



Building a Community-Based Children's Mental Health System

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Many Connecticut children and youth suffer from untreated mental health problems that pose risks to their healthy development and school success.

In any given year, about one out of every five Connecticut children (87,500 to 125,000) struggles with a mental health or substance abuse problem. More than half receive no treatment.

Historically, Connecticut's behavioral health spending has been heavily weighted toward institutional care, with little growth in spending for community-based services. A 2000 study of behavioral health spending for children enrolled in HUSKY found that 70% of all behavioral health dollars (about \$145 million) was being spent for psychiatric hospitalizations and residential treatment, serving only 18% of all HUSKY children. By comparison, just 30% of all behavioral health dollars (\$61 million) was used to provide home and community-based services to the other 82% of the children who sought care.

Over the last decade, multiple commissions and task forces have examined how to improve children's mental health services. Their recommendations have been quite consistent. The Governor's Blue Ribbon Commission on Mental Health (2000) and multiple commissions and task forces before and since, identified key goals for the reform of Connecticut's children's mental health "system." They include:

- Eliminating gridlock in the care delivery system and over-reliance on residential treatment and hospital care by markedly expanding the continuum of community-based services in each region of the state;
- Continuing to develop the local systems of care;

- Continuing to bring home children who are receiving residential care out of state;
- Integrating primary prevention and early intervention into the behavioral health system (especially through schools);
- Strengthening and expanding mental health awareness, consultation, and early intervention services in child care settings;

Failure to build a strong, community-based mental health system results in unnecessary and expensive psychiatric hospitalizations.

- Ensuring easy passage for youth with severe illness who are transitioning from DCF to the Department of Mental Health and Addiction Services (DMHAS);
- Adjusting reimbursement rates to providers to ensure the system has adequate capacity;
- Blending funding streams to gain more flexibility in financing services (across DCF, DMHAS and DSS), e.g., through a carve out of behavioral health services from managed care (see below);
- Drawing down more federal dollars to which Connecticut is entitled, and re-investing these funds (and funds "saved" by moving children out of expensive in-patient and residential facilities) in continuing to build our community-based system.

Failure to build a strong, community-based system has resulted in unnecessary (and unnecessarily long) psychiatric hospitalizations. A 2003 study found the leading reason for hospitalization of children enrolled in Medicaid managed care was treatment of mental disorders (48% of all admissions). A robust array of outpatient and emergency mobile psychiatric services reduces the need for some of these admissions.

Connecticut has been making significant new investments in community-based mental health services, but gaps remain. DCF has expanded its local systems of care and funds an increasingly robust array of community-based children's mental health services. These include care coordination, emergency mobile psychiatric services, family advocacy, intensive in-home services for children at risk of out-of-home placement, multi-systemic therapy, extended day treatment, crisis stabilization beds, mental health consultation services for programs serving young children (to identify and help children early), therapeutic group homes and out-patient services at child guidance clinics.

While critically important, these investments have not wholly eliminated gaps in the continuum of care and ended system gridlock. Better integration with DCF's foster care and juvenile justice reforms also is essential to avoid parallel service systems.

The new CT Behavioral Health Partnership (CT BHP) is an important next step in helping to eliminate gaps in care. However, it must be closely monitored to ensure it meets its goals. On January 1, 2006, the CT Behavioral Health Partnership (CT BHP) – a joint DCF-DSS initiative – began operation. Value Options, under a non-risk-based contract with the state, administers the program. Children enrolled in HUSKY (and their parents/caretaker relatives), as well as children under the care or custody of DCF, now receive mental health and substance abuse services from the CT BHP. DSS, rather than the HUSKY managed care organizations, sets provider rates and pays claims for the services provided by participating behavioral health providers. The HUSKY Managed Care Organizations (MCOs) will continue to pay primary care practitioners for behavioral health services, as well as pay for mental health-related prescription medications and transportation. To pay for the CT BHP, a percentage of the funds that had been paid to HUSKY MCOs are being “carved out” to pay claims;

additional funding comes from DCF's budget. The legislature appropriated funding in 2005 to help pay for administration of the CT BHP; the FY 07 budget assumes a shift in funding of \$103.7 million *from* the MCOs to the BHP. Funds also were budgeted to accommodate a projected increase in service utilization, as well as the cost of the contract with the ASO. DSS estimates that this Initiative will result in a *net increase* in costs for behavioral health services for its target population of \$8.3 million in FY 06 and \$12.8 million in FY 07.

It is too soon to tell if the CT BHP will meet its goal of providing “enhanced access and coordination of a more complete and effective system of community-based health services and supports to improve members' outcomes.” To improve the chances of success, the Behavioral Health Partnership Oversight Council was created to oversee implementation. Issues identified by Council members to date include: a) whether there is sufficient funding for the program; b) if the correct mix of grant and fee-for-service funding exists; and c) if the funding changes will provide non-HUSKY children (e.g., some of the children who receive services through DCF's Voluntary Services program) with sufficient access to community-based services. The Council will present its first report to the General Assembly in March of 2006.

Better coordination among state agencies will improve mental health outcomes for children. Although DCF is the lead state agency for children's mental health, it is not the only state agency with some involvement and responsibility. For example, more than half of all children's mental health services are provided by Connecticut's schools; the Judicial Department spends millions each year on juvenile mental health assessments and treatment services; DSS (through HUSKY) finances many services, and DMHAS provides care to youth too old for DCF (and to parents of children in DCF care). Greater coordination among these agencies can assure that state funds are used most effectively, and the mental health needs of children and their parents are identified early and addressed in the most clinically-appropriate and timely way. The CT BHP is a beginning, but important, step at such coordination.