anticipated Outcomes

- . Treatment standards that will better define the requisites for the treatment of seriously emotionally disturbed children and youth in psychiatric hospitals and will define the requirements for providing less restrictive, clinically appropriate residential treatment.
- . Defined intake criteria published for regional use will reduce referrals by staff to multiple facilities.

Objective 4: Utilization Review Process

Extend utilization review procedures to residential treatment facilities so that residential treatment is based upon clinically determined need - (SFY 91).

Anticipated Outcomes

- . Lengths of stay will be determined by clinical review and through utilization review procedures.

Objective 5: Cost Models for Residential Services

Develop cost models for desired improvements in residential services - (SFY 90 and 91).

Anticipated Outcomes

- . Public/private agreement on cost components in desired program enhancements.

Objective 6: Regional Planning for Inpatient and Residential Treatment Services

Develop regional plans designed to address identified gaps in psychiatric hospitalization and residential treatment services - (December 1990).

Anticipated Outcomes

- . The development of plans and resource estimates to ensure that children and adolescents receive timely and appropriate residential and inpatient psychiatric care.

Objective 7: Permanency Planning for "Functionally" Homeless Children

Develop regional plans to achieve permanency for children and youth who are seriously emotionally disturbed and have been psychologically or physically abandoned by their families or when return to their home from residential or inpatient treatment is clinically unacceptable - (Beginning SFY 90 and ongoing).

Anticipated Outcomes

- . Regions will identify current additional resources (type and estimated costs) required to meet the specific needs of this population.
- . Creation of community-based alternatives for these seriously emotionally disturbed child or youth reflecting the unique needs and resources of each of the six regions.

Objective 8a: Transitional Services for Young Adults with Substance Abuse and Mental Health Needs

Assist the department of Mental Health and the Connecticut Alcohol and Drug Abuse Commission and their advisory Councils to develop transitional plans for meeting the needs of young adults who turn age 18 in hospitals and residential treatment programs and who require continued adult mental health or substance abuse residential services or supervised community living arrangements - (Beginning SFY 90 and ongoing).

Objective 8b: Support for Interagency Agreement with Department of Mental Retardation

With the Department of Mental Retardation, develop budget options to allow implementation of the DCYS-DMR Interagency Agreement concerning the transfer of youth to DMR services by age 18, and the joint delivery of services, as appropriate, to children and youth who are eligible for assistance from both DCYS and DMR - (SFY 90).

Objective 8c: Delinquency Services

Develop plans and program models, with the courts and the juvenile correctional facility, for meeting the needs of adjudicated and non-adjudicated delinquents with serious emotional disturbance who must be treated in secure facilities - (SFY 90 and 91).

Anticipated Outcomes

- . Jointly sponsored budget options (where required) for additional funds to meet the services needs of the seriously emotionally disturbed youth who require joint planning, programing, and special services from these state agencies.
- . Interagency agreements designed to meet the special treatment and interdepartmental transition requirements of these populations.

Objective 9: Acute Clinical Back-up/Support

Develop service agreements among providers to assure that psychiatric hospitals and residential facilities provide acute clinical and respite services to those who have been discharged and require short term additional intensive outpatient and/or short term residential care or psychiatric hospitalization - (SFY 90).

Anticipated Outcomes

- . The creation of necessary back-up/support (clinical and/or residential) from residential treatment facilities or psychiatric hospitals.
- . Briefer residential or hospital treatment time frames.

GOAL II

Develop Regional Triage and Case Management Processes

Objective 1: Regional Triage

Through formal interagency agreements and utilizing staff of public and private providers of mental health services, establish regional triage teams designed to meet both planned and acute mental health needs - (SFY 91)

Anticipated Outcomes

- . An initial screening of those cases referred to DCYS will be available.
- . Regional clinical teams will identify regional service requirements, and necessary modifications.
- . Budget options detailing resource needs will be submitted in October 1989 for SFY 91 implementation.

Objective 2: Regional Case Management

Develop and implement regional mental health case management models designed to accommodate the special treatment needs of the seriously emotionally disturbed child/ adolescent as well as the unique characteristics of each region - (SFY 92).

Anticipated Outcomes

- . In conjunction with the CASSP and Casey initiatives, case management models will be identified along with resource estimates.
- . Budget options detailing resource needs will be submitted in August 1990 for SFY 92 implementation.

GOAL III

Based on the proposed model and with representatives from mental health provider associations, department advisory councils, parents and department staff, develop a comprehensive array of community based mental health services for children and adolescents with severe emotional disturbance so that whenever possible the child or youth may be appropriately maintained with their families and/or in their communities - (SFY 90 through 92).

Objective 1: Regional Proposals for a Comprehensive Array of Community-based Services

Based on the model for a complete continuum of services, develop regional proposals and strategies to increase availability of in-home and community based services for children and youth with serious emotional disturbance - (By December 1990).

Anticipated Outcomes

- . Regional mental health proposals will be developed describing current service gaps and resource needs.
- . Budget options detailing resource needs will be submitted in August 1990 for SFY 92 implementation.

Objective 2: Implement currently funded core program components

Implement statewide those components of the model system for which funding is currently available including:

Intensive Family Preservation services in each of the regions - (SFY 90).

Community alternatives to residential treatment in each region - (SFY 90 and 91).

Anticipated Outcomes

- . An increased number of seriously emotionally disturbed children will receive home and community-based services as alternatives to residential placement.

Objective 3: Regional Crisis Intervention

Develop 24 hour psychiatric crisis intervention services as necessary in each region, beginning with the establishment of six to eight community based beds for short-term evaluation and stabilization as well as 24-hour outpatient crisis intervention - (SFY 91).

Anticipated Outcomes

- . Each region will develop interim plans for the provision of short term psychiatric inpatient care for the seriously emotionally disturbed child or youth, with utilization of current resources within their respective regions.
- . Budget options detailing resource needs developed by August 1989 for SFY 91 implementation.

Objective 4: Mental Health Services for Special Needs

Increase or develop mental health services for children, youth and their families, with special needs, i.e. children who have experienced physical and/or sexual abuse, children in need of post adoptive services, children who have witnessed serious domestic violence, are mentally and/or physically handicapped, substance abusers, homeless or whose families reside in shelters for either the homeless or victims of domestic violence.

Anticipated Outcomes

- . Regions will identify those unique services required to meet mental health needs of these "special needs" children and youth.
- . Budget options detailing resource needs developed by August 1989 for SFY 91 implementation.

GOAL IV

Improve the operational support system for Connecticut's mental health delivery system for children and adolescents - (SFY 90, 91, 92).

Objective 1:

Create a standing committee comprised of members of the Department of Children and Youth Services State Advisory Council (SAC), the Chairman of each of the six DCYS Regional Advisory Councils (RAC's), Deputy Commissioner of Program Services, DCYS Chief Psychiatrist, representatives of the Child Psychiatric Community, provider representatives and selected DCYS management staff to monitor plans and evaluate plan progress - (By November 1989).

Anticipated Outcomes

- . As the SAC and RACs committees are comprised of professionals in child mental health, consumers and providers, their chairmen will, through participation in this standing committee be able to monitor and evaluate the agencies progress in meeting the goals and objectives of the mental health plan, provide consumer and professional input, oversight and advocacy.

Objective 2: Staff Development and Training

Develop specialized training on issues of serious emotional disturbance among children and adolescents in order that staff and providers are more knowledgeable in the identification, and treatment of children and youth with mental health problems -(SFY 90 and ongoing).

Anticipated Outcomes

- . With CASSP Statewide Policy Institute membership and support, special training modules will be designed to train residential and community program staff in treatment of serious emotional disturbance, family intervention, advocacy, and behavior management.
- . DCYS and private agency supported training seminars on the treatment and control of the seriously emotionally disturbed child or adolescent. These training seminars will be held in conjunction with the CASSP project.

Objective 3: Management Information/Data Systems

Enhance the management information systems of the Department by developing an automated data base designed to provide data for tracking, placement utilization, research, and identification of areas of treatment needs not being provided for the seriously emotionally disturbed - (SFY 90 and ongoing).

Anticipated Outcomes

- . Development of Interagency agreements to develop a cross-agency data base for the seriously emotionally disturbed.
- . Budget options detailing resource needs will be submitted in August 1990 for SFY 92 implementation.

Objective 4: Financing Mechanisms

With CASSP Statewide Policy Institute explore new alternatives to fund mental health services for the seriously emotionally disturbed children and youth of Connecticut - (Beginning Fall 1990).

Anticipated Outcomes

- . Issue papers will be developed on ways to maximize the use of third party payments to support community based activities, Title XIX reimbursements and other monies which may be utilized in interagency strategies to provide integrated, community based mental health services for this population.
- . Budget options detailing resource needs will be submitted in August 1990 for SFY 92 implementation.

GOAL V

Develop targeted community advocacy efforts for the seriously emotionally disturbed child and support groups for their parents - (Beginning Fall 1990).

Objective 1: Public Education and Advocacy

Work with families, children's interest groups, provider associations and DCYS advisory groups to develop public education and advocacy strategies.

Anticipated Outcomes

- . Public hearings held in conjunction with the CASSP initiative.
- . Regional and state-wide advocacy strategies developed for the target population.

Objective 2: Parent Support

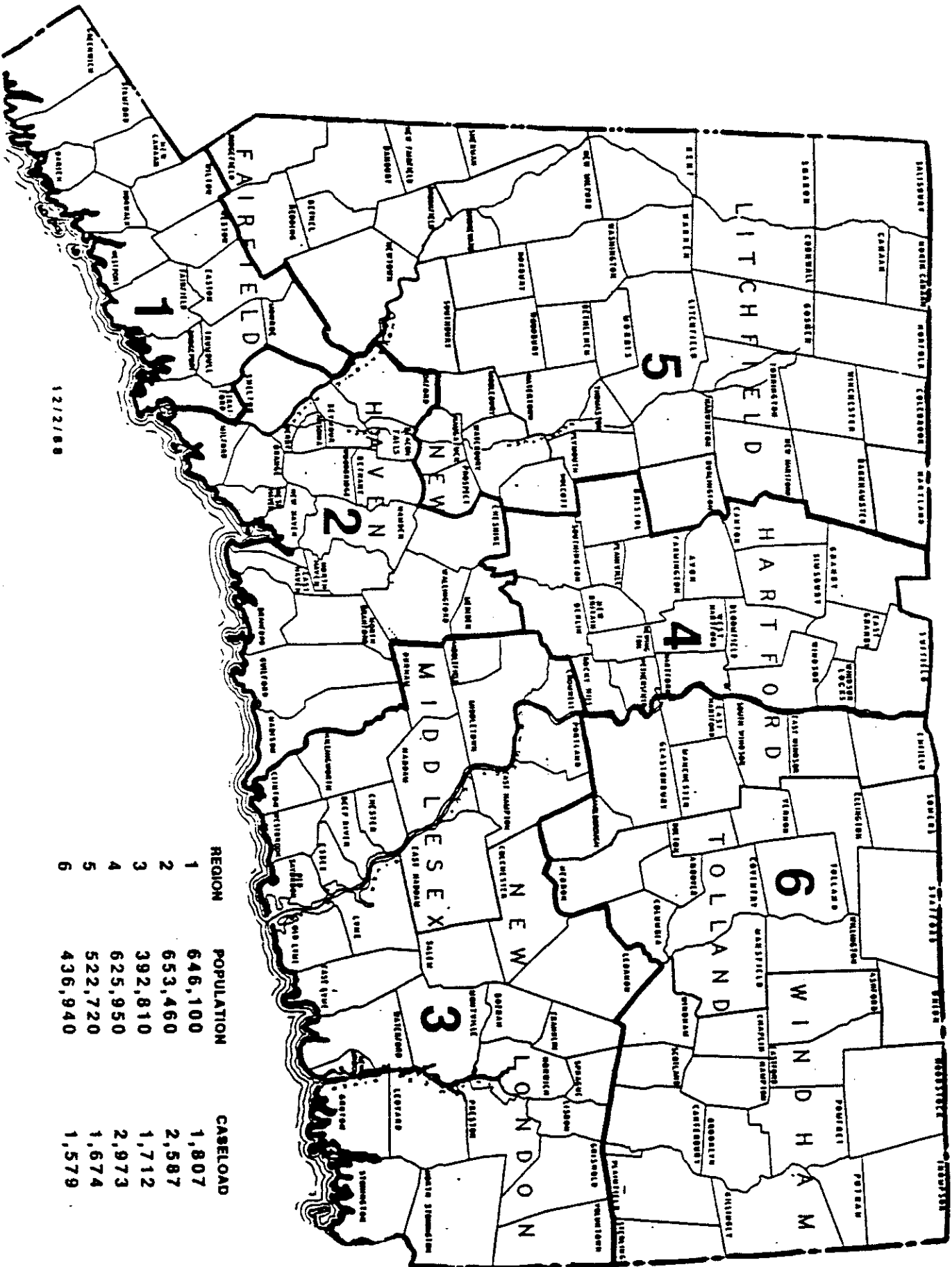
Develop parent support groups in each region and within each major population center - (Beginning Spring 1990).

Anticipated Outcomes

- . Formation of parent support groups will be aided by the providers of mental health services in each area of the state.

DEPARTMENT OF CHILDREN AND YOUTH SERVICES

Regional Boundaries



REGION	POPULATION	CASELOAD
1	646,100	1,807
2	653,460	2,587
3	392,810	1,712
4	625,950	2,973
5	522,720	1,674
6	436,940	1,579

12/2/88

The Connecticut Children's Mental Health Needs Assessment Program

In 1985, the Connecticut Department of Children and Youth Services (DCYS) initiated an ongoing children's mental health needs assessment program. A multistage data gathering effort was designed by a multidisciplinary advisory committee consisting of representatives of the Department of Children and Youth Services and faculty of Yale School of Medicine's Child Study Center.

The full program of needs assessment includes four phases of data collection. A description of the proposed program and current status of the various assessment phases are given below:

<u>Phase</u>	<u>Description</u>	<u>Status</u>
I	Community prevalence surveys	<p>Pilot survey of 822 parents, 501 teachers was completed in 1986-87 in a predominantly minority urban center (New Haven)</p> <p>1988-1989 regional survey of 1,600 parents and teachers is underway in a rural-small town administrative planning region (Region III).</p> <p>Bi-annual screening of remaining planning regions of the state is proposed: 1990-1991 Needs assessment of Regions IV and V; 1992-1993 - Needs assessment of Regions I and II.</p>
II	Surveys of facilities serving seriously emotionally disturbed children. The purpose of facility surveys will be to obtain information on treated prevalence, referral patterns and barriers to optimal placement.	Proposed
III	Evaluation of interventions through follow-up surveys.	<p>Evaluation component of proposed Annie E. Casey Foundation program in New Haven will utilize needs assessment data as baseline data. Evaluation of alternative case management models planned.</p> <p>Other regional and facility interventions will utilize needs assessment surveys as baseline data and include follow-up surveys as components of evaluation.</p>
IV	Integration of a core database from ongoing community and facility surveys into the DCYS Management Information System.	Proposed.

State-Academic Partnership:

The Connecticut Mental Health Needs Assessment Program has been implemented as a collaborative state-

academic effort. The program directorship is shared by a member of the Department of Children and Youth Services, Dr. Walter Pawelkiewicz, and by Dr. Gwendolyn Zahner, an epidemiologist on the faculty at Yale. The development of the program also benefited from the involvement of many other members of DCYS and the Yale Child Study Center, most notably Dr. John DeFrancesco of DCYS, and Ms. Jean Adnopoz of the Yale Child Study Center.

The needs assessment program has also provided a framework for several scientific sub-studies undertaken by Yale University investigators, with research projects funded by the National Institute of Mental Health, the MacArthur Foundation, and the Lowenstein Foundation. The pilot survey for the needs assessment program in New Haven served as a community field trial of the NIMH Diagnostic Interview Schedule for Children, providing preliminary population-based estimates of the prevalence of DSM-III-R diagnoses for the state planning effort. NIMH funding has been obtained by investigators at Yale (Dr. Mary Schwab-Stone and Dr. Gwendolyn Zahner) to undertake further developmental work on the DISC in the Region III survey.

Epidemiologic needs assessment surveys:

Use of a population-based or epidemiological model has provided otherwise unavailable planning information on the barriers to treatment experienced by "hard to reach" populations -- that is, families not already known to the service system who feel that their children need professional assistance. This model, which solicits opinions of parents and teachers through structured questionnaires, also gives consumers of services a formal role in the planning process. Also, the needs assessment model, covering a spectrum of needs and service use, was specifically designed to reflect agency's mission of comprehensive service provision for the broad welfare of the child and its focal role in interagency coordination for children's mental health services in Connecticut.

The objectives of the epidemiological needs assessment are four-fold:

- 1) To estimate prevalence of children's emotional and behavioral problems in representative samples of children in defined geographic areas, and also to identify broader health and educational needs;
- 2) To concurrently map service utilization patterns across a wide variety of mental health, health, educational, legal, religious and other service settings;
- 3) To specify service preferences and to identify barriers to treatment experienced by consumers (and would-be-consumers) of children's services, focusing primarily on opinions of careproviders of children (parents and teachers);
- 4) To provide detailed information on population characteristics, permitting identification of "high risk" populations and extrapolation to communities not surveyed directly.

Epidemiologic survey measures:

A major methodological objective of the pilot survey was to develop and test standardized questionnaires for ongoing needs assessment. These questionnaires include measures of mental health, health and academic needs, service utilization patterns, service preferences and barriers to treatment. A description of the measures designed for this program is as follows:

(a) Measures of population levels of children's mental health service needs:

The parent and teacher screening questionnaires measure mental health needs from several perspectives, encompassing different conceptualizations of "need" and increasingly stringent definitions of psychiatric impairment. The primary measures of service needs are:

(1) **Children "at risk":** Two screening measures are used to identify children "at risk" of mental disorders: (1) a total score in the clinical range (upper 10th percentile) of Achenbach and Edelbrock's Child Behavior Checklist; (2) a question asking whether the child needs help or a special program for a problem on the behavior checklist.

(2) **Children with functional limitations:** The proportion of children at risk who also exhibit functional disability is assessed by parent and teacher reports of limitations in school, play or other activities resulting from behavior checklist problems.

(3) **DSM-III-R diagnoses:** A field trial of the NIMH Diagnostic Interview Schedule for Children (DISC) was carried out by Dr. Zahner and colleagues at the Child Study Center as a second stage of data collection with a small grant from NIMH and contract support from the Division of Epidemiology and Psychopathology. The field trial has provided preliminary prevalence estimates for thirteen DSM-III-R diagnoses using (1) computer scoring algorithms and (2) clinician review diagnoses. Child psychiatrists also reviewed the second stage assessment battery to score impairment; persistence; and treatment needs associated with the DSM-III-R diagnoses.

(b) Health and educational needs:

A checklist of childhood illnesses was adapted from the national Health and Nutrition surveys; information on accidents, injuries, medications, and emergency room use is also measured. Academic performance is measured through school record information on school failure, grade repetition, achievement test scores, and areas of learning problems reported by teachers.

(c) Service utilization patterns:

Parents describe service contacts for current behavior checklist problems using a standardized checklist covering a broad range of mental health, health, educational, and other community settings. For current problems noted on the behavior checklist, parents report on (1) lifetime use (2) age at first visit; (3) number of visits in past year; and (4) primary reason for visit. Teachers provide detailed information on school service use for behavior checklist problems.

For purposes of planning and resource allocation, the utilization information provided by parents and teachers is reclassified into the four typologies:

- source of funding (DCYS/non-DCYS);
- location of service contact (mental health, health, educational, other community service);
- type of provider seen (mental health, health, educational, and other (including legal, religious personnel); and
- level of care (evaluation; out-patient; on-going program; out-of-home placement).

(d) Service preferences:

Parents and teachers complete a standardized checklist describing all types of care they feel the child currently needs. The preferred provider and setting for care of emotional and behavioral problems.

(e) Barriers to treatment:

The epidemiologic data provides unique information on the problems experienced by "hard to reach" populations who have been unable to enter the service system. Parents and teachers complete a checklist of barriers they are experiencing for receiving the care they feel the child needs for checklist problems. The parent checklist includes the following barriers:

- service availability;
- quality of services;
- cost;
- distance;
- knowledge about services;
- fear of labelling the child;
- spouse or community disapproval;
- child refusal to receive services.

A small number of motivational factors (eg. belief in mental health treatment; attitudes about local providers; likelihood to seek care; family and community response to seeking mental health services) were also incorporated into the parent measures.

The barriers checklist reported by teachers is divided between administrative barriers (e.g. delays in obtaining services, referral problems; availability of services; and family problems (disagreement about need for services; cost or scheduling difficulties for families).

(6) Demographic and risk factors:

Brief demographic and risk factor measures have been incorporated into the needs assessment questionnaires to permit identification of high risk groups and extrapolation to communities not sampled in the survey. These measures include the child's age and sex; family composition; birth order; religious denomination; race/ethnicity; parental marital status and custody arrangements; parental education, income, and work status; life events in past year; neighborhood quality; child's social involvement and isolation; and school and classroom characteristics.

For purposes of the planning effort, analyses of the New Haven needs assessment data have focused on the following high risk groups:

- a. minorities (Black and Hispanic families);
- b. children of whose mothers are:
 - teenagers (at time of child's birth);
 - high school drop-outs;
 - single parents;
 - working outside the home.

Recent analyses have also examined children at risk for homelessness following mortgage foreclosure or eviction.

Urban needs assessment: Examining the mental health service needs of the poor and minority populations

The pilot survey for the Connecticut Mental Health Needs Assessment Program took place in New Haven, CT, one of the three major metropolitan centers of the state. This city represents an upper limit in the state for: (1) urban poverty, and (2) service availability. The population of the city is predominantly

minority (1980 Census estimates for families of elementary school age children: 50% Black and 14% Hispanic), and the pilot survey accurately represents these minority populations within 2%.

A community survey was undertaken of a stratified random sample children who were residents of the city of New Haven and between the ages of 6 and 11 on a census date (1/1/86). With residency information provided by the Department of Education, the sample was drawn from the enrollment lists of all public, private, and parochial schools in Connecticut. Fifty four out of the fifty-six sampled schools agreed to participate in the project.

Informants selected for the needs assessment were individuals who would first recognize a problem and initiate help-seeking: parents (n=822) and teachers (n=501). Six phases of notification and follow-up were used to obtain parent responses (a flyer, two school distributions, a post-card prompt, telephone interviews, and home visits). The response rate was 70% for parents who could be located for intensive follow-up, and the refusal rate was 10%. Twenty one percent of the addresses provided by the schools were invalid and could not be obtained, resulting in a completion rate of 56% of the original sampling frame. Seventy eight percent of parents gave permission for school information to be completed. After three phases of notification and follow-up, seventy eight percent of teachers contacted completed needs assessment questionnaires.

Key needs assessment findings from the urban survey:

a) Prevalence.

Annual Prevalence Rates of Children "at Risk" of Emotional and Behavioral Disturbance.

Each of the screening measures for children "at risk" (a report that the child needs help or a score in the clinical range of the Child Behavior Checklist) identified between sixteen to twenty percent of children to be at risk of emotional and behavioral problems. This rate is similar to estimates reported in other surveys of child psychiatric disorders in urban areas.

However, different children were identified by our two informants (parents and teachers) and by the two screening measures (need for help and the Child Behavior Checklist). Close to forty percent (38.6) of the population was screened as being at risk on one of these indicators by at least one informant; this group of children constitutes the program's broadest screening measure of children "at risk" for psychiatric disturbance. Four percent of the population were screened positively on both measures by both informants.

Annual Prevalence Rates of Impairing Emotional or Behavioral Problems.

Parents reported that 3.6% of children were impaired at school, play, or other activities because of behavior checklist problems. Teachers reported that 10.0% of children were so limited. The higher rates of limitation reported by teachers is attributed to their ability to observe academic and social problems in the classroom. Less than one percent (.8%) of the population was identified with a functional limitation by both parents and teachers, and 11.7% of the 6 to 11 year olds in this surveys were reported to be limited by report of either parent or teacher.

Current Annual Prevalence Rates of DSM-III-R Diagnoses

A probability sample of children screened with parent and teacher child behavior checklists was enrolled in a field trial of the NIMH Diagnostic Interview Schedule for Children (DISC). The data from the second stage interviews were weighted to reflect the probability of selection from first stage survey. Detailed information on rates of individual diagnoses yielded separately by parent and child interviews are provided

in Tables 2 and 3. These tables provide DSM-III-R diagnoses based on computer scoring algorithms (column 1), and diagnostic ratings made by child psychiatrists after reviewing the assessment battery. The child psychiatrist ratings included information on impairment and need for treatment as well as DSM-III-R axis I diagnoses. Also, because many of the DSM-III-R criteria for childhood disorders are controversial, the psychiatrists were asked to rate the probability the child was a "true case" of the disorder under consideration. For parent interview data, rates of definite Axis I diagnoses based on clinician's ratings ranged from 14% (Separation Anxiety) to 0% (Panic and Obsessive Compulsive Disorder), and 35% of the sample were judged to meet criteria at least one definite Axis I disorder. Based on a review of child interview data, 25% of the sample were identified with a definite Axis I disorder, and 3.2% required out of home care.

Table 3 displays the overlap between diagnostic ratings from parent and child interviews. In addition, psychiatrist ratings of DSM-III-R Axis I conditions derived from a review of all first and second stage information provided by parents, children and teachers. Because of funding limitations, this information was only provided for children ages 9 to 11. These data suggest that within this age group, Attention-Deficit Hyperactivity is the most prevalent condition (8.4%) followed by oppositional-defiant disorder (6.2%), and overanxious disorder (3.1%). Twelve percent of the population was judged to fulfill criteria for a definite DSM-III-R Axis I condition, which is in line with national estimates; however, only 1.4% of the sample was assessed to be in need of intensive treatment such as out-of-home placement.

b) Service utilization patterns

Rates of contact with service providers in the urban pilot community are summarized in Table 4. The left hand column provides the proportion of the total population that has ever had a service contact for a current checklist problem; the right hand column reports these rates for children screened "at risk" of emotional and behavioral problems. Schools and educational personnel provided most of the care for emotional and behavioral problems in this inner city. Health care settings were the second most frequently used location for mental health contacts. The comparatively low use of DCYS services clearly points to the need for inter-agency coordinated case management, which has been one of the major planning initiatives resulting from the needs assessment.

c) Estimates of unmet need and barriers to treatment.

Half of the children who were screened to be at risk of emotional or behavioral problems had not been in contact with the service system. Lack of knowledge about how to obtain services was the most frequently cited barrier by parents; approximately one in five parents of children "at risk" reported that they didn't know how to get services. In response to this barrier, a recommendation has been made to increase availability of confidential hotline services. Teachers were most likely to report referral and administrative problems as barriers to treatment. This finding supports the introduction of a coordinated case management program in New Haven, which has submitted in a proposal to the Annie E. Casey Foundation.

Among the high risk groups studied for the planning effort, single parent mothers stood out as the group least likely to use services and most likely to report that they didn't know how to obtain services. Also, Hispanic mothers who reported that their children needed help were three times less likely to be in contact with the service system than other parents. These two groups have been prioritized in the planning of outreach services.

Analyses have also been undertaken to identify the needs of the children at risk for homelessness in the New Haven sample. By use of weighted frequencies in this stratified random sample, we have estimated that approximately 515 children in the survey population of 9,448 elementary school aged children have

lost homes in the year of the survey because of eviction. These children do not differ from the general population on most of the social characteristics we have examined in our planning effort (age, sex, race, ethnicity, households where mothers have no high school education, were teenagers when the child was born, or are employed outside the home). However, a significantly higher proportion of children from single parent homes have lost residences: the eviction rate in this group was eight percent versus three percent in two parent household. Children at risk for homelessness were also significantly more likely to score positively on our four risk indicators for psychiatric disturbance, with the strongest association occurring with teacher's perception of the child's need for a service program. Whereas sixteen percent of the children who did not experience residential loss were reported by teachers to need services, teachers indicated that forty two percent of children who had lost homes through mortgage or foreclosure were in need of services (Chi-square 13.08, df 1, p=.000). This association maintained statistical significance after controlling for all other social characteristics under study in the planning effort. Further detailed analyses of the characteristics of children at risk for homelessness and their mental health service needs are planned

Preliminary comparisons of children "at risk" for mental health services in a rural-small town region with rates reported for the urban center.

A three county survey of Health Service Area III (Eastern Connecticut) took place in 1988-1989. This planning region was divided into seven areas representing a spectrum of population density and social character: three "middle cities" in this region (100% urban, < 50,000 pop., comprising 19% of the region's population); three "suburban areas" surrounding these cities (1-99% Urban; 29% of the population); and thirty seven "rural townships" (0% urban; 53% of the population). Middle cities were over-sampled to achieve a minority quota in the sample. Thirty-two primary sampling units ("PSU's") of schools (or groups of schools) were drawn: eight PSU's from the middle cities strata; eight from three suburban strata; and sixteen from the rural townships. These PSU's included 50 public schools from 24 school systems and 34 non-public schools. Eighty three schools participated in the survey; one small Bible Academy declined to participate. A random sample of 2,377 students was drawn from participating schools.

Parent surveys were distributed with six phases of notification and follow-up (flyer, 2 school distributions; post-card prompt, and telephone survey). As of July 1, 1989, seventy one percent of the sample responded (n=1,685). Seventy one percent of parents gave permission to contact teachers, and 870 teachers (73% of those contacted) responded by the close of the academic year. These response rates are preliminary as follow-up is ongoing.

The preliminary rates of children "at risk" based on the first stage screening indicators are listed below. For purposes of comparison, rates for the urban site are also listed.

	Rural-small town region	Urban site (New Haven)
Child Behavior Checklist:		
-Parent	14%	20%
-Teacher	13%	18%
Report that child "needs help" for checklist problem		
-Parent	14%	16%
-Teacher	15%	17%
Screen positive rate, by any of above measures: children "at risk"	32%	39%

Projections based on previous surveys suggested the rural site would show a two fold decrease in rates over the urban site. However, the rates in the rural-small town region appear to be higher than projected. A detailed examination of levels of need in middle city, suburban, and rural areas, and an analysis of service utilization patterns in this area will be central activities of the planning effort.

Table 1
 Diagnostic Evaluation of Children in New Haven Community Sample: Ratings Based on Interview with Parent
 (Weighted N=767; Unweighted N=143)

Psychiatric Disorder	Computer Diagnosis		True Case		Impairment		Need for Treatment							
	Psychiatric Rating: DSM-III-R Axis I	Diagnosis	Post-Prob-able	Prob-able	Mild	Mod-erate	Sev-ere	Eval-ation	Out-pat-ient	Out-home				
Attention-Deficit Hyperactivity	X	13.9 (106)	17.6 (35)	19.6 (51)	16.7 (32)	25.1 (95)	15.1 (16)	9.6 (74)	13.1 (100)	4.4 (34)	0.5 (7)	25.6 (96)	10.2 (78)	5.2 (40)
Oppositional Defiant Disorder	X	9.6 (74)	18.8 (44)	9.4 (72)	6.8 (52)	18.3 (41)	10.0 (77)	3.2 (26)	13.1 (100)	4.4 (34)	0.5 (7)	24.5 (98)	4.2 (33)	1.8 (14)
Conduct Disorder	X	4.4 (34)	4.4 (34)	3.5 (27)	2.1 (16)	4.0 (31)	3.4 (26)	2.1 (16)	1.7 (13)	4.2 (32)	0.0 (0)	4.3 (33)	3.7 (28)	1.4 (11)
Separation Anxiety	X	3.4 (26)	5.7 (44)	9.7 (74)	6.1 (47)	5.1 (39)	9.3 (71)	5.2 (40)	8.1 (57)	5.2 (62)	0.0 (0)	11.9 (90)	6.4 (49)	0.8 (6)
Phobias (Simple, Social, Agoraphobia)	X	13.0 (100)	11.1 (85)	4.9 (36)	2.1 (16)	9.4 (72)	2.3 (18)	1.3 (10)	5.8 (44)	0.5 (4)	0.7 (5)	9.5 (73)	0.9 (7)	0.0 (0)
Overanxious Disorder	X	7.3 (56)	11.1 (85)	12.1 (92)	9.6 (73)	9.1 (70)	17.9 (137)	1.6 (13)	15.4 (110)	5.0 (38)	0.0 (0)	14.1 (107)	10.5 (81)	1.1 (9)
Generalized Anxiety	X	0.0 (0)	0.5 (4)	0.0 (0)	0.7 (6)	0.5 (4)	0.0 (0)	0.7 (6)	0.0 (0)	0.7 (6)	0.0 (0)	0.9 (7)	0.4 (3)	0.0 (0)
Panic Disorder	X	0.3 (2)	0.3 (2)	0.0 (0)	1.4 (10)	0.9 (7)	0.7 (5)	0.0 (0)	0.2 (1)	0.9 (7)	0.0 (0)	0.4 (3)	0.9 (7)	0.0 (0)
Obsessive Compulsive Disorder	X	0.4 (3)	2.8 (22)	0.7 (5)	0.0 (0)	0.3 (2)	0.7 (5)	0.0 (0)	0.0 (0)	0.7 (5)	0.0 (0)	0.3 (2)	0.7 (5)	0.0 (0)
Major Depressive Disorder	X	1.9 (15)	1.5 (12)	3.1 (24)	0.7 (6)	2.5 (19)	2.5 (19)	0.0 (0)	1.7 (13)	2.5 (19)	0.0 (0)	2.5 (20)	1.9 (14)	0.3 (2)
Dysrhythmic Disorder	X	0.4 (3)	2.6 (20)	0.6 (5)	0.8 (6)	2.5 (19)	1.3 (10)	0.3 (2)	1.9 (15)	1.3 (10)	0.0 (0)	1.6 (12)	1.9 (15)	0.3 (2)
All Disorders (n=13)	X	32.8 (252)	19.2 (147)	32.7 (250)	25.7 (197)	33.9 (260)	22.5 (172)	9.9 (76)	24.9 (191)	4.0 (31)	0.3 (2)	42.7 (327)	17.2 (132)	3.3 (25)

* Children's Global Assessment Scale ratings (mild 70-51; moderate 50-41; severe 40-0).
 Zahner et al. Draft 6/23/89

Table 3
Frequencies of 13 DSM-III-R Axis I Diagnoses in a Community Sample of 9-11 Year Old Children:
Rates based on Psychiatrist's Review of Parent and Child Diagnostic Interviews
(Weighted n=267)

<u>DSM-III-R Disorder</u>	<u>Individual Informant Rates: Overlap between Parent and Child Reports</u>			<u>Psychiatrists' "Best Estimate" Diagnoses - All Available Data</u>
	<u>Parent only</u> % (n)	<u>Child only</u> % (n)	<u>Parent & Child</u> % (n)	<u>% (n)</u>
Attention-Deficit Hyperactivity				
-Definite	7.9 (24)	2.4 (7)	3.8 (12)	8.4 (22)
-Probable & Definite	19.0 (59)	13.9 (43)	9.5 (29)	20.8 (56)
Oppositional Defiant Disorder				
-Definite	6.4 (19)	0.7 (2)	1.4 (4)	6.2 (17)
-Probable & Definite	13.0 (39)	8.8 (26)	5.5 (16)	22.5 (60)
Conduct Disorder				
-Definite	2.7 (8)	3.2 (10)	0.7 (2)	1.6 (4)
-Probable & Definite	3.8 (12)	0.7 (2)	4.6 (14)	7.4 (20)

Separation Anxiety Disorder				
-Definite	3.5 (10)	9.5 (28)	0.7 (2)	2.4 (6)
-Probable & Definite	5.4 (16)	16.1 (48)	5.3 (16)	15.4 (41)
Phobic Disorder				
-Definite	2.7 (8)	3.1 (10)	0.0 (0)	1.5 (4)
-Probable & Definite	2.7 (8)	7.6 (24)	1.3 (4)	4.3 (12)
Overanxious Disorder				
-Definite	7.6 (24)	9.7 (30)	1.6 (5)	3.1 (8)
-Probable & Definite	12.8 (39)	31.8 (98)	8.1 (25)	20.0 (53)
Generalized Anxiety				
-Definite	0.0 (0)	0.7 (2)	0.0 (0)	0.0 (0)
-Probable & Definite	0.0 (0)	1.3 (4)	0.0 (0)	0.8 (2)
Panic Disorder				
-Definite	1.7 (5)	0.0 (0)	0.0 (0)	0.0 (0)
-Probable & Definite	1.7 (5)	0.0 (0)	0.0 (0)	0.0 (0)
Obsessive Compulsive Disorder				
-Definite	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)
-Probable & Definite	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)

Major Depressive Disorder				
-Definite	0.0 (0)	0.0 (0)	0.0 (0)	0.8 (2)
-Probable & Definite	4.6 (14)	3.6 (11)	0.0 (0)	3.1 (8)
Dysthymic Disorder				
-Definite	1.1 (3)	0.7 (2)	0.0 (0)	0.0 (0)
-Probable & Definite	1.8 (5)	2.0 (6)	0.0 (0)	1.5 (4)

All Disorders (N=13)				
-Definite	11.8 (36)	18.3 (57)	10.0 (31)	12.3 (33)
-Probable & Definite	18.4 (57)	27.7 (86)	33.2 (103)	40.4 (108)

Table 2
 Diagnostic Evaluation of Children in New Haven Community Sample: Ratings Based on Interview with Child
 (Weighted N=755; Unweighted N=138)
 Psychiatrist's Rating:

Psychiatric Disorder	Computer Diagnosis	Psychiatrist's Rating			True Case			Impairment			Need for Treatment		
		Possible	Prob- able	Defi- nite	Possible	Prob- able	Defi- nite	Mild	Mod- erate	Sev- ere	Eval- uation	Out- pat- ient home	
Attention-Deficit Hyperactivity	X (n) 15.4 (113)	22.7 (171)	15.0 (115)	12.1 (91)	25.6 (185)	15.0 (113)	1.6 (12)	19.3 (146)	3.8 (29)	0.0 (0)	26.3 (190)	10.7 (81)	0.8 (6)
Oppositional Defiant Disorder	X (n) 6.1 (46)	14.2 (108)	16.4 (122)	0.8 (6)	23.4 (177)	3.9 (30)	2.8 (21)	8.4 (64)	4.3 (33)	0.0 (0)	24.6 (186)	2.8 (21)	0.3 (2)
Conduct Disorder	X (n) 2.5 (19)	5.2 (40)	3.1 (23)	1.9 (14)	4.3 (33)	5.1 (38)	0.3 (2)	2.7 (20)	4.8 (36)	0.0 (0)	6.6 (50)	2.2 (17)	0.3 (2)

Separation Anxiety	X (n) 45.7 (343)	24.1 (179)	26.3 (196)	14.3 (106)	30.6 (231)	15.9 (120)	10.6 (80)	18.3 (138)	10.7 (81)	0.4 (3)	33.0 (249)	13.1 (99)	2.9 (22)
Phobias (Simple, Social, Agoraphobia)	X (n) 12.0 (90)	6.9 (52)	7.8 (59)	7.3 (55)	4.2 (32)	9.1 (69)	3.7 (28)	7.4 (56)	2.9 (22)	0.0 (0)	9.5 (72)	2.6 (20)	0.0 (0)
Overanxious Disorder	X (n) 13.3 (100)	16.0 (120)	31.8 (239)	7.9 (59)	25.9 (196)	27.7 (209)	0.3 (2)	26.8 (202)	3.0 (23)	0.0 (0)	36.6 (276)	8.0 (61)	2.0 (15)
Generalized Anxiety	X (n) 1.4 (11)	4.6 (35)	0.9 (7)	0.5 (4)	4.9 (37)	0.5 (4)	0.3 (2)	0.5 (4)	0.6 (4)	0.0 (0)	5.4 (41)	0.3 (2)	0.0 (0)
Panic Disorder	X (n) 0.4 (3)	1.7 (13)	0.0 (0)	0.0 (0)	1.1 (9)	0.6 (4)	0.0 (0)	0.9 (7)	0.0 (0)	0.0 (0)	0.8 (6)	0.6 (5)	0.0 (0)
Obsessive Compulsive Disorder	X (n) 2.6 (19)	2.7 (20)	0.0 (0)	0.0 (0)	0.8 (6)	0.0 (0)	0.0 (0)	0.9 (7)	0.0 (0)	0.0 (0)	0.9 (7)	0.0 (0)	0.0 (0)

Major Depressive Disorder	X (n) 1.8 (13)	7.6 (57)	2.1 (16)	0.3 (2)	7.7 (58)	1.4 (11)	0.3 (2)	3.3 (25)	0.6 (5)	0.3 (2)	6.1 (46)	1.0 (8)	0.9 (7)
Dysthymic Disorder	X (n) 0.3 (2)	4.2 (31)	0.6 (4)	0.6 (4)	3.4 (26)	0.8 (6)	0.6 (4)	0.8 (6)	1.2 (9)	0.3 (2)	3.4 (25)	0.8 (6)	0.6 (4)

ALL DISORDERS (n=13)	X (n) 59.0 (445)	18.8 (142)	32.1 (242)	35.2 (266)	38.9 (295)	34.9 (262)	3.9 (29)	31.4 (236)	2.8 (21)	0.4* (3)	48.6 (367)	20.3 (153)	2.5 (19)

* Children's Global Assessment Scale ratings (mild 70-51; moderate 50-41; severe 40-0).
 Zahner et al. Draft 6/23/89

TABLE 4
CONNECTICUT CHILDREN'S MENTAL HEALTH NEEDS ASSESSMENT PROGRAM

**POPULATION SERVICE USAGE FOR CURRENT PROBLEMS NOTED ON THE PARENT AND TEACHER
CHILD BEHAVIOR CHECKLISTS FOR CHILDREN AGES 6-11 IN NEW HAVEN, CT.**

N=501

	% TOTAL SAMPLE	% CHILDREN SCREENED 'AT RISK'
TPOLOGY A: <u>DCYS SERVICE USAGE</u>¹		
DCYS SERVICE USED	5.8% (25/480)	10.9% (20/183)
NON-DCYS SERVICES USED	30.2% (147/486)	54.5% (102/187)
TPOLOGY B: <u>LOCATION OF SERVICES</u>¹		
MENTAL HEALTH SETTING	5.2% (25/480)	10.9% (20/183)
PHYSICAL HEALTH/PRIMARY CARE SETTING	9.8% (47/480)	16.9% (31/183)
SCHOOL SETTING	23.3% (113/480)	43.9% (82/187)
OTHER SETTING	4.0% (19/480)	7.7% (14/183)
TPOLOGY C: <u>PROVIDER TYPE</u>¹		
MENTAL HEALTH PROFESSIONAL	15.6% (75/482)	32.4% (60/185)
HEALTH PROFESSIONAL	8.3% (40/480)	14.8% (27/183)
SCHOOL PERSONNEL (ACADEMIC)	18.4% (89/484)	36.0% (67/186)
OTHER PROVIDER TYPE	2.9% (14/480)	6.6% (12/183)
TPOLOGY D: <u>LEVEL OF CARE</u>		
NONE	69.7% (338/485)	46.8% (87/186)
EVALUATION/CONSULTATION	10.9% (53/485)	15.6% (29/186)
OUTPATIENT/AMBULATORY CARE	4.1% (20/485)	9.1% (17/186)
DAY TREATMENT PROGRAMS (INCL. SPECIAL EDUCATION)	13.8% (67/485)	25.3% (47/186)
OUT-OF-HOME CARE (FOSTER PLACE- MENT, RESIDENTIAL CARE, INPATIENT HOSPITALIZATION)	1.4% (4/485)	3.2% (6/186)

¹ CATEGORIES OF SERVICE USAGE NOT MUTUALLY EXCLUSIVE

LAWS AND SAFEGUARDS RELATED TO PATIENTS' RIGHTS

The following laws and other safeguards are in place to assure children's and youth's rights are protected:

- . Connecticut General Statutes Section 17-205 - Commitment of Mentally Ill Children.
- . Connecticut General Statutes Section 17-206 - Patients' Rights.
- . Parental involvement in treatment planning.
- . The Department of Children and Youth Services' Division of Quality Assurance holds six month administrative case reviews for those children in out-of-home placement who are on the Regional caseload.
- . State and Regional Advisory Council involvement in planning for services.
- . The Attorney General's Office.
- . Connecticut Office of Protection and Advocacy.
- . Case Worker Advocacy.

Once the new case management system becomes operational, case managers will also assure that patients' rights are protected utilizing the mechanisms above.

**ORGANIZATIONS PARTICIPATING IN THE PLANNING GROUP
AND PLAN REVIEW PROCESS**

Represented in the Children's Mental Health Focus group:

- . Department of Children and Youth Services' State Advisory Council
- . Department of Children and Youth Services' Regional Advisory Councils I, IV and VI
- . Connecticut Association of Mental Health Clinics for Children
- . Connecticut Council of Child Psychiatrists
- . Connecticut Commission on Children
- . Yale University Faculty
- . Department of Children and Youth Services

In addition to those represented on the Focus Group, the following groups or organizations submitted commentary on the Draft Plan:

- . Mental Health Association of Connecticut
- . Connecticut Probate Court
- . National Association of Social Workers
- . Connecticut Association of Child Caring Agencies
- . Academy of Pediatricians
- . Regional Advisory Councils II, III and V