Summary of Comments Received on the Connecticut Children's Behavioral Health Plan

109 people submitted written comments through the www.Plan4Children.org web site during the comment period after the Plan's release on Friday, September 5, 2014. The outpouring of comments within a tight commenting window was a testament to the high level of interest in this plan from all sectors. We heard from a number of professional associations of behavioral health providers, from hospitals, and from state officials as well as from individual practitioners and parents and relatives of children using behavioral health services.

Detailed comments filled over 73 pages. Following is a summary of the comments that were most commonly cited, organized by thematic areas. The planning team is currently taking all this feedback, including many detailed edits and suggestions, into account in preparing the next draft of the plan that will be submitted to DCF.

Overall

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Overall themes reflected across multiple comments include:

- More data on the systems and outcomes is needed to drive the planning.
- More focus on immediate action and fewer proposed studies, task forces, and further planning.
    - A number of commenters expressed frustration at the number and length of planning processes (past and proposed) and urged action on the known issues.
- More specifics on timelines on different elements of the proposed work.
- More emphasis on prevention of behavioral issues through evidence based preventive practices involving children of all ages.
- More clarity on how this process relates to the SIM process and other task forces and reform efforts.
- More focus on the involvement of the juvenile justice system.
- Need to look beyond medical models – focus on family environments and community solutions.

System and Organization

Organizational issues (Goal A.2)

- Several commenters were concerned that regional Care Management Entities would be hard to manage and create too much bureaucracy.
- A number of concerns about DCF role and also that DCF has child protection focus in looking at these issues.

Care Coordination (Goal A.2)

- Many agreed with need for more and better care coordination, but there was disagreement with the idea of regional care management entities vs. a statewide approach and on the best place to locate the care coordinators (centrally, regionally, or in community agencies).
- Concern expressed that commercial insurance plans, and thus many children, would not be part of the care management plans at first. Timeline for this requested.

System Capacity & Quality Assurance (Goal C.1)

- Many commenters urged expansion of capacity across many parts of the system and cited delays and waiting lists for services like psychiatric evaluations, counseling, and other core services.

- Several urged full implementation of EPSDT requirements in Medicaid.
- Comments that expanding services is not sufficient—need to assess need for changes in services as we seek expansion – need way to look at quality and effectiveness of current investments and be open to innovations.

Reimbursement Rates

- Many comments that reimbursement rates (both public and private) are not sufficient to recruit and maintain the most qualified workforce.
- Rates for inpatient care have been frozen for six years and the state has eliminated pay for performance for this service.

Birth To Three System

- Comments that Birth To Three system, as part of the array of services, needs to address social-emotional needs of young children.

Access (Goals A.1, C.1)

- Several commenters reinforced concerns expressed during the planning period about the difficulty parents sometimes have in securing the right services for their children and the frustrations in dealing restrictions on length of stay.
    - Many comments, especially from parents and relatives of children in the system, were about specific ways commercial insurers (Goal C.1, Strategy C.1.3) make access to necessary care difficult, echoing many comments heard in the planning process.
- Issue of parents seeking DCF-funded services – need to create a "compassionate, effective legal remedy of shared custody of a child for the purpose of accessing intensive mental health treatment and care."
- Several urged review of DCF Voluntary Services program and its design.
- Geographic disparities in service capacity and coverage noted by several.

Specific areas

Screening and Assessment (Goal B.1)

- Advice not to specify specific tools.
- Concern that screening and assessment tools have inherent biases that unintentionally perpetuate racial or ethnic stereotypes that may lead to inappropriate treatment or diagnosis.
- Several concerns about ramping up screening before system capacity issues are dealt with.
- Several noted need to assess for an array of risk factors for children that contribute toward stress
- Several commenters urged use of a suicide screening tool in schools.

Prevention (was under both Goal B.2 and C.2 – now part of new dedicated goal B.3)

- Many commented that the plan needs to recognize the potential to avoid many behavioral health issues through increased investment in systematic and evidence-based prevention in schools and community settings.
- Several referred to a "public-health approach to prevention" as cost effective.
- Strengthening families and parenting support are critical to prevention and early intervention.
- The importance and role of quality after school activities and community programming as a preventive strategy was stressed by many people.

Early Childhood Services (under Goal C.2)

- Many commenters from the early childhood community wanted to ensure a strong or stronger focus on early childhood interventions, particularly those aimed at strengthening parent-child attachment, addressing maternal issues like depression, and addressing the impact of Adverse Childhood Experiences (ACEs) and specifically trauma.
- A number of people recommended extending public insurance coverage to a number of models (e.g. Child FIRST, Triple P).
- Array of services by intensity needs to be developed for youngest children in manner designed for young children.
- Recommended to link and align the plan to the Office of Early Childhood Early Learning and Development Standards.

Schools (Goal C.3)

- Many comments on role of schools in providing services and as a location for services. Many cited importance and advantage of school-based services, most notably as the place where children are and the possibility to reduce the impact of stigma (although some saw increased risk of stigma as students are "pulled out"). Many cited the inherent limitations of this approach, most notably the difficulty of coordination with community-based providers, the difficulty of involving parents and other caregivers during the school day, and the limitations of school hours and summer and vacation breaks in terms of continuity of care. Several commenters preferred a co-location model over increase in school district staff for continuity of care over summer.
- Need cited for a detailed framework for what constitutes a 'gold standard' for behavioral health services in schools.
- Concern that the State not mandate collaboration – needs to be built on relationships.
- Several cited need for wraparound services in school settings.

Service Array

Community Based Solutions

- Several commenters cited promising community-based approaches to connecting families and children to services.
- Several stressed the need to fund non-traditional interventions.

Integration with Pediatric Primary Care

- Many endorsed this direction, but some concerns were expressed as to pediatricians having the time to take on a bigger role and space issues in pediatric offices.
- Several stressed improving referral relationships as critical to the success of this connection.

Outpatient Services

- Some commenters urged greater flexibility to be able to provide innovative treatment options in addition to evidence-based practices.
- Several felt routine outpatient services such as those provided by Child Guidance Clinics are under-represented in the Plan as they are core system building blocks.

Crisis Services

- Several recommendations to develop alternative crisis management capacity to bypass ED and inpatient needs.

- Several questioned the presentation of the crisis situation and the way bed closure decisions have been made by DCF.

Substance Abuse Services

- Several reviewers urged more focus on adolescent substances abuse services.

Inpatient / Congregate Care

- Comments varied on this—acknowledged as major issue; several wanted to see more beds.
- Several expressed need to validate the continuing role of congregate care within the system and that it should not be left out.

Transition to adulthood

- Several commenters cited a desire to see a stronger approach on ensuring a smooth transition from children's services to adult services in both mental health and developmental disability systems.

Parent Training & Engagement

- Several objected to naming one parent training model while not mentioning others.
- Concern expressed about paying parents to participate in governance.
- Need to recognize and address issues with parents with mental health needs as well as other needs that impact children's development.

Advocacy

- Many wanted to see expansion of parent advocacy services/ resources to help them navigate the system.

Workforce

- Many commenters encouraged more investment in the workforce for quality improvement through training, timely response and customer service skills, expansion in numbers to provide needed capacity, and more diversity. Comments went to both initial training and to continuing education.
- Several parents cited a need for a more highly trained and skilled workforce across the field.

Miscellaneous

- Commenters pointed out that the plan is too medically focused and some issues, like autism, are a neurological disorder that requires a special education response.
- Some commenters want more specific actions to address stigma.