Strengthening the Foundation: Analysis of Connecticut's Outpatient Mental Health System for Children

A report prepared for the Connecticut Department of Children and Families

Developed by the Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut

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INTRODUCTION AND METHODS

This brief report summarizes findings from a study of the strengths and needs of routine outpatient mental health treatment in Connecticut and provides recommendations for system improvements. The full report can be found at http://chdi.org/publications.php.

Routine outpatient mental health treatment is defined as services provided to children and families, primarily in office-based settings, using individual, family, and group therapy techniques, and including case management and other supporting services. Important characteristics of outpatient services in Connecticut, including characteristics of providers, clients, and services provided, are not well understood. In addition, there has been limited work conducted to identify and prioritize needs for service improvements. The current study was designed to begin to address these issues.

The Department of Children and Families (DCF) commissioned and paid for this study through a Personal Service Agreement with the Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute (CHDI), with additional funding and support from the Children's Fund of Connecticut and the Connecticut Health Foundation. The decision to examine outpatient treatment was based in part on a recommendation from the CCEP Advisory Board, which comprises

state agency administrators, mental health service providers, researchers, and family advocates. The target audience for this report includes all parties who are interested in routine outpatient mental health treatment for children, including but not limited to the following stakeholders: DCF, outpatient treatment providers, children and families, family advocates, and funders. The findings and recommendations from this report can contribute to a collaborative process among these stakeholders to identify and prioritize areas for statewide service improvements in routine outpatient treatment and to plan for how these service improvements will be implemented.

Children with mental health needs in Connecticut require a comprehensive array of services and supports. Routine outpatient mental health treatment is one of the most fundamental programs in a comprehensive service array, serving more children with mental health needs each year than any other mental health service. Statewide efforts to reduce reliance on more restrictive levels of mental health care (e.g., residential treatment, inpatient hospitalization) and increase community-based treatment options have expanded, particularly since implementation of KidCare in 2005. It is unclear, however, whether expansion of the routine outpatient treatment system has been sufficient to meet the demand for services. Increased attention to routine outpatient treatment would help establish a strong foundation for Connecticut's community-based children's mental health treatment system, and prepare this system to meet the current and future needs of Connecticut's children and families.

The study sought input from a number of stakeholders in outpatient treatment including representatives from the following: parents and family members; the Connecticut Community Providers Association; DCF Central Office, Area Office, and Area Resource Group (ARG) staff; Child Guidance Clinic (CGC) and other routine outpatient program clinicians and administrators; and ValueOptions Intensive Care Managers (ValueOptions is the Administrative Services Organization for the Connecticut Behavioral Health Partnership). Input from a diverse group is intended to bring together the best thinking and experience related to outpatient treatment. Survey data were collected from 32 agencies across the state and site visits were conducted with nine agencies. Participating agencies served the ten most populated communities in Connecticut; thus, the sample referenced in this report is representative of the largest segment of children and families receiving mental health services in the state.

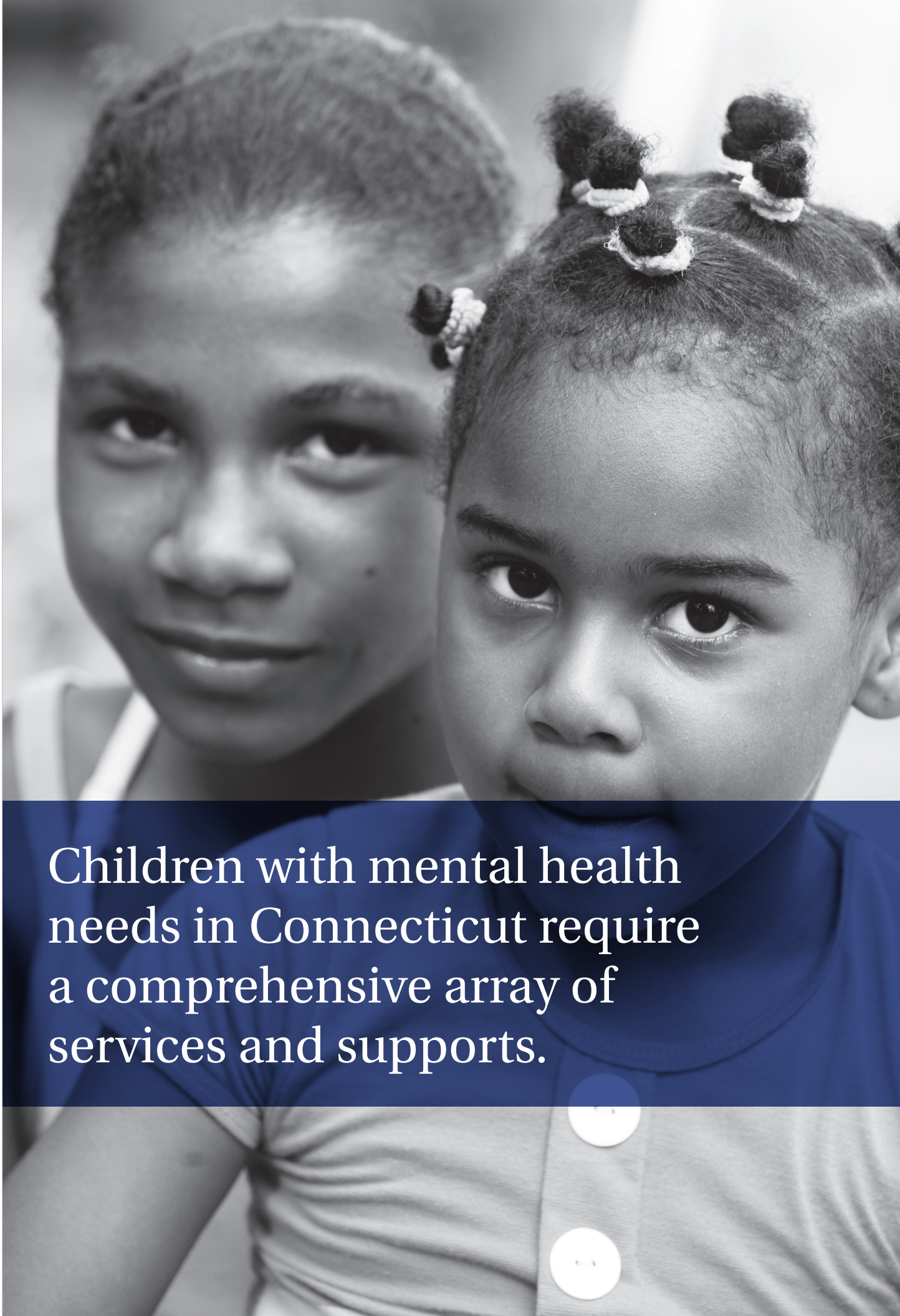
Study methods included interviews, focus groups, and online surveys. Key practice areas and characteristics were examined and findings are summarized below in each area, including:

(1) **Characteristics of clinicians and agencies**
(2) **Characteristics of children and families served**
(3) **Indicators of client and case complexity**
(4) **Screening and assessment practices**
(5) **Service delivery practices**
(6) **Staffing and workforce development**
(7) **Data collection, analysis, and application**

One of the goals of this report was to examine quantitative data on characteristics of clients and service delivery practices. The data infrastructure and internal reporting processes at each outpatient clinic varied a great deal, with some providers producing extensive reports based on their data and other providers relying on the summary reports provided by the Connecticut Behavioral Health Partnership (CT BHP) or a statewide data reporting system. Furthermore, some providers have access to data from the past month, the past quarter, or the past year, and these time frames differ among providers. One challenge in this report was to find a common way to summarize quantitative data given these constraints. In this study, we asked for a level of data that all providers were able to produce, often in the form of percentages. When summarizing percentages, we chose to analyze these data descriptively by providing medians and ranges.

SUMMARY OF FINDINGS

Strengthening the Foundation:
Analysis of Connecticut's Outpatient
Mental Health System for Children



Children with mental health needs in Connecticut require a comprehensive array of services and supports.

CHDI

SUMMARY OF FINDINGS

The Role of Outpatient Services in Connecticut's System of Care

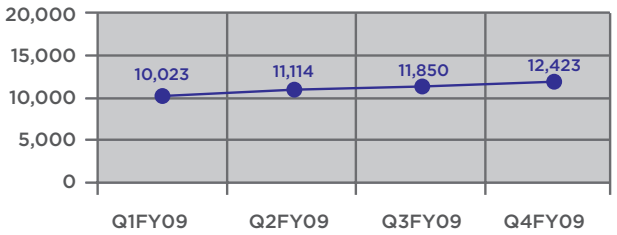
Nationally, as well as in Connecticut, the majority of children and adolescents who become involved with the behavioral health service system are seen in routine outpatient treatment settings. The Behavioral Health Data System (BHDS) and the Program and Services Data Collection and Reporting System (PSDCRS) are the data systems most recently used to track case flow indicators such as admissions, discharges, total enrollment, and length of stay. Historically, both DCF and the outpatient provider community have had concerns about data quality and reliability for these data systems. Although recent efforts have been directed toward improvement in this area, current data should be interpreted cautiously and further data should be collected to determine trends.

Network-level BHDS submissions from CGCs through the 4th Quarter of Fiscal Year (FY) 2009 (July 2008 through June 2009) underscore the important role of outpatient treatment in the state, and highlight sustained demand for services within this level of care. BHDS submissions during this time indicate the following:

- **An average of 2,309 children were admitted to CGCs each quarter**
- **An average of 1,641 children were discharged from CGCs each quarter**
- **Median length of stay in CGCs was 11.6 months; mean length of stay was 17.2 months**

Figure 1 displays BHDS data on the total number of children remaining in care for each quarter of FY 2009.

Figure 1: Children Remaining in Child Guidance Clinic Care: FY 2009 BHDS Submissions

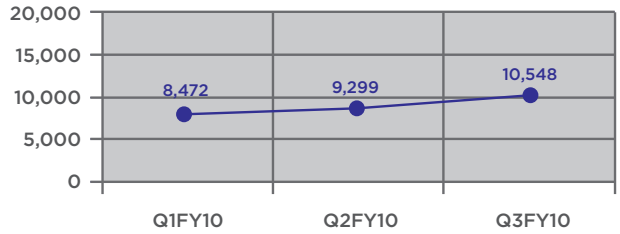


In FY 2010, DCF began using the PSDCRS to track enrollment indicators. DCF indicates that not all providers are consistently reporting data to PSDCRS and that the system continues to build toward full implementation. Nevertheless, PSDCRS data from the first three quarters of FY 2010 indicate the following:

- **An average of 2,731 children were admitted to CGCs each quarter**
- **An average of 1,889 children were discharged from CGCs each quarter**
- **Median length of stay in CGCs in Quarter 3 was 6.9 months; mean length of stay in Quarter 3 was 12.4 months**

Figure 2 displays PSDCRS data on the total number of children remaining in care for the first three quarters of FY 2010.

Figure 2: Children Remaining in Child Guidance Clinic Care: FY 2010 PSDCRS Submissions



…outpatient treatment in Child Guidance Clinics is a highly utilized component of the mental health treatment system that serves many children and families.

Given their limitations, it is not appropriate to use these data alone to reliably establish trends or project future enrollment. However, both BHDS and PSDCRS data indicate that outpatient treatment in CGCs is a highly utilized component of the mental health treatment system that serves many children and families. Furthermore, the data suggest that enrollment in CGCs could be growing. As PSDCRS builds toward full implementation, outpatient stakeholders will be able to monitor trends in enrollment, admissions, discharges, and length of stay with increased confidence and use these data to support planning and decision-making.

The possible growth in outpatient services during FY 2009 and FY 2010 is consistent with the goals of KidCare and this level of growth, if accurate and sustained over time, could have important policy and practice implications. Some outpatient providers expressed serious concerns as to whether the outpatient treatment system had the capacity to accommodate a high level of growth. If significant growth in enrollment does occur, meeting the treatment needs of many more children and families in the next few years would require recruiting, hiring, retaining, and training more outpatient clinicians. It is unclear from these data alone whether the current capacity of the outpatient mental health system would be sufficient to meet a large increase in demand. It is possible that further strains on capacity due to growth in enrollment without a sufficient infusion of additional resources could lead to compromises in treatment access, quality of care, and compliance with licensing, accreditation, and documentation requirements. Outpatient enrollment growth and related issues of treatment capacity require continued analysis and planning.

Characteristics of Agencies, Administrators, Clinicians, and Clients Served

Responses to two versions of an online survey (Agency Survey completed by directors, Clinician Survey completed by clinicians) were used to estimate socio-demographic and employment characteristics of the professionals providing and managing the delivery of outpatient treatment, as well as the children and families they serve. Although 32 agency administrators responded to at least part of the Agency Survey, approximately 18 administrators responded to most or all of the survey.

There was a wide range in the number of clinical staff at outpatient clinics, with some very large and some very small clinics represented. There were approximately 23 agency administrators that responded to most items to describe outpatient clinics. Results are summarized in Table 1. Specific findings include:

- **The average total number of clinical full-time equivalents (FTEs) was 7.8 (s.d.=5.7) with a range of 0.60 to 26.0.**
- **The number of psychiatry hours provided to children varied from 2 to 500 hours per month, with a median of 46 hours.**
- **The outpatient clinics that were surveyed reported few exclusionary criteria for outpatient treatment; however, when they did so, outpatient providers were most likely to exclude children with substance abuse disorders and significant mental retardation or developmental disabilities.**
- **Exclusionary criteria point to potential gaps in the system of care and highlight the importance of ensuring that treatment options are available to these youth.**

Outpatient administrators responded to survey questions regarding their demographic characteristics. The degree to which the sample is representative of all outpatient administrators is unknown. The results of the survey, therefore, are considered an estimate of administrator characteristics. Among responding administrators:

- **72% were over the age of 40**
- **91% were Caucasian**
- **63% were women**
- **91% held an advanced degree in psychology, social work, or a related field including 72% with a master's degree and 19% with a doctoral degree**
- **84% were licensed in Connecticut to provide clinical services**

Table 1. Staffing Characteristics

Staff Member	n	Mean (standard deviation)	Median	Range
Clinician FTEs	23	7.8 (5.7)	7.0	0.6 - 26.0
Psychiatrist FTEs	23	1.0 (0.9)	1.0	0 – 3.5
Volunteer FTEs	19	0.5 (0.2)	0	0 - 1
Intern FTEs	23	2.4 (2.2)	2	0 - 10
Fee for Service FTEs	18	1.6 (3.0)	0.2	0 - 12
Psychiatry Hours	20	103.8 (122.4)	46	1.96 - 500

Responses to the Clinician Survey were used to estimate characteristics of the population of clinicians providing services to children and families in Connecticut. The degree to which these findings generalize to all outpatient clinicians is unclear. However, survey results revealed the following characteristics among those who responded to the survey:

- 63% of clinicians were under 40 years old
- 87% of responding clinicians were Caucasian
- 83% were employed full-time
- 34% had been employed for one to five years
- The median annual income was in the range of $40,000 to $49,999
- 57% were licensed in the state of Connecticut to provide clinical services
- 81% endorsed a cognitive-behavioral theoretical orientation and 75% endorsed a family systems orientation
- 6% were fluent in English and Spanish

Agency administrators reported the characteristics of children and families served in their outpatient clinics. Because administrators reported their data in percentages, summary data that are provided on the participating agencies are reported using median percentages and ranges as the best indicators of central tendency. In terms of socio-demographic information, clinicians and the children served differ in terms of gender, race/ethnicity, and Spanish language proficiency. This underscores the importance of ensuring a culturally diverse and culturally competent outpatient workforce. As a point of comparison, survey results from this study were compared to the most recent findings from the Behavioral Health Data System. These results are summarized in Table 2. Among the surveyed clinics, the following characteristics were found:

- The median reported percentage of adolescents (13 to 17 years old) served by responding outpatient clinics was 39.5% and the median reported percentage of younger children (4 to 7 years old) served was 17.5%.
- Across agencies, the median reported percentage of children that speak English was 84% and the median reported percentage of youth that speak Spanish only was 5%.
- The median reported percentage of Hispanic youth served was 20.5%. In addition, the median reported percentages of Caucasian and African-American youth were 50% and 14.5%, respectively.

Table 2. Demographic Characteristics of Clients Served: Survey and BHDS Data				
Client Socio-Demographic Characteristic	Survey: Number of Responding Administrators	Survey: Median Percentage	Survey: Range of Percentages	BHDS Data [a]
Age				
0-3 years old	Not reported	Not reported	Not reported	3%
4-7 years old	24	17.5%	0% - 35%	25%
8-12 years old	25	34%	5% - 70%	39%
13-17 years old	26	39.5%	15% - 100%	33%
Gender				
Boys	25	51%	40% - 80%	58%
Girls	25	49%	20% - 60%	42%
Primary Language				
English only	23	84%	5% - 100%	Not reported
Spanish only	20	5%	0% - 50%	Not reported
English and Spanish	21	10%	0% - 80%	Not reported
Other	13	0%	0% - 10%	Not reported
Race/Ethnicity				
White/Caucasian	24	50%	5% - 92%	40%
Hispanic	24	20.5%	3% - 85%	34%
Black/African-American	24	14.5%	1% - 40%	15%
Native American	14	0%	0% - 3%	Not reported
Asian/Pacific Islander	17	1%	0% - 4%	Not reported
Biracial/Multiracial	23	5%		Not reported
Other	Not reported	Not reported	Not reported	11%

Note. Response options between this survey and the BHDS do not match exactly. On the current survey, respondents could select more than one category when Hispanic ethnicity is considered in a combined race/ethnicity category.

In addition, the following characteristics were reported on the Agency Survey:

- **The median reported percentage of children living with their biological parents at intake was 71%**
- **The median reported percentage of children covered by Medicaid was 70%**
- **The median reported percentage of children involved with DCF was 43.5%**
- **In terms of referral source, the highest median reported percentage was for children referred by parents (38%)**

[a] BHDS data reflect percentages of the total population of children served in CGCs according to data submitted for Quarter 3 of FY 2009.

Treatment Capacity and Access

All stakeholders that were part of this study are interested in improving treatment capacity and access and improving attendance, as well as increasing outpatient clinic revenues. The average caseload among full-time clinicians responding to this survey was 29 clients, with variability among other types of clinical staff such as supervising clinicians, psychiatrists, and interns. Our results suggest that at least some clients are not seen weekly, which allows clinicians to see a larger caseload, thereby increasing access for new clients.

Among the clinics surveyed, the average number of monthly referrals, scheduled intakes, and completed intakes was 49.7, 40.1, and 34.0, respectively (see Table 3).

Table 4 summarizes data on average monthly scheduled intakes and referrals among all responding outpatient clinics. The data suggest that, on average, outpatient clinics schedule 71% of all referrals for an intake appointment and completed intakes for 59% of all referrals. Among those referred clients who schedule an intake, 84% complete the intake process.

Our findings suggested that some agencies advocate a long-term treatment episode of care that maintains a connection to a family, whereas other outpatient clinics emphasize brief episodes of care with tolerance for re-admissions, as needed. One outpatient administrator characterized their belief in shorter episodes of care in the following way:

"It's not normal for kids to be in therapy, they should be out in the community doing kid things and they're going to have bumps along the way where they will come back in and get some support and get some therapy. But what we do in our clinics is therapy, it's not being your friend or being your mentor, and that was a real line that we drew."

It was acknowledged by many outpatient stakeholders that average treatment length can have an effect on treatment capacity and access. The combination of growing enrollment in outpatient clinics and longer lengths of stay can result in therapy appointments that take place on a less than weekly basis.

Table 3. Number of Monthly Referrals and Intakes

Referral Indicator	n	Mean (s.d.)	Range
Number of Clients Referred	15	49.7 (44.4)	4 – 140
Number of Clients Scheduled for Intake	17	40.1 (33.1)	2 – 100
Number of Clients Who Completed Intake	16	34.0 (29.2)	2 – 100

Table 4. Proportions of Scheduled and Completed Intakes

Referral Indicator	n	Mean (s.d.)	Range
Scheduled Intakes / Referrals	14	71% (24%)	20% - 100%
Completed Intakes / Referrals	14	59% (20%)	16% - 90%
Completed Intakes / Scheduled Intakes	16	84% (12%)	61% - 100%

Table 5 summarizes data on caseloads among responding clinicians. According to these findings, clinicians report that, on average, they see 64% of their clients on a weekly basis.

Quantitative and qualitative data suggest potential concerns about treatment engagement, defined as attending six or more treatment sessions. Existing research suggests that less than one-half of all children that are referred for outpatient treatment engage in treatment for six or more sessions. This is a possible area for improvement in Connecticut. Although the Enhanced Care Clinic (ECC) initiative has significantly reduced the length of time from referral to intake, there remain concerns on the part of some stakeholders about the length of time from referral to treatment. Addressing treatment barriers also could improve attendance and treatment engagement rates. All stakeholders are concerned about treatment attendance and no-show rates as it pertains to maintaining productivity and financial viability. Increased family engagement and enhanced business practices can help address financial concerns and enhance treatment capacity to meet the demand for services. Results from the study of average treatment sessions are presented in Table 6.

This study did not collect the data necessary to respond to the question of whether treatment duration is, in fact, related to treatment quality. Rather, this study summarizes general perceptions on the issue as articulated by various stakeholders. The treatment literature is inconclusive as to whether total number of treatment sessions is related to children's outcomes. At least three studies demonstrate no relationship between the number of attended sessions and outcomes; however, many of these studies examined a simple relationship between number of sessions and outcome.[1-3] At least one study has reported a reverse-dose-response relationship whereby fewer sessions were related to better outcomes.[4] Another study found a positive dose-response relationship linking more sessions to better outcomes.[5] A recent study of 125 children randomly assigned to a public county-wide system of care examined dose-response relationships using multiple standardized outcome measures.[6] In each of the analyses examining the impact of total number of sessions on various measures of treatment outcome, there were no significant dose-response relationships discovered. As becomes clear from the literature and from the perceptions provided in this study, the issue is complex and requires further study in order to inform policy.

Table 5. Caseload Information

Type of Outpatient Clinician	Median Percentage	Range of Percentages
Clinicians (n=36)		
Percentage seen weekly	64%	16% – 100%
Percentage seen bi-weekly	31%	0% – 100%
Percentage seen monthly	10%	0% – 100%

Table 6. Average Treatment Sessions

Average Treatment Sessions	n	Median Percentage	Range of Percentages
0 treatment sessions	8	4%	0% - 16%
1-5 treatment sessions	9	23%	2% - 38%
6 or more treatment sessions	10	70%	45% - 100%
Completed treatment	10	65%	12% - 80%

Case Complexity, Case Management, and Family Engagement

The theme of increasing client complexity in outpatient treatment was relatively consistent across all stakeholder groups we encountered. The agencies that were part of this study reported that their clients were more likely to present to outpatient clinics with significant case management needs. The top five most identified indicators of case complexity included:

- **Treatment requires parent/family involvement**
- **Treatment requires communication with other agencies**
- **Child has co-morbid conditions**
- **Family is experiencing significant poverty**
- **Parent has a mental health diagnosis**

In addition, outpatient administrators reported that a significant proportion of their client population presents to treatment with a range of complex secondary clinical characteristics. These findings are presented in Table 7.

In addition to these issues, a significant portion of children and families seeking outpatient treatment have substance use issues, maltreatment history, and DCF involvement. These conditions often require significant case management and there are substantial limitations to reimbursing some case management services under current Medicaid regulations. Currently, there is limited use of standardized screening and assessment instruments to assess indicators of case complexity and treatment need in order to determine level of need and guide treatment planning.

Given these circumstances, the families and other stakeholders we surveyed described the need for more case management for families in outpatient treatment. Balancing mental health business practices with a commitment to maintaining high quality of care is a challenge, particularly during difficult economic times. Case management in children's mental health is a large and often hidden cost to agencies and some of these activities can be difficult to reimburse. Despite this, some of the outpatient clinics that were part of this study have increased their case management to

Table 7. Other Clinical Characteristics

Clinical Characteristics	n	Median Percentage	Range of Percentages
Substance abuse	19	5%	0% – 27%
Co-morbid psychological condition	17	50%	5% – 80%
Previous hospitalization	18	15%	3% – 80%
Residential placement	18	5%	1% – 20%

A comprehensive statewide initiative on family engagement in outpatient treatment could have important effects on treatment attendance, outcomes, and outpatient revenue.

clients, particularly for off-site case management (e.g., at schools). Consistent attention to and monitoring of case management activities and standards would help assess the need. Within existing rules and guidelines, creativity in seeking reimbursement for case management activities would help enhance this important aspect of outpatient treatment.

There was no disagreement among stakeholders on the importance of family engagement as a particularly important aspect of case management. Clinicians highlighted several indicators related to family engagement when asked to report the most important factors contributing to positive outcomes. Other stakeholders, including parents, also reported that there is a need for enhanced focus on family engagement. A comprehensive statewide initiative on family engagement in outpatient treatment could have important effects on treatment attendance, outcomes, and outpatient revenue.

Connecticut has experienced some recent success in addressing issues of family engagement in a state-funded program. The Extended Day Treatment program recently participated in an initiative to enhance family engagement based on a model developed by Mary McKay from Columbia University. Outpatient stakeholders in Connecticut should carefully review this initiative and consider a similar initiative for outpatient treatment.

Screening, Assessment, and Service Delivery Practices

Intake procedures were relatively consistent across clinics that were part of the study, although some used intake coordinators and others required clinicians to conduct their own intakes. Intake protocols were common and most followed a bio-psycho-social approach. Our findings suggested that 80% of surveyed clinicians reported using screening and assessment instruments during the intake process. Our interviews indicated that the Ohio Scales are commonly used because DCF requires this measure for outpatient treatment; however, the use of other screening and assessment measures to identify treatment needs and guide treatment planning was variable. Parents requested more efficient sharing of intake data within and across programs and services in order to reduce redundancy. Further ECC initiatives will focus on enhancing the capacity of clinics to assess and meet the needs of youth with co-occurring psychiatric and substance abuse conditions.

Stakeholders reported limited access to assessment and treatment for children with substance abuse, mental retardation and developmental disorders, and autism spectrum disorders. Currently, there is limited availability of treatment specializations in outpatient clinics, which will be an upcoming focus for ECCs. Families requested increased access to alternative interventions in the community besides office-based therapy and described the importance of early discharge planning to ensure that children remain in their natural surroundings with a sustainable network of services and supports. In terms of time allocation, clinicians reported that they spent most of their time in individual therapy and family therapy, case management, and completing clinical paperwork.

Across all system stakeholders, the importance of good intake assessment procedures was acknowledged. Many stakeholders believed that in addition to a bio-psycho-social intake process there would be tangible benefits to using standardized instruments to assess and track level of treatment need, identify strengths, and use that information to guide the treatment process. Many stakeholders expressed the importance of ensuring that intake and assessment information is transferable across clinics and can follow cases regardless of their point of access in the mental health service system.

Screening and assessment of specific conditions and diagnoses was also reported as a potential area for improvement in Connecticut. Treatment gaps were identified for children with autism, substance abuse disorders, as well as psychiatric medication needs. Clinicians with treatment specializations in these areas would have important benefits for Connecticut's children and families. Furthermore, parents identified a need for alternative treatment options and enhanced discharge planning.

Evidence-Based Treatments

A number of survey items and focus group questions addressed the issue of evidence-based treatments (EBTs). EBTs are interventions that have significant research support for positive outcomes, usually evidenced by one or more randomized controlled trials. EBTs are very well described treatments with numerous required practice supports to promote effective implementation. Evidence-based practices and treatments have become an important part of the service array in Connecticut and across the nation, yet several implementation barriers remain.

The penetration of EBTs in routine outpatient settings lags behind intensive in-home settings, although by the end of FY 2010, sixteen outpatient clinics will have received comprehensive year-long training in the DCF-funded Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative. A learning collaborative has been reported to be an effective mechanism for dissemination of EBTs.

Several barriers to implementation of EBTs were reported by outpatient stakeholders. Our findings suggest that implementation barriers exist at the individual, agency and system levels, and these barriers tend to be conceptual and logistical in nature. Some providers reported the perception that manualized EBTs do not have sufficient flexibility to meet the complex needs of their clients or that it is difficult to obtain the necessary training and ongoing supervision for staff, as well as the necessary quality assurance to maintain treatment fidelity.

Some providers reported concerns that EBTs are more expensive to implement than usual practices because of the increased need for supervision, meeting time, collateral contact and planning. Several outpatient providers, however, report that their use of EBTs contributes to increased productivity and client outcomes. Providers also reported a need for enhanced capacity to collect and analyze outcome data in order to support the successful implementation of EBTs.

Connecticut should consider investing in technical infrastructure development and training in order to prepare the outpatient mental health system to include more EBTs into routine practice.

As one outpatient stakeholder noted:

"One of the consequences of evidence-based practices is that it is accompanied by extra documentation, extra research, extra data collection, which often times is not accompanied with any extra funding. So, it's overtaxing already overtaxed organizations that often times have no choice but to accept the evidence-based model if they want to expand services. But yet, they have to contribute out of pocket for all the necessary infrastructure supports to make that happen."

In order for EBTs to be successful, agency staff acknowledged that buy-in and support from every level within the agency was vital. In short, the outpatient providers that were part of this study indicated that EBTs were an important part of the future, but indicated that implementation supports were necessary to ensure their successful integration into routine outpatient settings. The use of Learning Collaborative methodology to disseminate and sustain EBTs could be an important part of future implementation efforts.

Some outpatient clinics reported the presence of several EBTs, however, few are believed to include the necessary supports for effective implementation. Recent reports have identified the importance of "implementation drivers" that underlie effective service delivery and bridge the gap between research findings and implementation of those findings in community settings. This research identifies core implementation components, including:

- **Staff selection**
- **Pre-service and in-service training**
- **Ongoing coaching and consultation**
- **Staff evaluation**
- **Decision-support data systems**
- **Facilitative administrative support**
- **Systems intervention**

In addition to the above factors that support EBT implementation, stakeholders in outpatient treatment identified the following facilitators of EBT implementation:

- **Actively promoting EBTs during clinical and administrative meetings**
- **Investing in clinician training**
- **Adjusting productivity requirements to accommodate the need for increased training, supervision, and smaller caseloads**
- **Seeking supplemental funding from local, state, and federal sources**
- **Providing ongoing supervision and support to implement and sustain EBTs**
- **Building the capacity of provider organizations to use data and monitor fidelity of programs**

Connecticut should consider investing in technical infrastructure development and training in order to prepare the outpatient mental health system to include more EBTs into routine practice.

Staffing and Workforce Development

All system stakeholders we interviewed agreed that outpatient clinicians are hard-working and dedicated to the children and families they serve. All stakeholders also agreed with the need to hire and retain a cadre of well-trained outpatient clinicians that have strong incentives to remain employed in outpatient treatment settings. Clinicians and administrators we interviewed reported that low pay, burnout, and limited opportunities for training, professional development, and career advancement were the primary factors related to staff turnover. In the face of staff turnover and budget constraints, outpatient programs hire interns and practicum students to round out their clinical workforce. Some system stakeholders reported that a few providers rely excessively on interns for service delivery. Because interns generally leave after one year of employment, clinics that utilize interns as service providers are more likely to face the challenges associated with increased treatment disruptions. Excessive reliance on trainees to round out the outpatient workforce becomes problematic considering the following factors:

- **Insufficient supervision of trainees**
- **The clinical implications of yearly training cycles and turnover**
- **Trainees with poor preparation for direct service delivery**

There is some research guidance on the issue of how clinical experience relates to quality and outcomes. The empirical literature suggests that years of experience, as a marker of clinician expertise, has little relationship to psychotherapy outcomes, which suggests that years of experience could be a poor indicator of overall clinician experience.[8-9] A recent study suggests that therapists that see patients with similar presenting problems in rapid succession to one another typically achieve the best clinical outcomes.[10] This conceptualization of therapist experience suggests that client outcomes will be best among clinicians who are highly trained in a specific area of practice. This conceptualization is consistent with efforts to promote specialization areas and to train clinicians in specialized skills such as EBTs for specific conditions.

The importance of adequately preparing graduate students for clinical work was highlighted, as was the importance of hiring a culturally and linguistically diverse and competent workforce. Outpatient administrators reported that clinician retention and job satisfaction were supported by intensive in-service training opportunities, support and stability of agency leadership, clear and reasonable expectations, and competitive compensation and benefits.

Many agencies reported their desire for hiring interns and trainees that have exposure and training in EBTs. The Mental Health Transformation State Improvement Grant (MHT-SIG) links evidence-based practices and treatments closely with the need for enhanced training and workforce development. As part of the MHT-SIG workforce development project, students in graduate

All stakeholders reported that data has not been extensively utilized to monitor treatment outcomes, inform outpatient treatment practices, or guide treatment decision-making.

social work programs are receiving intensive training in specific home-based evidence-based treatments such as Multisystemic Therapy, Functional Family Therapy, and Multidimensional Family Therapy. Graduates who have participated in these courses are selected for placements in clinical sites that implement these treatments, which often can lead to employment opportunities upon graduation. This is an important demonstration of a model approach to enhancing the availability of a highly-trained workforce with skills in implementing evidence-based treatments. Results of this project could be monitored and considered for further replication.

Many outpatient providers described the importance of retaining talented clinicians in outpatient treatment settings. Many engaged in innovative strategies to promote clinician retention. Our site visit interviews revealed several factors and strategies related to staff retention, including:

- **Intensive in-service training opportunities**
- **Support and stability of agency leadership**
- **Clear and reasonable expectations for clinicians**
- **Respectful treatment as "valued and connected" team members**
- **Competitive compensation and benefits**
- **Financial incentives for consistently meeting productivity requirements**
- **Effective conflict-resolution procedures**
- **Financial support for pursuing continued education, training, and credentialing**

Data Collection, Analysis, and Application

Data collection is a part of everyday clinical practice for most outpatient programs, as evidenced by DCF and CT BHP requirements to collect and report basic demographic information as well as Ohio Scales outcomes data. Monthly and quarterly reports from CT BHP are provided for clinics designated as an ECC. Wide variability exists among clinics in their *application* of data. All stakeholders reported that data has not been extensively utilized to monitor treatment outcomes, inform outpatient treatment practices, or guide treatment decision-making. Clinicians also reported that they are the least likely to have data shared with them which can compromise the ability to use data to inform treatment.

Historically, the causes behind problems with data collection and application have been cyclical in nature. Outpatient program administrators that were surveyed reported that, although much data has been collected, relatively little data has been reported back to sites. On the other hand, DCF indicates that the quality of the provider data submissions has been variable, which significantly limits the usefulness of these data for analysis and reporting. The recent implementation of the Program and Services Data Collection and Reporting System (PSDCRS) has significant implications and potential for outpatient treatment, as does continued use of CT BHP utilization reports for ECCs. Many system stakeholders noted a need for enhanced use of data to guide continuous quality improvement, outcomes evaluation, and advocacy. Several indicators, besides Ohio Scales outcomes, were

suggested as potentially useful indicators of service quality and client outcomes. Suggested indicators included the following:

- **Stability of child's living situation**
- **Parent/guardian's responsiveness to child's needs**
- **DCF staff ratings of satisfaction with outpatient clinic services**
- **Creativity in meeting families' needs**
- **Participation of outpatient clinics in cross-system collaboration**
- **Reentry to treatment services and foster care**
- **Rates of substantiated maltreatment**
- **Rates of placement disruption (for children in foster care)**
- **Progression from higher levels of care into community-based services and supports**
- **Rates of closed DCF cases due to sufficiently lowered risk and improved functioning**

Outpatient stakeholders should continue to work together to identify a meaningful set of outcome indicators that accurately measure treatment effects.

Systems-Level Issues

Gaps in other areas of the mental health service system can create strain on outpatient departments. System stakeholders reported that routine outpatient treatment often is used for children that are waiting for, or stepping down from, higher levels of care. In addition, many children often present for multiple episodes of outpatient treatment. Parents and clinicians reported that access to other services in the mental health service array was important. They reported a shortage of non-therapeutic, natural supports and services in the community, such as school- and community-based recreational programs and activities, as well as housing, legal, and financial services. Residential treatment and psychological testing also were reported as least accessible in the broader service system.

The Clinician Survey asked clinicians to rate the accessibility of various services in the broader mental health system. The programs and services that outpatient clinicians rated as *most accessible* included:

- **24-hour emergency support (e.g., Emergency Mobile Psychiatric Services)**
- **Psychiatric assessment and medication management**
- **Medical services**
- **Mental health treatment for parents**
- **Therapeutic support services**

Early planning can have important benefits for implementing service improvements.

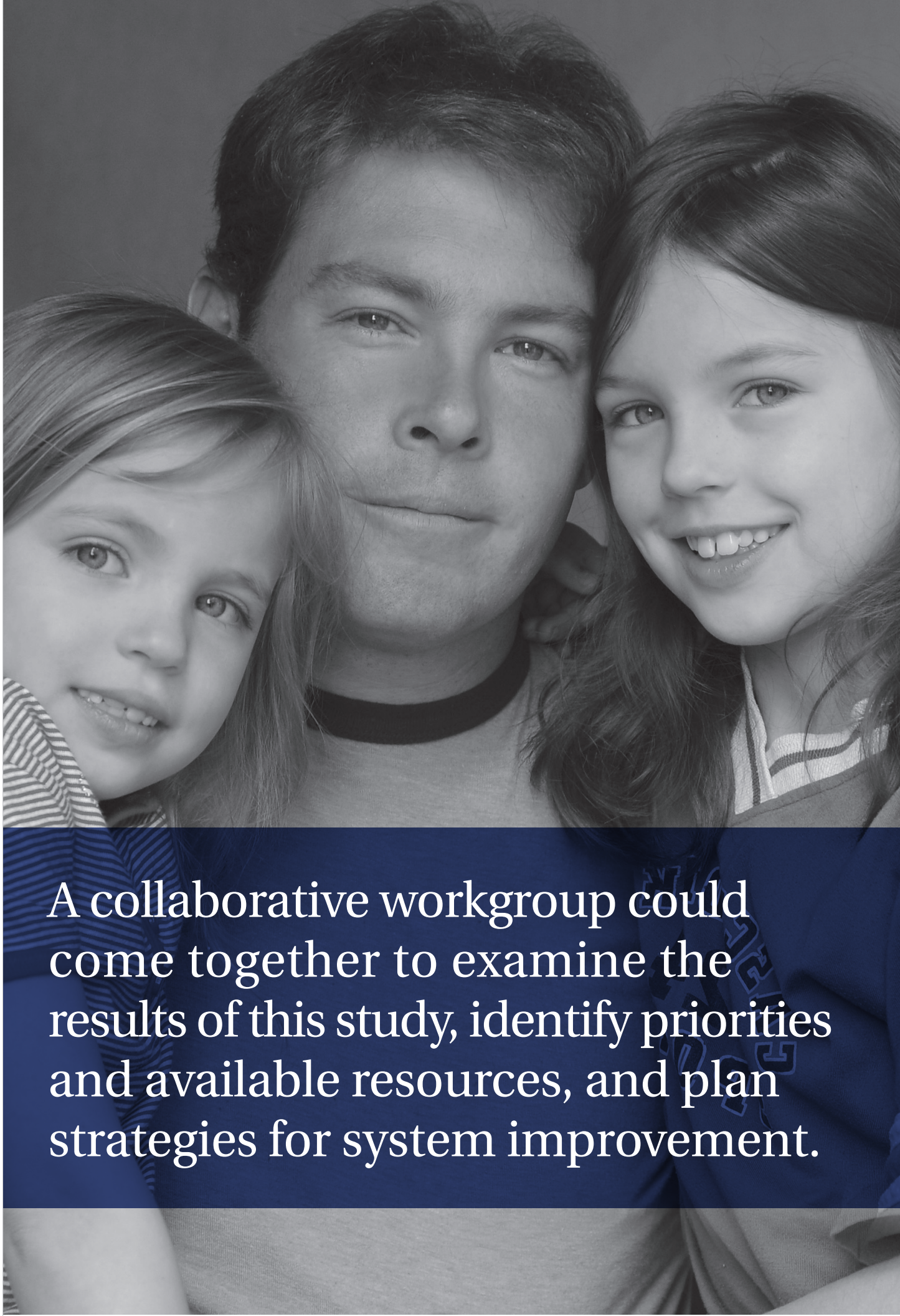
The programs and services that outpatient clinicians rated as *least accessible* included:

- **Residential treatment**
- **Psychological testing**
- **Non-traditional services (e.g., art, music, drama)**
- **Housing services**
- **Legal services**
- **Financial services**

In addition to gaps in the treatment system, there were other issues identified by outpatient stakeholders related to the functioning of the broader mental health system. One consistent area of concern was the amount of time and effort required to meet various licensing and accreditation requirements. Outpatient treatment providers reported that meeting these requirements placed a burden on agencies as well as individual clinicians, sometimes in ways that decreased the amount of available time for direct service delivery. There were also concerns about the perceived lack of alignment between fiscal and treatment goals and priorities as it related to outpatient treatment. As one outpatient provider stated the issue:

"The silos between education, DCF, juvenile justice, all the funding streams…just makes it very difficult and limiting."

Finally, although it is clearly not the case for all clinics and all DCF Area Offices, several stakeholders interviewed reported long-standing tensions between DCF Area Offices and the CGCs in their catchment areas. In addition, the landscape of DCF Area Offices has changed significantly, resulting, in some cases, in disrupted relationships. Further, outpatient providers note that managing the requirements and expectations of multiple licensing and funding bodies can create fragmentation and inefficiencies in business and clinical practices. Systems issues could be eased through enhanced collaboration and coordination between DCF and outpatient providers as well as alignment of licensing and funding requirements.



A collaborative workgroup could come together to examine the results of this study, identify priorities and available resources, and plan strategies for system improvement.

RECOMMENDATIONS

The following recommendations draw upon the findings of this study and the broader context of Connecticut's mental health service delivery and financing system. When appropriate, recommendations addressing separate sections of the report above are combined in order to consolidate similar recommendations and reduce redundancies.

1. Enhance Collaboration to Support Outpatient Treatment

a) It is recommended that DCF convene regular CGC meetings with managers from all contracted providers, youth and families, and other stakeholders.

b) This workgroup can develop an annual improvement plan to identify priorities, establish a timeline with goals and objectives, and develop an implementation strategy for the outpatient treatment system. Workgroups and subgroups can be helpful for implementing strategies on specific aspects of outpatient funding and service delivery.

2. Treatment Capacity and Access

a) Develop a quality assurance database to track and report case flow indicators for the statewide outpatient network and for each individual outpatient provider. Potential indicators would include number of referrals, number of scheduled and completed intakes, length of stay in treatment, time from referral to intake and from referral to treatment, and number of attended sessions.

b) Report data on treatment capacity and access to sites on a monthly, quarterly, and annual basis.

3. Case Complexity and Case Management

a) Funding for enhanced case management can be explored by further leveraging Medicaid dollars and seeking additional external funding through grant support and fundraising.

b) Paraprofessionals, parents, and interns can be used as additional resources to assist in case management.

c) Provide training to outpatient providers on Medicaid regulations regarding case management reimbursement and include system-wide training on better articulation and integration of Medicaid regulations across systems.

d) Increase monitoring and quality assurance focused on case management activities.

e) Incorporate more case management activities into the treatment session in order to reduce the amount of additional out-of-session time spent on case management.

4. Family Engagement

a) Involve outpatient providers and family members in a statewide initiative, similar to the recent learning community that DCF implemented with Extended Day Treatment programs.

b) By taking lessons learned from the current Mental Health Transformation State Incentive Grant Wraparound Initiative, the state can work with all stakeholders to disseminate the Wraparound approach in order to enhance family-driven treatment through identification of family needs and strengths.

c) By tracking and monitoring family engagement as an indicator of treatment quality, family engagement practices can be enhanced.

5. Screening, Assessment, and Service Delivery Practices

a) Increase the use of standardized screening and assessment tools that will facilitate consistent assessment of child and family functioning, ongoing treatment need, treatment response, and treatment decision-making.

b) Include in all screening and assessment practices an enhanced focus on identifying child and family strengths and incorporating them into treatment and discharge planning.

c) Identify and promote policies that facilitate sharing of screening and assessment data within and between programs and agencies to minimize the redundancies experienced by children and families.

d) Use screening and assessment data to inform the identification and delivery of evidence-based and best-practice treatments.

6. Evidence-Based Treatments

a) Providers, DCF, CT BHP, and other stakeholders can work together to identify, adopt, and disseminate a range of outpatient evidence-based practices and treatments to meet identified needs within the system of care. For example, one way to enhance the existing service array is to explore the adoption of EBTs for children with autism, children with internalizing behavior disorders, young children, and children with oppositional behaviors whose parents require behavior management training. Promote access to EBTs in all regions of the state.

b) When possible, use comprehensive and systematic approaches to EBT implementation such as the Learning Collaborative methodology. Identify the conceptual and logistical needs and barriers of provider organizations and work together to meet those needs in order to successfully implement and sustain evidence-based practices within outpatient services. Include training and supervision at multiple levels including the organization, administration, and clinicians. Integrate family engagement strategies whenever possible.

c) Include in all EBT dissemination efforts a focus on quality assurance and evaluation and support ongoing outcome data collection and analysis.

d) Creatively explore ways to fund EBTs and ensure that they can be sustained after grant funding ends, using lessons learned from the implementation of other EBTs in Connecticut. Explore special incentives or enhanced reimbursement rates for agencies that implement EBTs and achieve improved outcomes. Consider a statewide center for promoting and sustaining EBTs that provides ongoing technical assistance, quality assurance, and support.

7. Staffing and Workforce Development

a) To promote cultural competency, agencies should continue to recruit and retain bilingual and bicultural staff and ensure that sufficient training in cultural competency is provided.

b) Examine compensation for outpatient treatment providers. Stakeholders can consider innovative strategies to promote performance and productivity and use this extra revenue to provide incentives to clinicians. In addition to increasing clinician compensation, this could improve treatment capacity and access.

c) Whenever possible, provide training and professional development opportunities for outpatient staff. As one option, consider contracting with an outside entity responsible for developing and implementing a comprehensive training curriculum specific to the needs and interests of outpatient providers and consumers.

d) Examine the use of students and interns who provide outpatient care. Promote agency policies that help ensure that students and interns are receiving adequate supervision and not treating cases that exceed their competency or that require long-term care.

e) Closely monitor the results of the MHT-SIG workforce development project as it relates to the employment of individuals with experience in the field, including experience with EBTs, and efforts to work with high schools, community colleges, undergraduate, and graduate institutions to prepare the behavioral health workforce. Consider this project for statewide replication.

f) Promote clinician credentialing for specialty treatment areas.

g) Enhance use of Peer Specialists in outpatient clinics when possible. Peer Specialists can be helpful in case management, family engagement, and community outreach.

8. Data Collection and Reporting

a) Provider capacity for data collection and reporting can be enhanced by investing in infrastructure development and technical support, which is particularly important as PSDCRS reaches full implementation.

b) All stakeholders will benefit from efforts to develop a culture in which data is viewed as part of the service, not as a separate activity. Such an approach can help promote a shared responsibility for outcomes improvement.

c) Providers, DCF, CT BHP, and other stakeholders can work together to identify a set of performance and outcome indicators that can be collected, analyzed, and reported on a regular basis, in addition to measuring and reporting case flow indicators (see Recommendations 2a and 2b). Performance and outcome results should be analyzed at the aggregate level and for each individual provider. Incorporate benchmarking, control chart methodology, and continuous quality improvement methodologies.

d) Examine utilization patterns across multiple episodes of outpatient care to better understand service need and long-term outcomes.

9. Systems Issues

a) Clearly define routine outpatient treatment within the system of care, including its services, roles, and expected outcomes.

b) Recognize and promote the importance of behavioral health for children across DCF's mandates, including child welfare. Work to further integrate behavioral health and child welfare across the state.

c) DCF, CT BHP, and provider organizations can work collaboratively to identify and attend to treatment gaps for children with particular diagnoses or treatment needs, including children with substance abuse, mental retardation and developmental disorders, autism, and other conditions. This is necessary to ensure that these youth receive needed services and are not disproportionately placed in inpatient and residential treatment programs.

d) If appropriate, expand access to intermediate levels of care and other intensive community-based programs and services, including intensive in-home services, Extended Day Treatment, and Partial Hospitalization Programs in order to ease the burden on outpatient care.

e) Whenever possible, provide expanded access to natural, community-based, and non-traditional services and supports other than office-based treatment.

10. Further Research into Outpatient Needs and Strengths

a) As part of a comprehensive research agenda, build upon these initial findings to systematically and regularly examine needs within the outpatient treatment system. Ensure that appropriate resources are dedicated to meet identified needs.

b) Collect and analyze follow-up data to determine how these findings apply to urban, suburban, and rural areas of the state. The current study provides aggregated findings from across the state, including outpatient clinics in geographic areas that are very different from one another.

c) Enable providers to access and utilize data to better understand and identify needs.

Increased attention to routine outpatient treatment would help establish a strong foundation for Connecticut's community-based children's mental health treatment system.

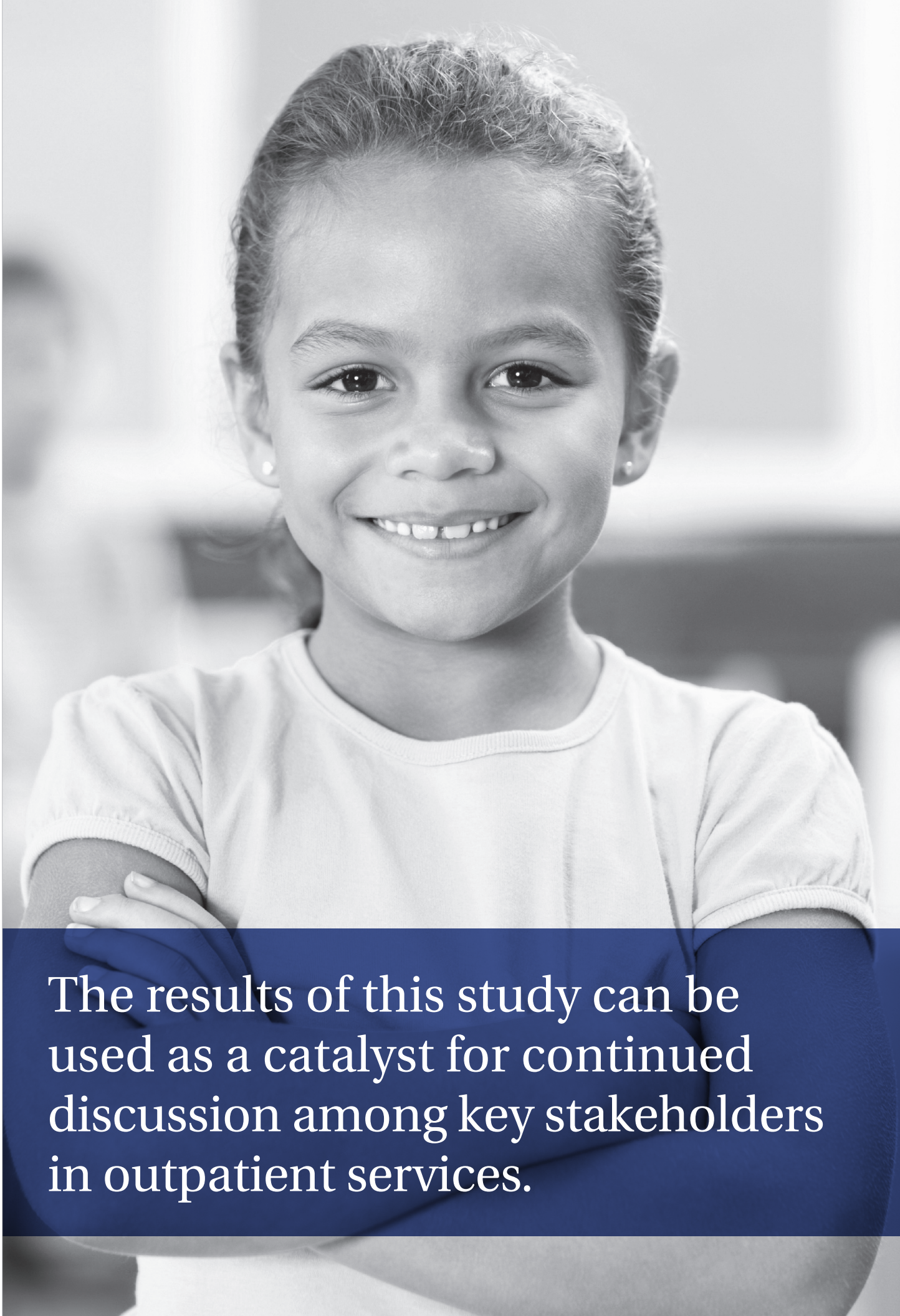
CONCLUSIONS AND NEXT STEPS

The outpatient mental health system serves more children than any other program, and the number of enrolled children appears to be growing. Outpatient clinicians and administrators are dedicated and hard-working professionals that often face significant challenges to service delivery. In addition, DCF's role can be challenging due to the variability among providers in their service delivery practices and their overall service quality. In order to support this vital service in the children's mental health service array, focused attention to service improvements in several key areas would be beneficial.

Recent efforts to improve treatment access through the ECC initiative have had important benefits. Given the likelihood of growing enrollment, increased focus on building capacity could help prepare for the future. Our findings suggest that the typical child and family seeking outpatient treatment has complex needs. To address this complexity, case management and family engagement were highlighted as critical aspects of service delivery, and focused attention in this area could have important benefits for improving treatment attendance, improving outcomes, and generating revenue to support the outpatient treatment system. In terms of service delivery, the intake assessment process is relatively standardized across outpatient clinics; however, the use of standardized screening and assessment measures varies. Enhanced use of screening and assessment instruments could help identify important treatment needs, guide treatment planning, ensure that families receive the services and supports they need, and improve outcomes. EBTs are increasingly important in many areas of children's mental health treatment, but the penetration of EBTs in outpatient treatment has been inconsistent across the state. In order to implement EBTs in outpatient settings, conceptual and logistical barriers need to be addressed, and appropriate implementation supports should be identified and put into place to promote fidelity and sustainability. Outpatient clinicians are an important resource in the treatment system. In difficult economic times, some outpatient clinics can rely too heavily on interns to round out their workforce and this practice can have benefits and drawbacks. Recruiting and retaining a cadre of well-trained and culturally competent clinicians continues to be critical. Finally, although data collection is part of routine outpatient treatment, use of data to monitor outcomes and to guide clinical decision-making is variable across the state. Use of the PSDCRS and CT BHP data collection and reporting mechanisms to monitor outcomes and contribute to continuous quality improvement processes would help guide outpatient treatment.

The current study sought to gather and synthesize information from multiple sources; however, the study was not exhaustive. The findings and recommendations can be considered an additional resource and considered in the context of all available information on outpatient treatment. Further research would help to clarify these findings. Sufficient funding will not be available to support all of the recommendations in this report; however, many system and practice level improvements can be accomplished by re-aligning existing resources in innovative ways.

The results of this study can be used as a catalyst for continued discussion among key stakeholders in outpatient services. For example, a collaborative workgroup could come together to examine the results of this study, identify priorities and available resources, and plan short- and long-term goals and strategies for system improvement. This workgroup could include leaders from state agencies, CT BHP, juvenile justice, child welfare, outpatient providers, community representatives, and families. Ideally, the findings from this report will be used in that planning process, along with other sources of information. It is vital that all system stakeholders work together to pursue their common goal of providing the very best outpatient care to children and families in Connecticut.



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