July 16th, 2025
2:00pm – 3:30pm
ZOOM

July Services Workgroup Meeting Agenda

1. **Welcome and Introductions**
2. **TCB Administrative Updates**
    a. TCB Monthly Meeting Updates
    b. Workgroup Updates
3. **Overview of Evidence Based Practices (EBPs) & Implementation of EBPs for Children and Youth Presentation**
    a. Q&A
4. **Services Array Updates**

TCB Services Workgroup June Meeting Summary

July 16, 2025
2:00pm-3:00pm

Attendance

Edith Boyle	Karen Snyder	Reena Kelley	
Erin Williamson	Katie Newkirk	Rita Demo	
Jack Lu	Keri Floyd	Tiffany Franceschetti	
Jason Lang	Kris Nobles	Yann Poncin	
Jennfer Abbatemarco	Kristen Parsons		
Jill Farrell	Melanie Wilde-Lane		

TYJI Staff

Emily Bombach
Erika Nowakowski
Jacqueline Marks
Stacey Olea

Meeting Objectives:

- TCB Administrative Updates
- Overview of Evidence Based Practices (EBPs) & Implementation of EBPs for Children and Youth Presentation
- Services Array Update

Meeting Summary:

1. ***TCB Administrative Updates:***
    a. TYJI Staff gave an overview of the June Monthly TCB Meeting and provided workgroup updates for the School Based, System Infrastructure, and Prevention Workgroups.
2. ***Overview of Evidence Based Practices (EBPs) & Implementation of EBPs for Children and Youth Presentation:***
    a. CHDI provided an overview of the variety of trauma–focused evidence-based practices (EBPs) offered in schools and outpatient treatment. CHDI collaborates with DCF, along with multiple community agencies and schools across CT, to ensure positive outcomes for children and families who receive mental health and trauma treatment.
        i. EBP implementation required first adopting a collaborative quality improvement approach and has now progressed to the sustainment phase. CHDI consults with providers quarterly and facilitates meetings of EBP teams across CT to track data for Continuous Quality Improvement (CQI) and report on outcomes and equity.
        ii. The presenter provided an overview of outpatient-based EBPs and highlighted the aim and intent for each, including Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct Problems (MATCH-ADIC), and Attachment, Regulation,

and Competency (ARC). TF-CBT combines trauma-sensitive intervention with CBT, teaching knowledge and skills related to processing trauma, managing distressing thoughts, and enhancing family communication. MATCH-ADIC is a modular trans-diagnostic treatment protocol designed to treat multiple psychiatric diagnoses. ARC is a flexible components-based treatment that works with caregivers and youth to address complex trauma, receive coping tools, and gain resilience to target trauma.

iii. The presenter provided an overview of School-Based EBPs and highlighted the aim and intent of Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back. CBITS are for grades 5-12 and provides treatment for trauma related to violence or abuse, while teaching coping skills to foster healthy relationships, community engagement, and reduce symptoms of PTSD and depression. Bounce Back is an adaptation of CBITS, which is intended for grades K-5 and aims to include age-appropriate tools such as books and visuals to teach feelings identification and other key areas.

iv. DCF-funded EBPs have saved over $225 million in future costs and savings and have been a great investment for Connecticut.

b. Q&A

i. A workgroup member inquired about the challenges with cost, unbillable elements, and training on EBPS. The presenter responded that clinicians receive a stipend and financial compensation for their time, depending on the amount of funding available.

a. Another member added that reimbursement for up-front training costs is provided in the implication cost of EBPs' ongoing delivery of the service.

b. Another CHDI member pointed out the notion of value-based reimbursement, explaining that if there are superior outcomes with EBPS, they should be reimbursed at a higher rate. He added that there are sustainability models in other states that are further along than CT and expressed models and training that could be successful.

ii. A workgroup member inquired about provider access to EBP training. This member asked who can be contacted, what the funding cost for a training fee is, and how trainee partners are identified. A CHDI member replied that funding is a significant factor, and some grants have enabled annual training opportunities. Providers can reach out for training, but training opportunities are shared publicly, and interested organizations can join the yearly training.

iii. A workgroup member asked if the EBPs training certifications are available in graduate programs. The presenter answered that she does not think so, and the clinical training for EBPS is beyond a graduate level.

   a. A Workgroup member added that there are schools in CT that offer EBP training, which provide a high level of understanding of the EBP programs and treatment, but it is not the full training. The training requires consultation to ensure students are performing the model accurately.

iv. A workgroup member asked if EBPS covered under family first receive the same support CHDI provides. A CHDI member answered that some EBPs may have state contract manager support, and others have direct contracts with treatment developers with their own proprietary QI models and systems.
   a. Another member added that there are substitute service arrays contracted under Advance Behavioral Health to provide services in the state. The contracts do not include the Multidimensional Family Treatment Institute (MDFTI) for families.

v. A workgroup member expressed interest in coordinating with TCB to create a presentation of the other EBPS offered in CT to include all children and families.

vi. A workgroup member asked the presenter what the funding is for EBPs and if grants keep the organization going. CHDI answered that they have contracts with the state to do quality improvement for EBPs and federal grants.

3. ***Services Array Update:***
   a. The presenter shared that the survey is ready for dissemination, and she is working with TCB to have a centralized place for all materials and questions.
   b. The presenter overviewed the glossary compiled for the survey and recommended that it have a vetting process for terms and definitions that are specific to the work of the Services Service Array Survey subgroup.
4. ***Next steps:***
   a. The next meeting will be held September 10th, 2025.

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Evidence-Based Practices in Children's Behavioral Health in Connecticut

Katie Newkirk, Ph.D.
Tiffany Franceschetti, LCSW

Trauma-Focused EBPs

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) – ***also for Anxiety, Depression, and Conduct***

Attachment, Regulation, & Competency (ARC)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

BounceBack (BB)

Initial Implementation: Learning Collaborative

A quality improvement methodology that promotes system-wide transformation and rapid adoption of evidence-based practices in outpatient community-based behavioral health settings.

Brings together teams from multiple sites to work on improving a process, practice, or system

Requires ongoing participation by all the stakeholders involved, including, clinicians, supervisors, and administrators both during and between the Learning Sessions.

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Implementation Sustainment

- Facilitate meetings with EBP team leads across providers for learning, peer-support, bidirectional input
- Quarterly consultation with each provider to support implementation, review data, and set goals
- Managing databases of clinical and training data to ensure fidelity and engage in Continuous Quality Improvement (CQI)
- Helpdesk support for data system
- Regular reporting to monitor access, quality, outcomes, and equity
- Ad hoc data analyses to identify trends, potential drivers of performance, etc.
- Determining and providing for additional training needs and supports
- Create Issue Briefs and other resources for providers
- Run an annual EBP conference for provider network
- Facilitating professional development of rising leaders in the model
- Training-of-trainers to allow for in-state expert trainers to reduce costs, increase training availability, and allow sustainability
- Creating sustainability funding benchmarks and distributing funds based on performance

Outpatient-Based EBPs: TF-CBT, MATCH, ARC

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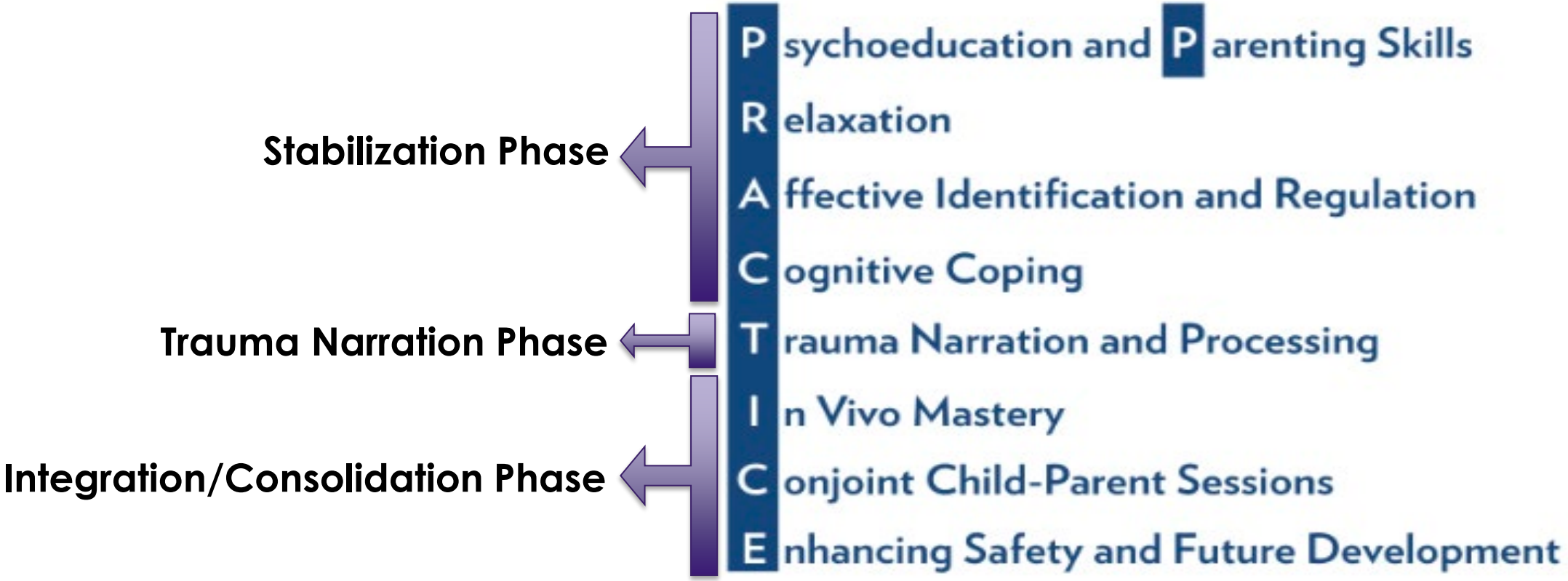
What Is Trauma-Focused Cognitive Behavioral Therapy(TF-CBT)?

- The most widely studied evidence-based treatment addressing trauma-related symptoms in children
- For children ages 3-18 with symptoms related to trauma exposure, including PTSD symptoms, depression, and anxiety
- Combines trauma sensitive interventions with CBT
- Conjoint model – caregiver and child
- Average 16-22 weekly sessions

- Teaches children and caregivers knowledge and skills related to:
  - Processing trauma
  - Managing distressing thoughts, feelings and behaviors
  - Enhancing safety, parenting skills, and family communication

- Focuses on these principles:
  - Components-based
  - Respectful of cultural values
  - Adaptable and flexible
  - Family-focused
  - Therapeutic relationship is central
  - Self-efficacy

TF-CBT Treatment Components



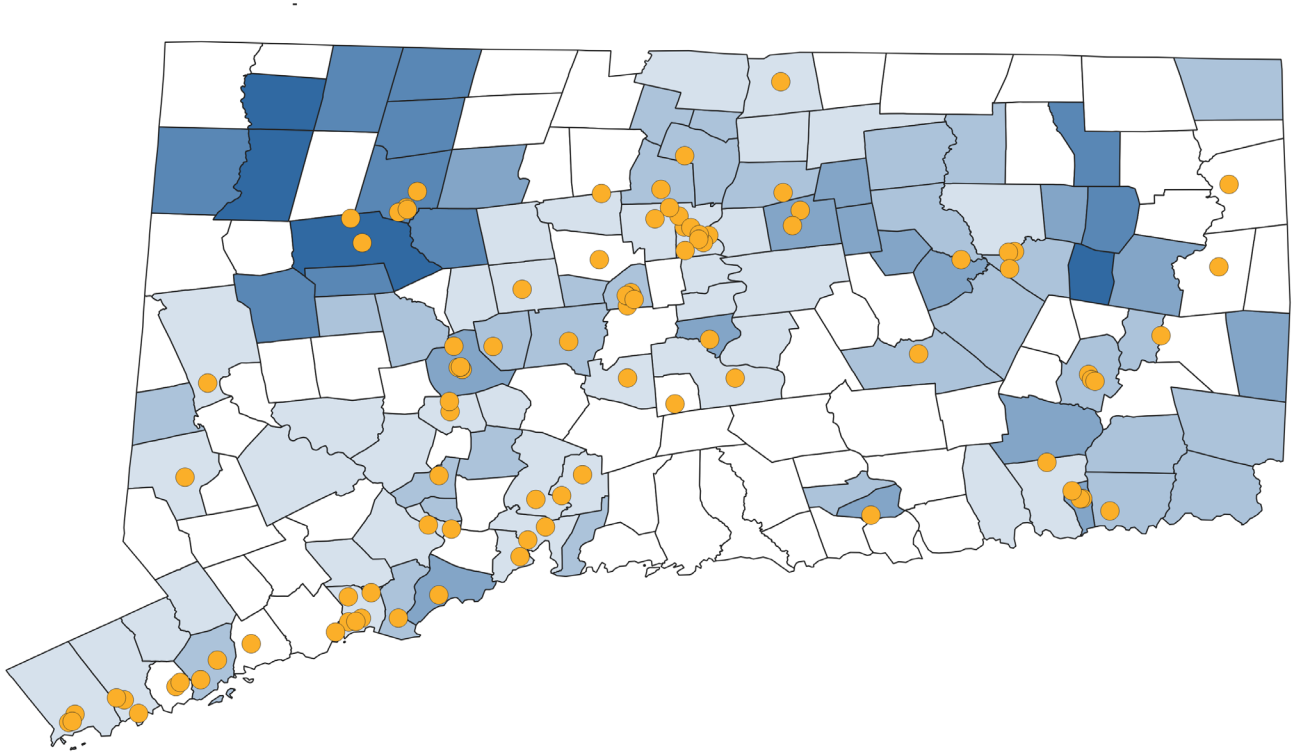
Trauma-Focused Cognitive Behavioral Therapy(TF-CBT)

Research Support for TF-CBT

- 10 randomized-control trials (RCTs) and 2 systematic reviews found greater short- and long-term improvements in PTSD, Anxiety and Depressive symptoms compared to, waitlist, TAU and other active treatments.
- Has been successfully used in urban, suburban, and rural settings and different treatment modalities, such as In-person, hybrid and over telehealth.
- Across studies, the percentage of Black youth ranged from 2%-59% and the percentage of Hispanic youth ranged from 1% to 29%.

TF-CBT Dissemination

TF-CBT Intakes SFY 2024 (per 10,000 Children)



12,500 Children Served
SFY07 – SFY24

	FY24	All Time
Children Served	816	12,500
Providers	49	73
Sites	93	137
Clinicians	320	1133
Workforce Trained	59	1124

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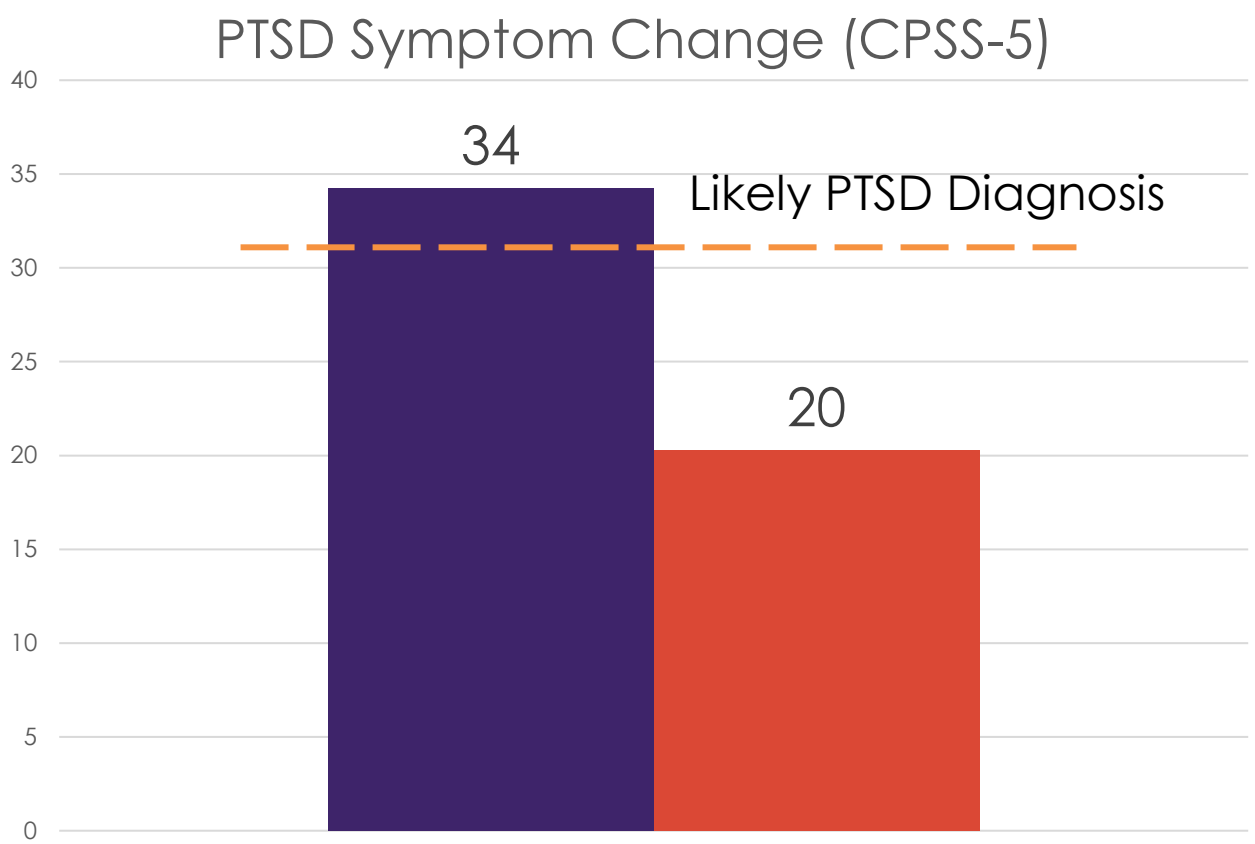
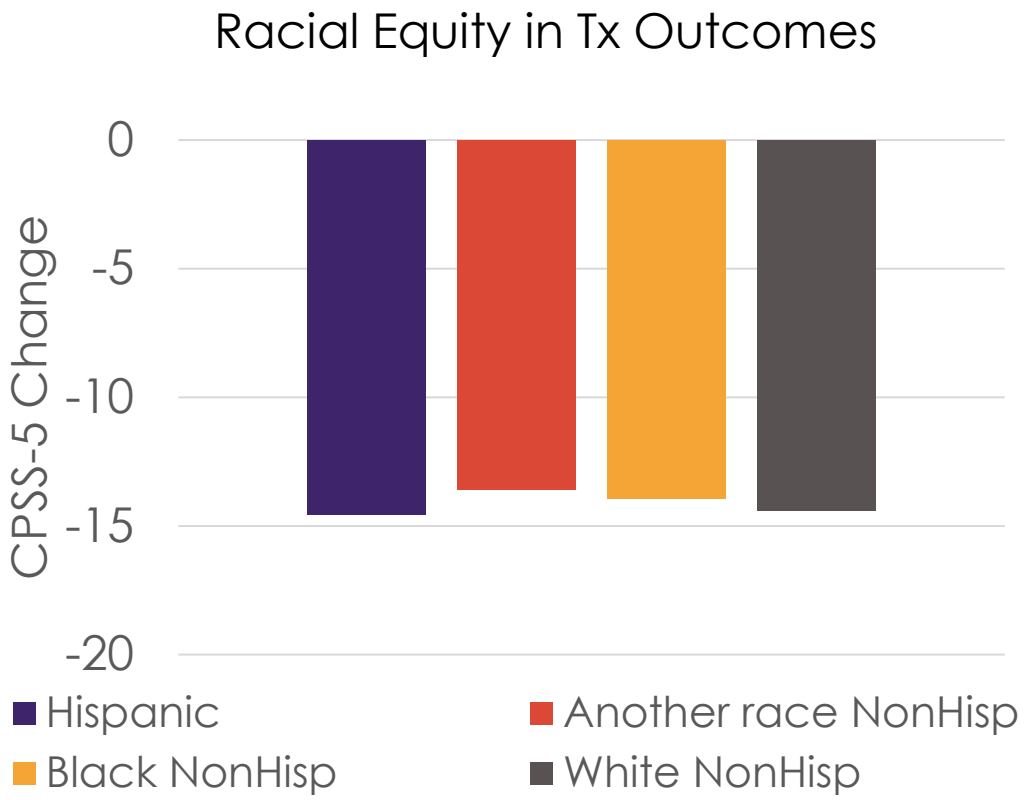
TF-CBT

Youth receiving TF-CBT in 2022-2024 reduced symptoms to below the clinical threshold. There were no significant differences in symptom improvement by sex, race and ethnicity, or DCF involvement.





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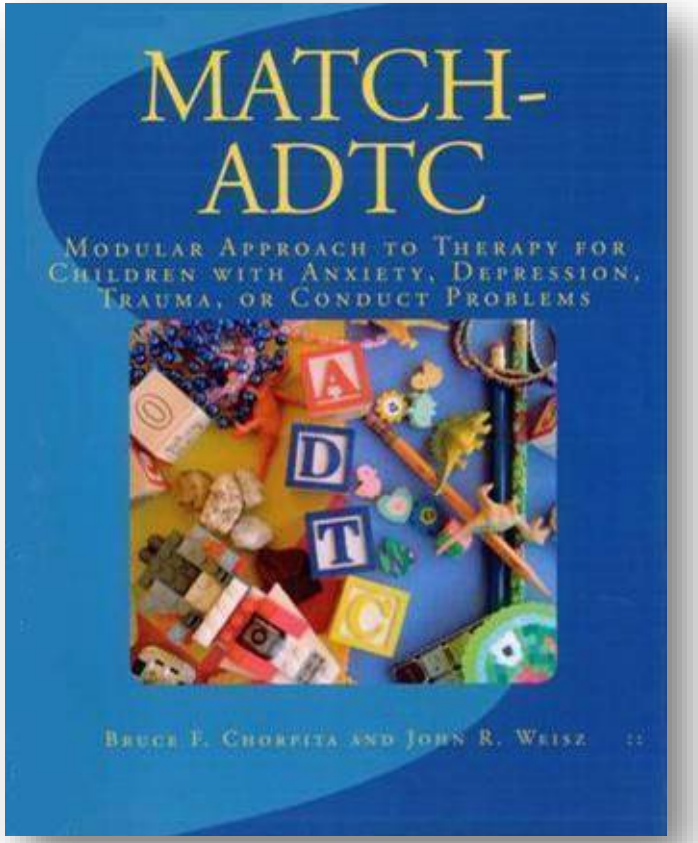
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)



What is MATCH?

- Evidence-based treatment for four common behavioral health concerns among children: **Anxiety, Depression, Posttraumatic stress, and Conduct problems**
- A modular , trans-diagnostic treatment protocol for children who may experience a range of psychiatric diagnoses
- Synthesizes common elements found across dozens of evidence-based treatments into one model that is flexible and responsive to the complex needs of children and families.

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Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)

Who is MATCH for?

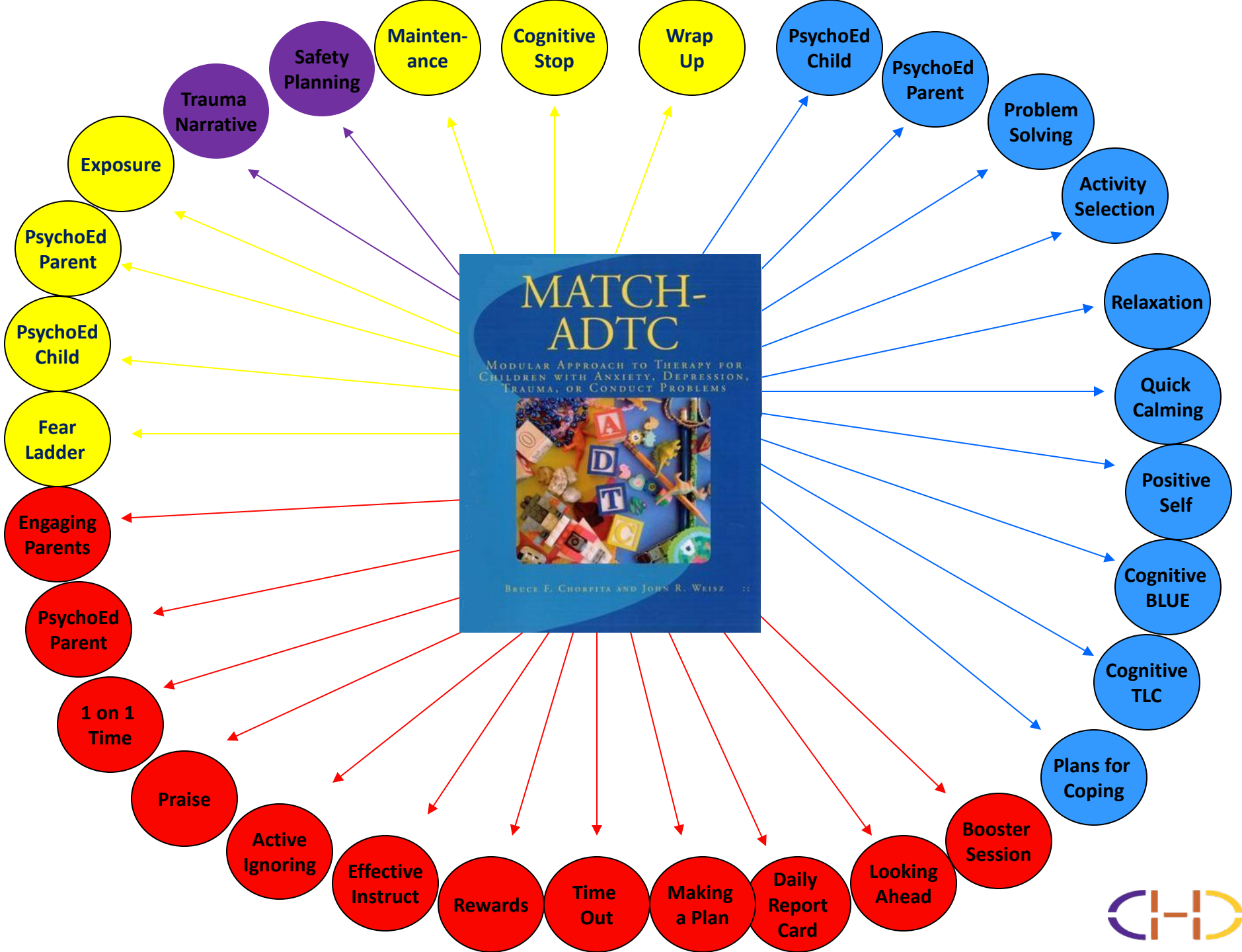
- For children and adolescents ages 6-15 with a diagnosis or difficulty in one or more of the MATCH problem areas
- Approximately 71% of youth served in the OPCC network meet MATCH eligibility criteria based on data in PIE
- Referral sources include community providers, DCF, schools, clinicians, and family/youth self-referrals, etc.

Research support for MATCH

- In 5 RCTs, MATCH resulted in greater improvements in internalizing/externalizing problems, fewer diagnoses, and utilization of fewer service settings post-treatment compared to TAU
- Studies were conducted in MA, HI, CA, and Norway in urban, suburban, and rural settings
- Across studies, the percentage of Black youth ranged from 5%-10% and the percentage of Hispanic youth ranged from 2% to 78%

Why MATCH-ADTC?

- Integrates EBTs for multiple youth disorders
- Simplifies learning for the clinician (one unified approach)
- Broadens coverage (70%+) child outpatient caseloads in North America (aged 7 to 13)
- Can shift focus during treatment
- Designed specifically to address co-morbidity
- Mirrors how EBTs are practiced in real-world setting



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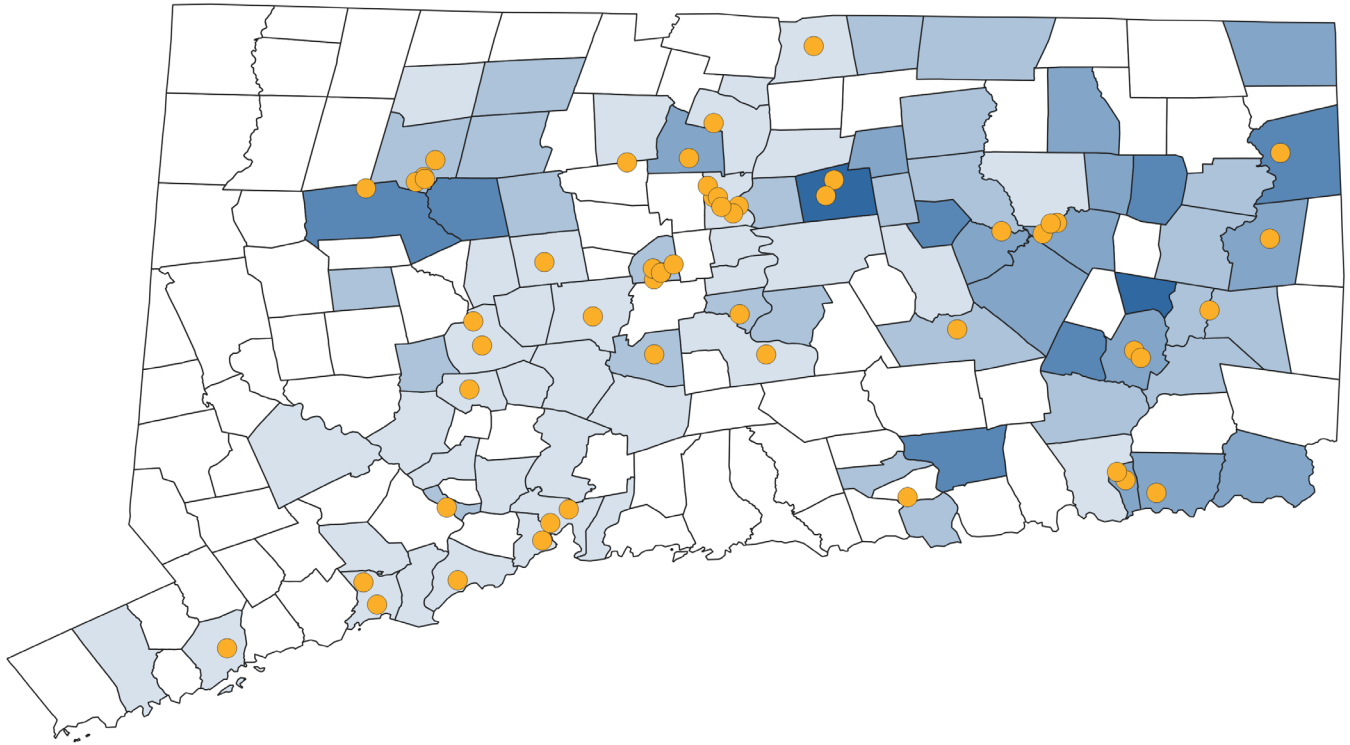
MATCH-ADTC Dissemination

MATCH-ADTC Intakes SFY 2024 (per 10,000 Children)



3769 Children Served
SFY15 – SFY24

	FY24	All Time
Children Served	667	3,769
Providers	22	25
Sites	56	65
Clinicians	136	362
Workforce Trained	50	477

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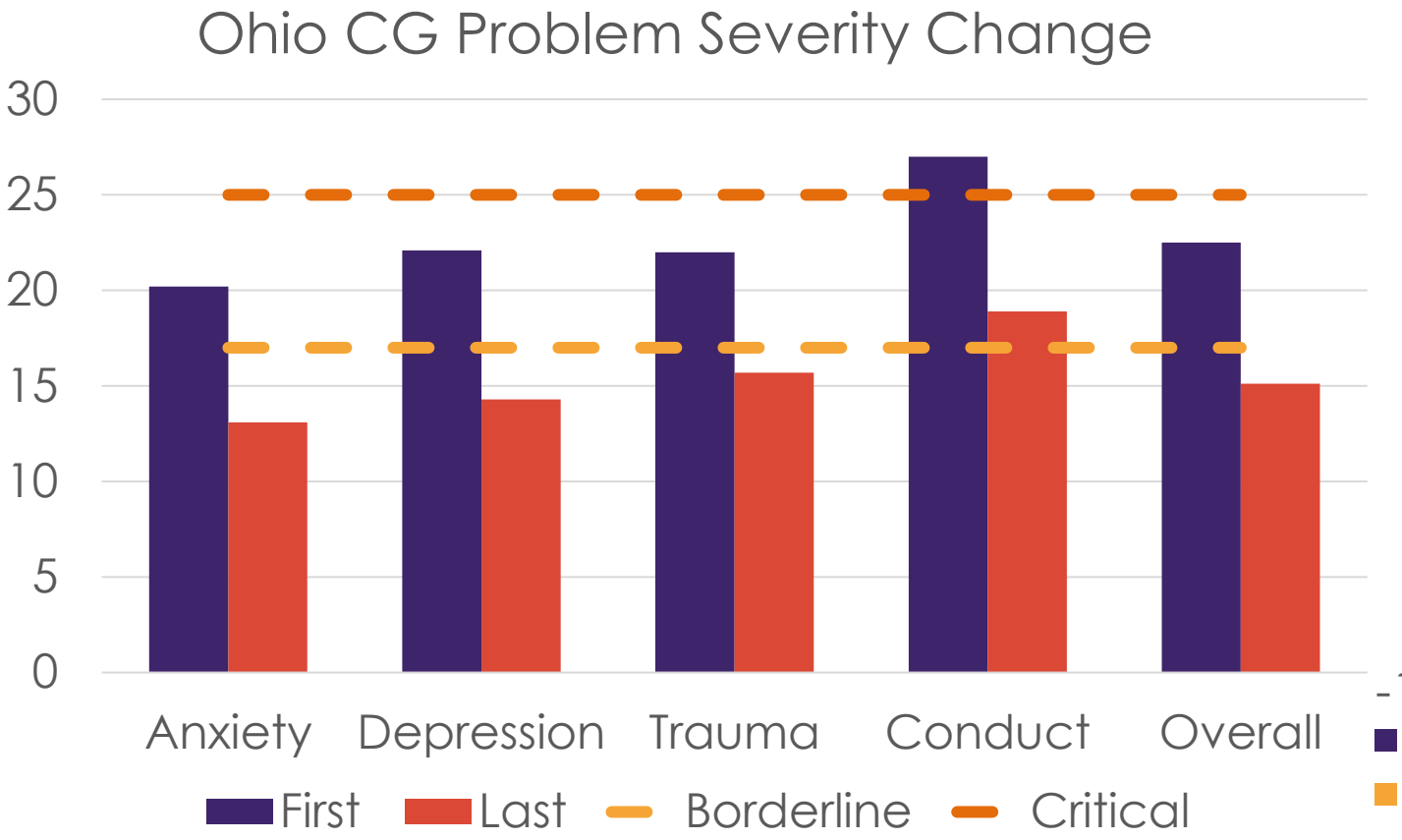
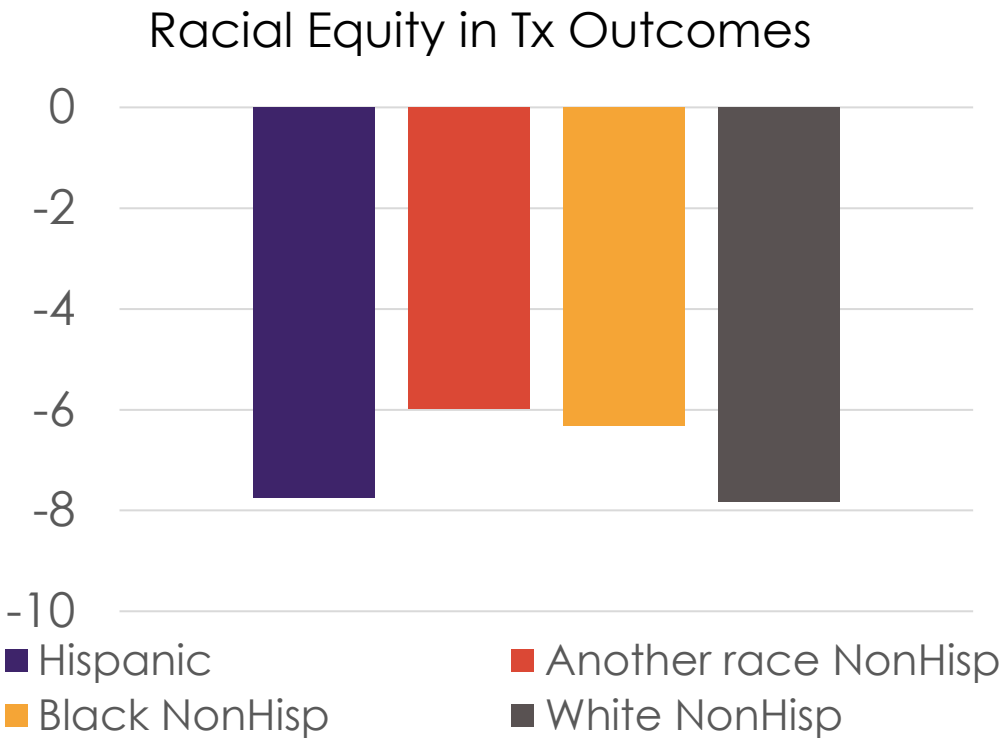
MATCH-ADTC

Youth receiving MATCH-ADTC in 2022-2024 experienced significant symptom reduction. There were no significant differences in symptom improvement by sex, race and ethnicity, or DCF involvement.





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Attachment, Regulation, and Competency (ARC)

What is ARC?

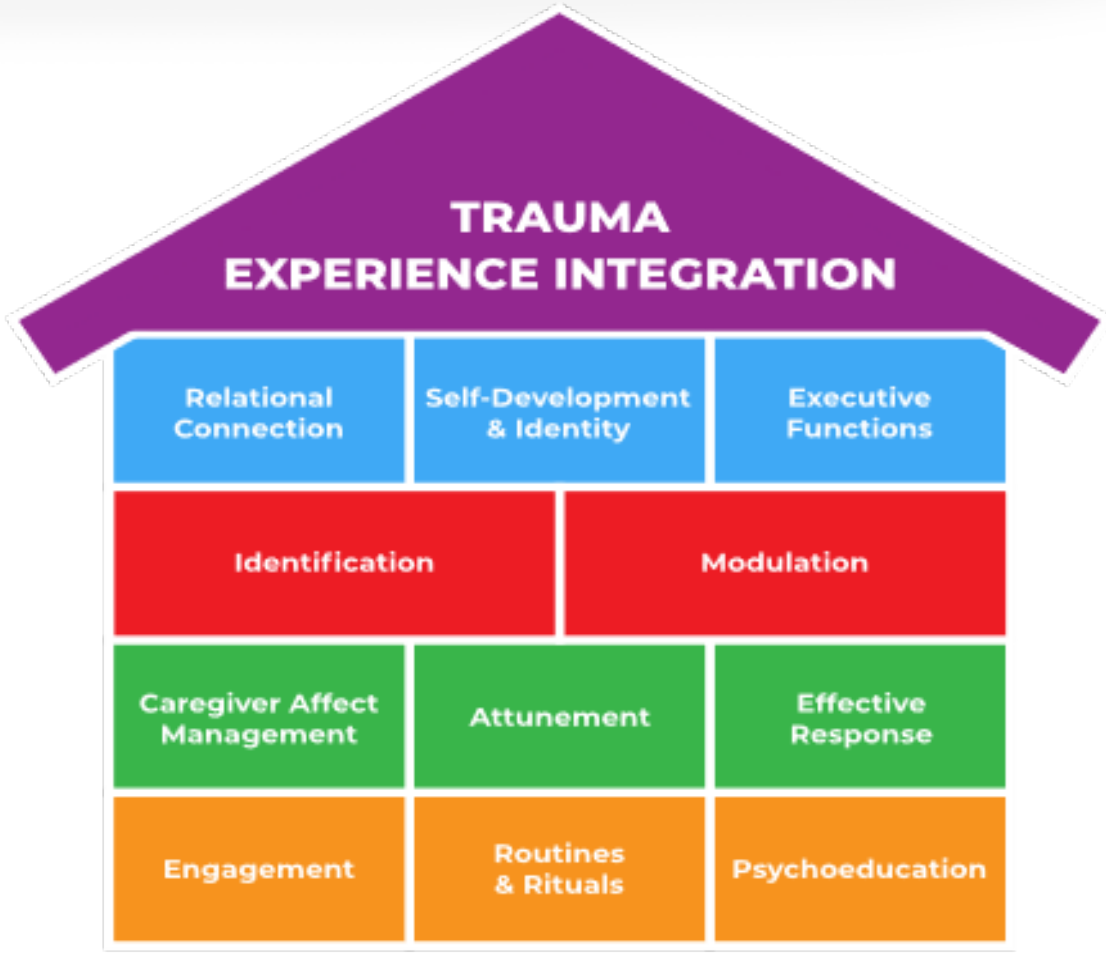
A flexible, components-based evidence-based treatment to address complex trauma

Focuses on:

Supporting families to build safe, healthy relationships ***(Attachment)***

Helping kids learn how to be aware of, understand, label and have tools for feelings and energy states ***(Regulation)***

Helping kids build capacities associated with resilience and targeting the youth's understanding of his or her experiences ***(Competency)***



Attachment Regulation Competency

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Attachment, Regulation, and Competency (ARC)

Who is ARC for?

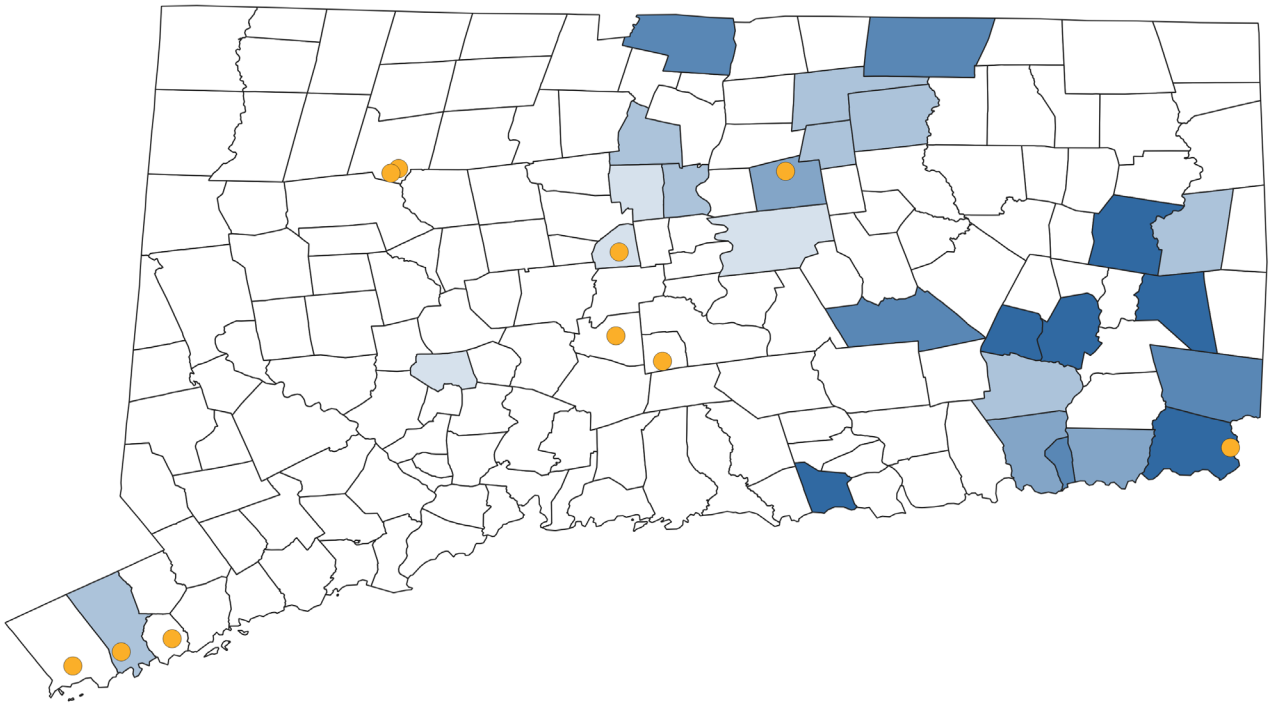
- Young trauma survivors ages 0-21 and their caregivers.
  - Designed to work with various caregiver systems including biological, kin, foster parents, as well as residential systems
  - Effectively used with youth with a range of developmental and cognitive functioning levels, and with a wide range of symptom presentations
  - Used within different cultural contexts (e.g., Native American/Native Alaskan youth, urban youth of color, etc.)
  - Referral sources include community providers, DCF, schools, pediatricians, clinicians, and family/youth self-referrals, etc.

Research support for ARC

- 10 studies found reductions in PTSD symptoms, externalizing and internalizing symptoms and decreases in caregiver stress for a wide age range, Birth to 22 yrs old.
- Across studies, the percentage of Black youth ranged from 2%-42%, Hispanic youth ranged from 4% - 8%, and American Indian/Alaskan Native youth ranged from 2% - 65.6%.
- ARC has been studied in the child welfare system, outpatient care, pre-adoptive placement, Head start preschoolers and in elementary schools.

ARC Dissemination

ARC Intakes SFY 2024 (per 10,000 Children)



869 Children Served
SFY17 – SFY24*

	FY24	All Time
Children Served	150	869
Providers	8	13
Sites	10	17
Clinicians	40	145
Workforce Trained	0	176

*ARC was added to the TF-CBT Contract in Q3 FY24

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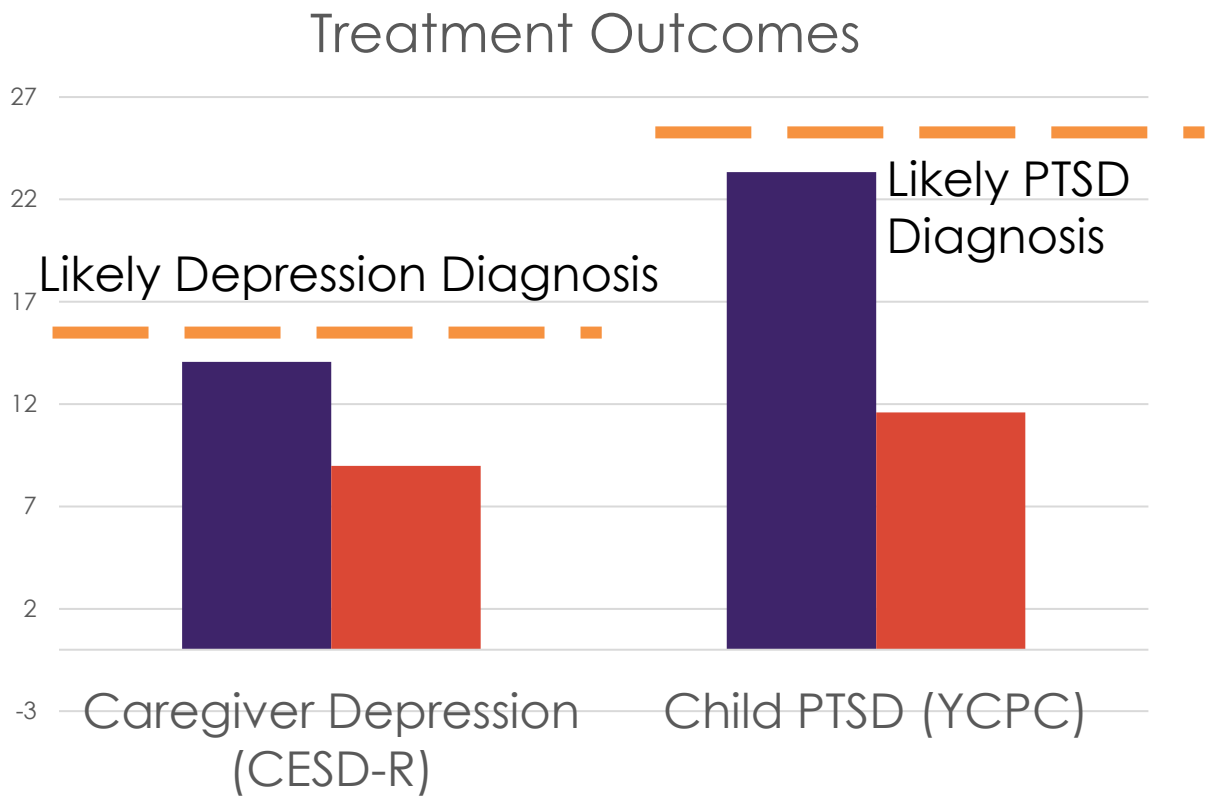
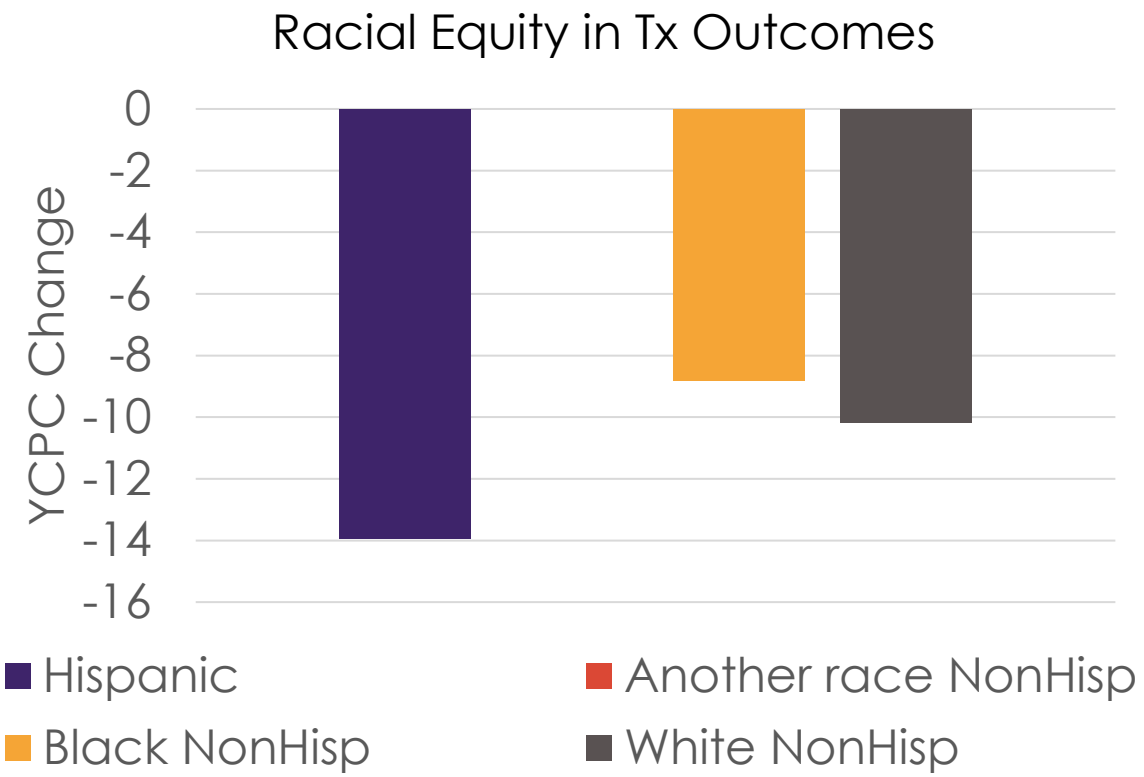
ARC

Youth and caregivers receiving ARC in 2022-2024 experienced symptom reduction. There were no significant differences in symptom improvement by sex, race and ethnicity, or DCF involvement.





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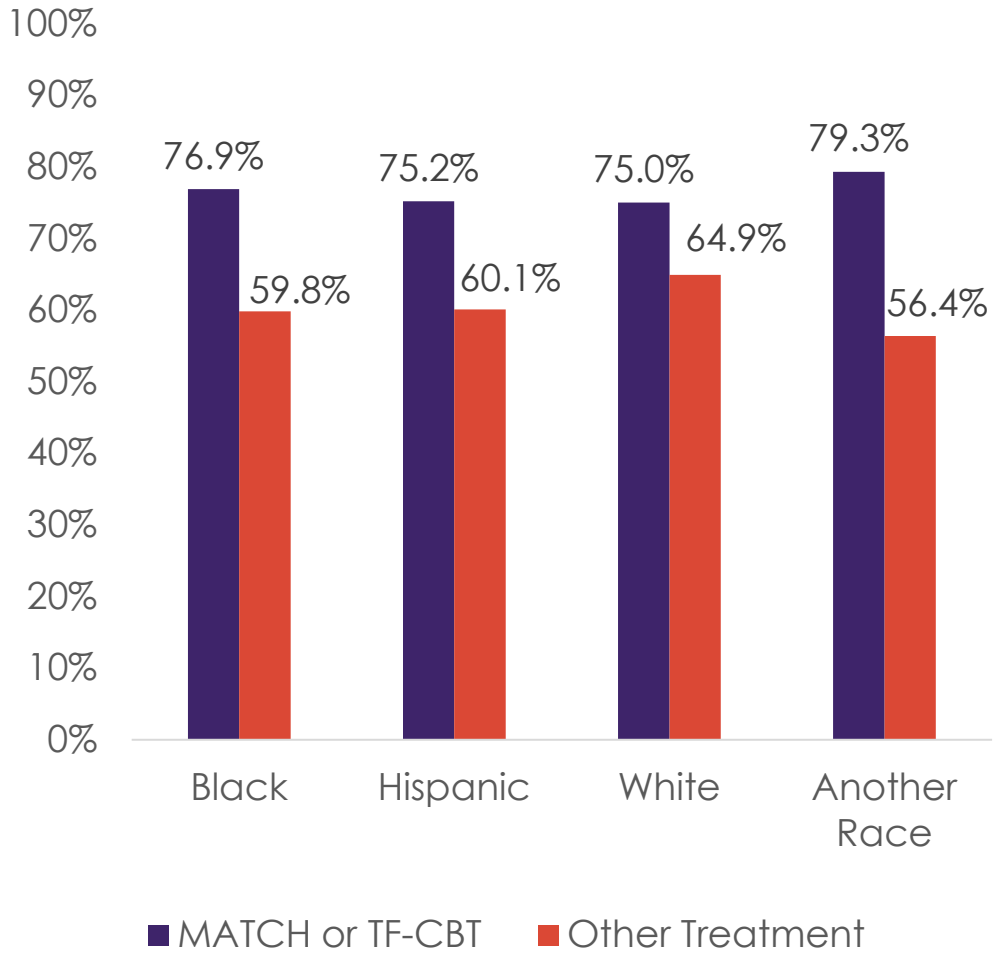
Overall outcomes for Outpatient EBPs

- In FY24, 76% of youth receiving TF-CBT or MATCH met treatment goals compared to 61% receiving any other treatment.
  - Youth met treatment goals at equivalent rates across race and ethnicity when receiving TF-CBT or MATCH, but White youth met treatment goals at higher rates than all other youth when receiving any other treatment



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School-Based EBPs: CBITS and Bounce Back

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What is CBITS and Who is it for?

Cognitive Behavioral Intervention for Trauma in Schools

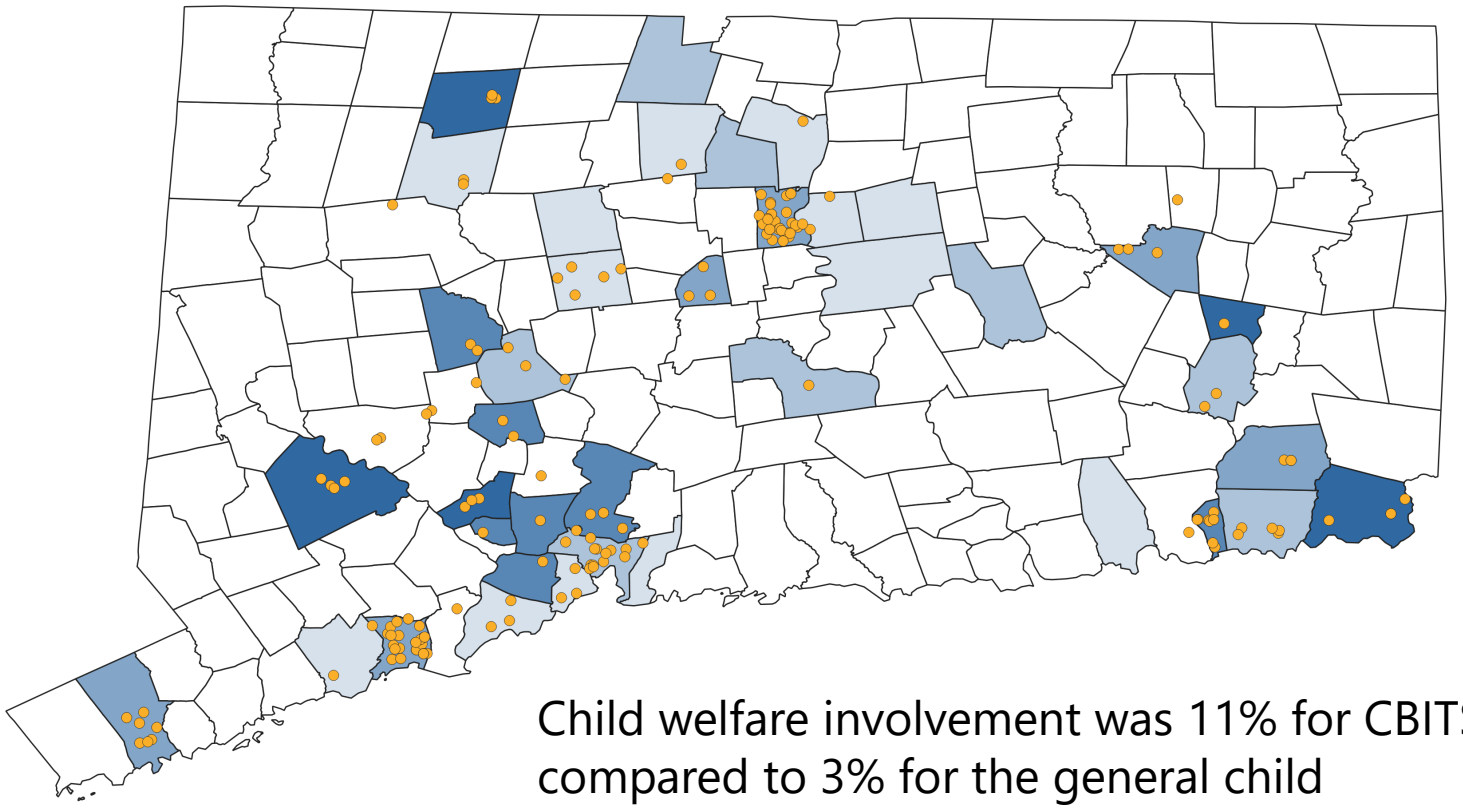
- Short-term, evidence-based, manualized group intervention for youth reporting post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma.
- Intended for children in grades 5-12
  - Criteria: report **at least one trauma** and at least moderate post-traumatic stress symptoms

- School-based group therapy
  - 10 manualized group sessions with individual, caregiver, and teacher sessions

- Uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem-solving, cognitive restructuring, and exposure)
  - Goals are to reduce post-traumatic stress symptoms and behavior problems and improve functioning, peer and parent support, and coping skills.

CBITS Dissemination

CBITS Intakes SFY 2024 (per 10,000 Children)



Child welfare involvement was 11% for CBITS compared to 3% for the general child population

3,568 Children Served SFY16 – SFY24

	FY24	All Time
Children Served	441	3,568
Providers	35	47
Sites	167	316
Clinicians	96	396
Workforce Trained	47	567

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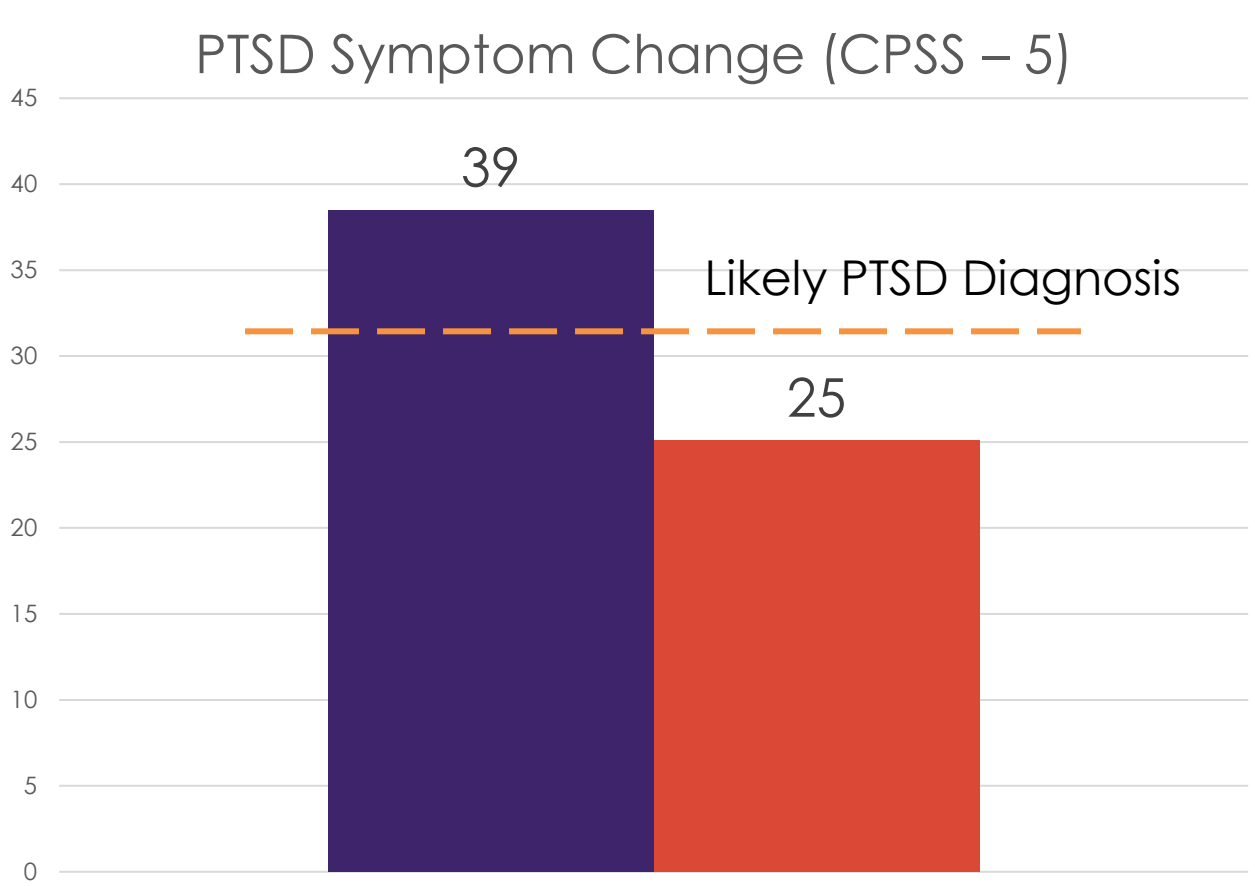
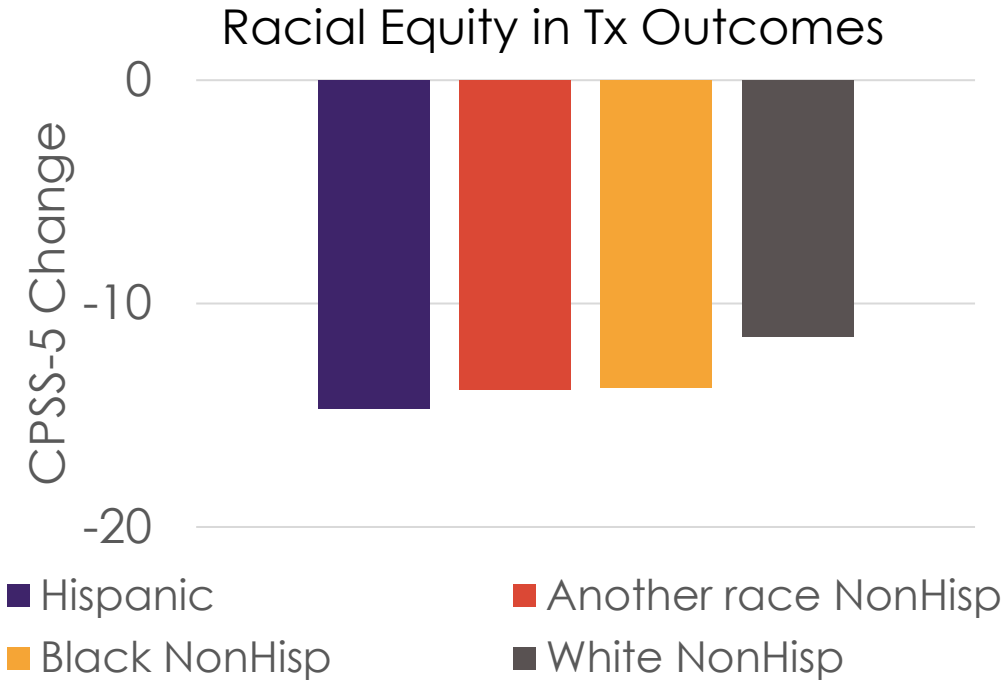
CBITS

Youth receiving CBITS in 2022-2024 reduced symptoms to below the clinical threshold. There were no significant differences in symptom improvement by sex, or DCF involvement.





Hispanic children were significantly more likely to have reliable symptom improvement compared to White children

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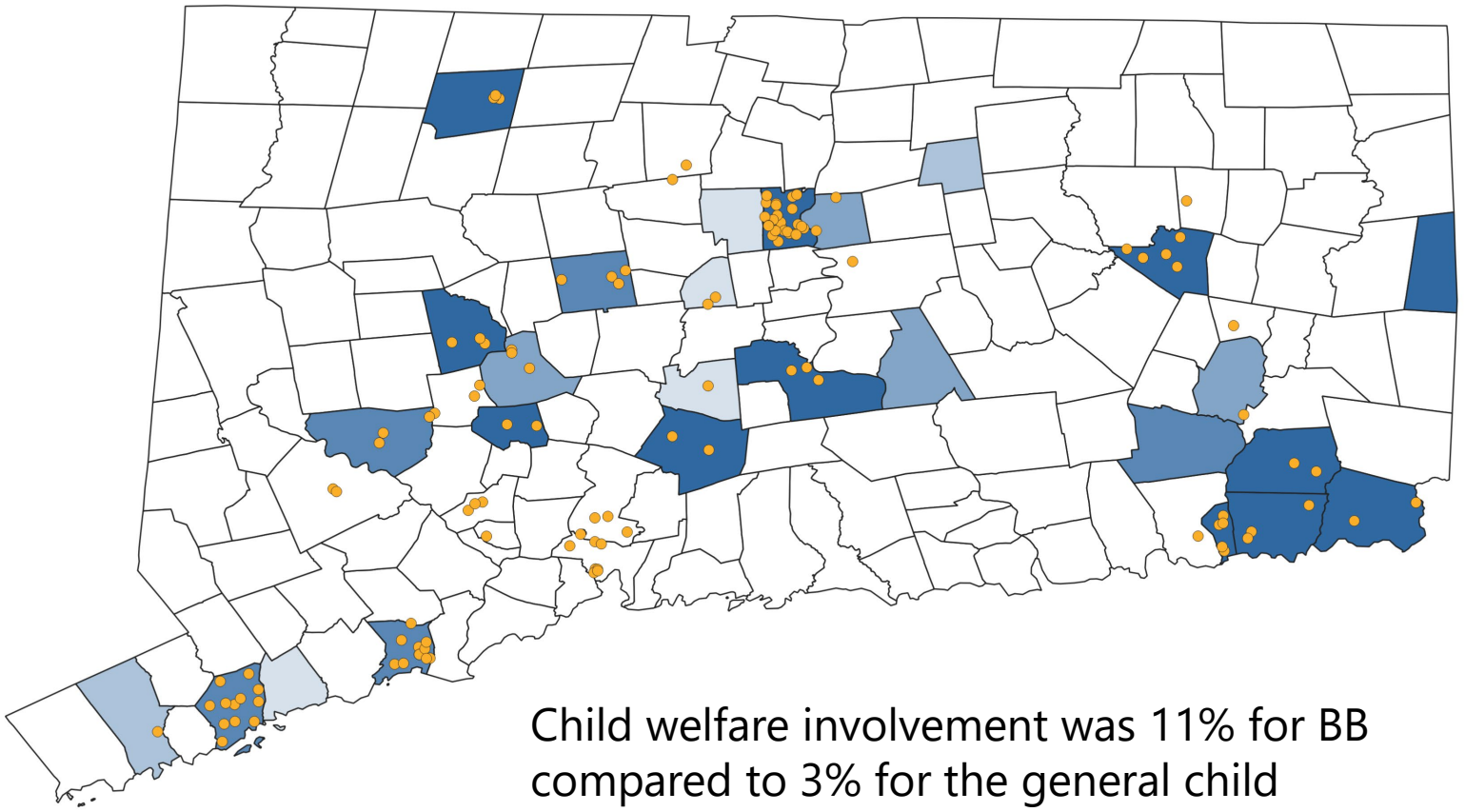
What is Bounce Back and Who is it For?

- An adaptation of CBITS intended for kids in grades K-5
- Uses the same cognitive and behavioral skills as CBITS, with the addition of feelings identification and positive activities
- School-based group therapy with 10 manualized group sessions
  - Individual and caregiver components built-in
  - Greater emphasis on caregiver participation during individual exposure sessions
- Uses playful, age-appropriate tools such as books and visuals to teach feelings identification and other key ideas

Bounce Back Dissemination

Bounce Back Intakes SFY 2024 (per 10,000 Children)



Child welfare involvement was 11% for BB compared to 3% for the general child population

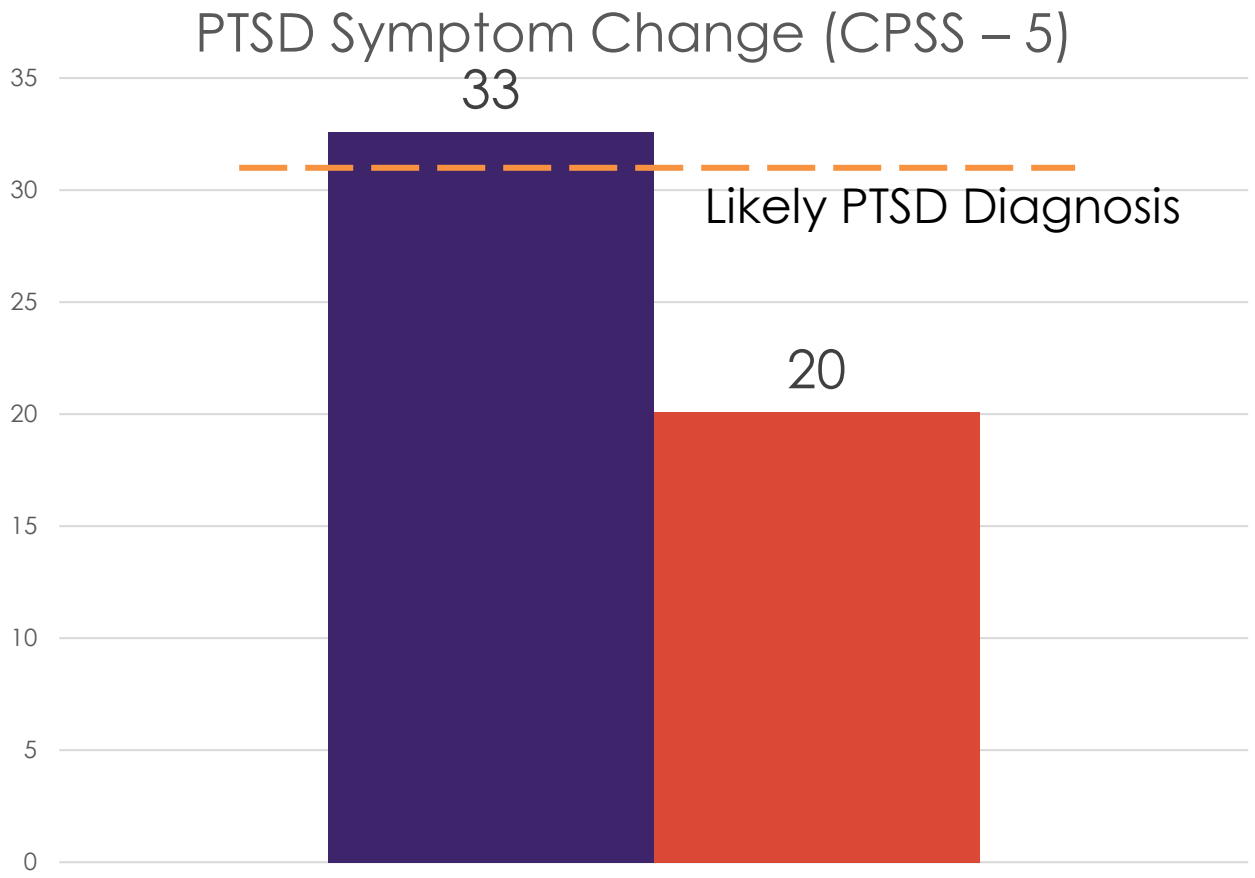
2,349 Children Served
SFY16 – SFY24

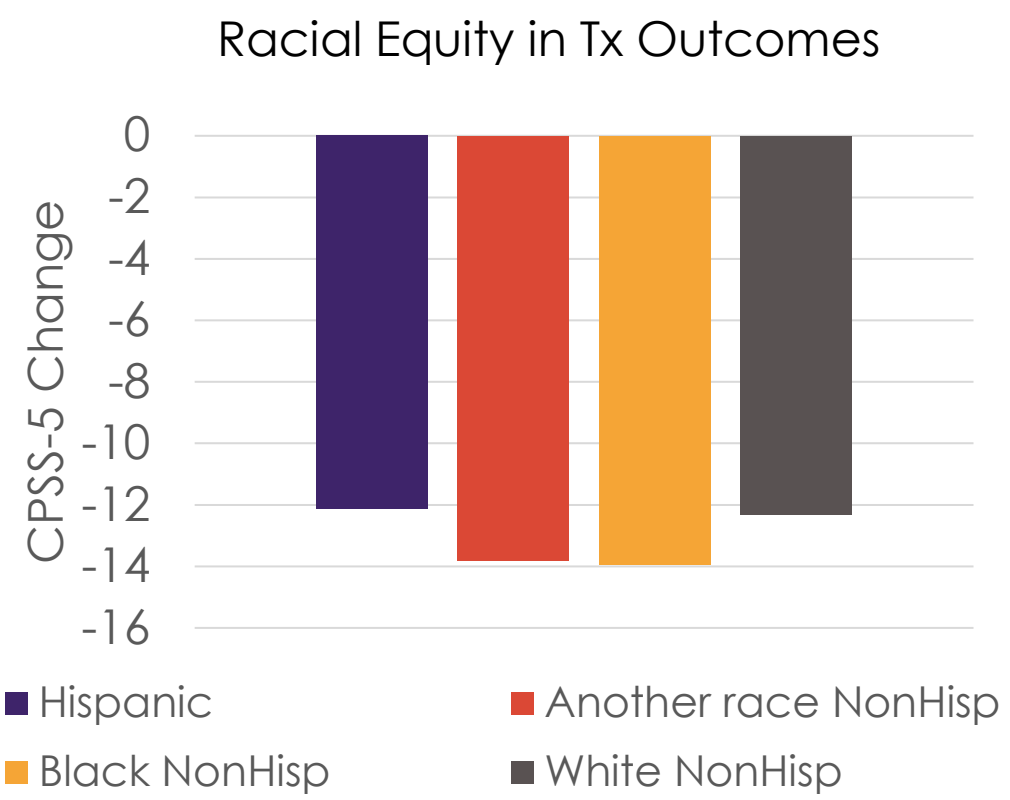
	FY24	All Time
Children Served	334	2,349
Providers	31	42
Sites	128	246
Clinicians	84	132
Workforce Trained	34	392

CHDI® Child Health and Development Institute

BounceBack

Youth receiving BounceBack in 2022-2024 reduced symptoms to below the clinical threshold. There were no significant differences in symptom improvement by sex, race and ethnicity, or DCF involvement.





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Cross-EBP benefits to systems and families

Children Receiving Treatment in Connecticut...

...experience an average of *7 potentially traumatic events* before treatment and are often involved in other systems.

24% are child welfare involved.

26% have identified special education needs in school.

2% are involved with the juvenile justice system.

7% visited an emergency department for a behavioral health issue within the 3 months prior to treatment.

How EBPs Have Helped Youth and Families

23,000+ children and youth have received one or more of these EBPs
83% experienced significant symptom reduction
95% of caregivers were satisfied with treatment

A family who received TF-CBT, " The girls' grades in school started climbing back up. They were sleeping through the night again—no more complaints about nightmares and intrusive daytime thoughts. The older child slept over a friend's house for the first time since the abuse was disclosed. They could stand to be away from Mom. They were smiling again, caring again and bickering like sisters again.“

What do providers think about EBPs?

MATCH provider, "MATCH serves a number of populations. The flexibility makes it sustainable and a great addition to the agency. MATCH understands that we have to fit our unique families."

EBP provider, "This work is proven to be effective and have positive outcomes. It helps provide a level of engagement and hope with those caregivers and families that we're working with that things can get better."

CBITS provider, "CBITS has certainly offered the students I've worked with the space to be validated in their experiences and come to the realization that they are not alone in those experiences of trauma. It also gave them a chance to digest their trauma and make room for new thoughts and insights."

Broader Benefits of EBPs

Effective treatment saves children, caregivers, and the public money over time

A conservative estimate shows DCF-funded EBPs have saved over $225 million in future cost savings and benefits*

*** Calculations based on estimates provided by the Washington State Institute for Public Policy; the models for which cost-saving figures are available are ARC, CBITS, BB, MATCH-ADTC, and TF-CBT.

THANK YOU!

Child Health and Development Institute

Transforming Children's Behavioral Health Policy and Planning Committee

2025 LEGISLATIVE RECOMMENDATIONS IN BRIEF

tyji Tow Youth Justice Institute

Making connections. Informing solutions.

University of New Haven

2025 TCB RECOMMENDATIONS *Note: Recommendations were revised following the January TCB Meeting.*		
Children's Medicaid Behavioral Health Reimbursement Rate Recommendations	1. It is recommended that effective October 1st, 2025, the legislature and the Governor should adequately fund the Department of Social Services to implement an increase of Children's Medicaid behavioral health reimbursement rates based on access needs. The Children's Medicaid reimbursement rate increase should include: a. Adjustment to meet peer-state benchmark rates for children's behavioral health where an applicable benchmark is available, and funding is needed to address access issues. Where a benchmark rate is not available, DSS should recommend a methodology for equitably distributing rate increases to address any access issues/needs. 2. The Department of Social Services should conduct an additional Medicaid Rate Study that specifically evaluates children's behavioral health and compares codes to peer states. The report shall describe how Medicaid investments are reducing the number of codes remaining below the benchmark and evaluating access needs. This study should report the following to the TCB by October 1st, 2025: i. The breakdown of children's behavioral health spend, and where clinic codes are located, ii. After each investment to children's behavioral health (FY '25, '26), The Department of Social Services should evaluate if CT is closer to peer	Fiscal Impact/ Children's Committee

	state benchmarks on code basis and total spending amount, and iii. Identify the proportion of the system that was not matched in the Phase 1 Medicaid Rate Study and provide the TCB a set of recommendations regarding how to approximate access needs for those codes. 3. It is recommended that effective July 1, 2025, the Department of Children and Families should sustain 24/7 mobile crisis expansion initially funded through ARPA. 4. The Department of Social Services should promote Medicaid and commercial billing for UCC services by refining the interim model and rates established for UCCs (as needed) and report on provider billing status under Medicaid to the TCB by Oct 1st , 2025. 5. The Office of Health Strategy (OHS) should submit to the TCB a report on any updates in commercial coverage of UCCs, including changes to plans and contracts, and claims data. The report should be submitted to the TCB by Oct 1st, 2026.	
Workforce Stabilization Recommendations	1. It is recommended that the Department of Social Services conduct a feasibility determination and fiscal analysis to estimate adding a billing code to help off-set initial costs for on-boarding and training clinical staff in evidence-based models, before they can bill for services (e.g. "observation and direction"). This should include: a. Potential Medicaid reimbursement for training and ramp-up, where extensive	Children's Committee

	clinical training in an evidence-based model is needed before billing can occur. b. Feasibility assessment and fiscal analysis estimate should be submitted no later than October 1st, 2025. 2. The Department of Social Services should include as part of the Certified Community Behavioral Health Clinics (CCBHCs) planning and designing grant the following: a. the development of separately payable acuity-based care coordination service to improve outcomes of children, b. a value-based payment model that holds providers accountable and rewards them for improved outcomes, c. and navigation support. 3. It is recommended that the Department of Social Services and Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) Model Development and Operations (MDO) at the Yale Child Study Center, review and design levels of the IICAPS model for consideration. This should be reported back to the TCB by October 1st, 2025. a. Such model should consider the needs and time-demands placed on families and children, and the ability to deliver positive outcomes in a sustainable manner. 4. It is recommended that TCB contract with IICAPS Model Development and Operations (MDO) at the Yale Child Study Center to a. determine what additional federal funding and reimbursements may be available to IICAPS MDO and the	

	IICAPS network as an evidence-based/promising practice treatment program, and if determined prudent, b. conduct a randomized controlled trial (RCT) of IICAPS for the purpose of qualifying IICAPS federally as an evidence-based treatment program. Interim recommendations to TCB by October 1st, 2025.	
ASD Recommendation	1. The TCB recommends an amendment to Sec. 38a-514b (group coverage) and Sec. 38a-488b (individual coverage) of the general statues section to strike through the age of insurance coverage of ABA from 21 to 26, effective January 1st, 2026.	*Insurance*
Continuum of Crisis Services Study Recommendation	1. It is recommended that TCB conduct a study to review utilization and anticipated demand of the children's BH crisis continuum, which includes 211/988, mobile crisis, Urgent Crisis Centers (UCCs), Sub-Acute Crisis Stabilization, and ED, to assess and advance optimal capacity utilization. a. Studies should include current utilization of services, marketing efforts, outreach strategies, referral pathways, and resource allocation. b. TCB should submit a report of recommendations by November 1st, 2025.	Children's Committee
School-Based Health Center Study Recommendations	1. It is recommended that TCB contract with an outside entity to conduct a School Based Health Center (SBHC) study for a. Developing and administering a survey to better understand current data collection practice and the anticipated challenges and opportunities	Children's Committee

	in implementing a more robust data and QI system. b. Identifying effective reporting standards for SBHC's to report to the Department of Public Health (DPH). c. The study will be designed and piloted in collaboration with the Department of Public Health (DPH) and the department of Children and Families (DCF). d. A standardized definition of SBHCs. 1. It is recommended that all School Based Health Centers (SBHCs) report to DPH the following effective January 1st, 2026, annually thereafter a. Establish comprehensive reporting across all SBHCs to inform targeted investment by utilizing reporting mechanisms outlined in the study above.	
School Health Services Recommendation	1. A review of Medicaid and private insurance billing codes (e.g behavioral health services provided and billed within schools) to ensure non-duplicative billing and opportunities to fully claim reimbursement for services provided. ***Note: This language is pending.***	Children's Committee