May 15th , 2025
3:00 – 4:30 pm
Zoom

**TCB Prevention Workgroup May Agenda**

1. **Welcome, Introductions**
2. **Administrative TCB Updates**
    a. TCB Legislation Updates
    b. Workgroup Updates
    c. UConn Services Array Updates
    d. 2025-2028 Strategic Plan
3. **Substance Exposed Pregnancy Initiative (SEPI) CT Presentation**
    a. Q&A
4. **Early Childhood Prevention**
    a. Q&A
5. **Mapping of Prevention Services and Data**
    a. Next Steps and Upcoming Presentations

**May 15th, 2025**

**3-4:30PM ZOOM**

# TCB Prevention Workgroup May Meeting Summary

| **Attendance** | | **TYJI Staff** |
|---|---|---|
| Corina Restrepo | Ingrid Gillespie | Emily Bombach |
| Katie Rudek | Darcy Lowell | Jacqueline Marks |
| Daniella Arias | | Stacey Olea |
| Kimberly Karanda | | |
| Alexis Melville | | |
| Sarah Lehberger | | |
| Pamela Mautte | | |
| Angela Duhaime | | |

**Meeting Objectives:**

- **TCB Updates and Strategic Plan**
- **Substance Exposed Pregnancy Initiative (SEPI) CT Presentation**
  - Q&A
- **Early Childhood Prevention Presentation**
  - Q&A

**Meeting Summary:**

1. ***TCB Updates & Strategic Plan:***
   a. TCB Updates
      i. TCB Senior Project Manager provided an update on the May monthly TCB meeting, which included a focus group activity from Health Equity Solutions, and a presentation from the Prevention Workgroup Co-chairs. The meeting materials from the Prevention presentation are located within one drive.
   b. Legislative Updates
      i. The TCB Project Manager provided an update on the TCB's bills going through the legislative process; HB 7109, HB 6951, and HB 7263.

ii. The TCB Project Manager explained that the bills will likely be merged into one bill.

b. Workgroup Updates
   i. The TCB project Manager gave a brief overview of the other workgroups within the TCB; Services, System Infrastructure, and School Based, and touched upon their current focus areas and upcoming meeting dates.

c. TCB Strategic Plan
   i. The TCB Senior Project Manager briefly highlighted the TCB Strategic Plan, specifically the prevention section. Workgroup members were encouraged to review and specifically look at the measures of success.

2. ***Substance Exposed Pregnancy Initiative (SEPI) CT Presentation:***
   a. A presentation was given on the Substance Exposed Pregnancy Initiative (SEPI-CT). An overview of the program, as well as funding, marketing strategies, outreach, data collection, and an overview of the population was provided.
      a. SEPI-CT is a nearly two-decade old program founded by the Connecticut Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMAHS).
      b. SEPI-CT aims to strengthen capacity at the community, provider, and systems levels to improve health and wellbeing of infants born substance exposed through supporting the recovery of pregnant people and their families.
      c. An overview of the Executive team, core team, and workgroups within SEPI-CT was given.
         i. The executive team consists of the SEI program manager, DMAHS and DCF leadership, and the Executive Implementation Team.
         ii. The Core Team consists of stakeholders with lived experience who provide guidance and direction for the initiative.
         iii. The Workgroups meet on a monthly basis and touch upon CAPTA and Family Care Plans.
      d. The Presenter then gave an overview of the overall goal of the program, which is to ensure birthing people, children, and families have access to SEI and SUD treatment, recovery, and support resources.
      e. The Presenter gave an overview of the Child Abuse Prevention and Treatment Act (CAPTA) and Family Care plans.
         i. The Goal of SEPI CT is to promote a broad understanding of CAPTA reporting requirements and the value of Family Care Plans.
         ii. The presenter gave an overview of the SEPI-CT CAPTA Trainings. Training information is posted on the SEPI-CT website.

f. The presenter went over marketing and materials posted on the SEPI-CT website, as well as videos posted on YouTube.
g. The floor was open to questions from the workgroup.

3. ***Mental Health Prevention Begins in Early Childhood:***
   a. The presenter gave an overview of Mental Health Prevention beginning in Early Childhood touching upon why it is so important to address mental health problems in early childhood.
      a. The presenter started the presentation by stating the prevalence of mental health problems in children from 0-5 years of age. The presenter emphasized that all early childhood relational/ mental health services are prevention. Additionally, the presenter noted that social drivers of health are critical components of understanding the child and family.
      b. The presenter highlighted mental health problems in young children and emphasized that all behavior has an underlying meaning. Additionally, the presenter went over disorders of infancy and early childhood, such as genetic or biologically based disorders, relationship/environmental disturbances, and symptoms of emotional distress. The Presenter then touched upon the importance of addressing the needs of early childhood prevention, as prevention/intervention at an early age can lead to an array of positive outcomes. Additionally, the presenter touched upon barriers and needs for families accessing services, and provided a brief overview of Primary and Secondary, and Tertiary prevention in early childhood.
      c. The presenter briefly went over some of the recommendations and will continue the presentation at the June meeting.

4. ***Next meeting:***
   a. **June 26th, 3-4:30PM (ZOOM)**

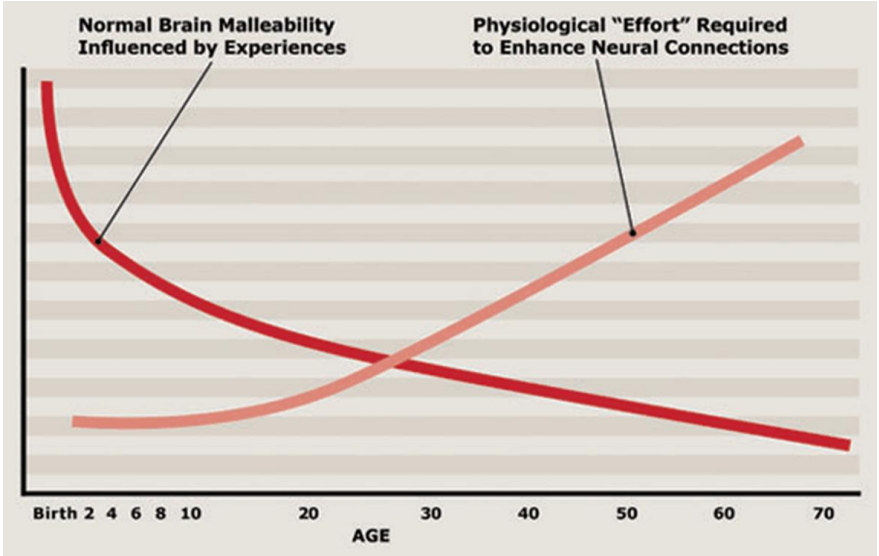
# Mental Health Prevention Begins in Early Childhood

Prevention Workgroup of TCB

May 15, 2025

# 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% (15-26%)
  - Children that live in poverty (<100% of FPL) = 22% or higher
  - Children who are victims of child maltreatment have nearly 4-fold greater risk = 49%
- All early childhood relational/mental health services are PREVENTION. This stops the pipeline of older children and youth needing intensive services, residential treatment, and hospitalization later.
- Scientific evidence has proven the efficacy of identifying and intervening at the earliest possible time – when the is most plastic.
  - Change is easy early in development.
  - Change is much more difficult and costly with increasing age.



# Essentials of Early Childhood Mental/Relational Health

- Early childhood mental health field has expanded its purview. Now use term "**early relational health,"** a broader, more inclusive term.
- Reflects the underlying philosophy and scientific understanding that **early safe, stable, nurturing, responsive caregiver-child relationships** are the foundation of early childhood social-emotional and mental health, child well-being, and **resilience**.
  - Infrequently see the use of the term "behavioral health"
- Understanding that children communicate through their behavior. Behavior is a symptom. **All behavior has meaning**. Take a reflective stance – What is this child trying to tell me about his feelings, thoughts, motivations. What is going on inside of this little person?
- **SDOH** are critical component of understanding the child and family.
- Look for **protective factors** – relationships, connections, belonging are key.

# Infant and Early Childhood Mental Health

## Definition of Infant and Early Childhood Mental Health

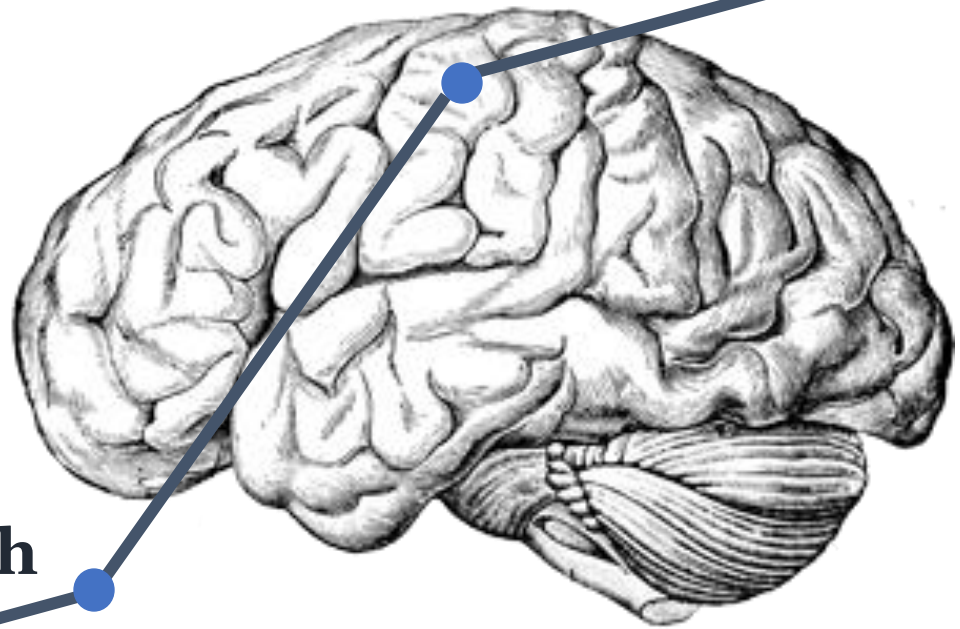
**Zero to Three**

"IECMH is the developing capacity of the infant/young child to form **close and secure relationships**; **experience, manage, and express a fully range of emotions**; and **explore the environment and learn** – all in the context of **family, community, and culture."**

# Rapid Brain Growth – First Three Years of Life

3 years

1 year



**80%** of brain growth is **COMPLETE**

**250,000**
New neurons every **MINUTE**

Birth

**50 ➞ 1000 trillion**
synapses at a rate of
**1 million per SECOND**

Prenatal

child first

# Environment Is Critical

- Genes and the environment act together.
- **Child's early experiences** play a **critical role** in how brain architecture and physiologic systems develop.
  - **Foundation** for all later development.
- High levels of **stress and adversity can significantly damage the young developing brain and metabolic systems.**
- Parent/caregiver mediates the environment for the infant and young child. Therefore, the **environmental stressors and adversity** (both present and past) have **critical impact on the caregivers' ability** to nurture and facilitate healthy development of their children.
- All prevention efforts must include the **Social Drivers of Health**.

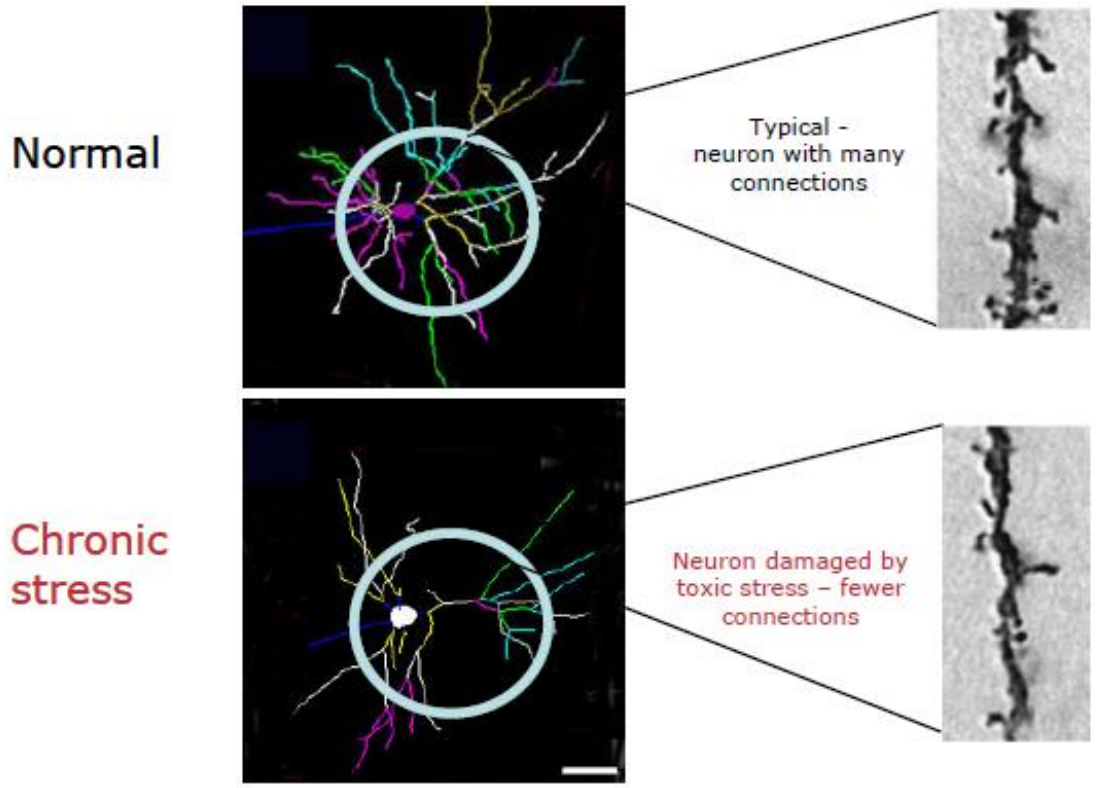
# Brain Science – Impact of Adversity

Social Drivers of Health (SDOH) are a critical component of prevention strategies.

## 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




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

# Mental Health Problems in Young Children

- Young children express their feelings (e.g., joy, anger, fear, sadness, pain, anxiety, empathy, pride) through their bodies and their behavior.
- Behavior is how they communicate. **All behavior has underlying meaning.**
- Behavior must be interpreted in the context of the **stages of development, familial expectations, and culture.**
  - This determines whether the behavior is a due to a normal developmental expectation or challenge or to a disturbance that indicates that the child is experiencing excessive mental/emotional distress. (Examples: crying, sleep disturbance, vomiting, biting, tantrums)
- **Children depend on their primary caregivers to mediate their experiences – especially if the experiences are stressful.** Caregivers are there to calm and comfort. This teaches children how to self-regulate. It makes stress **tolerable** and a source of learning.
- If parents/caregivers are overwhelmed, anxious, depressed, angry, abusive, withdrawn, using substances, and/or absent – **the child's experience of stress can overwhelm their regulatory system!** This is **toxic** and can lead to brain and metabolic changes, expressed as behavioral/mental health disturbances.

# Disorders of Infancy and Early Childhood

- **Genetic or biologically based** disorders include: Autism, Sensory Responsivity, Neonatal Abstinence Syndrome, Attention Deficit Hyperactivity Disorder, Tourette's Syndrome, infectious diseases, high lead or other toxic exposure, other genetic disorders.
  - Impact of biology is always mediated by the environment.
- **Relationship/environmental disturbances** include: Anxiety (separation, social), Depression, Posttraumatic Stress Disorder, Adjustment Disorder, Reactive Attachment Disorder, Sleep Disorders, Excessive Crying Disorder, Grief Disorder, Obsessive Compulsive Disorder
- **Symptoms of emotional distress** are seen in many different mental health disorders.
  - Inconsolable crying, bodily dysregulation with vomiting or diarrhea, food rejection or overeating, sleep disturbances, persistent nightmares, aggression (biting, kicking), defiance, poor peer relationships, frequent and severe temper tantrums, unusual fears or constant worries, repetitive play, anxiety at separation or in social situations, lack of seeking comfort from primary caregivers, freezing, hyperactive, difficulties with attention or concentration, lack of energy, withdrawal, sadness, isolation, regression in developmental milestones, poor eye contact, unusual bodily movements, obsessions, explosive emotional reactions, self-harm, harm to animals.

**Need to address the underlying problems, not just the symptoms.**

# Safe, stable, responsive, nurturing caregiver-child relationships are critical for child mental health and wellness.

Scientific research has proven **nurturing relationships**:

- Buffer and heal developing brains and metabolic systems from damage caused by adversity, stress, and trauma.
- Most important protective factor, even with biologically-based disorders.
- Build child resilience.

# CT's Transforming Children's Behavioral Health: Why Include Early Childhood Prevention?

- Early childhood mental health needs and services are largely absent in TCB planning, including Prevention Workplan
- Benefits of prevention/intervention at the earliest possible time:
  - Change is easier, more effective, less costly early in development when brain is more plastic.
  - Prevents later serious problems in multiple domains – e.g., mental health, health, substance use, juvenile justice, educational achievement.
  - Change in parents' caregiving and attention to family stressors has impact on entire family wellbeing.
  - Alleviates suffering of young children and families, rather than allowing it to progress and intensify.

# Barriers and Needs for Families Accessing Services

- **Parents do not know** there is help out there!
- Existing **web-based CT Directories** for Mental Health Services (including AIM) **are NOT helping parents find options** for mental health services for young children!
- There is **little help** to navigate the system
- **Inadequate services** (locations, age served, language) with **long waitlists**
- Few services available in **home or community setting** (FRCs, Pediatrics)
- **Stigma**, lack of respect, cultural norms
- **Fear** of losing children
- **Undocumented** status (current)

# Plan for Early Childhood System of Care

Essential to develop an Early Childhood Plan that reflects the continuum of needed services at all levels:

- **Promotion: Universal**
  - Facilitates optimal child development for all children and families
  - **Screening and surveillance**
    - OEC encouraging use of Sparkler App (Ages and Stages)
    - May lead to referral:
      - 0-3 years: Birth to Three for further assessment
      - Over 3 years: Some Child Guidance Centers or FQHCs?
      - Often the only component included in early childhood planning: CT Behavioral Health Plan for Children – CHDI – 2014
    - Locations: Pediatrics, some early care and education, home visiting, 211 Child Development Infoline (Help Me Grow)

**SCREENING without available services is NOT enough!**

# Plan for Early Childhood System of Care

- **Primary Prevention: Risk present; susceptible population**
  - Population served: Parents experiencing challenges like poverty, homelessness, unemployment, food insecurity, social isolation, poor health care, unmet basic needs
  - Locations: Home visiting – NFP, HFA, PAT; Pediatrics; early care and education – Head Start; parenting education; (not Birth to Three)

- **Secondary Prevention: Some signs and symptoms are present; early intervention; prevention of progression of disturbance**
  - Population served: Parents often with multiple challenges as above, also including depression, PTSD, substance misuse and actions/behavior that lead to parent-child relationship disorder; child neglect; child is expressing anger, pain, anxiety, fear, dysregulation through challenging behavior or withdrawal
  - Locations: Birth to Three, Child Guidance Centers, FQHCs, University-based clinics, therapeutic nurseries, ACCESS Mental Health, Early Childhood Consultation Partnership, potentially Pediatrics, home-based intervention
  - Services: Circle of Security, Triple P, ARC, PCIT, CPP, Child First, TF-CBT (over 5)

# Plan for Early Childhood System of Care

- **Tertiary Prevention: Symptomatic with functional interference; needs intervention or treatment; prevents much more severe disturbance later in childhood**
  - Population served: Parents with multiple challenges above, also including depression, PTSD, substance misuse, and significant personal histories of trauma and child abuse or neglect; parent actions/behavior indicate significant parent-child relationship disorder.
    Child has experienced trauma, abuse or neglect, or significant separation from primary caregiver; they are expressing anger, pain, anxiety, fear, dysregulation through increasingly challenging behavior or withdrawal.
  - Locations: Intensive home-based intervention, some Child Guidance Centers, FQHCs, University-based clinics
  - Services: Child First, CPP, Family Based Recovery, IICAPS (over age 4)

**MAJOR NEED FOR EARLY INTERVENTION AND TREATMENT SERVICES**

# Full Landscape Analysis Needed!

- **What services are currently available for young children at each level of intensity?**
  a. **Geography:** Where are they? What agencies? Location in State?
  b. **Location:** Home, childcare, mental health agency, FQHC?
  c. **Provided by whom**?
  d. **Training:** Specific training for work with young children?
     Training in relationship-based dyadic treatment?
     Training in DC: 0-5?
  e. **Specific ages** served?
  f. **Capacity?** Waiting list? What is the actual need?
  g. **Evidence-based models**?
  h. **Data collection? Outcomes?**
  i. **Payment** from whom?
  j. **Sustainability?**

# State-level Task Force on Early Childhood Mental/Relational Health

- Who is responsible for mental health services for young children?
  - Which state agency has primary responsibility? How do they collaborate to meet the needs of young children and families?
    - DCF: Mental health services for children
    - OEC: Early childhood services – promotion and prevention
  - Other state agencies: DSS, DMHAS, DPH, SDE, DDS
- Convene State-level Task Force: State agencies, early childhood experts, mental health agencies, pediatricians, early care providers, and other providers of services for young children and families, parents, legislators, other stakeholders
- Develop an early childhood, relational health continuum of care, with clear responsibilities, funding, and collaboration.

# Social Drivers of Health

- **Social Drivers of Health (SDOH) – Essential**
  - Need strong **community collaboration** within a system of care
    - Unmet family social and economic supports must be addressed.
    - Community resources are a primary source of services and supports for families.
    - Opportunity for surveillance to identify children and families needing intervention
  - Must look at the **whole family.** SDOH are major factors in parents' own mental health and capacity to nurture and support their children.
    - If parent is depressed or suffering from PTSD, are they connected to their own treatment? If the family has food or housing insecurity, is that addressed?
  - **Parental economic and social hardships** have been documented as major causes of family and child emotional distress and child maltreatment
    (Prenatal to Three Policy Impact Center – 5/14/2025)
  - Need **team approach** with care coordinators, community health workers, health navigators, etc.

# Issues of Critical Importance

- **All early childhood mental health interventions must include the parents/caregiver.**
- **Protective factors** are essential!
  - Most important for young children: **Early nurturing relationships**!
  - Many others, as per the Prevention presentation at TCB
- **Equity and diversity throughout the system!**
- **Parents must be central. Family trust, safety, and relationships are essential for true engagement and partnership.**
- **Community collaboration**
- **SDOH and Environment**
- **Workforce**

# Role of Pediatricians

- **Promotion and Identification** – Current expectations
  - Currently with inadequate time and inadequate payment
  - Anticipatory guidance and checklists consume time in well visits
  - Burnout
  - No time and no training in building **safe, trusting relationships with parents – essential to understanding parents' true concerns**
- With major shift in priorities of AAP: **Recognition that the building of safe, stable, nurturing parent-child relationships – key to child well-being and resilience.**
- **Mental health workforce shortage:**
  - Opportunity for pediatricians to fill some of the gaps and provide both **primary and possibly secondary relational intervention** as well.
- Provide both **mental health consultation** and **reflective supervision** to pediatricians
- **Integrate mental health clinicians into the pediatric office** settings as part of the clinical team.

# Possible or Existing Funding Streams

- DCF: State funding, Family First (Title IV-E); CAPTA
- OEC: State funding; IDEA Part C federal funding; MIECHV (Maternal, Infant, and Early Childhood Home Visiting); other federal grants
- DSS: Medicaid/EPSDT, TANF
- VOCA (Victim of Crime Act)
- DPH – Title V
- Mental health block grants
- State and federal grants – e.g. SAMHSA
- Philanthropy

# Summary of Recommendations

- Conduct a **comprehensive landscape analysis** of early childhood mental health/relational health services.
  - Track all young children identified with any social-emotional/behavioral needs in a systematic way to look at services received, outcomes, and cost.
- Develop a **comprehensive system of care** for young children with social-emotional, relational, mental health needs and their families.
  - Create an Early Childhood Mental Health Workgroup that is part of TCB and the Children's Behavioral Health Plan Implementation Advisory Council.
  - Examine all early childhood and family prevention and mental health services, located in or funded by CT Departments (OEC, DCF, DSS, DPH, DMHAS, SDE, DDS), with the goal of creating a coordinated early childhood system of care.

# Recommendations - continued

- Increase services for young children and families who need mental health intervention, especially **secondary prevention (early intervention) and tertiary prevention (intensive treatment)**
- Leverage all possible **federal funding** streams for future mental health services for young children and families.
  - Access Medicaid/EPSDT reimbursement for young children, including children under age 4 years in outpatient settings.
- Provide **training** in evidence-based treatment to clinical workforce in early childhood mental health (perhaps through CT AIMH)
- **Revise web-based mental health inventories** so that parents and caregivers are able to find services for their young children.

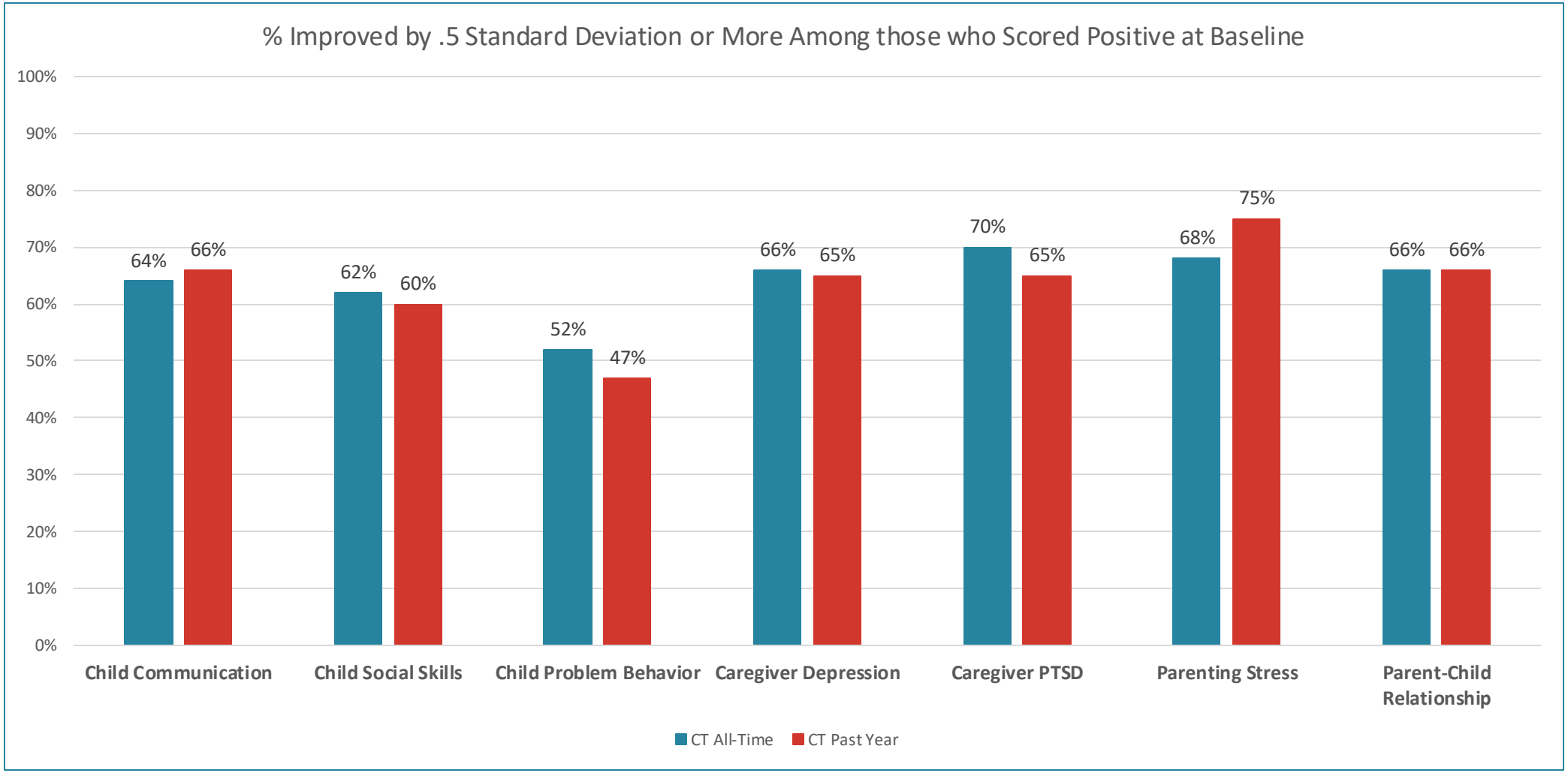
# Recommendations - continued

- Utilize **Pediatric Primary Care** as an extremely valuable source of primary prevention, identification, early intervention, and referral.
  - Train and support Pediatric providers in order to providing **secondary prevention/early intervention into Pediatric practice,** with appropriate payments.
  - Provide **mental health consultation and reflective supervision** to Pediatric providers.
  - **Integrate mental health clinicians** into the Pediatric care team.
- Integrate the **Social Drivers of Health** into prevention, identification, and intervention efforts.
  - Access funding for Care Coordinators, Community Health Workers, Health Navigators, etc.

# Early Childhood System of Care

# Percent Improvement in Outcomes - Connecticut

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



# Cost Savings

- Child First implementation cost per family = $9,000 (both child and parent)
- Cost-Benefit:
  - Child-Parent Psychotherapy (CPP): Child First MH clinicians are all trained and rostered in CPP. 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.
  - Cost of residential treatment for one child = $96,000/4 months.
  - 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 other mental health, healthcare, and education services, and in juvenile/criminal justice.

# SEPI-CT Substance Exposed Pregnancy Initiative of Connecticut

CONNECTICUT
Mental Health and Addiction Services

Transforming Children's Behavioral Health
(Prevention Workgroup)
May 15, 2025

Kimberly Karanda, Ph. D., LCSW
Section Chief, Statewide Services Division
Office of the Commissioner
CT Mental Health and Addiction Services

# Substance-Exposed Pregnancy Initiative - Connecticut

- Co-funded by CT DMHAS and CT DCF
  - Nearly two-decade long collaboration.
- Funding supports 2 full-time positions (1 Program Manager and 1 Family Care Plan Coordinator) at Wheeler Clinic.
- Initiative is guided by a 5-year strategic plan.
- SEPI-CT aims to strengthen capacity at the community, provider, and systems levels to improve the health and well-being of infants born substance-exposed through supporting the recovery of pregnant people and their families. https://www.sepict.org/

# SEPI-CT 5-Year Strategic Plan Framework

- **Executive Team**: The SEI Program Manager, together with DMHAS and DCF leadership, form the Executive Implementation Team. This group meets biweekly to maintain consistent communication on the ongoing status of the initiative and provides guidance and support to the SEI Family Care Plan Coordinator.
- **Core Team**: Comprised of a group of stakeholders who provide guidance and direction for the initiative. These individuals and agency representatives have expertise in maternal, infant and child health, mental health, substance use, recovery, child welfare, pediatrics, neonatology, and advocacy for birthing people. This group meets quarterly to discuss updates and emerging/related work in the field.
- **Workgroups**: The workgroups support each of the plan's priority areas including: CAPTA and Family Care Plans, Screening and Brief Intervention, Marketing and Training, Treatment,  Recovery and Wellness Support.
  - Addition of *Accidental Ingestion Workgroup* in 2024.

# Treatment, Recovery, and Wellness Support

## GOAL: Ensure birthing people, children, and families have access to SEI and SUD treatment, recovery, and support resources.

- Maximize the use of existing CT resources available to birthing people, children, and families including substance use treatment and recovery supports, health care, developmental assessments, etc.
- Continue to support, enhance, and/or create opportunities for **family-centered, multi-generational interventions**.
- Empower individuals to work with their provider and/or local community resources to gain support with alcohol use and/or substance use disorder treatment.
- SEPI-CT website contains resources for families affected by SUD.

# Child Abuse Prevention and Treatment Act (CAPTA) and Family Care Plans

## GOAL: Promote broad understanding of CAPTA reporting requirements and the value of Family Care Plans

- Provide ongoing educational opportunities for providers and systems that touch families to remain current on accurate CAPTA reporting practices and statewide progress and opportunities within CAPTA.
- Continue to empower birthing people to use the Family Care Plan and **normalize it as a tool for anyone who is thinking about becoming pregnant, currently pregnant, or has recently given birth.**
- Continued refinement of CAPTA portal data requirements.
- Ongoing attention to health equity themes that surround reporting practices.

# SEPI-CT CAPTA Training

- Trainings are delivered to APRNs, RNs, Recovery Navigators/peers, Social Workers, Midwifery students, SUD providers, staff in MOUD clinics, Labor and Delivery, and others…
  - Technical Assistance
  - Promotional & Educational Materials
  - Videos
  - 1:1 Assistance
- Objectives:
  - Understanding current iteration of CAPTA/CARA legislation.
  - Know the difference between a CAPTA Notification and DCF 136 Report of Suspected Child Abuse/Neglect report – prevent underreach and overreach.
- Training information posted on SEPI website. **Family Care Plan & CAPTA Training | SEPI-CT**
  - Link to **PROUD Training Series - https://cthosp.org/education/proud/**
  - Link to **ACCESS Mental Health & Substance Use for Moms - https://www.accessmhct.com/moms/training/**

# SEPI-CT Website

In FY24 the SEPI-CT website hosted 1,557 users compared to 958 users in FY23.

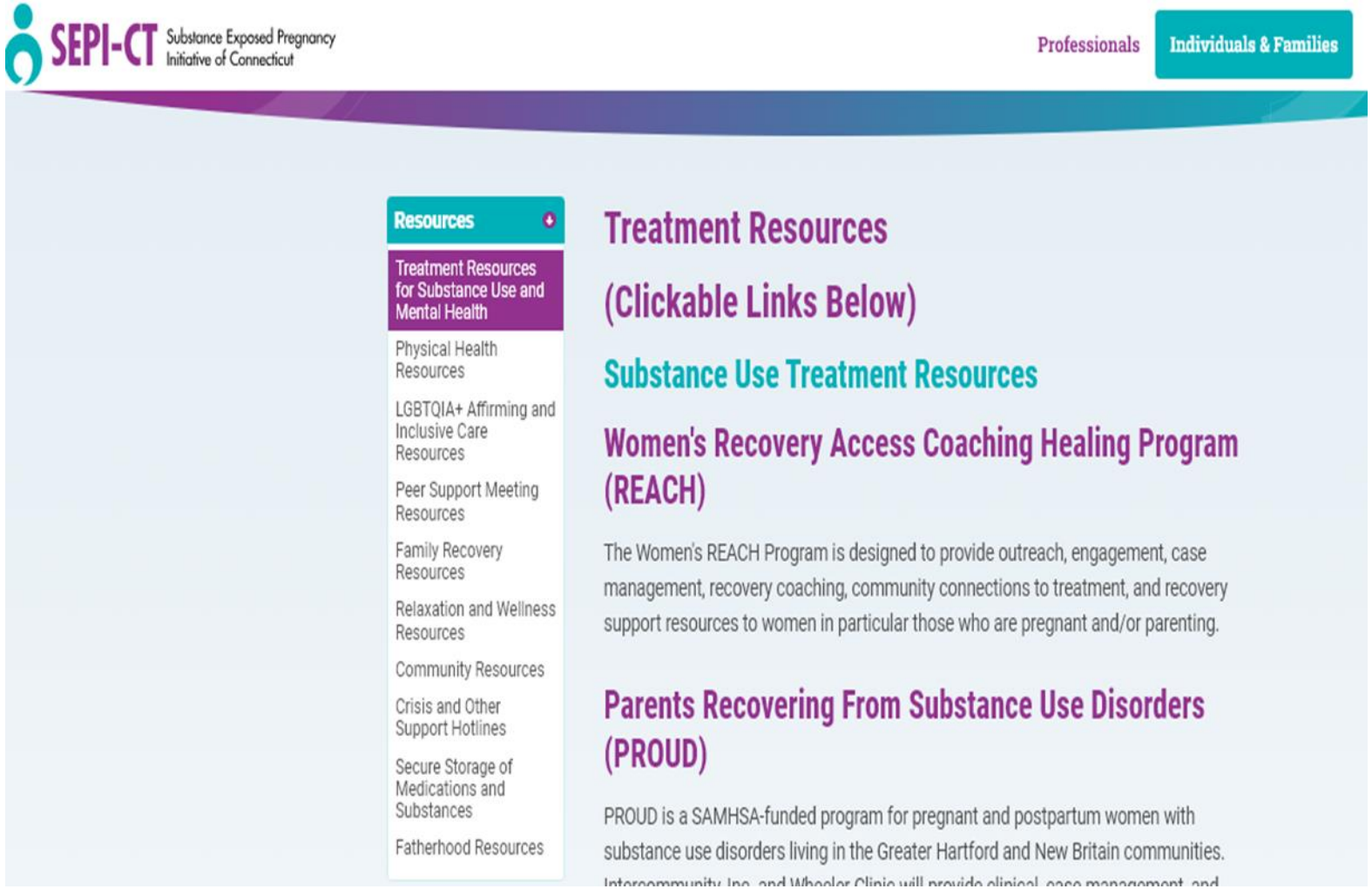
Pageviews totaled 3,725 compared to 2,723 in FY23.

The number of sessions totaled 2,160 compared to 1,375 in FY23.

The website is promoted through meetings with hospitals, at CAPTA trainings, and at all meetings the SEPI-CT program manager and FCP coordinator attend.

# Resources for Individuals and Families

- [Individuals and Family Resources | Substance Exposed Pregnancy Initiative (sepict.org)]

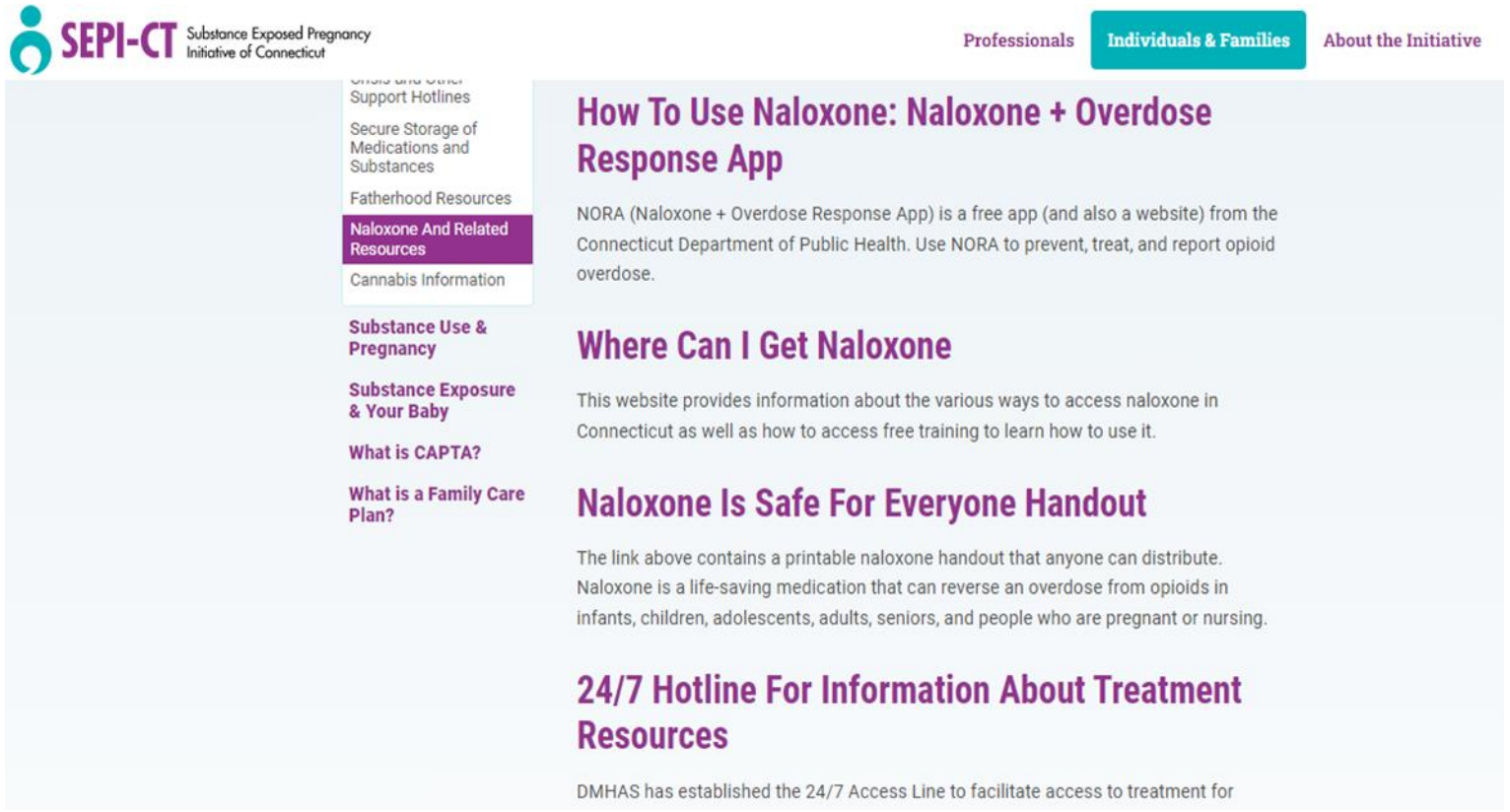


# Secure Storage and Marketing Materials

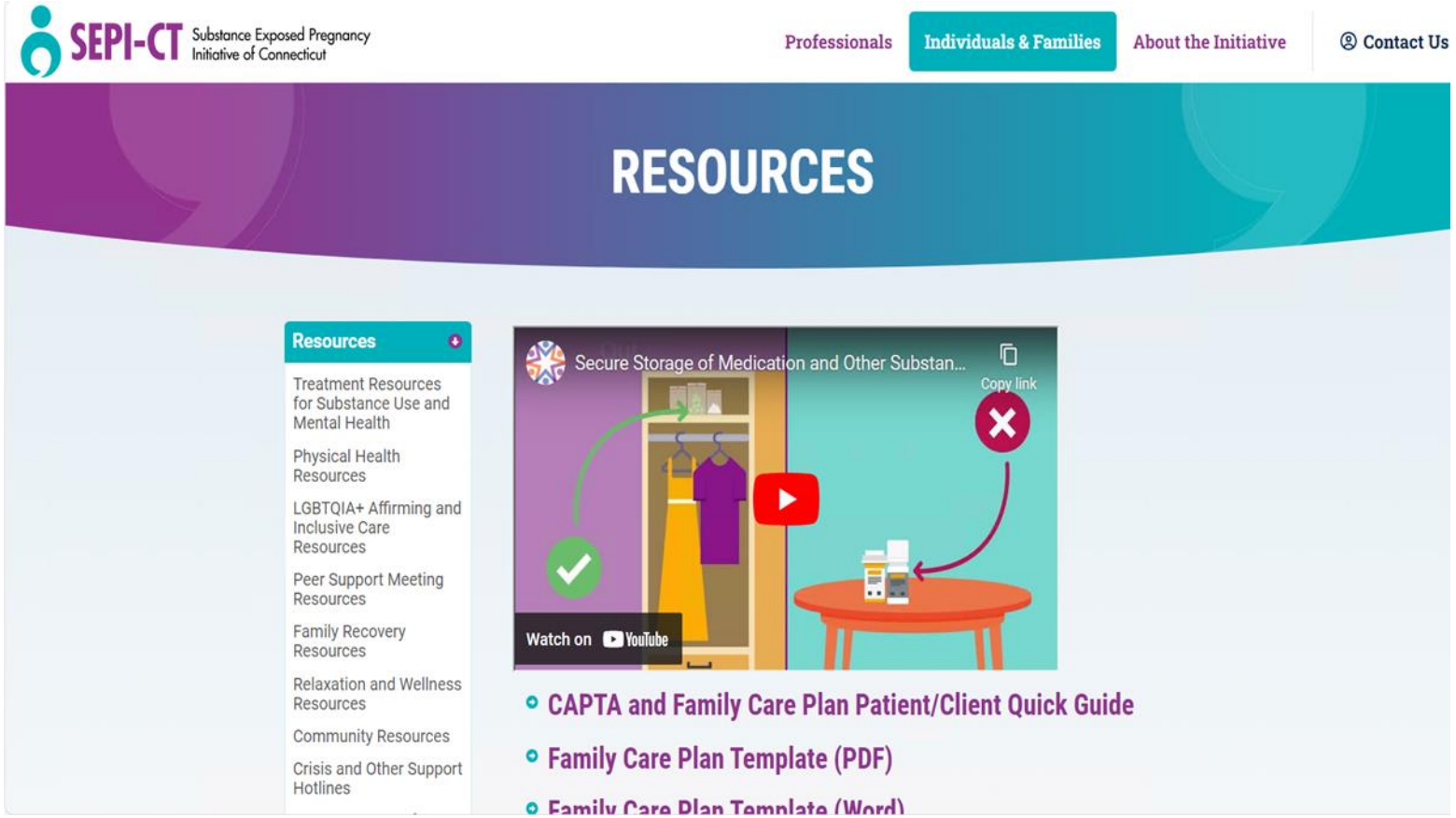
May 2023 launch of the video, "Secure Storage of Medication and Other Substances," viewed 900 times on the CT Clearinghouse YouTube page. The video is viewed and promoted at all CAPTA Trainings and shared through the CT Clearinghouse Listserv, the SEPI-CT Network, and to DMHAS and DCF providers and stakeholders.

Continued education around the topic of secure storage, designed, purchased and distributed Secure Storage Banner Pens and Secure Storage Half-Page Informational Sheets.
initiative continues to distribute SEPI-CT Wallet Cards to hospitals and behavioral health agencies.
In FY24, 3,520 English and Spanish cards have been physically distributed.

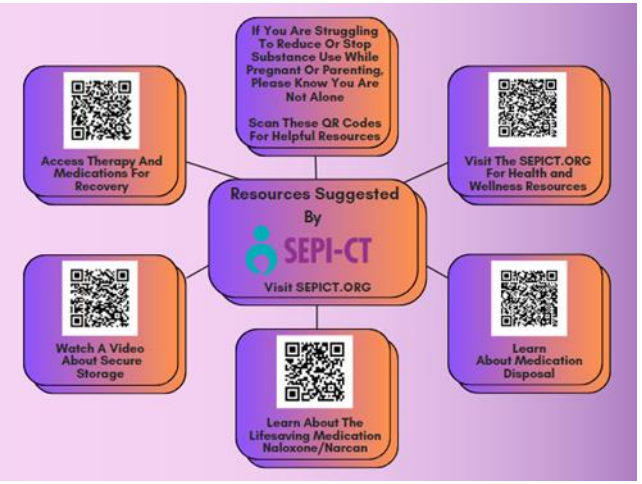
# Naloxone Campaign and Webpage

# Secure Storage of Medications and Other Substances Video and Webpage




[Resources for Individuals & Families | SEPI-CT (sepict.org)]



- **Secure Storage Half Sheet**
- **Banner Pens**
- **Instant Downloads of Information Campaigns**
- **SEPI-CT Videos – Subscribe to our Youtube Channel @SEPI CT:** https://www.youtube.com/channel/UCU1xnySg1z_nrgkxIuYRm4A

# Lockboxes / Naloxone Distribution

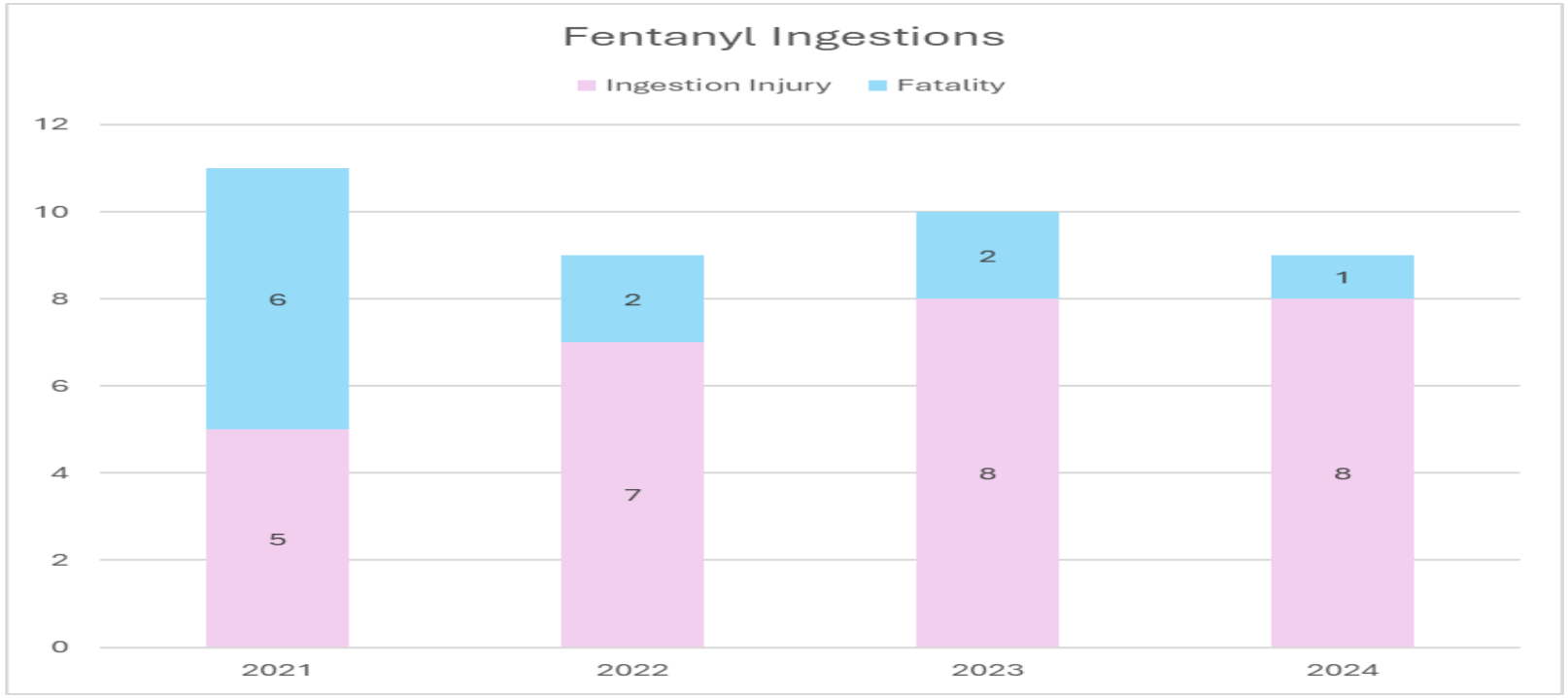
500 Secure Storage Lockboxes are currently being distributed to hospital labor and delivery units containing:

- Naloxone and associated information
- Deterra bags – at home medication disposal information
- Maternal mental health information and hotline
- SEPI-CT resource card
- Information on Intimate Partner Violence and Safe Connect hotline
- Suicide prevention information and hotlines/988

**Distributed 469 standalone Naloxone kits and over 200 lockboxes to birthing hospitals to date.**

# Accidental Ingestion

Through 5 months of 2025, no reported incidents of opioid ingestion injuries or fatalities in young children.






CONNECTICUT
Mental Health and Addiction Services

# DMHAS/SEPI–CT Specialty Projects

- Virtual FCP Tool Developed
  - Family Care Plan | Substance Exposed Pregnancy Initiative CT

- Community Baby Showers
  - DMHAS Region 4 and 5 occurred in Fall 2024, remaining regions 1, 2, and 3 scheduled for Spring 2025.

- Labor and Delivery Unit Project
  - Partnering with hospitals statewide to build collaborations and support new families.
  - Kits including lockbox, Naloxone, medication disposal bags and resources on securing home environment, treatment and recovery.

- Next Day Animation Video Series
  - SEPI-CT – Youtube
  - Topics include Access Mental Health and Substance Use for Moms, Pregnant and Parenting Programs, PROUD, REACH, Secure Storage, Family Care Plans.

# Contact Information and Key Resources

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Woman and Children's Services

Substance Exposed Infant Initiative CT | Creating Better Outcomes