

### TCB Level Setting Training Agenda

**Date:** January 5<sup>th</sup> 2024

**Time:** 8:30 am- 5:00 pm

**Location:** 100, Training Hill Road, Middletown, CT

Time	Topic	Presenter
8:30 – 9:00 am	Check-in and Registration	
9:00 – 9:10 am	Welcoming Remarks by TCB Chairs	<p><b>Sen. Ceci Maher</b> Children's Committee Co-Chair Senate</p> <p><b>Claudio Gualtieri,</b> Senior Policy Advisor Office of Policy and Management</p>
9:10 – 9:15 am	Overview of the agenda	<p><b>Erika Nowakowski, MSW</b> Executive Director Tow Youth Justice Institute</p>
9:15 – 12:00 pm	Experiential Activities: Setting the Foundation for Future TCB Work	<p><b>Rachel Keyworth</b> Therapeutic Recreation Consultant Eagle House Sub-Acute Residential Treatment Program The Village for Families &amp; Children</p>
12:00 – 1:00 pm	Networking Lunch	
1:00 – 2:00 pm	Understanding Children's Behavioral Health in Connecticut	<p><b>Laine Taylor, DO, MBA,</b> Medical Director, The Village for Families and Children</p> <p><b>Jeana Bracey, Ph.D.,</b> Associate Vice President of School and Community Initiatives, Child Health, and Development Institute</p>



Time	Topic	Presenter
		<p><b>Melissa L. Whitson</b>, Ph.D, Professor of Psychology</p> <p>Program Coordinator of Community Psychology M.A. Program, University of New Haven</p>
2:00 – 3:00 pm	Overview of the Behavioral Health Treatment System for Children in Connecticut	<p><b>Elisabeth Cannata</b>, Ph.D, Vice President, Community-Based Family Services and Practice Innovation, Wheeler Clinic</p> <p><b>Jennifer Nadeau</b>, LCSW, Senior Vice President of Child and Family Services, Community Health Resources</p>
3:00 – 3:10 pm	Break	
3:15 - 3: 45 pm	Mental Health Treatment for Young Children	<b>Darcy Lowell</b> , MD, Founder, and former CEO, of Child First, Inc, Associate Clinical Professor, Yale University School of Medicine
3:45 - 4:15 pm	Children and Youth with Neurodevelopmental Disorders	<b>Michael Powers</b> , Psy.D, Founder and Executive Director, The Center for Children with Special Needs
4:15 – 4: 45 pm	Coffee and Table Conversation with the presenters	
4:45 – 5:00 pm	Closing Remarks	<b>Erika Nowakowski</b>



## Meet the Trainers



### Rachel Keyworth, M.Ed, CTRS

Rachel Keyworth attended Springfield College and earned a B.S. in Rehabilitation and Disability Studies. She then continued her education at Springfield College to pursue a master degree in Therapeutic Recreation. Since becoming a Recreational Therapist, Rachel has worked in a wide variety of settings including mental health, adapted sport, autism services, and community based recreation. Currently, Rachel is an Assistant Professor at Springfield College and the Program Director for the Recreation Industries and Therapeutic Recreation program. Rachel is also a consultant for the Village for Families and Children Sub-Acute residential youth program. At the Village, her work focuses on building and supporting leisure repertoires for all types of learners, developing the therapeutic recreation curriculum, providing tailored consultation to clinical and school based programs, and the facilitation of staff development training programs.



### Laine Taylor, DO, MBA

Dr. Laine Taylor is a board-certified Child and Adolescent Psychiatrist and serves as the medical director for The Village for Families and Children. Dr. Taylor oversees and supports The Village's Psychiatry Department and psychiatric-related programs. She collaborates with other departments, outside organizations, state agencies, and stakeholders to ensure that The Village remains a center of clinical excellence by upholding its values and innovating to achieve its mission.

Dr. Taylor earned her undergrad at Xavier University of Louisiana, her medical degree at Kansas City University of Medicine and Biosciences, and a healthcare leadership master's from Rockhurst University during medical school. She completed her general psychiatry residency at the University of Arizona and her Child and Adolescent Fellowship at The Yale Child Study Center. Dr. Taylor worked with adults in Hollywood, Florida for a year before becoming an adjunct professor at The Yale Child Study Center in Connecticut. Dr. Laine Taylor's diverse background shapes her approach to patient care, perspectives on healthcare systems, advocacy for state policy, and community service.



### Melissa L. Whitson, Ph.D

Dr. Melissa Whitson, a leading expert in childhood trauma, holds a Ph.D. in Counseling Psychology from Columbia University and a Postdoctoral Fellowship in Community Psychology from Yale University. Her research has identified risk and protective factors for low-income and marginalized children and families, who often have a disproportionate number of unmet mental health needs because of lack of availability, lack of insurance, and stigma. Dr. Whitson closely studies children who have been exposed to adverse experiences and traumatic events and examines how mental health services have impacted them and their families. Her research aims to increase the services' effectiveness and improve the mental health and well-being of these children and families. Dr. Whitson's research shows that children's mental health services need to focus not only on the child who presents for services but also on the child's parents and caregivers, as their stress levels will impact treatment outcomes for the child.



### Jeana Bracey, Ph.D

Dr. Jeana Bracey is Associate Vice President of School and Community Initiatives at the Child Health and Development Institute (CHDI) in Connecticut. She currently directs several school and community-based systems development activities, including the CT School-Based Diversion Initiative (SBDI), the Connecting to Care statewide Systems of Care Initiative, and Statewide Comprehensive School Mental Health Initiatives. She has experience in school-based mental health, juvenile justice diversion, health equity, and program implementation and evaluation, and serves on several state-level committees to advance policy and practice on social emotional learning, family and community engagement in schools, health equity/racial justice, and juvenile justice diversion. She earned her PhD in Clinical/Community Psychology in 2010 from the University of Illinois at Urbana-Champaign.

## Meet the Trainers



**Elisabeth Cannata, Ph.D**

Dr. Elisabeth Cannata, a clinical psychologist with 35+ years of experience, specializes in working with children and families across various behavioral health programs, including those involved with child welfare, juvenile justice, and special education. In her role as Vice President of Community-Based Family Services and Practice Innovation at Wheeler, she has overseen the implementation of several evidence-based treatments and was at the helm of Wheeler's first efforts at behavioral health and primary care integration. She has also partnered with model developers in piloting and studying the effectiveness and transportability of model adaptations to strengthen families and maintain children in their homes. Dr. Cannata has extensive expertise in cross-disciplinary education in the areas of integrated healthcare and Evidence Based Practice, with multiple publications in these areas. Over the years she has served on various system advisory boards and workgroups, and is currently an appointed Tri-Chair of the Connecticut Children's Behavioral Health Plan Implementation Advisory Board.



**Jennifer Nadeau, LCSW**

Jennifer Nadeau, LCSW, Senior VP of Child and Family Services at CHR, oversees all programs in the division, including crisis services, outpatient clinics, residential programs, intensive home-based therapy, and foster care. Jennifer joined CHR in 2009 and served as a Child and Family Service Director. She oversaw various evidence-based community programs, including FFT and MDFT teams, school-based clinics, the Caregiver Support Team program, and Child Outpatient clinics in East Hartford and Manchester. Throughout her career with CHR, she has held various roles with progressively increasing leadership responsibilities for outpatient and community-based programs. Beginning her career in 2006 as a clinician in outpatient settings, Jennifer is a recognized expert in trauma-focused services for children, teens, and families. She played a key role in implementing four innovative trauma-focused models in CHR's clinics. Jennifer is a statewide trainer for MATCH-ADTC, actively engaging in regional, statewide, and national training initiatives for child and family services. Jennifer holds a Master's degree in Social Work from Loyola University Chicago.



**Darcy Lowell, MD**

Dr. Darcy Lowell, MD, a renowned developmental and behavioral pediatrician, is the visionary founder of the evidence-based Child First model, where she served as Chief Officer from 2001 to 2023. Nationally recognized with the IMH-E (IV) Infant Mental Health Mentor Endorsement, she specializes in clinical services, research, child advocacy, and system innovation, focusing on early, responsive relationships to prevent and heal trauma. Under her leadership, the Child First model, created in 2001, is an evidence-based intervention endorsed by multiple registries and replicated nationally in six states. Holding a BA from Yale University and completed several fellowships at Yale University School of Medicine, Dr. Lowell actively engages in various organizations at local, state, and national levels, playing key roles in infant mental health, child development, and trauma prevention initiatives, including founding the National Child Traumatic Stress Network's Category II Center for Prevention and Early Trauma Treatment.



**Michael Powers, Psy.D**

Dr. Michael D. Powers is the Founder and Executive Director of The Center for Children with Special Needs in Glastonbury, Connecticut, and Associate Clinical Professor of Psychology at the Yale Child Study Center, Yale University School of Medicine. He completed his undergraduate and graduate training at Rutgers College, Columbia University, and Rutgers University. Dr. Powers specializes in the diagnosis, assessment, and treatment of individuals with autism and related developmental disabilities and has published and presented extensively on these topics. He is also the author of *Asperger Syndrome and Your Child*, the award-winning book *Children with Autism: A Parent's Guide* (second edition), and co-editor (with Dr. Fred Volkmar) of the *Encyclopedia of Autism Spectrum Disorders*. Dr. Powers has been involved in designing educational programs, staff training, and program evaluation for students with autism spectrum disorders throughout the United States and abroad for over 45 years. Dr. Powers is on the Editorial Board of the *Journal of Autism and Developmental Disorders*, a member of the Professional Advisory Boards of MAAP Services for Autism and Asperger Syndrome and The Geneva Centre for Autism in Toronto, and a former member of the Board of Directors of the Autism Society of America.



# Getting to Know Youth A Mental Health Primer

**Jeana Bracey, PhD**- AVP School and Community  
Initiatives Child Health and Development Institute

**Laine Taylor, DO, MBA**- Child Psychiatrist and Medical  
Director The Village for Families and Children

**Melissa Whitson, PhD**- Professor of Psychology  
University of New Haven

January 5, 2024

# Objectives

- Understand the distinction between behavioral health and mental health.
- Discuss developmental stages and how this can impact mental health presentations.
- Learn disorders common in different developmental stages.
- Understand the impact of childhood trauma across the lifespan.
- Discuss entry points for the mental health system.

- *The term “behavioral health” describes a broad spectrum of concerns related to the emotional and behavioral needs of children/youth, including well-being, resilience, mental health, and substance use prevention.*
- Broad definition allows for inclusion of trauma, suicidality, and substance use and addresses prevention, treatment, and support
- Behavioral health has traditionally been financed, structured, and regulated differently than other “health” conditions

## Development and Diagnosis

- **2-5 years-** Learning self-control
  - Testing limits is normal- learn consequences and autonomy
  - Pretend play
  - Can't discern real from imaginary- Afraid of monsters
  - Family/Caregivers are the center
- **Most common-** ADHD, anxiety, issues of attachment, and autism
- **Opportunity for early identification, prevention and early intervention**



### **Development cont.-**

Children begin to learn empathy and understand their impact on others

More interactive play- 2-4 peers at a time

Less aggression toward the end of this stage

Like to play tricks and are worried about tricks being played on them

**ADHD-** Hyperactivity, trouble staying with one task, forgetful, loses things

**Anxiety-** most commonly social anxiety and separation anxiety. Children struggle to separate from caregiver, refusals and tantrums with new experiences, sleep disturbance. School refusal can begin in pre-k and kindergarten.

**Issues of attachment-** attachment (child to parent) and bonding (parent to child) occur in infancy. If this is interrupted and there is no consistent caregiving and attunement to infant needs, the child's attachment can be disrupted. This presents with a variety of issues. Most commonly with tantrums, oppositional behavior, social withdrawal, and difficulty forming relationships with peers and adults

**Autism-** Can be diagnosed as a toddler. This is most commonly identified in school and pediatrician's office. This is a spectrum and can be hard to identify when more mild symptoms are present. Commonly presents with poor eye contact, often speech delay (expected development by 2 years old), shows little to no interest in peer relationships or play, struggles to express needs, repetitive behaviors, lack social smile, sensory difficult (textures, tastes, sound sensitivity).

**Prevention and Early Intervention-** Work with schools, primary care offices, and community programs to identify child or family risk factors and referral to the necessary basic needs or mental health support services. Focus must be on the family and involved systems to scaffold the youth who may show risks for a mental health disorder. If the child has begun to show signs of functional or behavioral decline, early intervention can prevent need for higher levels of care.



## Development and Diagnosis

- **6-8 years**- Learning the rules
  - Rule focused and learn adult social graces (thank you, apologize, morals), learn how to build relationships
  - Play cooperatively and with more kids
  - Exploring new activities
  - More complex coping skills develop
- **Most common**- ADHD, Behavioral Disorders, Anxiety, Autism



Complex imaginative play

Doing chores, more responsible and independent

Prefer same gender play

Exploring new activities

More complex coping skills develop

**ADHD**- Hyperactivity, trouble staying with one task, forgetful, loses things, often gets into trouble for impulsive behavior, struggles with peer relationships, may show ability to hyperfocus with preferred activities (video games), trouble following 3+ step directions

**Behavioral Disorders**- This is an umbrella phrase for a set of disorders that primarily present with changes in behavior such as: defiance, lack or respect for authority figures, impulsive or risky behaviors, irritability, interpersonal conflict, and aggression

**Anxiety**- At this age, the most common anxiety disorders are social anxiety, separation anxiety, and generalized anxiety. Generalized anxiety usually manifests in fear of personal safety, safety of family, and risk of illness or death to self or loved ones. These fears/anxieties begin to impair the child's functioning leading to avoidance of novel activities or refusal to participate in activities that trigger the fear, even if the fear is very unlikely to happen.

**Autism**- For youth diagnosed at this stage or later may be "higher functioning" or have fewer impairments of social skills, language, or self regulation skills.

## Development and Diagnosis



- **8-11years-** Friends and independence
  - Peers more important
  - Behavior charts and incentives work best now
  - Need support and nurturing, but space to be independent to build self-confidence
  - Can start to engage in their community
- **Most Common-** Anxiety, Depression, PTSD, Behavioral Disorders
  - Substance abuse may emerge at this age

**Anxiety-** most common types of anxiety disorders in this age are generalized anxiety, social anxiety, and OCD can begin to emerge during this age. This presents with specific fears (injury to self or others for example) and may be accompanied by extinguishing behaviors (compulsions). If obsessive thoughts or images are present, there is awareness of it being irrational (especially in older youth), but the fear persists and rituals can be used to stop the fear or image from becoming reality.

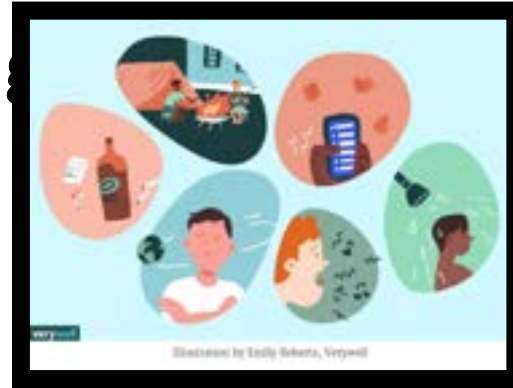
**Depression-** most commonly with irritability, sometimes aggression/refusal, changes in eating and sleep patterns, can have periods seeming “fine” or “normal”

**Post Traumatic Stress Disorder-** Must have identified trauma. Symptoms include hyperarousal (jumpy, examining room for safety), fear of an early death, intrusive memories, nightmares (may or may not be re-enactment of the trauma, but safety is often the theme), sometimes flashbacks. Children may not have explicit memories due to repression, but they may be more irritable, sensitive, or have behavioral outbursts. This most commonly comes after the traumatic event has ended. For youth with ongoing traumatic exposure, the trauma becomes a normalized experience and emotional numbing can occur.

**Behavioral Disorders-** This is an umbrella phrase for a set of disorders that primarily present with changes in behavior such as: defiance, lack or respect for authority figures, impulsive or risky behaviors, irritability, interpersonal conflict, and aggression

# Development and Diagnosis

- **Adolescence-** Risk taking
  - Friends are paramount
  - Risks taken
  - Complex relationships
  - Romantic relationships
  - Need adult support and guidance for decision making and coping strategies
  - Important to engage with their community
- **Most Common-** Anxiety, Depression, PTSD, Substance abuse, Eating Disorders



Generally, adolescents demonstrate higher risks for risky behaviors and suicide due to normal functioning during this stage. Risky behaviors serve to prepare for adulthood and separation from caregivers and are a requirement for adaptive adult functioning. This also makes them at higher risk for impulsivity and less regard for rules.

Prevention and early intervention is important at all stages, but addressing substance abuse and disordered eating early can have a positive impact on lifelong impairment from these issues. Prevention includes engagement in prosocial activities that promote positive self image and reduce isolation and negative peer influence.

Late adolescence is when schizophrenia or bipolar disorders can emerge



## Bias Considerations

- Systemic and Racial Bias
  - Impacts diagnoses
  - Impacts access to prevention and intervention
  - Impacts education in CT especially
  - Immigration status impacts access to early care, prevention, and services
    - Husky in Connecticut to age 12 in 2022

# ACES (Adverse Childhood Experiences)

Potentially traumatic events that occur before 18:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide
- growing up in a household with:
  - substance use problems
  - mental health problems
  - instability due to parental separation or household members being in jail/prison

\*could also include not having enough food to eat, experiencing homelessness or unstable housing, or experiencing discrimination.

Linked to mental illness, substance abuse, and chronic illness into adulthood.



# ACES (Adverse Childhood Experiences)

- ACES are common (64% of adults)
- Preventing ACES could reduce many mental and health illnesses
- Some people are at greater risk of experiencing one or more ACES
- ACEs are costly (health consequences = estimated \$748 billion annually)

## ACES linked to **toxic stress**

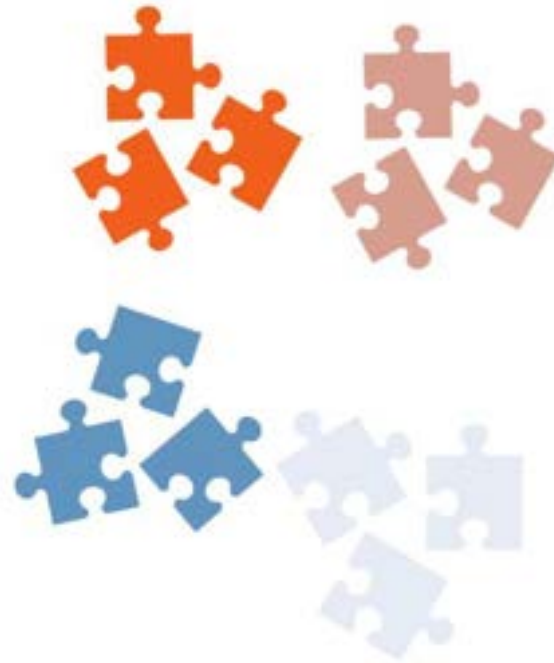
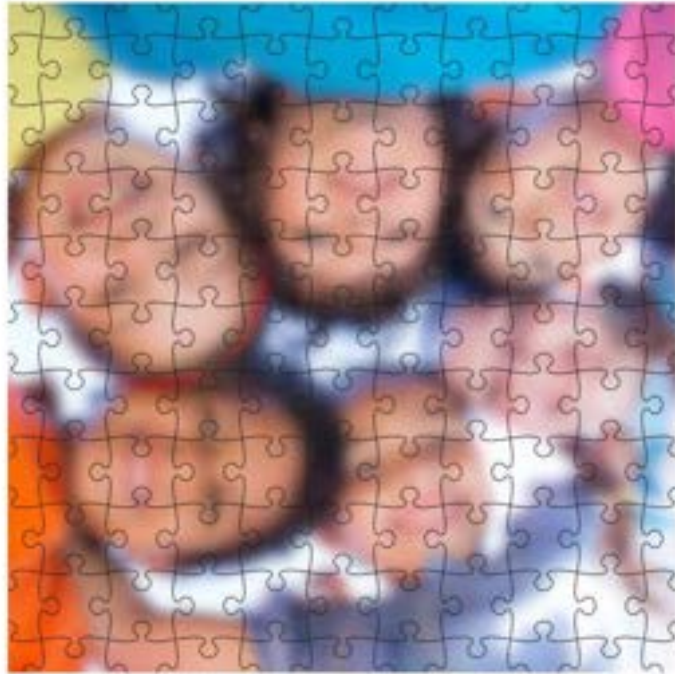
- Negatively impacts a child's developing brain, immune system, and stress response systems
  - This impacts a child's self-regulation, attention, learning, decision-making, impulsivity, conflict resolution and problem-solving, etc.
    - Increased risk of mental health and substance use problems



**Who  
are  
the  
Kids  
???**







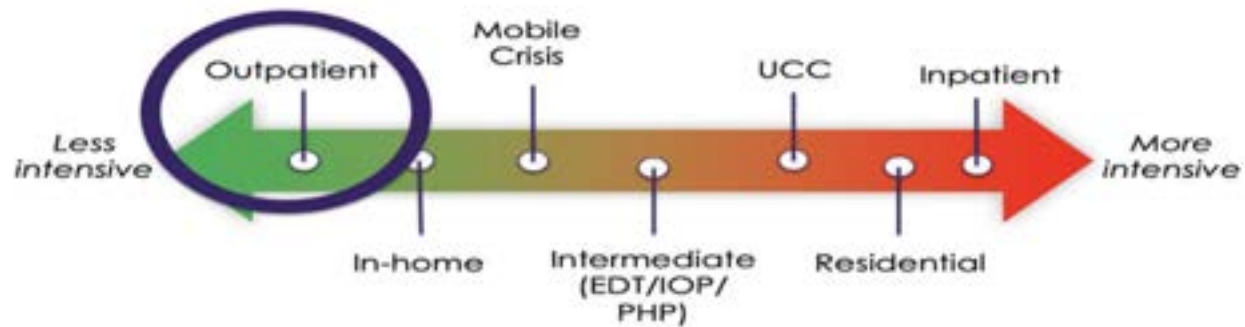
# How do children enter the system?

- Most Common Entry Points:
  - **Schools**
    - Behavioral issues, attention/learning, disciplinary issues
  - **PCPs or Family doctors**
    - Developmental or Attention/hyperactivity issues; Depression
  - **ERs or UCCs**
    - Depression, Behavioral issues, Psychotic symptoms
  - **Family or caregivers**
    - Relational conflict; Behavioral issues
  - **DCF**
    - Family system risk factors; ACEs
  - **Justice system (Judicial CSSD / DOC)**
    - School disciplinary issues or truancy; delinquent activity



## Levels of care

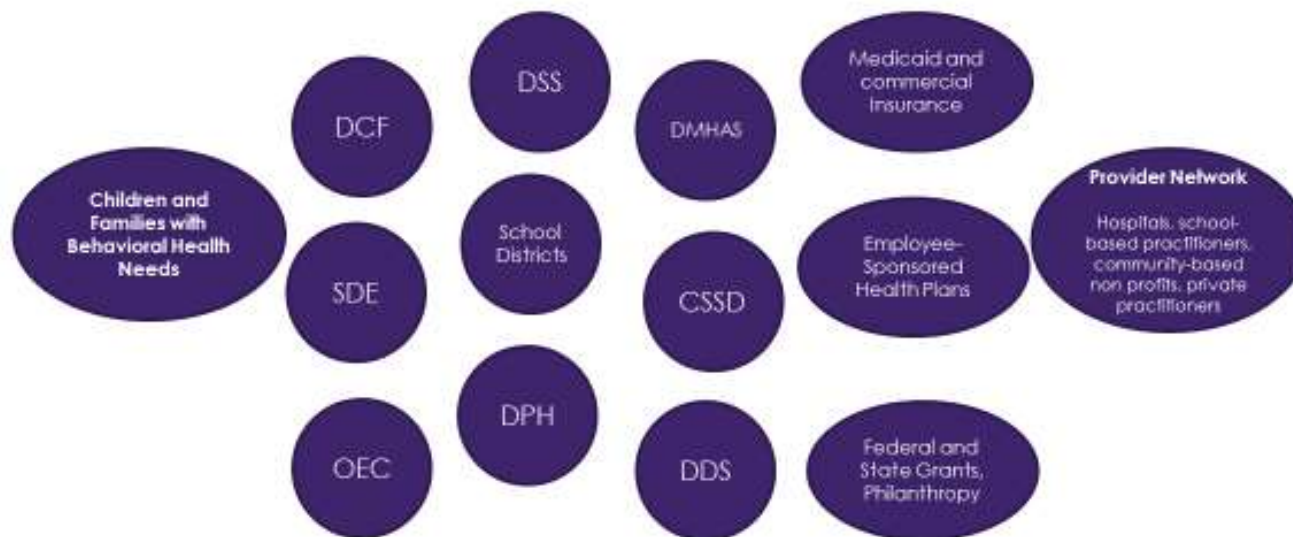
- Lower levels of Care: Mobile , Outpatient, Care Coordination
- Intermediate: Center-based (EDT, IOP, PHP) and intensive in-home (MST, MDFT, FFT, IICAPS)
- Higher LOC: Inpatient, PRTF, residential, group home.



Systems of Care is an organizing principle with the SOC values and principles as the “north star” in system development.

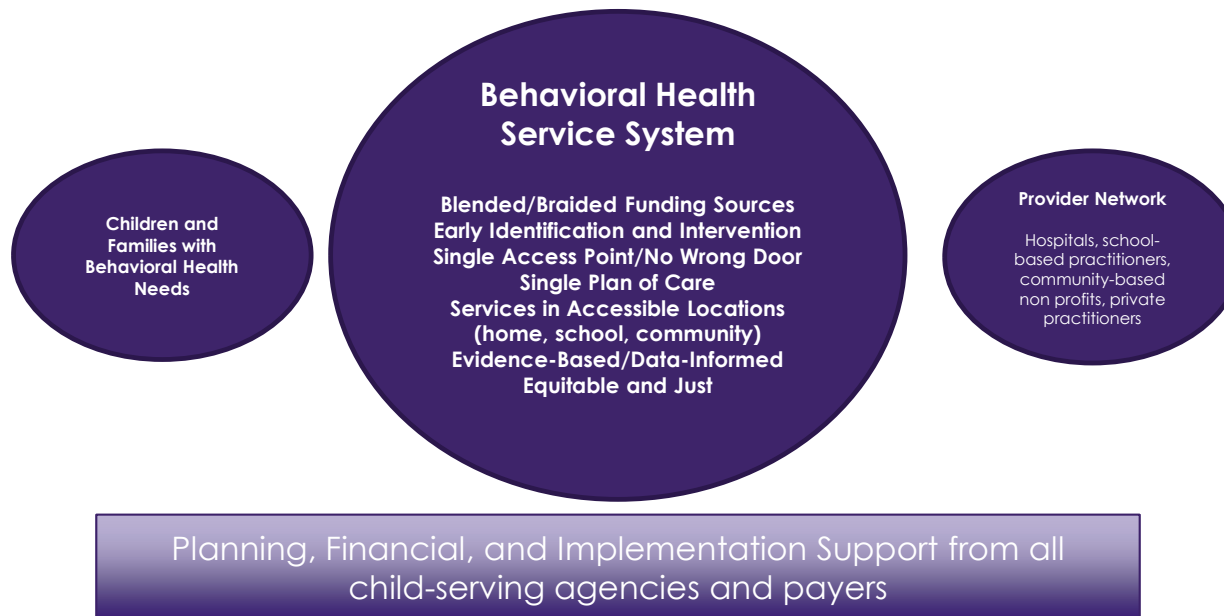
The overarching goal is around ensuring equitable access, quality, and outcomes for all of CT’s children.

## Behavioral Health System



- Each has their own set of eligibility criteria and "menu" of available services
- **So...do we have a children's behavioral health system?**

# Behavioral Health System



# Citations

1. <https://www.cdc.gov/childrensmentalhealth/data.html>
2. Cyr, D, Kabachia, L, Leen, E, Ruth, L, Cruz, J. Connecticut Voices for Children. "State of Early Childhood." June 2022.
3. <https://www.cdc.gov/violenceprevention/aces/fastfact.html>
4. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

# Thank you

## Questions?

Dr. Jeana Bracey- [jbracey@chdi.org](mailto:jbracey@chdi.org)

Dr. Laine Taylor- [ltaylor@thevillage.org](mailto:ltaylor@thevillage.org)

Dr. Melissa Whitson- [mwhitson@newhaven.edu](mailto:mwhitson@newhaven.edu)

# OVERVIEW OF THE BEHAVIORAL HEALTH TREATMENT SYSTEM FOR CHILDREN IN CONNECTICUT

Elisabeth Cannata, Ph.D.,  
Vice President, Community-  
Based Family Services and  
Practice Innovation,  Wheeler  
Wheeler Clinic

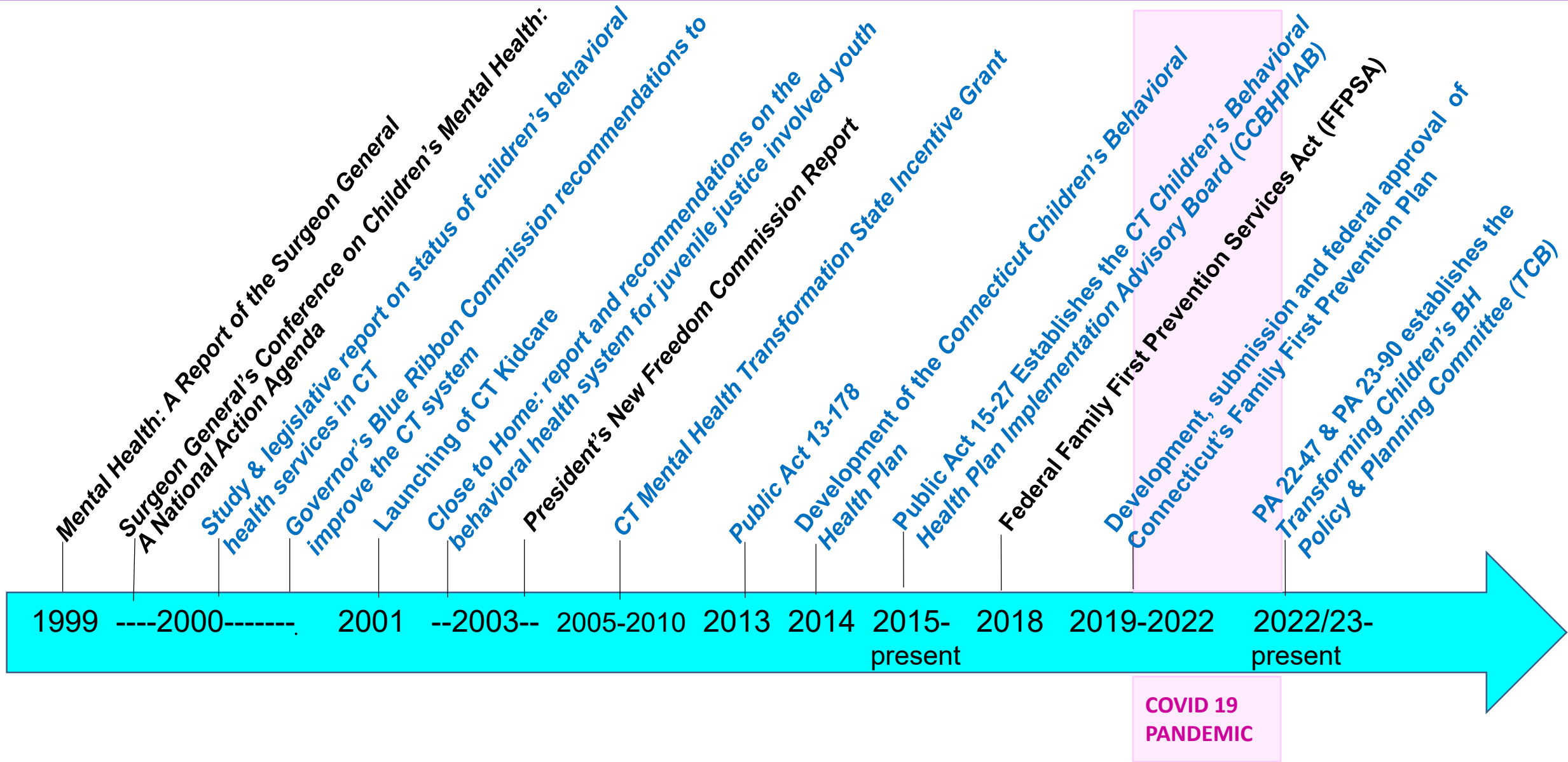
COMMUNITY | HEALTH | CARE

Jennifer Nadeau, LCSW,  
Senior Vice President of  
Child and Family Services,  
Community Health  
Resources

  
REAL LIFE. REAL HOPE.

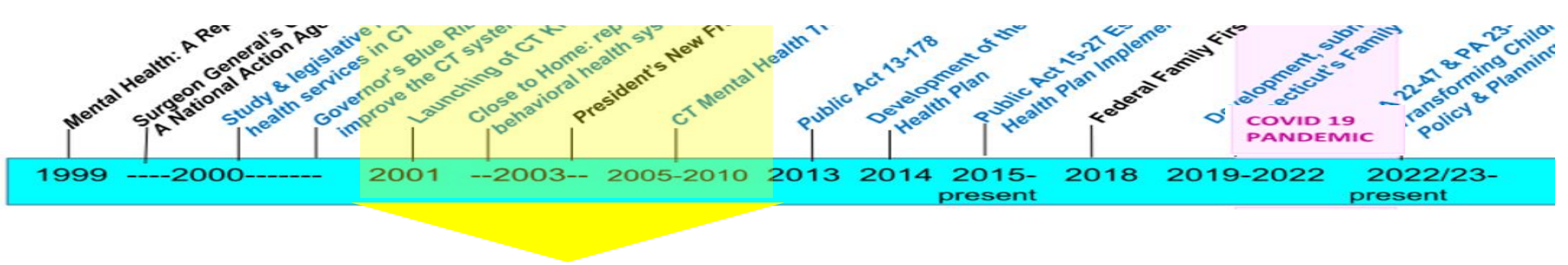


# SINCE 1999: AN ONGOING MOVEMENT IN CONNECTICUT (AND NATIONALLY) TO IMPROVE THE BEHAVIORAL HEALTH TREATMENT SYSTEM FOR CHILDREN & FAMILIES





- National data:
  - 20% of children displaying symptoms consistent with a Behavioral Health (BH) diagnosis
  - 5% at a level of “extreme functional impairment”
  - Only 20% of those in need get to treatment
- Recommendations:
  - Serious emotional disturbance in youth best addressed with a “systems” approach
  - Families are essential partners in delivery of BH services to children and adolescents
  - Continue to develop, disseminate and implement scientifically proven prevention & treatment – train providers in these practices
- CT data:
  - 70% of state BH \$ spent for inpatient or residential care for only 19% of child population receiving BH services
  - “Kids are languishing” in more restrictive settings because of shortage of community-based services
  - Children in DCF custody comprise 5% of Medicaid population but accounting for 60% of BH expenditures
- Recommendations:
  - Encourage DCF, DSS, DMHAS to integrate multiple funding streams
  - Pursue untapped federal funds to augment services
  - Ensure consumers & families are equal partners in design & delivery of services



## Nationally:

- New Freedom Commission: Transform the BH system including:
  - Mental health care be consumer and family driven
  - Advance Evidence-Based Practices (EBPs) using dissemination and demonstration projects and create public-private partnership to guide their implementation
  - Improve & expand the workforce providing Evidence-Based BH services and supports

## Connecticut:

- KIDCARE is launched – expanding community-based services beyond office-based outpatient & inpatient/residential levels
  - Care Coordination
  - Emergency Mobile Psychiatric Services
  - Intensive Home-Based Services
- Family Advocacy organizations established & gain momentum
- Shift to treatment focus with EBPs in juvenile justice system
  - Families (not children) the clients and full members in treatment teams
  - Establish array of community-based EBPs to address diverse needs of JJ population in natural ecologies
  - Support infrastructure for effective implementation of EBPs
- Establishment of the CT Behavioral Health Partnership
- T-SIG Federal Resources to support BH infrastructure
  - Expanding family/consumer voice and contribution to BH service system
  - Focus on WORKFORCE DEVELOPMENT
  - Supporting strategies to engage higher ed in the development of BH providers ready to do the Evidence-Based community-based work



### Continued System Development & Impact:

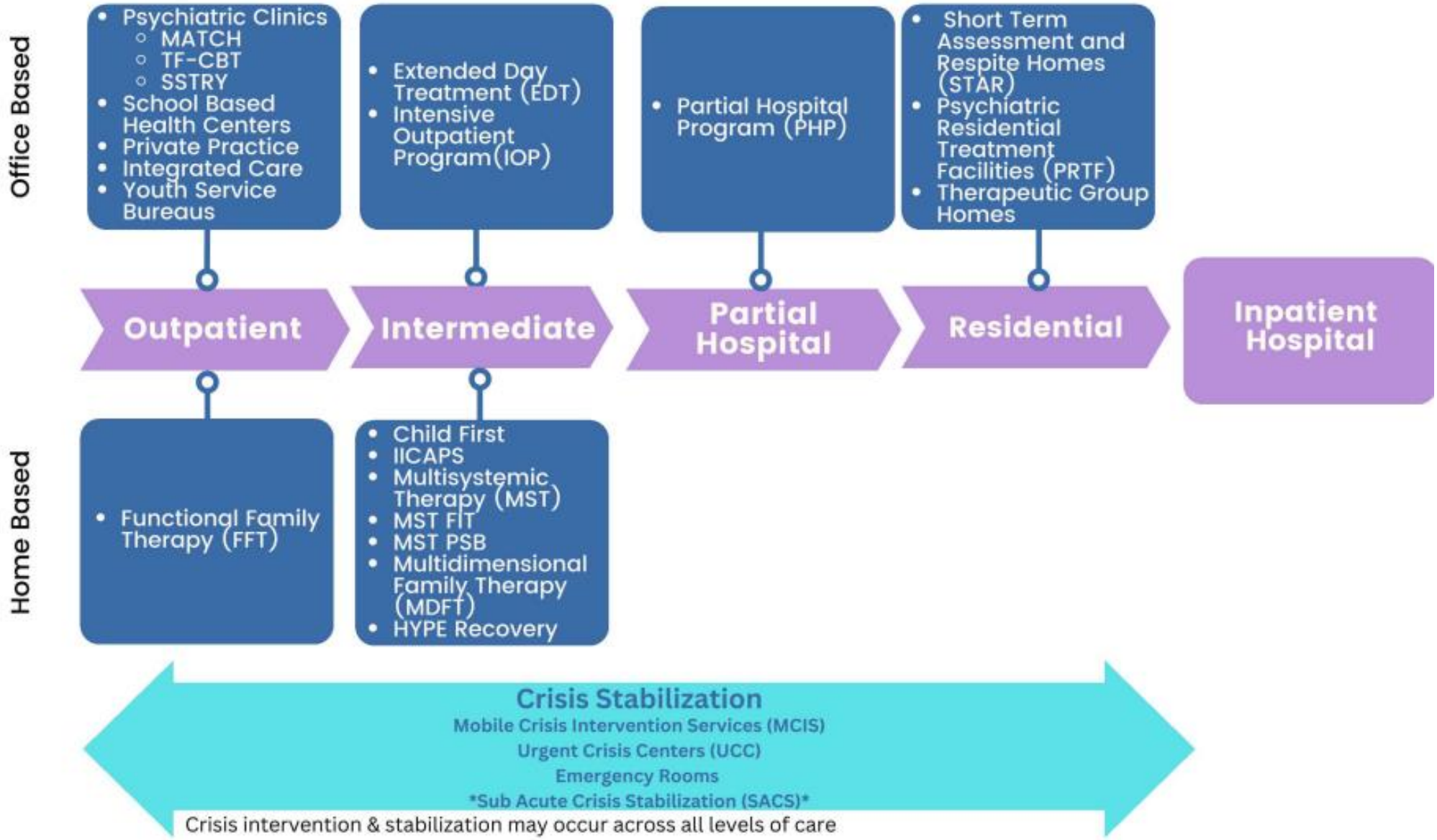
- Federal grants/reimbursements expanding BH services, system of care and family empowerment
- Reduced out-of-home care, reduced recidivism
- Partnerships with model developers to expand research and implementation of diverse treatments to address diverse needs
- CT Recognized as a leader in effective and sustained implementation and innovation in EBP

### CT Children’s Behavioral Health Plan - Current Roadmap of Children’s BH System Development:

- Chance to “reset/update” – what is working, not working, where room for improvement?
  - Extensive input from all stakeholder groups, including providers, state departments and leaders, advocates and over 339 family members and 94 youth with lived experience
  - Seven Thematic Areas with specific goals and strategies
- CT Children’s Behavioral Health Plan Implementation Advisory Board (CBHPIAB)
  - Includes representation of 15 State Departments/Agencies, OPM, Providers, Advocates, Commercial Insurance, private foundations and **family members with lived experience**
  - Establishment of Workgroups to address targeted areas of system analysis and development
  - Implementation of Plan goals through expanded state partnerships and targeted system contributions
  - Annual report to legislature with summary of progress and recommendations

**IMPACT TO THE DEVELOPING  
CONNECTICUT BEHAVIORAL HEALTH  
CONTINUUM OF CARE**

# LEVELS OF CARE



# Inpatient/Residential

- **Psychiatric Inpatient Hospitalization**
    - Hospital based evaluation and stabilization of acute behavioral health conditions, requiring 24-hour supervision and care.
  - **Psychiatric Residential Treatment Facility**
    - A congregate model of care that provides a diverse array of integrated behavioral and mental health treatment for youth who have significant and complex emotional and behavioral disorders.
  - **Short Term Assessment & Respite Home**
    - Temporary congregate care program that provides short-term care, evaluation and a range of clinical services to children removed from their homes due to abuse, neglect or other high-risk circumstances.
  - **Therapeutic Group Home**
    - Small, 4-6 bed, staffed home within a local community designed for youth with a diagnosed psychiatric/behavioral issue.
- 
- **Sub-Acute Crisis Stabilization**
    - Serves youth experiencing behavioral health crises to de-escalate, stabilize and refer to ongoing care. Short term, up to 14 days.

# Care Coordination

- Care Coordination
  - Provides high-fidelity Wraparound, an intensive, individualized care planning process for youth with serious or complex needs to maintain youth in their home and community.
- Voluntary Care Management/Community Pathways
  - Works with families, local providers and DCF to ensure access for CT's children and their families to parenting, behavioral health and other services that prevent instances of child abuse and neglect.
- Intensive Care Coordination
  - Services children and youth with serious behavioral or mental health needs who are returning from congregate care or other restrictive treatment settings or who are at risk of removal from home or their community.



**A new interactive  
online resource:**

**TO HELP CONNECT FAMILIES TO  
TREATMENT WELL-MATCHED TO  
CHILDREN'S SPECIFIC BEHAVIORAL  
HEALTH INTERVENTION NEEDS**



Development of the AIM Tool web-based platform and expansion of the AIM Tool was supported by SAMHSA System of Care Expansion and Sustainability Grant that funds Connecting to Care CT



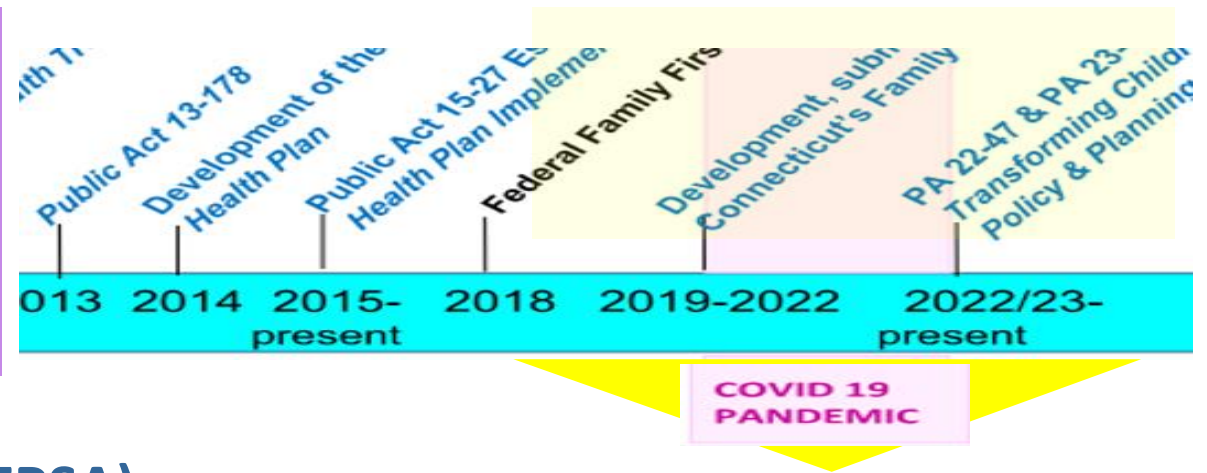
[www.connectingtocarect.org/supports-services/aim/](https://www.connectingtocarect.org/supports-services/aim/)



SCAN HERE!

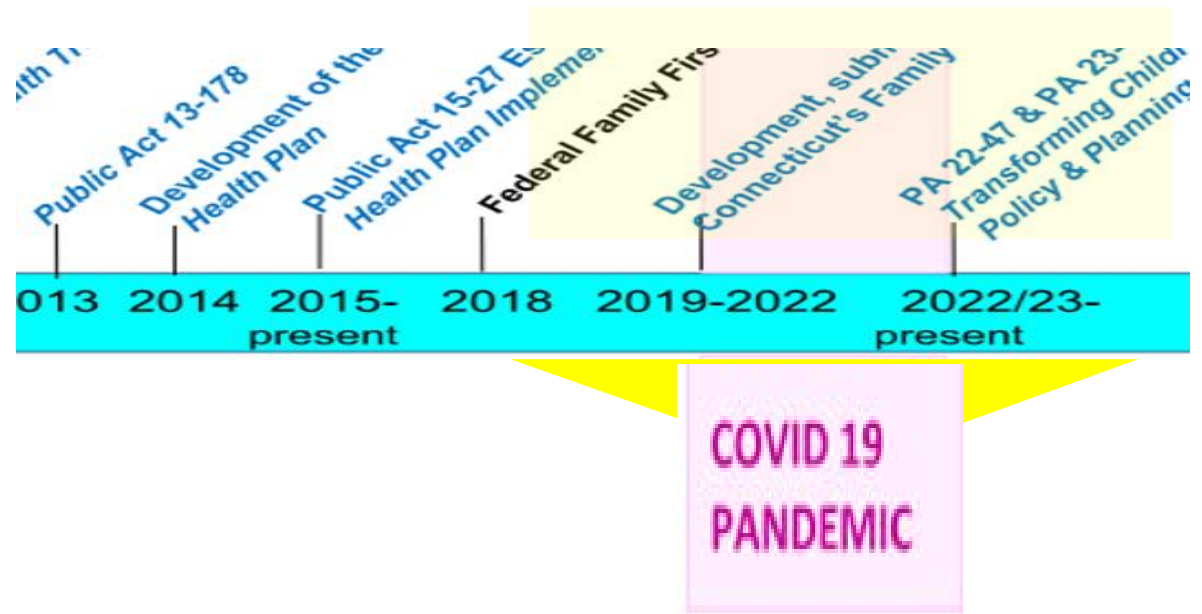
A screenshot of a web browser displaying the AIM tool page. The browser's address bar shows the URL: https://www.connectingtocarect.org/supports-services/aim/. The website header features the 'CTC Connecting to Care' logo on the left and navigation links for 'Supports &amp; Services', 'Training &amp; Info', 'About Us', and 'Get Involved' on the right. A language dropdown menu is set to 'English'. The main content area has a dark blue background with a pattern of light blue circles. On the left, the 'AIM' logo is displayed in large white letters, with 'Assisted Intervention Matching Tool' written below it. Underneath, the text reads 'The Assisted Intervention Matching (AIM) Tool'. A white button with a green arrow icon and the text 'Get Started' is positioned at the bottom left. On the right side of the page, there is a photograph of two men in hoodies talking outdoors.

# CURRENT SYSTEM ATTENTION: OPPORTUNITY & NEED



- **Family First Prevention Services Act (FFPSA):**
  - Federal legislation to promote the reduction of placement in foster care by strengthening families through: Evidence-based mental health and substance use interventions, In-home parent skill-based programs, Kinship navigator programs
  - Connecticut's Approved Plan developed through extensive collaborative process involving over 400 unique community partners including parents and youth with lived experience, decision makers throughout state government, community organizations, advocates, and contracted providers
  - Stakeholders emphasizing opportunity for prevention of protective service involvement through **COMMUNITY PATHWAYS** to promote access to BH treatments designed to strengthen families
- **Transforming Children's Behavioral Health Policy and Planning Committee (TCB):**
  - Continuing legislative attention to Children's behavioral health system
  - Opportunity to build upon current foundation & promote coordination/reduce duplication with other efforts

# CURRENT SYSTEM ATTENTION: OPPORTUNITY & NEED



## IMPACT OF COVID 19 PANDEMIC:

- **To behavioral health workforce**
  - Shortage of behavioral health providers at every level of care
  - Reduced interest in entering the field at current pay scale (particularly where job demands are higher (e.g. in-home, high-risk populations, on-call duties))
- **To child wellbeing**
  - Increased rates of serious mental health conditions (anxiety, depression, feelings of isolation and hopelessness, increased suicidality)
    - For e.g. CDC data from survey of highschoolers reporting “Mental Health was not good most or all of the time” in 2021 in CT (versus nationally): 28.5% (29.3); for female students this increases to 40.5% (40.8%)
    - Similar increases in youth behavioral health distress reported by parents for teens and younger children
  - In context of decreased access to services and renewed “bottleneck” of access to community-based services

# Recommendations:

- Preserve our rich service array
- Addressing the workforce CRISIS
  - Immediate Action to addressing financial barriers:
    - Increased reimbursement rates by Medicaid
    - Increased grant funding to programs
  - Continued study of maximizing contribution to the system
    - Blended and braided funding
    - Alternative payment methodologies
    - Commercial Insurance coverage of all programs in CT treatment array
- Continued partnerships to promote interest in, entry to, and diversity of behavioral health workforce

# Mental Health Treatment for Young Children

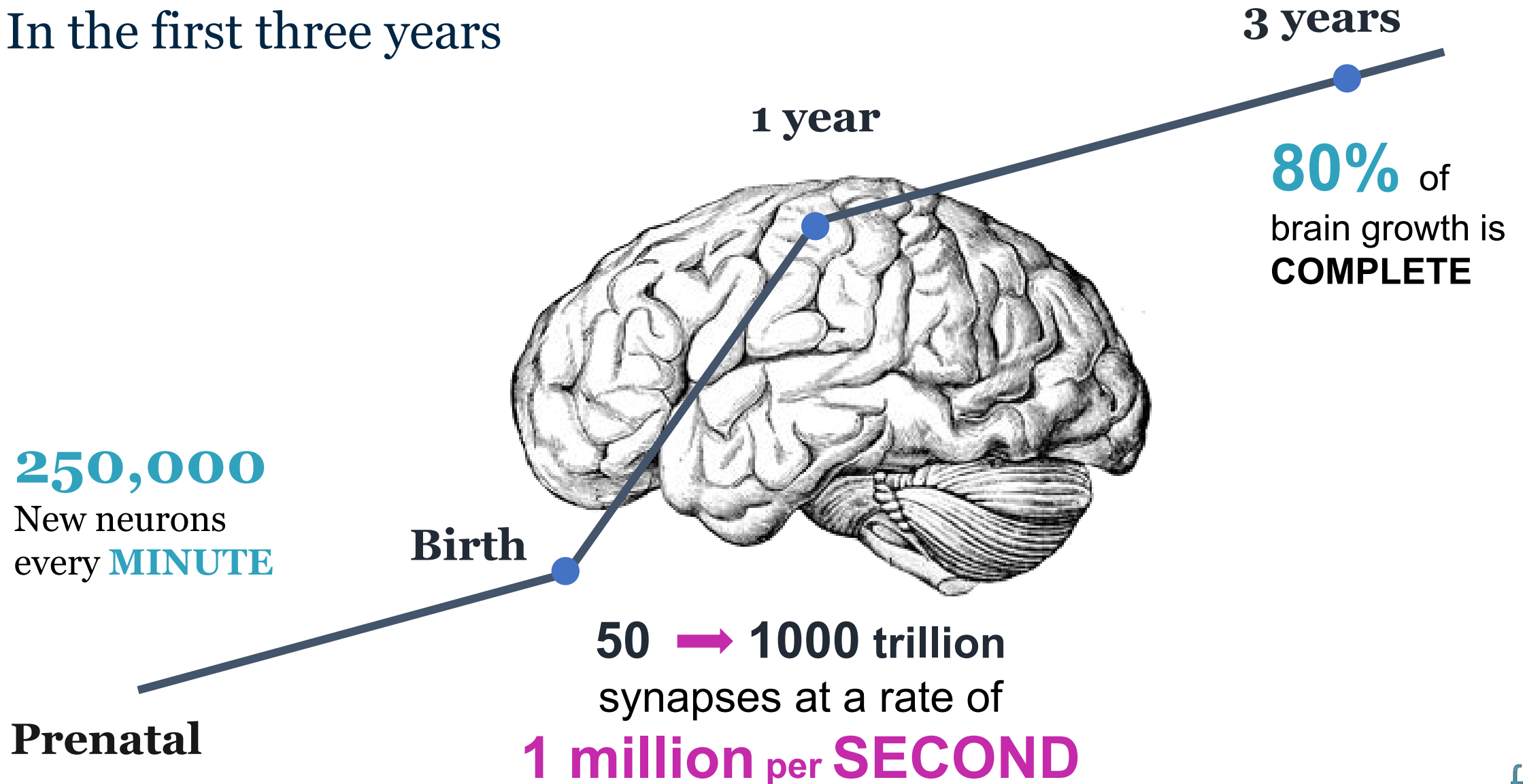


# Why is it so important to address mental health problems in very young children?

- Prevalence of mental health problems in children 0-5 years:
  - Overall prevalence of diagnosable mental health disorders = 16-20%
  - Children that live in poverty (<100% of FPL) = 22%
  - Children who are victims of child maltreatment have nearly 4-fold greater risk = 49%
- Must be a continuum of care based on level of need – each child and family unique
  - Promotion, prevention, early identification and screening, early intervention, and intensive home-based treatment
- If we are going to stop the pipeline of older children needing intensive services, residential treatment, and hospitalization, we must identify and intervene at the earliest possible time.
- Major gaps in mental health services for young children.
- In spite of all the scientific knowledge that we now have, young children have been left out.

# Brain Development

In the first three years





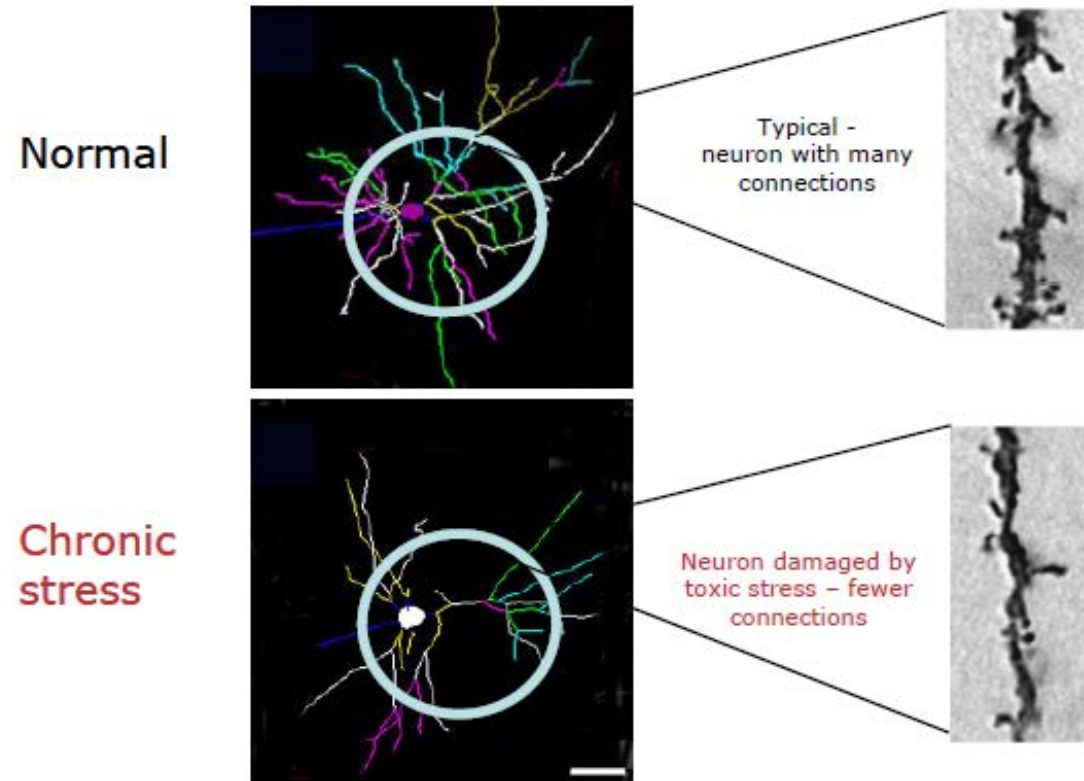
# Brain Science – Impact of Adversity

High levels of stress and adversity can significantly damage the young developing brain.

## Toxic Stress or ACEs:

- Extreme poverty
- Domestic and community violence
- Trauma and child abuse
- Caregiver depression, PTSD, and other mental health issues
- Substance misuse
- Homelessness
- Isolation and lack of social supports
- Racism
- Child neglect
- Incarceration
- Unemployment
- Poor health care
- Lack of education
- Poor quality childcare
- Food insecurity
- Unmet basic needs

# Persistent Stress Damages Brain Architecture



Normal

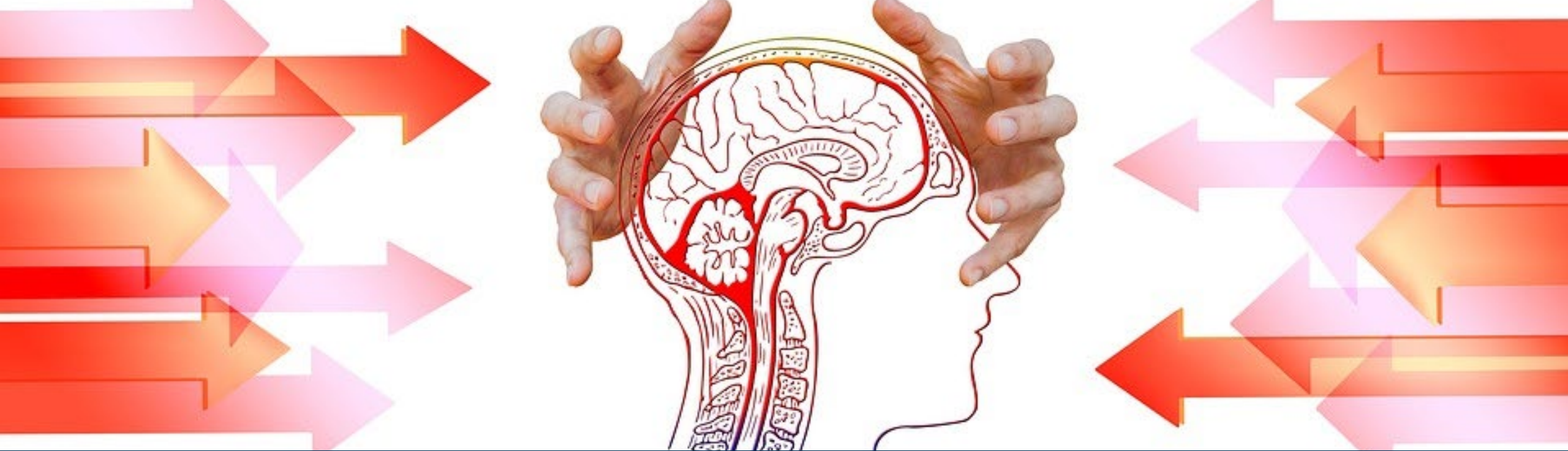
Typical -  
neuron with many  
connections

Chronic  
stress

Neuron damaged by  
toxic stress - fewer  
connections

Prefrontal Cortex and  
Hippocampus

Source: C. Nelson (2008)  
Bock et al Cer Cort 15:802 (2005)



**Toxic stress and ACEs** cause a rise in cortisol and epigenetic changes which damage the developing brain and can lead to lifelong problems



**Mental  
illness**



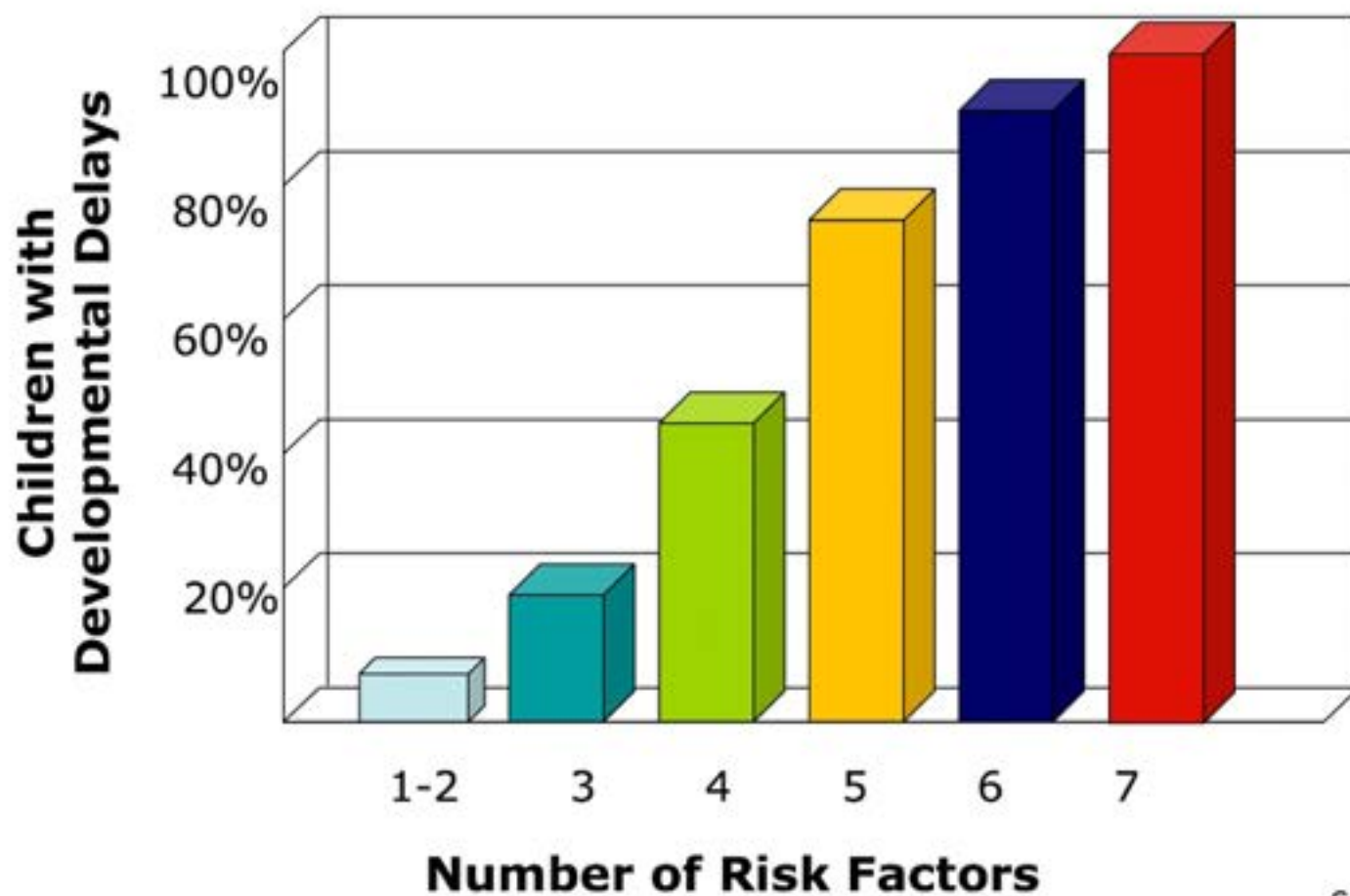
**Academic failure or learning  
disabilities**




**Chronic health  
problems**



## Significant Adversity Impairs Development in the First Three Years



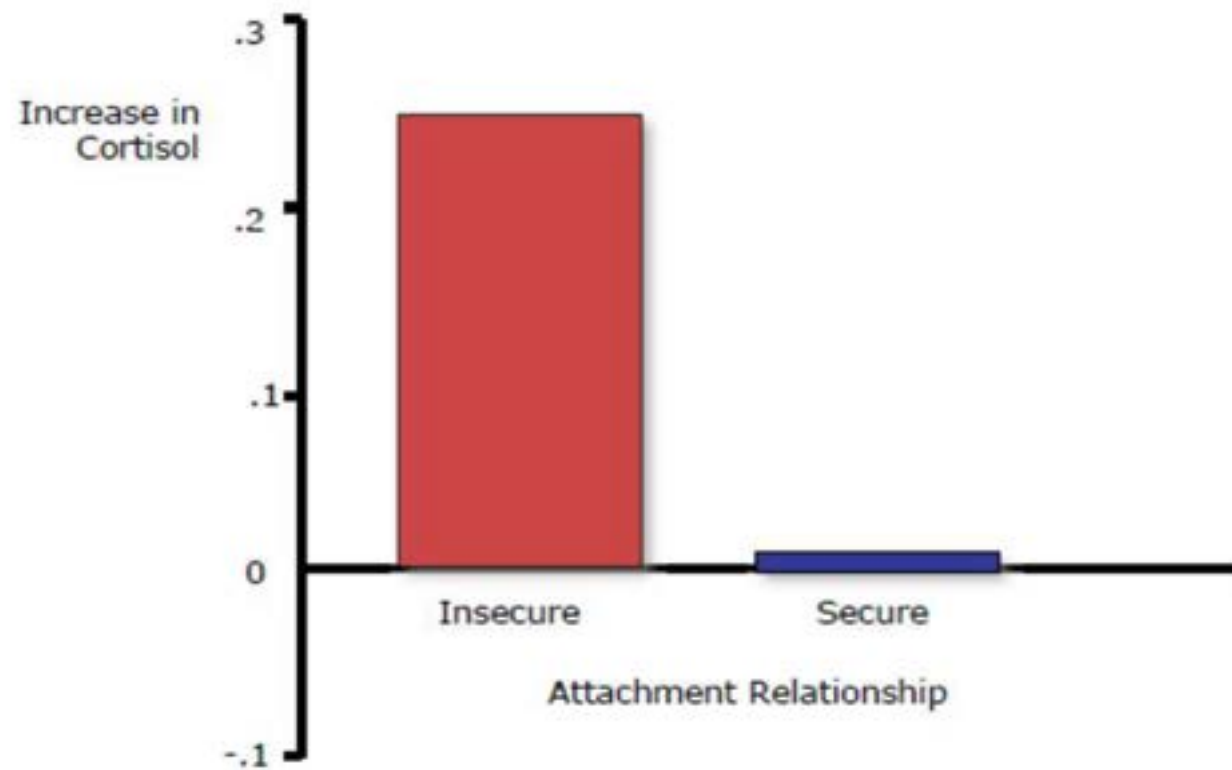


**Responsive relationships protect the developing brain.**

**Scientific research has proven that responsive, nurturing, protective relationships between children and caregivers are able to both buffer and heal developing brains from the damaging effects of toxic stress, while building child resilience.**

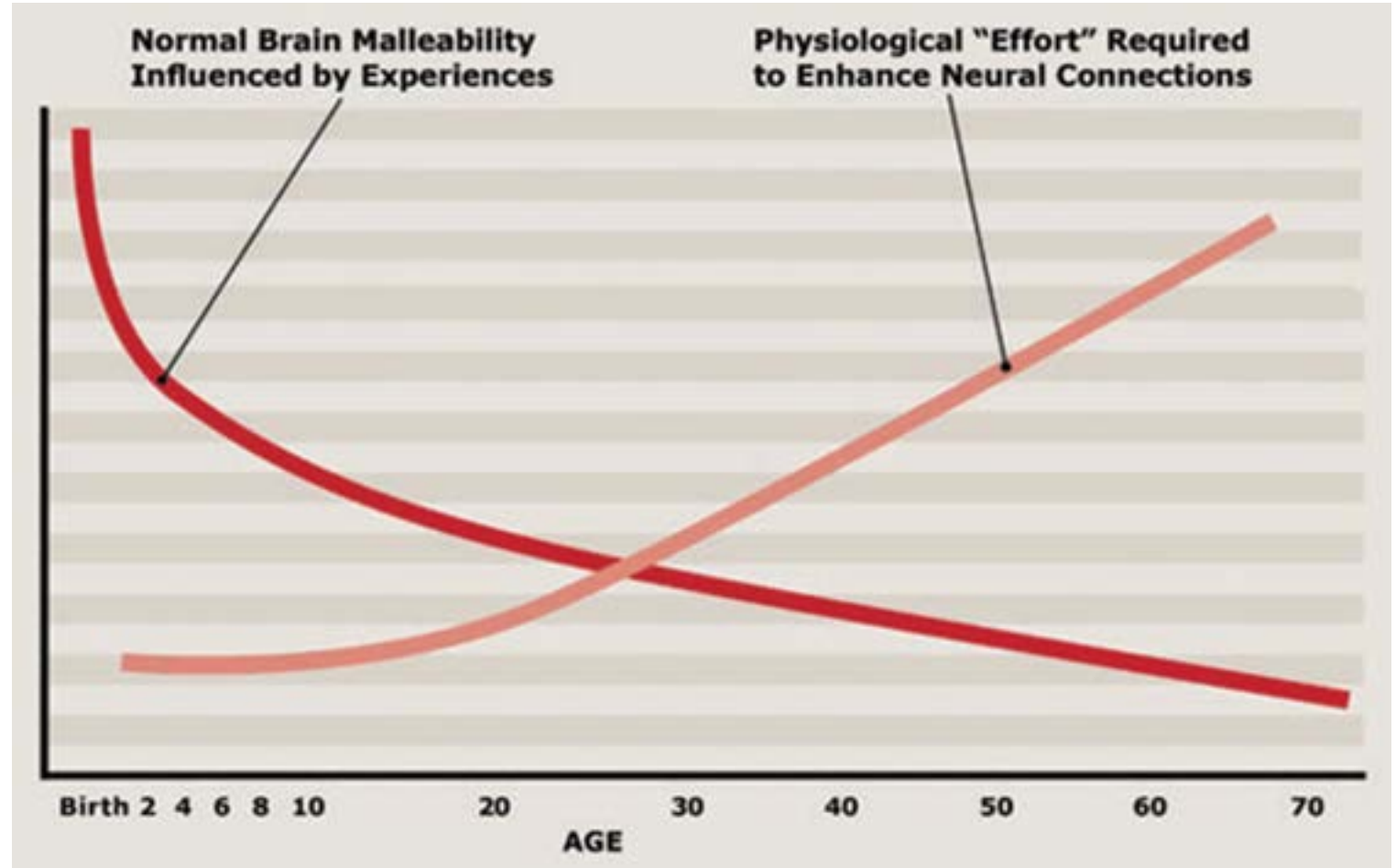


## Secure Relationships Calm Children's Stress Hormone Response



# Early Treatment Can Prevent Severe Mental Health Problems

- Intensive early treatment **prevents** later severe mental health problems
- Earliest years, the brain is most malleable:
  - Much easier to make change
  - Much less costly





**Child First is an evidence-based, two-generation, home-based intervention that serves young children and families experiencing trauma and adversity.**



# Target Population: Two-Generations

## Children: Prenatal to age 6 years

- Any problem that threatens healthy development
  - Emotional/behavioral problems
  - Developmental/learning problems
  - Trauma
  - Abuse and neglect



## Parents/Caregivers:

- Multiple challenges
  - Child protective services
  - Depression and other mental health problems
  - Substance use
  - Domestic violence
  - Homelessness
  - Poverty



# Based on Brain Science: Child First Team Approach

## Mental Health/Developmental Clinicians

- Promote responsive, nurturing, protective parent-child relationships to heal and buffer child's developing brain from high stress.
- Address parental trauma.
- Promote child attachment, safety, emotional health, and cognitive development.

## Care Coordinators

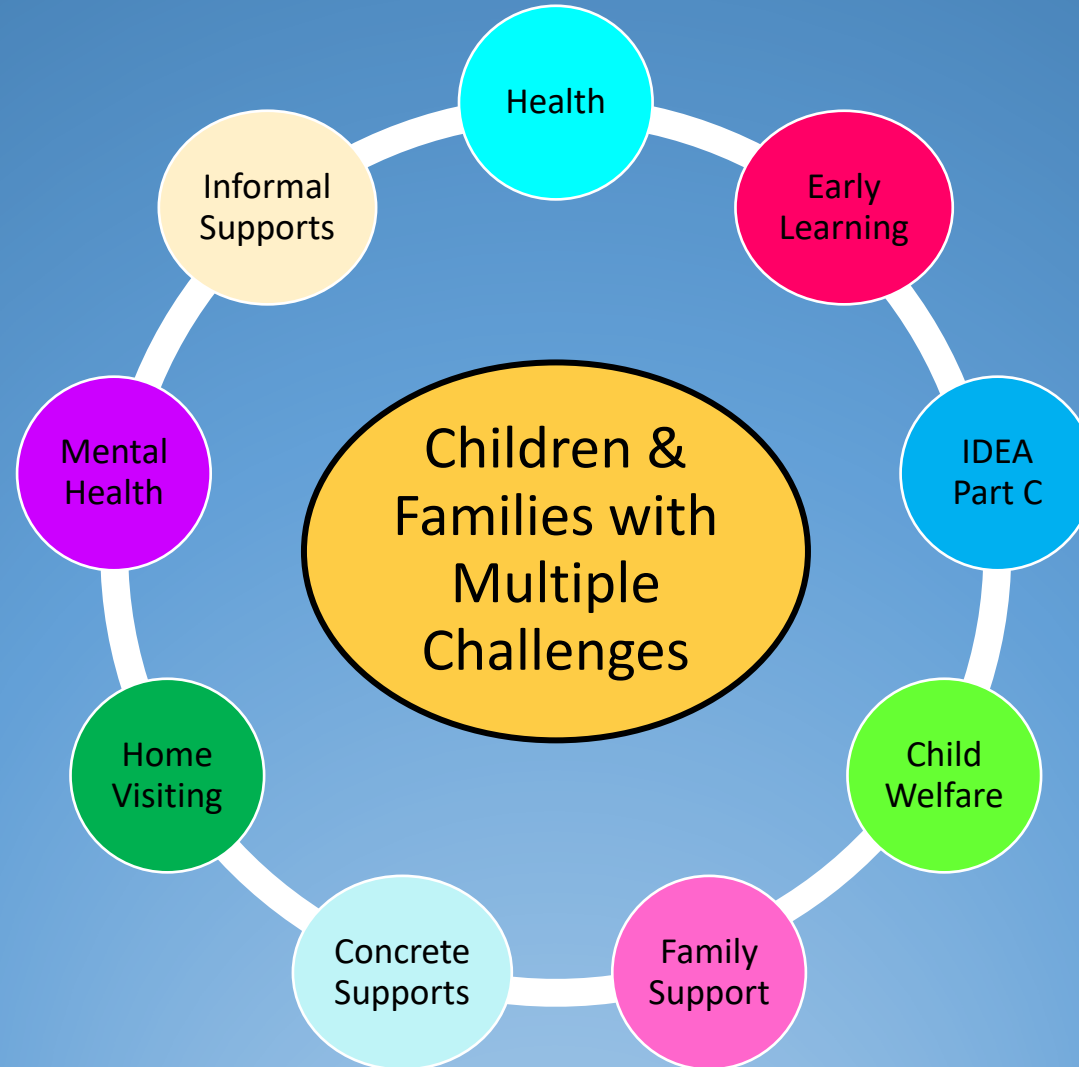
- Stabilize family.
- Connect family with comprehensive services and supports to decrease stressors.
- Enhance child and parent executive functioning.
- Promote growth-enhancing opportunities for whole family.

# Overview: Child First Intervention

- Family engagement
- Family stabilization
- Comprehensive assessment
- Family-driven Plan of Care
- Mental health consultation in early care and education
- Child-Parent Psychotherapy
- Connection to community services and supports – address SDoH
- Building executive functioning

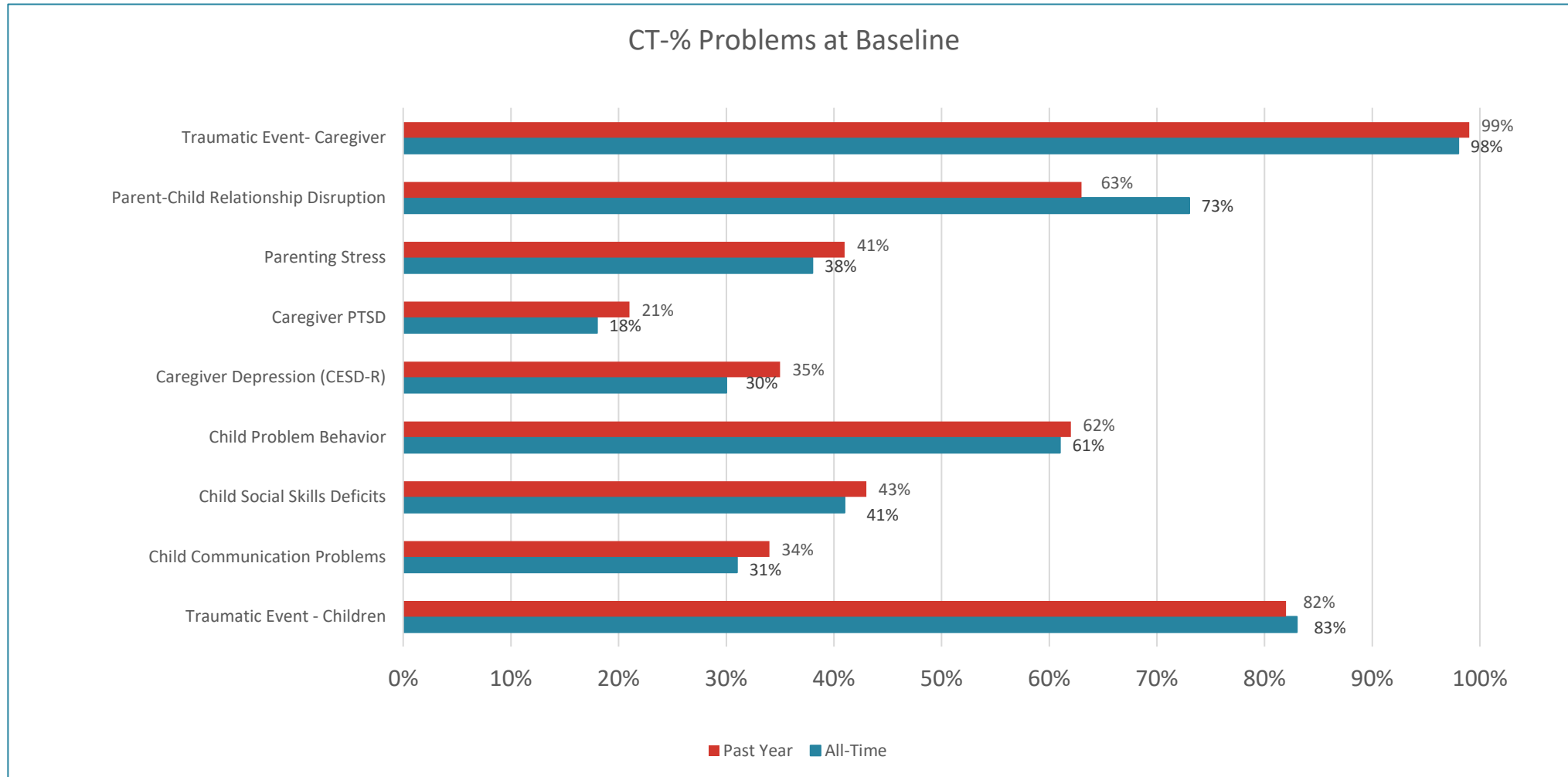


# Early Childhood System of Care



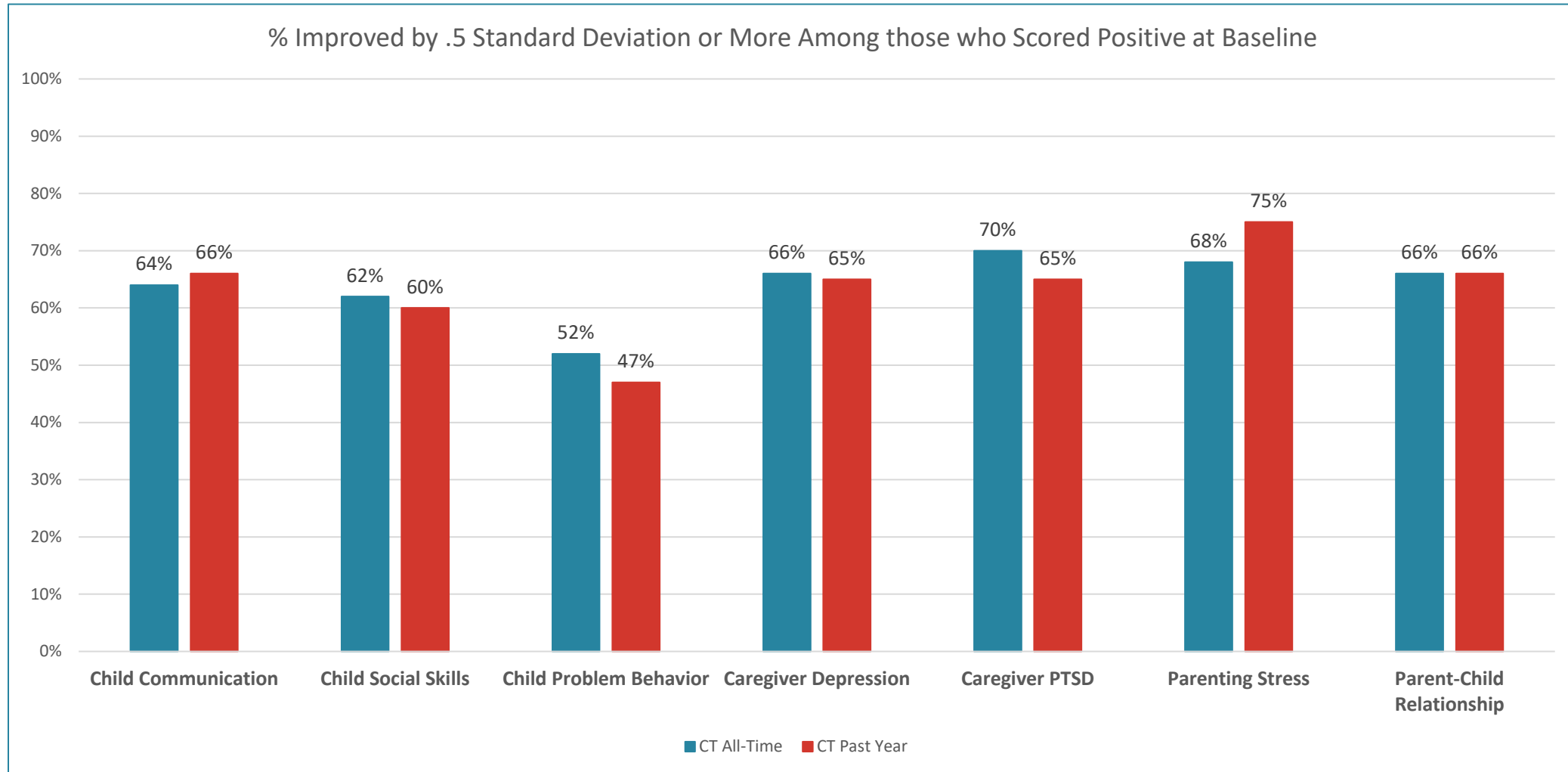
# Prevalence – Connecticut

Comparison among admissions 2010-2022 (All-Time) and January-December 2022 (Past Year)



# Percent Improvement in Outcomes - Connecticut

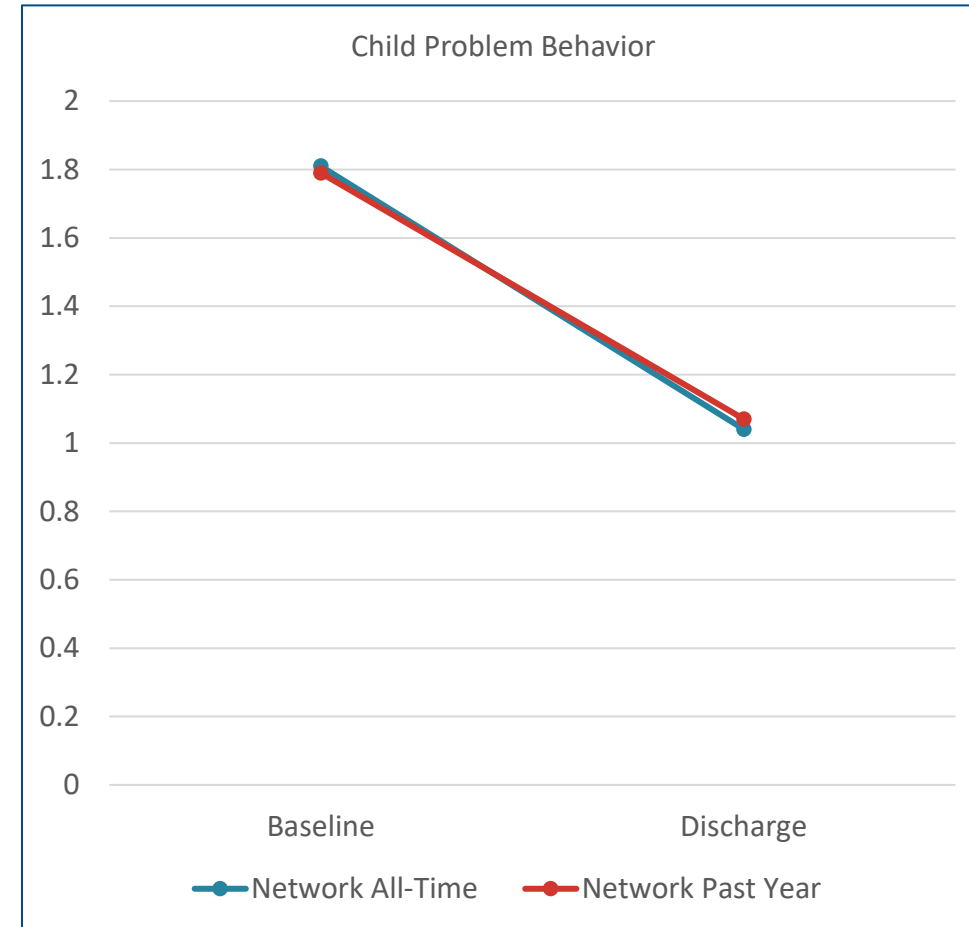
Comparison by Domain among Outcomes 2010-2022 (All-Time) and January-December 2022 (Past Year)



# Child Problem Behavior

## BITSEA & PKBS-2

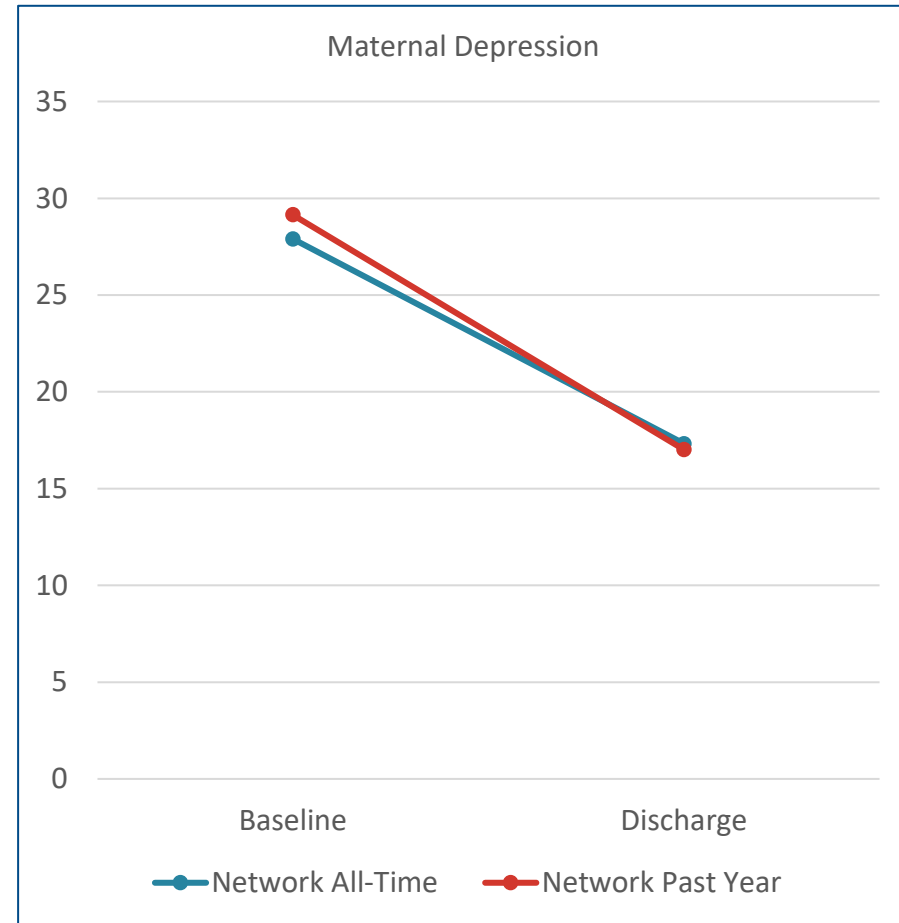
- Children that presented with problem behaviors at baseline showed large improvement
- Statistical significance:  
 $p < .0001$
- Effect size:  
All-time Cohen's  $d = 0.80$   
Past Year Cohen's  $d = 0.80$



# Maternal Depression

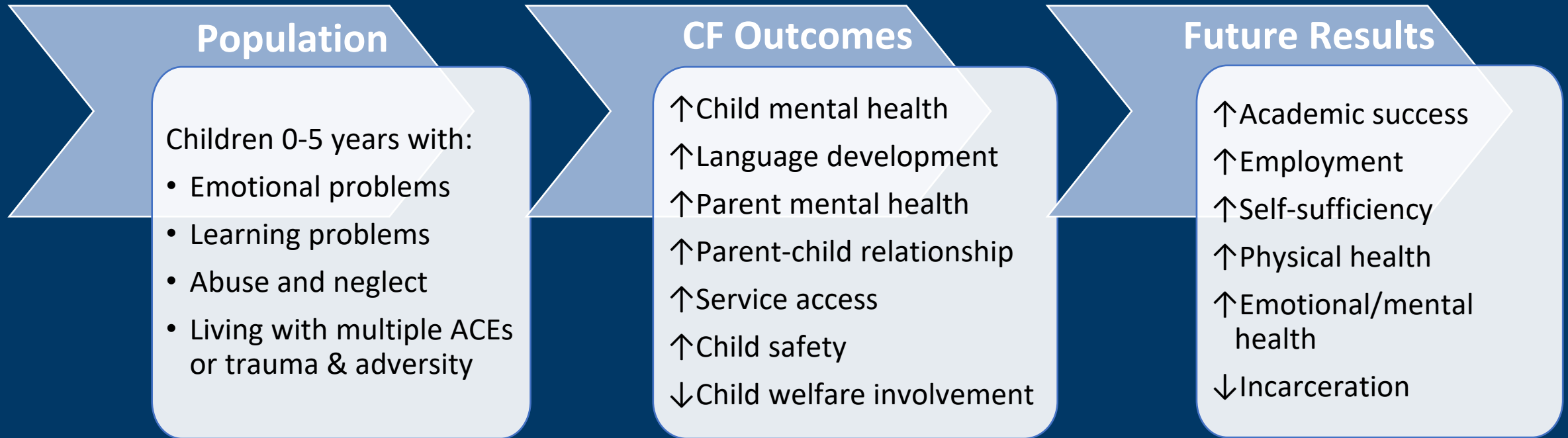
## CESD-R

- Mothers that presented with depression at baseline showed large to very large improvement
- Statistical significance:  
 $p < .0001$
- Effect size:  
All-time Cohen's  $d = 0.95$   
Past Year Cohen's  $d = 1.08$





# Trajectory of Children Served by Child First



# Cost Savings

- Child First implementation cost per family = \$9,000-\$10,000 (child and parent)
- Cost-Benefit:
  - Child-Parent Psychotherapy (CPP): Child First MH clinicians are fully trained. CPP returns \$13.82 for every \$1 spent to deliver the service.
  - Child First RCT showed: Decrease in child maltreatment: At 1 year = 40% decrease, at 3 years = 33% decrease. Cost of substantiation = \$34,000. Lifetime cost per victim of non-fatal maltreatment = \$210,000.
  - Of those children admitted to Child First “at risk for removal,” 75% remained in their homes. Cost to DCF for one child in foster care = \$81,232/year.
  - Youth with only 1 behavioral health ED visit in a year = \$12,043.
  - Cost of special education in CT for one child = \$28,548/year.
  - Societal cost of untreated maternal depression and anxiety = \$32,000.
  - Also cost savings in child and adult mental health services, healthcare, education, and juvenile/criminal justice.

# Child First Summary

- Families experiencing trauma and adversity
- Children with behavioral/mental health problems
- Intensive in-home service - Two-generation treatment
- Evidence-based – MIECHV, FFPSA, NREPP, California Clearinghouse, Colorado Blueprints
- Prenatal to age 6 years
- Trauma informed psychotherapeutic intervention – CPP
- Comprehensive care coordination, focused on SDOH, ACEs
- Rigorous training, supervision, data collection
- Strong consistent outcomes over 12 years
- Cost effective





# Thank you!

Darcy Lowell, MD  
Founder, Child First

# Addendum

# Capacity / Waitlists

- Child First began at Bridgeport Hospital in 2001, began replicating in 2010, and had coverage in all regions of the state by 2021.
  - Maximum number of agencies = 15
  - Maximum number of teams = 57
  - Capacity to serve 1,311 families
- **Current capacity** has decreased markedly, after OEC's focus on primary prevention and the elimination of ARPA funding.
  - **Current number of agencies = 11**
  - **Current number of teams = 36**
  - **Capacity to serve 828 families**
- Existing agencies are trying to cover the entire state. Saw 950 families in 2022.
- Current waitlist across CT is over 200 children and families, which is not reflective of the much higher need for services in CT.
  - Single agency with a waitlist of 74 families.

**Loss of 4 agencies, 21 teams, capacity to see 483 families.**

# Current Funding Streams

## Current:

- DCF: Funds 11 affiliate agencies with 25 teams (Some TANF funding)
- OEC: Funds 9 teams (Some MIECHV funding from HRSA)
- VOCA (Victim of Crime Act) funds 1 team
- Philanthropy funds 1 team
- TOTAL: 36 teams

## Future possible funding:

- Medicaid / EPSDT
- MIECHV - \$1.4 million in new federal funds
- Family First (Title IV-E) - Child First is “Supported” and in the middle of another RCT.
- TANF
- CAPTA
- State funding

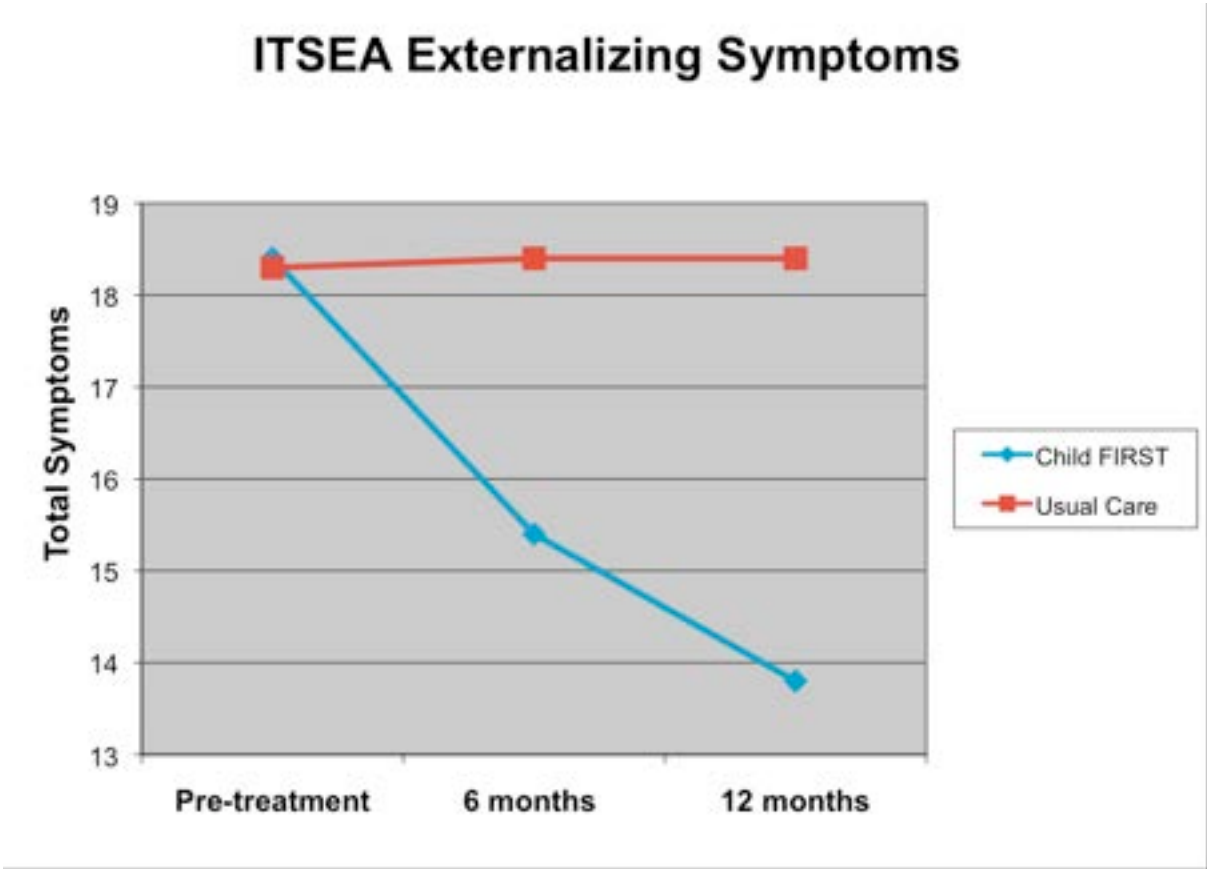
# Child First Randomized Controlled Trial

[*Child Development*, January/February 2011]

- **Ethnicity/Race:**
  - 59% Latino, 30% Black, 7% Caucasian
- **Family Challenges:**
  - 94% public assistance
  - 67% unmarried
  - 64% unemployed
  - 54% depression
  - 53% did not complete high school
  - 44% history of substance abuse
  - 25% history of homelessness

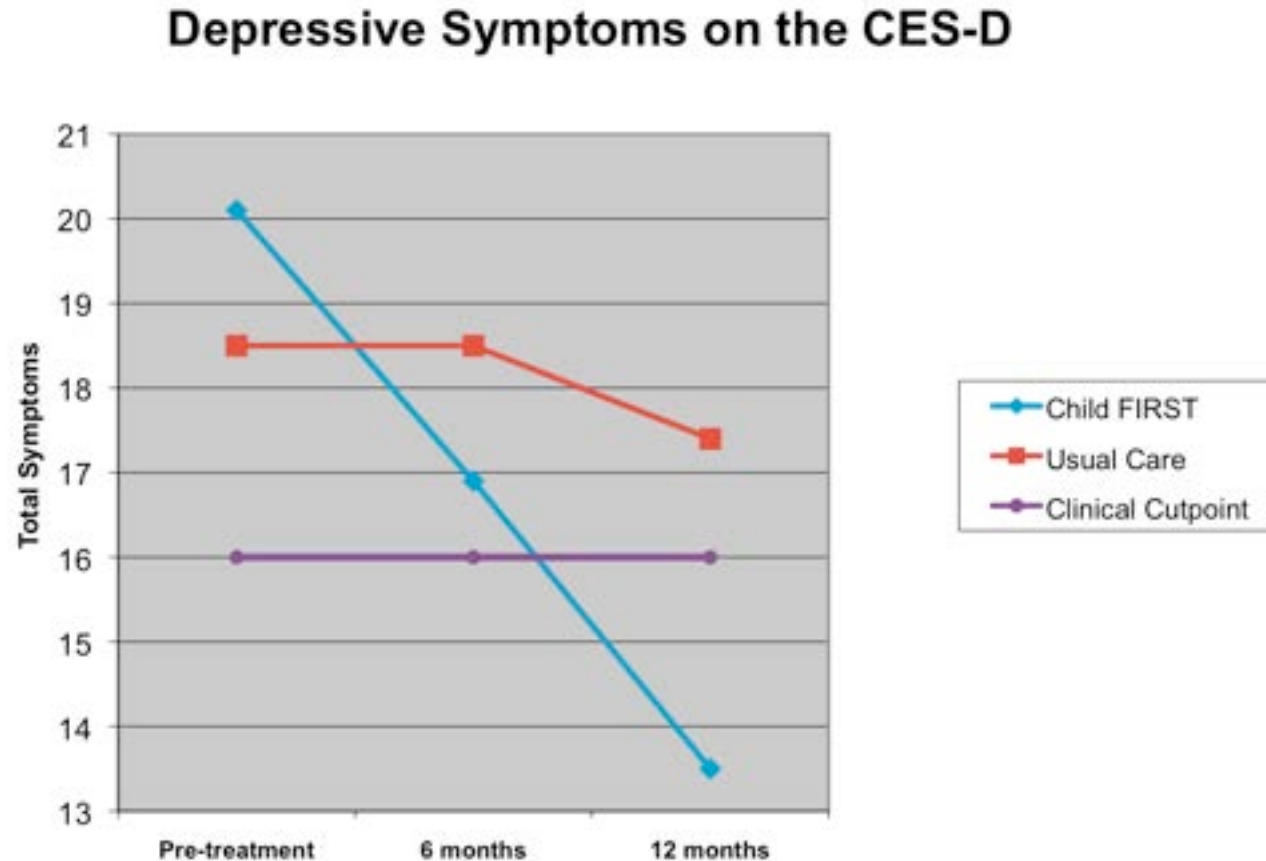


# Child Mental Health Problems



42% decrease in aggression, defiance, impulsiveness

# Maternal Depression



64% less likely to have depression or mental health problems



# Children and Youth with Neurodevelopmental Disorders

**MICHAEL D. POWERS, PSY.D.**

THE CENTER FOR CHILDREN WITH SPECIAL NEEDS  
GLASTONBURY, CONNECTICUT  
AND  
YALE CHILD STUDY CENTER  
YALE UNIVERSITY SCHOOL OF MEDICINE  
NEW HAVEN, CONNECTICUT

[WWW.CCSNCT.ORG](http://WWW.CCSNCT.ORG)



“Early onset neurodevelopmental disorders include a broad range of conditions that affect brain function in children, including different diagnostic categories such as fetal alcohol syndrome, attention-deficit/hyperactivity disorder, intellectual disability, and autism spectrum disorders. They are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. Combined, they affect more than 10% of all children, and some disabilities are permanent throughout their lifetime. Causes are heterogeneous ranging from social deprivation, genetic and metabolic diseases, immune disorders, infectious diseases, nutritional factors, physical trauma, and toxic and environmental factors.”

Bourgeron T. What Do We Know about Early Onset Neurodevelopmental Disorders?  
In: Nikolich K, Hyman SE, editors. *Translational Neuroscience: Toward New Therapies*.  
Cambridge (MA): MIT Press; 2015. Chapter 2. Available from:  
<https://www.ncbi.nlm.nih.gov/books/NBK569702/>



# Who Are These Individuals?

- ***Autism Spectrum Disorder***
  - Deficits in social communication and social interaction, and
  - Restricted repetitive behaviors, interests, and activities (RRBs).
- ***Intellectual Developmental Disorder***
  - Both cognitive and adaptive deficits are implicated, but severity is determined by adaptive functioning rather than IQ score.
- ***Attention-Deficit/Hyperactivity Disorder***
  - With/without hyperactivity
- ***Communication Disorders***
  - Language disorder (expressive and mixed receptive-expressive language disorders), speech sound disorder (formerly phonological disorder), and childhood-onset fluency disorder (formerly stuttering), social (pragmatic) communication disorder
- ***Specific Learning Disorders***
  - E.g., Dyslexia, other specific reading disorders, disorders of mathematics, written expression
- ***Motor Disorders***
  - E.g., Tourettes disorder, persistent (chronic) motor or vocal tic disorder, stereotypic movement disorder, developmental coordination disorder

# Identified Prevalence of Autism Spectrum Disorder From The CDC Autism and Developmental Disabilities Monitoring (ADDM) Network 2000-2020 Combining Data from All Sites

Source: National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention

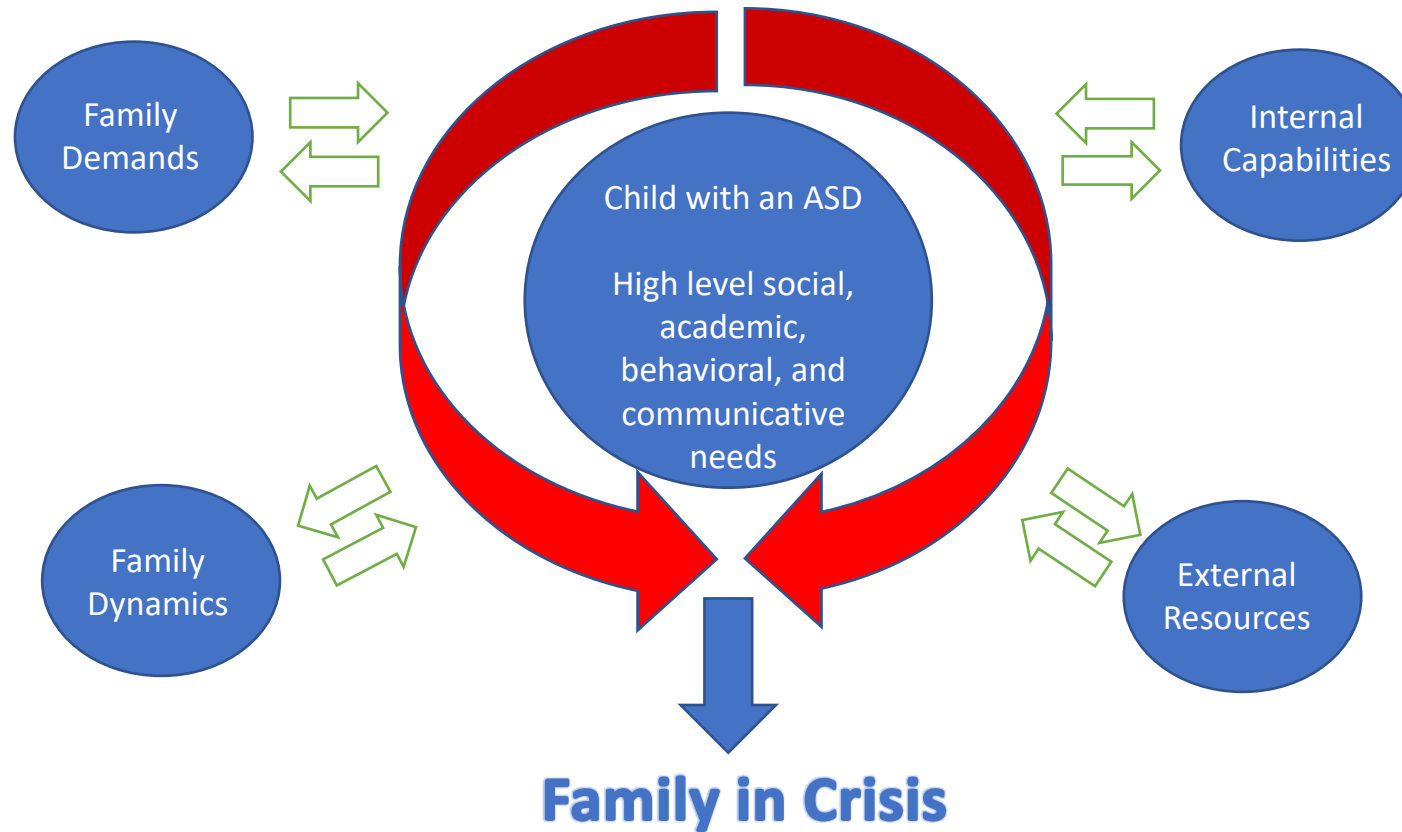
Surveillance Year	Birth Year	Number of ADDM Sites Reporting	Combined Prevalence per 1,000 Children (Range Across ADDM Sites)	This is about 1 in X children
2020	2012	11	27.6 (23.1-44.9)	1 in 36
2018	2010	11	23.0 (16.5-38.9)	1 in 44
2016	2008	11	18.5 (18.0-19.1)	1 in 54
2014	2006	11	16.8 (13.1-29.3)	1 in 59
2012	2004	11	14.5 (8.2-24.6)	1 in 69
2010	2002	11	14.7 (5.7-21.9)	1 in 68
2008	2000	14	11.3 (4.8-21.2)	1 in 88
2006	1998	11	9.0 (4.2-12.1)	1 in 110
2004	1996	8	8.0 (4.6-9.8)	1 in 125
2002	1994	14	6.6 (3.3-10.6)	1 in 150
2000	1992	6	6.7 (4.5-9.9)	1 in 150



# Prevalence of ASD in Children From 0-18 Years In Connecticut

- Population of children under 18 years of age in CT: **729,710**
- *Number of children estimated with ASD (2.8% per CDC): **20,432***
- Number of children living in poverty in CT: 12.7% of the population under 18, or **92,673** children. *Children living in poverty who have ASD are the most vulnerable and most likely to lack access to ASD services.*

# How Does A Crisis Arise in A Child With ASD?





# What Are Some Of The Behavioral Health Challenges That Might Occur?

- *Externalizing Problems*

- Aggression
- Self-Injury
- Property Destruction
- Inappropriate Social Behavior
- Stereotypy Or Ritualized Interests That Lead To Episodes Of The Above

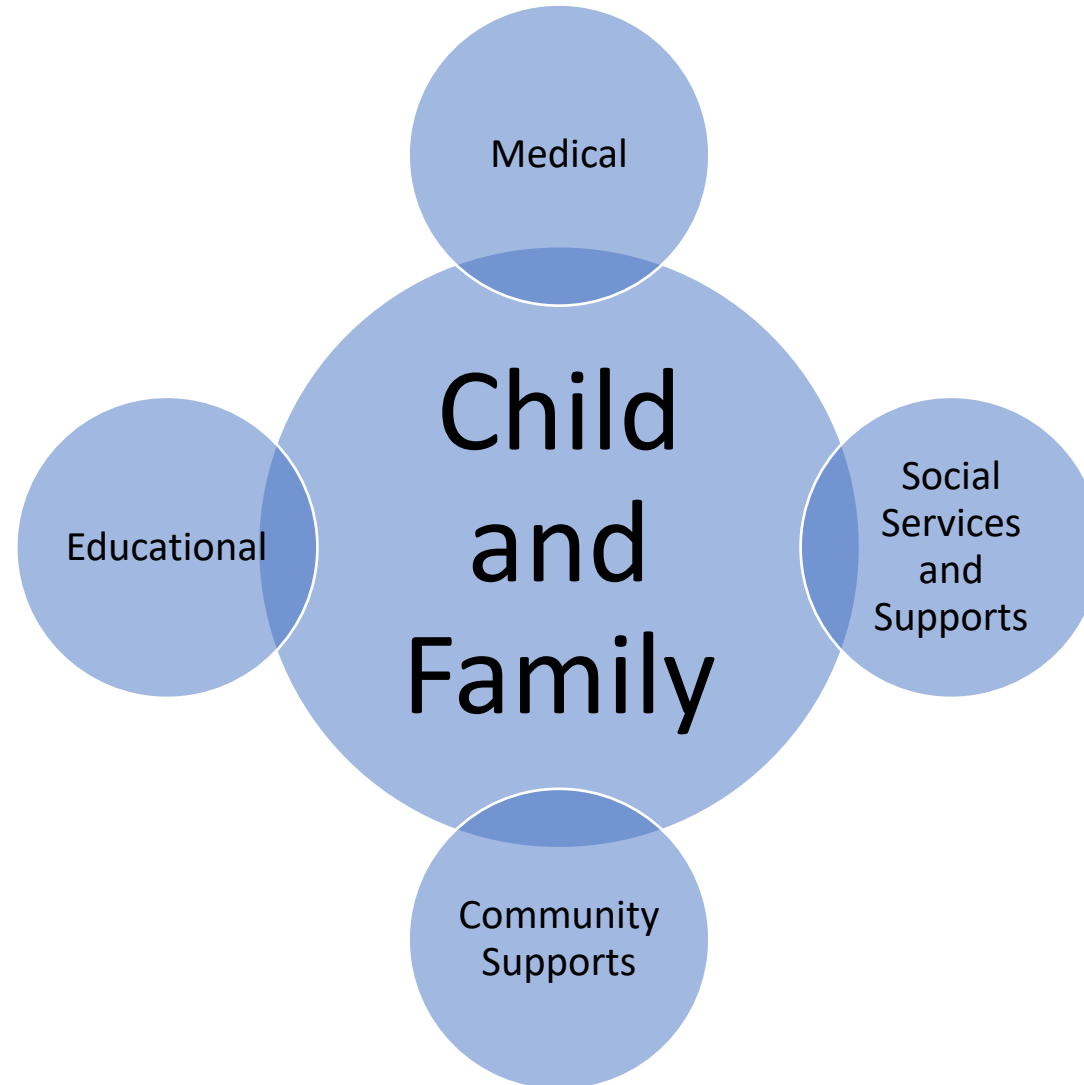
- *Internalizing Problems*

- Anxiety
- Depression
- Obsessive-Compulsive Disorder
- Gender Dysphoria

Trauma can exacerbate any of the above in ways that may be *inconsistent* with the experience of those who do not have ASD



# Understanding The Ecosystem Of Solutions





**Thank You**

**[mpowers@ccsnct.org](mailto:mpowers@ccsnct.org)**