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# **Task Force to Study the Provision of Behavioral Health Services for Young Adults**

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**Established Pursuant to Public Act 13-3 (Section 66)  
State of Connecticut**

## **Final Report**

**April 2014**

# Task Force to Study the Provision of Behavioral Health Services for Young Adults

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# Executive Summary

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## Background

The Task Force to Study the Provision of Behavioral Health Services for Young Adults was established pursuant to Public Act 13-3 (Section 66), entitled *An Act Concerning Gun Violence Prevention and Children's Safety*. The Task Force was directed to focus on behavioral health services for young people ages 16 to 25 years old, and was charged with analyzing and making recommendations in thirteen specific areas. Beginning in August 2013 the Task Force met monthly, then biweekly, and then weekly until April 2014. Initially, the Task Force heard presentations describing the current system of care. The Task Force then discussed and assessed gaps in available services, and finally discussed approaches to identified gaps. Multiple recommendations were then generated focusing on the thirteen specific charges to the Task Force. In formulating specific recommendations the Task Force recognized the need to be mindful of balance between recommendations and financial realities. The Task Force also felt strongly that this report, and its specific recommendations, needs to represent what would be an ideal behavioral health system if an ideal and effective behavioral health care system could be made equally accessible to all adolescents and young adults in need of services.

Much of the discussion and many of the issues that were addressed related to a lack of equal access across all payers, including commercial, employer (self-insured), and public insurers. (Throughout its work, the Task Force recognized that more than half of the private insurance market, which includes both commercial insurers and self-insured employers, consists of self-insured employers not subject to state jurisdiction.) The Task Force focused on specific issues of lack of work force and service capacity, uneven access to care, inequalities in coverage, and lack of consistent reporting and accountability regarding services provided and populations reached.

All of the recommendations made by the group were voted upon openly, and only those with a majority vote (many of which were unanimously accepted) were included in this report. Thus, while not all of the Task Force agreed with all of the recommendations, there was general consensus for virtually all of the recommendations that are included and discussed in this report.

The recommendations generally clustered into three large domains addressing: (1) capacity of the behavioral health service delivery system, including workforce capacity, in Connecticut (Cluster I); (2) access to behavioral health services in Connecticut (Cluster II); and (3) issues of rights under law for persons with behavioral health issues (Cluster III).

In Connecticut, about 10 percent of adolescents and young adults ages 16 to 25 years have experienced at least one episode of a major depressive disorder in the past year, about 20-25 percent of trauma-exposed youth will meet current mental health diagnostic criteria for post-traumatic stress disorders, 6 to 9 percent have attention-deficit/hyperactivity disorder, and

between 8 percent of adolescents and up to 24 percent of young adults will report alcohol and/or illicit drug use within the past year. Late adolescence and young adulthood are a high-risk time for onset of major mental illness including schizophrenia and bipolar illness. Particularly vulnerable subgroups include adolescents and young adults with developmental disabilities, those in the child welfare system, and court-involved juveniles.

These statistics describe a substantial public behavioral health burden for Connecticut children, adolescents, and young adults. This burden has large consequences not only for Connecticut families with vulnerable children, adolescents, and young adults, but also large direct and indirect yearly costs for the State including: costs for lost productivity, lost developmental potential, morbidity, and early mortality for afflicted individuals, as well as special education, police, health care, and court costs.

The Task Force endorsed eight overarching principles to provide guidance in addressing the provision of behavioral health services for adolescents and young adults in Connecticut including:

1. The primary importance of a long-term, longitudinal, and developmentally informed approach to behavioral health in the 0-25 year old population;
2. The importance of models of prevention in at-risk families;
3. The importance of *early* recognition, assessment, intervention and treatment of childhood and adolescent behavioral health disorders for Connecticut;
4. The importance of a multi-disciplinary team approach to child, adolescent, and young adult mental health disorders;
5. The importance of building on existing Centers of Excellence in Connecticut;
6. The importance of providing equal access to a basic minimum behavioral health standard-of-care for all those in need regardless of health care coverage status across the life span in Connecticut;
7. The importance of providing and articulating a basic set of core principles that serve to guide behavioral health service delivery for children, adolescents, and young adults in Connecticut; and
8. The importance of providing behavioral health services that are developmentally as well as culturally appropriate to the individuals, families, and populations being served.

## **Main Findings**

Although Connecticut has many examples of excellence in specific adolescent and young adult mental health programs, the Task Force was concerned that Connecticut's overall system of behavioral health care for children, adolescents, and young adults does not function well in providing for the needs of individuals and families, nor in providing for the state of Connecticut effective and accountable behavioral health care. Important and continuing problem areas identified include:

1. Inadequate identification of behavioral health issues early in development (preschool, childhood, adolescence);
2. A behavioral healthcare workforce for pediatric and young adults not presently sufficient to meet the health care needs of Connecticut: More child and adolescent psychiatrists, social workers, and psychologists who focus on the clinical evaluation and treatment of children and adolescents are needed in the State;
3. Inadequate pediatric mental health specialty provider training in diagnoses-specific evidence-based evaluation methods and treatments: Clinical service delivery must emphasize evidence-based treatments and benchmarking and accountability at the individual case level to help identify which patients improve with treatment and which do not improve, as well as which treatments are most effective;
4. System fragmentation: Inequalities in access to evidence-based mental health treatment coverage based on diverse payment systems exist in Connecticut and need to be addressed;
5. System fragmentation: Lack of treatment integration and coordination of care continues making it difficult for families in need to access care and difficult for patients to achieve continuity of treatment across various mental health systems and across multiple payers. The behavioral health care system is not user-friendly for those in need;
6. System fragmentation: There is a lack of integration across substance use and mental health systems of care. There is also fragmentation of care as adolescents transition from pediatric to adult-based services; and
7. Local Educational Authorities in need of enhanced capacity for behavioral health interventions for students at risk, and for services located in school settings.

## **Task Force Recommendations**

The Task Force has put forth 47 recommendations addressing the overall goal of improving the behavioral health care of children, adolescents, and young adults in Connecticut. The report's recommendations, when taken together, aim to accomplish the following overarching goals:

1. Enhance identification of early-onset mental health disorders for Connecticut's children, adolescents, and young adults.
2. Increase pediatric mental health care provider evaluation and treatment capacity (workforce capacity).
3. Address pediatric mental health care provider quality by enhancing training and developing expertise in evidence-based evaluation and intervention.
4. Decrease behavioral healthcare system fragmentation.
5. Increase behavioral healthcare ease-of-use for families in need.
6. Enhance mental health capacity in schools to address safety, student behavioral management issues, and early identification and treatment.
7. Continue discussion on involuntary outpatient commitment laws in Connecticut.

In the wake of the Newtown tragedy the Task Force recognizes the importance of Public Act 13-3 (Section 66), entitled *An Act Concerning Gun Violence Prevention and Children's Safety*. The work of the Task Force to Study the Provision of Behavioral Health Services for Young Adults in addressing the issues raised in this public act represents our sincere hope that the Legislature will move forward in this important area to improve Connecticut's system of care in the provision of mental health services to youth and to young adults.

**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>I</b>	1. Mandate screening for behavioral health problems by primary care providers of children, adolescents, and young adults ages 0-25 years old in Connecticut in the setting of their primary medical care provider (the health care setting).	27
<b>I</b>	2. Increase support to primary care providers for the extra time and effort required to complete recommended behavioral health care screening in the primary care office setting.	27
<b>I</b>	3. Increase the accessibility and affordability of existing early intervention programs, particularly for those young children identified as at-risk through screening.	27
<b>I</b>	4. Scale-up existing food security guarantee programs for in-need and at-risk families of young children ages 0-6 years old.	27
<b>I</b>	5. Enhance housing and shelter security for in-need and at-risk children, adolescents, and young adults ages 7-25 years old, and for families of young children ages 0-6 years old.	28
<b>I</b>	6. Develop and fund seven specialized Centers of Excellence for consultation and educational training to mental health organizations and to professional practice organizations working in outpatient treatment with children, adolescents, and young adults in Connecticut.	28
<b>I</b>	7. Expand state appropriations for ACCESS MH CT to include young adults up to 25 years old, making ACCESS MH CT available for children, adolescents, and young adults ages 0-25 years old.	28
<b>I</b>	8. Enhance behavioral health care through the creation of models that co-locate behavioral health providers with primary care physicians independently of insurance type. Encourage memoranda of understanding (MOUs) between primary care physicians and behavioral health agencies to facilitate co-management models within local behavioral health systems-of-care. [This model already exists and could be replicated across the state.]	28
<b>I</b>	9. Create regionalized networks of care and expand care coordination, in order to enhance integrated mental health care for children, adolescents, young adults, and their families. [Creating regionalized networks of care and expanding care coordination is currently proposed to be accomplished through the Behavioral Health Home model developed by DMHAS, DCF, and DSS that is currently under consideration by CMS. A similar model should be developed for individuals who are privately insured.]	28
<b>I</b>	10. Expand community collaboratives/systems of care into six regional networks of care that cut across town lines, state agencies, school systems, and private and public entities.	28

**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>I</b>	11. Expand and upgrade the current 2-1-1 Crisis Line in order to reach young adults by tying the DMHAS-funded Adult Mobile Crisis Lines to the 2-1-1 Crisis Line and promote this system for young adults in psychiatric crisis.	28
<b>I</b>	12. Create a “Pathways To Care” program including regional care navigators tied to the 2-1-1 Crisis Line who are knowledgeable about behavioral health services and supports in the caller’s local community.	28
<b>I</b>	13. Consider that all provided behavioral health services be developmentally as well as culturally appropriate to the individuals and populations being served.	29
<b>I</b>	14. Create and enforce a set of uniform standards and definitions across all insurers (public and commercial) regarding: 1) the range of behavioral health services to be provided; 2) the criteria for receipt of services across the spectrum to include out-patient, community-based intensive outpatient services, and inpatient services; and 3) definitions of medical necessity that include behavioral health conditions. (This in effect should work towards alleviating problems such as: a) piecemeal information on service quality; b) geographic maldistribution of mental health services; c) difficult systems of pre-authorization for services in the private sector; d) the limitation of inpatient beds for psychiatric emergencies and appropriate inpatient psychiatric care; e) the tendency to truncate inpatient stays due to cost issues; and f) lack of patient improvement indicators.) (The Task Force recognizes that more than half of the commercial market consists of self-insured employers not subject to state jurisdiction.) The Task Force also recognizes that Connecticut already has a statutory definition of medical necessity for individual and group health insurance policies that should be consistent with the definition used by public payers.	29
<b>I</b>	15. Integrate evidence-based behavioral health treatment of adolescents and young adults with evidence-based substance use treatment. [This has been done through implementation of the Integrated Dual Diagnosis Treatment (IDDT) model that is required throughout the DMHAS system and, again, is one of the requirements for increased payment in the enhanced care clinic system but does not exist on the private insurance side.]	29
<b>I</b>	16. Enhance and facilitate better methods of transitioning youth from adolescent to young adult services by developing a specific mechanism where DCF and DMHAS create a comprehensive co-agency program specifically to address transition of youth with mild/moderate as well as severe behavioral disorders, in terms of their health care and human service needs. A leadership task force would facilitate continuing discussion and suggestions to address these two important unresolved issues in transitions of care for adolescents in Connecticut.	29



**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>I</b>	17. Support and adopt the recommendations of the Legislative Program Review and Investigations Committee reports of December 2012 and June 2013.	29
<b>I</b>	18. Amend the public health statutes and/or regulations as needed to allow for combined licensure for adult mental health clinics and facilities for the treatment of substance abusing persons.	30
<b>I</b>	19. Amend the public health statutes and/or regulations as needed to allow for licensed psychiatric clinics for adults and licensed facilities for the treatment of substance abusing persons to provide “off-site” services in a similar fashion as is provided for in DCF licensed facility regulations, with specific reference to physician offices and other health care settings. [This proposal is consistent with the SIM Healthcare Innovation Plan.]	30
<b>I</b>	20. Review the suggested changes to the DSS Federally Qualified Health Centers (FQHC) billing regulations, which could greatly affect mental health clinician access including the use of interns and unlicensed clinicians and reimbursement rates for group therapy.	30
<b>I</b>	21. Expand the current pool of in-school social workers so that all school districts have social worker capacity and the optimal ratio of one social worker for every 250 regular education students is achieved, compared with the current ratio of one social worker to 530 students.	45
<b>I</b>	22. Expand the number of school psychologists to minimum national standards.	45
<b>I</b>	23. Provide “in-service training in mental health competencies” to school-based social workers and psychologists, as well as to other school personnel (administrators, teachers, and resource officers) so that they are able to: 1) provide needed assistance to teachers who may not be experienced enough to deal with behavioral problems or mental health concerns of their students as they occur; 2) change school protocols so that the response to children with behavioral problems is not out-of-school suspension, but in-school evaluation and treatment or mental health referral; and 3) identify and utilize appropriately those services in the community available for mental health treatment (outpatient services, emergency mobile psychiatric services (EMPS), and case management services). There should also be continued support and expansion of SAMHSA’s Mental Health First Aid initiatives throughout the state by delivering the training to: A) college students by making it mandatory during freshman year orientation programs; B) newly hired public servants (all vocations) by making it mandatory within the first year of employment; and C) the public by offering it at Connecticut’s community colleges free of charge.	45

**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>I</b>	24. Expand the presence of school nurses in elementary, middle, and high schools, and expand comprehensive school-based health centers, both in number and to support the inclusion of mental health services in all school-based health centers.	46
<b>I</b>	25. Make available to the behavioral health and developmental specialists located within each school in each school district a regional hub of mental health professionals under contract or memorandum of understanding (MOU). Private elementary and secondary schools as well as colleges and universities should also have access to this regional hub, so that services can be coordinated. This will require the development of MOUs between school mental health providers and any network of collaborating mental health professionals, in order to support any technical assistance activities.	46
<b>I</b>	26. Support the use of telemedicine in order to reach those districts that are geographically isolated.	46
<b>I</b>	27. Expand the capacity of school mental health personnel to work and collaborate with teachers and administrators in identifying those children, adolescents, and young adults who are most at risk and in need of early screening and identification in order to refer to higher levels of mental health treatment, through specific, required training.	46
<b>I</b>	28. Require, as part of teacher preparation in undergraduate or graduate level education, coursework on the issues of mental health, early identification, and how to deal with safety and classroom management issues in the school setting.	46
<b>I</b>	29. Require statewide across all school districts a standardized component of health education classes in elementary, middle, and high school regarding the importance and elements of mental health and well-being.	47
<b>II</b>	30. Increase efforts to enhance data-driven approaches to address the gaps in private behavioral health insurance that include: 1) mandating timely written responses; 2) third-party review of behavioral health data from private health plans; 3) requirements for specific data to be reported (as listed in explanation on pages 55-56 below); and 4) working towards addressing and bridging the gap between the menu of behavioral health services offered by commercial and self-funded plans and their financial support for the publicly funded programs from which their covered clients benefit. We suggest that this be a joint effort between commercial providers, the Connecticut Insurance Department, the Behavioral Health Care Partnership, and the Office of the Healthcare Advocate, with provided data to be de-identified and reported in aggregate to avoid HIPPA violations.	51

**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>II</b>	31. Invite the commercial healthcare and employer-based plans to participate with the Connecticut Behavioral Health Partnership in efforts to help insure a standard, uniform, and equitable system of behavioral health for youth 16 through 24 years of age.	51
<b>II</b>	32. Consider creating an <i>independent</i> Office within the current Office of the Healthcare Advocate that is charged, as one of its responsibilities, with the task of monitoring whether data from both public and commercial insurers regarding behavioral health services provided and outcomes are submitted and made available to the public in a timely and transparent manner. The Task Force recommends that this Office be called the Office of Behavioral Health Relations and Accountability. (See below for the additional proposed roles of this Office in reducing the stigma of mental illness and providing assistance to a clearinghouse. This Office could also monitor the compliance of all service providers with the new federal parity laws.)	52
<b>II</b>	33. Incentivize innovative public-commercial partnership models to pay for child, adolescent, and young adult behavioral health care.	52
<b>II</b>	34. Incentivize the commercial behavioral healthcare plans to collaborate with public sector payers to develop innovative public-commercial models to reduce discrepancies between behavioral health coverage in the commercial versus public sectors.	52
<b>II</b>	35. Incentivize value-based behavioral health payments to clinicians based on quality and performance outcome measures to reduce volume-driven payments, as described in the SIM Healthcare Innovation Plan.	52
<b>II</b>	36. Improve reimbursement rates to clinical providers so that clinicians will more readily accept Medicaid patients through consideration of:	52
	i. loan forgiveness programs for social workers, psychologists, and psychiatrists who are qualified to assess and treat children, adolescents, and young adults;	
	ii. tax credits for accepting insurance payments and/or working with children, adolescents, and young adults in underserved areas of Connecticut;	
	iii. bonuses for equal access and quality of care based on performance outcome measures;	
	iv. malpractice coverage incentives; and	
	v. free training on best practices, standards-of-care, and evidence-based clinical treatment interventions for children, adolescents, and young adults with mental health care needs.	

**Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults**

<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>II</b>	37. Incentivize clinicians to communicate with one another about the behavioral health needs of patients through strategies such as reimbursement for coordination of care via multi-disciplinary provider meetings or telephone consultation, to address the issue of poor communication between providers, as described in the SIM Healthcare Innovation Plan.	53
<b>II</b>	38. Incentivize financially child and adolescent psychiatrists (CAPS) to work with the state populations designated as in need and in the geographic areas designated as in need in Connecticut.	53
<b>II</b>	39. Incentivize clinical psychologists, clinical social workers, and advanced nurse practitioners through similar tangibles as used for CAPS in order to increase the pool of trained clinicians willing to work in the public sector.	53
<b>II</b>	40. Address the work force concerns cited in this report through the Workforce Council in the SIM Governance Structure.	53
<b>II</b>	41. Using the mechanism of <i>the proposed</i> Office of Behavioral Health Relations and Accountability to be located within the Office of the Healthcare Advocate, and working with other offices charged with similar tasks, and working with existing State of Connecticut efforts, including those put forth in Senate Bill 322 (2014 Session, Connecticut General Assembly), create a general information clearinghouse/website that is a single locator for information about behavioral health issues and mental health and substance abuse services available to adolescents and young adults in Connecticut. By expanding the scope of this clearinghouse to include electronic information via a well-advertised website, public information regarding behavioral health services will be more readily available and accessible to the public. It is also expected that this will increase the public's education about the issues of mental health being part of overall well-being and will reduce the stigma associated with mental health problems.	53
<b>II</b>	42. Work with new and existing mechanisms to develop public service announcements directly aimed at informing the public about mental illness and behavioral health.	54
<b>III</b>	43. Given the scope and complexity of the issue of involuntary outpatient commitment, and the wide variety of individuals who may need to have input regarding this issue, a separate Task Force should be appointed specifically for further discussion and possibly to make final recommendations regarding this issue. The Task Force would specifically address the use of psychotropic medications for adolescents and young adults who refuse such treatment. This Task Force would also address the question of allowing legally appointed conservators for adolescent and young adults with severe mental illness to consent to medication on behalf of their conservatees.	61

<b>Table 1. Recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults</b>		
<b>Cluster</b>	<b>Recommendation</b>	<b>Page</b>
<b>III</b>	44. DMHAS scale up Assertive Treatment Programs that provide aggressive outpatient services, shy of forced medication, to clients with severe illness in Connecticut.	61
<b>III</b>	45. Increase the age of majority to 18 years old for making decisions regarding one's mental health and substance abuse treatment, given the current understanding of mental illness to be a biologic disease. The Task Force wishes to emphasize that nothing said here is to infer that this is intended to contradict current access to care laws for minors or to diminish the rights of minors to consent to and obtain any medical or mental health treatment on their own without parental consent that is authorized by current state laws or precedents.	61
<b>III</b>	46. Clarify, and educate all those providers involved in clinical care of adolescents and young adults regarding, current patient privacy rights in order to allow communication between providers across both inpatient and outpatient settings, and when patients are being transitioned from higher to lower levels of medical care, in order to ensure continuity of treatment and safety of providers. Definitions for when this is necessary also need to be carefully elucidated and clarified.	62
<b>III</b>	47. Clarify, and educate all health care providers regarding, the current HIPAA and FERPA laws that address communication between clinical providers and school, college, and university settings where adolescents and young adults study in order to allow enhanced and timely communication when safety due to a mental illness (threat to self or others) is an issue.	62

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**FINAL REPORT**  
**TASK FORCE TO STUDY TO PROVISION OF BEHAVIORAL HEALTH SERVICES FOR**  
**YOUNG ADULTS**

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# Section I. Introduction

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## Creation of Task Force and Its Charge

The Task Force to Study the Provision of Behavioral Health Services for Young Adults was established by Section 66 of Public Act (P.A.) 13-3, entitled An Act Concerning Gun Violence Prevention and Children's Safety. The Task Force was directed to focus on behavioral health services for people ages 16 to 25 years old, and was charged with analyzing and making recommendations in thirteen specific areas, set out in Table 2, and reporting its findings and recommendations to the Connecticut General Assembly by February 1, 2014.

P.A. 13-3, which passed both Connecticut legislative chambers on April 3, 2013 and was signed by the governor the next day, was the first public act passed in Connecticut in response to the December 14, 2012 tragedy at Sandy Hook Elementary School in Newtown. There, a twenty year old young man shot and killed twenty children and six adults, after which he killed himself; earlier that day he had shot and killed his mother. Among other issues, the event focused attention on Connecticut's behavioral health services for young adults and raised questions about the extent of their availability, accessibility, and affordability.

## Task Force Approach

Beginning on August 14, 2013, the Task Force met monthly, then biweekly, and then weekly until April 2014 for a total of 13 meetings.<sup>1</sup> The Task Force process is described in more detail in Section V, which contains its 47 recommendations along with explanation and rationale. In this report, the Task Force acknowledges and tries to build upon other efforts currently underway or in the recent past to improve behavioral health care for children, adolescents, young adults, and their families in Connecticut. These include:

- The 2010 Mental Health Care "Blue Print" for Children in Connecticut<sup>2</sup>
- The Children's Mental Health Act (P.A. 13-178)
- The unfunded mandate legislated by P.A. 97-272 to create systems of care in Connecticut communities
- The Connecticut Health Care State Innovation Model (SIM)
- The Department of Public Health Study on the Provision of Behavioral Health Services by School-Based Health Centers (P.A. 13-287, Section 2)
- The Office of the Healthcare Advocate Report on Access to Mental Health and Substance Use Services in Connecticut
- Recent studies by the Legislative Program Review and Investigations Committee on substance use treatment for youth<sup>3,4</sup>
- Recent publications of the Connecticut Child Health & Development Institute<sup>5,6,7,8</sup>

- Current efforts described in the December 31, 2013 report by the Connecticut Insurance Department (CID) to the Insurance and Real Estate and Public Health Committees on CID methods to monitor mental health parity compliance (required by P.A. 13-3, Section 79), as well as the behavioral health claims toolkit developed by the insurance department

The recommendations of this report should be viewed within the context of and hopefully contribute to these other ongoing efforts in Connecticut to improve the behavioral health of its young citizens.

## **Complexity of Issues**

The recommendations of the Task Force to Study the Provision of Behavioral Health Services for Young Adults should be considered with an appreciation for the complexity of the issues involved. The Task Force struggled to arrive at definite conclusions about recommendations in a number of specific areas. Thus, the recommendations set out in Section V should be considered as our best attempt at consensus given the magnitude and complexity of the task set before the Task Force, and the short timeline assigned us by the legislature. As noted above, the recommendations of the Task Force should also be considered within the context of the many other recent reports and studies that serve to inform Connecticut's ongoing discussion of change and reform to the behavioral health system for children, adolescents, young adults, and families with mental health disorders. Many of the calls for system improvement and recommendations are similar across reports. It is the hope of this Task Force that our report will contribute to an ongoing discussion about how to improve the behavioral health care system as Connecticut looks to the future.

## **Report Contents**

The Task Force final report contains five sections. This introduction is Section I. Section II briefly describes the scope of the problem -- the nature and prevalence of behavioral health needs of young adults both nationally and in Connecticut, and the direct and indirect costs of behavioral health disorders in Connecticut. Section III sets out eight overarching principles endorsed by the Task Force to guide the provision of behavioral health services for children, adolescents, and young adults. Section IV contains a brief overview of the current state of Connecticut's system of adolescent and young adult behavioral health care, identifying some positive areas as well as continuing problems and issues, and explains why it is important to improve the system. Finally, Section V lays out the 47 recommendations developed by the Task Force based on its analysis of the thirteen areas for review per P.A. 13-3, as well as the rationale and explanation for the recommendations. As explained in Section V, the Task Force organized the 13 issues into three broad clusters: Cluster 1. The Capacity of the Service Delivery System; Cluster 2. Access to Available Systems of Care; and Cluster 3. Balancing Disclosure of Information, Mandating Services, and Patient Rights.

**Table 2. Thirteen Issue Areas for Young Adult Behavioral Health Services Task Force Analysis and Recommendations Set Out in Public Act 13-3, Section 66(b) and Three Clusters**

<b>Number</b>	<b>The Task Force Shall Analyze and Make Recommendations Concerning:</b>	<b>Task Force Cluster</b>
1	Improving behavioral health screening, early intervention and treatment	<b>Capacity</b>
2	Closing gaps in private insurance coverage	<b>Access</b>
3	Improving behavioral health case management services	<b>Capacity</b>
4	Addressing the insufficient number of certain behavioral health providers, including psychiatrists who specialize in treating children and those offering specialized services	<b>Access</b>
5	Improving the delivery system for behavioral health services	<b>Capacity</b>
6	Improving payment models for behavioral health services	<b>Access</b>
7	Creating a central clearinghouse with information for members of the public concerning behavioral health services	<b>Access</b>
8	Providing intensive, individualized behavioral health intervention services in schools for students who are exhibiting violent tendencies	<b>Capacity</b>
9	Requiring the State Department of Education to provide technical assistance to school districts concerning behavioral intervention specialists in public and private schools and for preschool programs	<b>Capacity</b>
10	Employing the use of assisted outpatient behavioral health services and involuntary outpatient commitment as treatment options	<b>Balance Rights</b>
11	Conducting behavioral health screenings of public school children	<b>Capacity</b>
12	Requiring disclosure of communications by mental health professionals concerning persons who present a clear and present danger to the health or safety of themselves or other persons	<b>Balance Rights</b>
13	Reducing the stigma of mental illness as it presents a barrier to a person's receipt of appropriate mental health services	<b>Access</b>

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## Section II. Scope of Problem

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### Mental Health and Behavioral Disorders

By ages 16 to 25 years, mental health is characterized by the achievement of social competence and behavioral and emotional self-regulation skills, allowing for the achievement of a positive quality of life, a sense of personal identity and self-efficacy, concern for the well-being of others, satisfying family and interpersonal relationships, and achievement in school and in the workforce. Behavioral health disorders are understood as serious deviations from expected cognitive, social, and emotional development with resultant impairment in daily functioning, and include disorders meeting criteria described by the *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition* (DSM 5), or the *International Classification of Diseases* (ICD). Substance use disorders are also included here.

### United States

Behavioral health disorders among children and adolescents (0-17 years old) and among young adults (18-25 years old) are an important public health issue because of their prevalence, relationship to adult psychiatric disorders, overall cost, early-onset, and impact on the child, family, young adult, and community. Nationally, 1 in 5 children suffers from a diagnosable behavioral health disorder, yet only 20-25 percent of those with a behavioral health disorder ever receive the treatment they require.<sup>9</sup> The overall cost of behavioral health disorders among persons  $\leq 24$  years in the United States is estimated to be \$247 billion per year, including costs for health care, service use, special education, juvenile justice, and decreased workforce productivity.<sup>10,11</sup>

Nationally, mood disorders, impulse control disorders (e.g., attention deficit/hyperactivity disorder, conduct disorder), traumatic stress disorders, and substance use disorders are among the most common behavioral health diagnoses in the 0-25 year old population, which increase risk for suicide, antisocial behavior, early arrest, decreased academic and occupational productivity, family dysfunction and stress, and increased rates of injury.<sup>11</sup> The onset of the first episode of a major mental illness including schizophrenia and bipolar disorder often occurs in the adolescent-young adult age range, increasing risk for persistent and serious mental illness. Half of all lifetime cases of adult mental illness for people 18 to 65 years old start by age 14 and three-fourths by age 24,<sup>12</sup> underscoring the importance of effective behavioral health screening, evaluation, and treatment in the child, adolescent, and young adult population.

In the United States the relationship between gun violence, public safety, and mental illness is complex and controversial, and poorly studied in the late adolescent-young adult age range. The vast majority of adults with mental illness do not engage in violence and are much more likely to be victims of violence rather than perpetrators. For adults  $\geq 18$  years, studies find that between 3 and 10 percent of the risk percentage for violence in society is due to mental

disorders such as schizophrenia.<sup>13</sup> Thus, even if mental disorders could be eliminated entirely from the population, 90 to 97 percent of violent behaviors would remain. Much of the risk seen in people with mental disorders is attributable to factors other than mental disorder, such as substance abuse.<sup>13</sup>

Having said all this, there is little debate that among certain people with behavioral health diagnoses, such as schizophrenia, there is six or seven times greater likelihood of violent or self-injurious behavior than among the population at large. There are some suggestions that treatment of specific behavioral health disorders can reduce adult criminality. For example, a study in Sweden reported information gathered on 25,656 adults with a diagnosis of attention-deficit/hyperactivity disorder during treatment with medication and then again when not receiving treatment. As compared with non-medication periods, when patients were receiving ADHD medication, there was a statistically significant reduction (32 percent) in the criminality rate for men.<sup>14</sup> These data suggest, at least for impulse control disorders in adult men, mental health treatment may reduce rates of antisocial behavior in society.

### ***Connecticut***

In 2010 Connecticut had 478,732 adolescents and young adults aged 15-24 years representing 13.4 percent of the total population in the State (U.S. Census Demographic Profile Data, 2010). Behavioral health statistics are generally reported for the population 0-17 years and separately again for those  $\geq 18$  years-old, so it is somewhat challenging to find relevant statistics spanning the age range of 16-25 years old. Nevertheless, data found by Legislative Program Review and Investigations Committee staff for the Task Force indicate that roughly one in ten 15 to 24 year olds living in Connecticut reports at least one episode of major depressive disorder in the past year (2010), and that between 7.9 and 8.4 per 100,000 Connecticut 15 to 24 year olds died by suicide each year in the decade spanning 2000 – 2010. (See Appendix A for Connecticut data.)

Mood disorders are associated with concurrent or subsequent substance abuse, sexual risk-taking behaviors, criminal behaviors including violence, suicide, and impaired psychosocial functioning, and commonly co-occur with other health and medical conditions including asthma, obesity, and diabetes.<sup>11</sup> In Connecticut, roughly 8 percent of youths aged 12 to 17 years and 24 percent of those aged 18 to 25 years have abused or become dependent on alcohol or an illicit drug within the past year.<sup>15</sup> Many young adults with substance abuse problems have a history of criminal justice involvement.<sup>16</sup>

Concerning disorders of traumatic stress and post-traumatic stress disorder (PTSD), outpatient child guidance clinics in Connecticut report 53 percent of 22,344 children served, and Emergency Mobile Psychiatric Services report 65 percent of 9,000 children evaluated, identify a history of traumatic stress.<sup>17</sup> About 20 to 25 percent of trauma-exposed youth will meet current

diagnostic criteria for post-traumatic stress disorders with a lifetime rate of PTSD of 5 percent.<sup>18,19</sup>

Although Connecticut-specific statistics on rates of impulse control disorders, first-episode psychosis, and anxiety disorders could not be found, the Centers for Disease Control report prevalence data by region for the United States. In the northeast region of the United States (including Connecticut) for children and adolescents 0-17 years-old, the rate of current attention-deficit/hyperactivity ranges between 6.8 and 8.8 percent; conduct disorder, 3.7 percent; autism spectrum disorder, between 0.8 and 2.3 percent; and anxiety disorders, 3.2 percent. For adolescents 12-17 years old, the rate for depression was 12.1 percent.<sup>11</sup> Since onset of behavioral health disorder prior to age 18 years increases vulnerability to and risk for adult psychiatric disorder a substantial percentage of young adults may be expected to be at risk for these disorders.

A particularly vulnerable group includes youth who have been in the child welfare system. A substantial percentage of these children or youth have experienced significant trauma, as the result of abuse or neglect, through forced separation from their families, or as a result of unstable or insecure living arrangements within the foster care system itself. Many others have entered the system expressly because of mental health challenges that have proven to be too complex for their families to manage. As a result, the majority of the approximately 4,000 children in Connecticut's foster care system on any given day have a continuing need for mental health treatment services. A recent analysis of national child welfare statistics reveals that more than 75 percent of children and youth in Connecticut's foster care system are identified as having serious mental health or behavioral conditions.<sup>20</sup> Year in and year out, approximately 200 older youth who are about to age out of Connecticut's child welfare system are determined to have serious and persistent mental health issues that will require continuing treatment and support from the adult mental health system. This group of youth, many of whom have already received years of intense treatment and are often without reliable family relationships or basic living resources, represents an unusually urgent and daunting challenge to the adult mental health system.

Another particularly vulnerable group is adolescents and young adults with developmental disabilities, including persons with intellectual disabilities and/or autism spectrum disorders. These individuals and their families, served by the Department of Developmental Services (DDS), often have great challenges in identifying and obtaining continuity of care as they transition from the pediatric service system to adult services.

Court-involved juveniles and young adults are another particularly high-risk group for behavioral health disorders. Nationally, 60 percent of the juvenile justice population is reported to have a behavioral health disorder.<sup>21</sup> In Connecticut, 70 percent of detainees have a diagnosable mental health disorder with high rates of attention-deficit/hyperactivity disorder and depression, 90 percent report trauma-exposure, 10-20 percent meet diagnostic criteria for post-traumatic

stress disorder, 61 percent misuse alcohol, 43 percent use marijuana, and between 12 to 24 percent have prescription pill or cocaine use disorder.<sup>22</sup>

## **Unmet Need**

These statistics describe a substantial public behavioral health burden for Connecticut children, adolescents, and young adults. Hidden within these statistics is a rising unmet need for modern behavioral health screening, evaluation, and evidence-based treatment. This burden has large consequences for Connecticut families with vulnerable children, adolescents, and young adults. Consequences may include individual and family turmoil and suffering, lost developmental potential in afflicted youths, early juvenile justice system involvement, high-risk behaviors increasing health care costs, diminished workforce productivity, and large cost burdens on school departments, police departments, prisons, foster care, and other state systems-of-care. Parents may be driven to seek publicly funded services because family cohesion, financial stability and family well-being are threatened by a vulnerable child, adolescent, or young adult caught in a fragmented, poorly coordinated, and under-resourced behavioral health care system. For example, one symptom of a dysfunctional Connecticut behavioral health system-of-care is the rising rate of hospital emergency department use to provide mental health care. In Connecticut, up to 5 percent of all hospital emergency department health care visits are for psychiatric and behavioral health disorders.<sup>23</sup> Furthermore, as children and adolescents with mental health disorders age into adulthood further costs occur for adult mental health and addiction services.<sup>24</sup>

## **Costs in Connecticut**

Yearly behavioral health care costs for children, adolescents, and young adults include costs for direct services including health care, child welfare, educational, and juvenile justice services. Economists would also include indirect costs to society as a result of mental and behavioral health disorders including costs for lost productivity, lost developmental potential, morbidity, and early mortality due to mental health disorders in the population. Direct costs are easier to quantify than indirect costs. Appendix B contains an estimation of direct costs of behavioral health disorders to Connecticut for children, adolescents, and young adults. As can be seen in the appendix, a rough estimate of the direct behavioral health costs for individuals' ages 0-25 years in Connecticut for 2012 is \$526,000,000. This is likely an under-estimation of the true costs of pediatric and young adult mental illness in Connecticut because it does not include an estimation of indirect costs (e.g., lost productivity, health morbidity, and early death).

Many qualified mental health professionals choose to “opt out” of the system and require cash payment for services, limiting access to professional care to families that can afford to pay out-of-pocket. The number of qualified mental health professionals in Connecticut choosing to not accept insurance payment for clinical services is currently not known. Their reasons for not accepting insurance are also not entirely clear. However, to the extent this process occurs it



stratifies mental health care based not on need but on socioeconomic status and contributes to inequalities in health care. Thus, this process is intrinsically unfair to those who wish to access these qualified professionals but must pay out of pocket, a cost that often quickly challenges middle class incomes. Moreover, this system of care reduces the pool of mental health professionals available to all those in need. Having a behavioral health system of care that allows for access to all of the pool of mental health professionals for those in need would be highly beneficial in increasing the available mental health workforce for children, adolescents, and young adults.

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## Section III. Guiding Principles

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### Overarching Principles

The Task Force endorsed eight overarching principles to provide guidance in addressing the provision of behavioral health services for children, adolescents, and young adults in Connecticut.

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#### **1. The primary importance of a long-term, longitudinal, and developmentally informed approach to behavioral health in the 0-25 year old population**

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The mental and behavioral health of adolescents and young adults is highly (although not completely) dependent on development at earlier stages of life (in utero, infant, toddler, pre-school, school-age). Adolescents and young adults who experience family stress and dysfunction, adversity and mental health problems at earlier stages of life, or who are exposed to toxins such as maternal alcohol, cigarette, and/or substance use before birth, are more vulnerable to continuing or new onset behavioral health problems as adolescents and young adults. The achievement of optimum development by young adulthood is thus highly associated with maternal health, parenting competence and family functioning especially when the child is young. Although heritable factors in vulnerability to mental health disorders are increasingly recognized, genes are not destiny and nurturing environments may modify expression of mental health vulnerability due to genetic risk.

Contained within human development are periods of life that are more sensitive to disruption in attachment relations and to achieving social-emotional competence than in other periods of development. These sensitive periods are when the infant's central nervous system adapts to the extant caregiving environment to achieve a "fit" with the caregiver. In an average expectable caregiving environment this is achieved without problem and the foundations for later child social-emotional competence are laid down. However, in caregiving environments that are stressed and dysfunctional (e.g., maternal depression, parental alcoholism and substance use, family violence, and traumatic stress) the infant's central nervous system may adapt in ways that are hard to reverse later in life and result in increased risk for maladaptive interpersonal attachment relationships and later psychopathology.<sup>25,26</sup> These sensitive periods occur between 0 and 6 years of age in human development.<sup>27,28</sup> Thus, to achieve successful social, emotional, behavioral, and cognitive competence in adolescence and young adulthood, support for maternal health, parenting competence, and family functioning early in a child's life is crucial.<sup>29,30</sup>

Recommendations for child and early-adolescent behavioral health in Connecticut are part of the mandate for the Task Force to Study the Provision of Behavioral Health Services in Young Adults, and the above makes clear that the mental health of young adults is inextricably linked to and highly dependent on what comes before in their lives.

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## **2. The importance of models of prevention in at-risk families**

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Many behavioral health disorders first occurring in the child, adolescent, and young adult years may be recurring and/or chronic. While effective clinical strategies for managing these disorders with acute treatment exist, including reducing symptom severity and improving daily functioning, these disorders may often be chronic and long-term with waxing and waning symptoms. While evaluation and acute treatment of those suffering from mental health disorders is crucial, early identification of at-risk children, adolescents, and young adults offers hope that early detection and treatment before mental disorders become entrenched may diminish overall disease morbidity, delay disease onset, and improve functioning over the lifespan of the affected individual. Thus, prevention strategies including the identification of at-risk youth early in life, and early referral to mental health providers for evaluation and treatment when required, may be helpful in diminishing the overall burden of young adult mental health disorders in Connecticut.

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## **3. The importance of early recognition, assessment, intervention and treatment of childhood and adolescent behavioral health disorders for Connecticut**

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Many psychiatric disorders emerge in the pediatric and young adult years and show substantial continuity with adult psychiatric disorders. This appears true for pediatric-onset anxiety disorders, depression, impulse control disorders such as attention-deficit/hyperactivity disorder, and adolescent-onset substance use disorders, all of which show substantial continuity across the lifespan and may increase risk for continued impairment into adulthood.<sup>12</sup> Mid-adolescence to young adulthood is the time of risk for disease onset for many adults with schizophrenia, psychotic disorders, and bipolar disorder. Given the continuities from childhood/adolescence to adult mental health disorders, early recognition, assessment, intervention, and treatment of childhood, adolescent, and young adult mental health disorders may provide opportunities to reduce the overall cost, morbidity, and early mortality associated with adult psychiatric and mental health disorders.

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## **4. The importance of a multi-disciplinary team approach to child, adolescent, and young adult mental health disorders**

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Children, adolescents, and young adults with mental and behavioral health disorders have complex developmental, biological, medical, social, educational, and family needs (e.g., safe neighborhoods, food security, and housing security). In order to be effective, mental health treatment needs to be delivered on multiple levels simultaneously including mental health treatment for the individual, educational services, care coordination, case management services, and education about psychiatric disorders and support for the family.<sup>31,32</sup> By necessity, this requires a multi-disciplinary team approach to treatment. The Task Force supports the primacy of the primary care provider medical home model in guiding individually-specific outpatient multi-disciplinary psychoeducational mental health treatment. Unfortunately, current models of

reimbursement for commercially insured families do not support a comprehensive multi-modal treatment approach to early-onset mental health disorders nor support a team approach to treatment planning and treatment.

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## **5. The importance of building on existing Centers of Excellence in Connecticut**

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After hearing testimony, the Task Force recognizes that there are many evaluation and treatment programs for children, adolescents, and young adults in Connecticut supported by a mix of private, local educational authority, and/or public payers. Existing Connecticut programs that function well should be identified and scaled-up to help address pediatric and young adult behavioral health issues. It is important to define and recognize “Centers of Excellence” in the State. Centers of Excellence may be recognized as mental health programs for children, adolescents, and young adults that:

- are mission-driven;
- use evidence-based evaluation and treatment methodologies;
- have clearly stated and individual-specific treatment goals;
- utilize quality indicator benchmarks to improve individual treatment and programmatic outcomes;
- have the capacity to intervene simultaneously at many different levels in an afflicted individual’s life (self, home, family, school, physical health, community);
- have the infrastructure to communicate with primary care providers and educational systems in the care of an individual; and
- are accountable within a system of care.

Once identified, these quality programs can be scaled-up to improve Connecticut’s overall system-of-care and reduce discrepancies in behavioral health treatment.

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## **6. The importance of providing equal access to a basic minimum behavioral health standard-of-care for all those in need regardless of health care coverage status across the life span in Connecticut**

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The Task Force endorsed the proposition that every individual from birth to death is entitled to a basic minimal standard-of-behavioral-health care in Connecticut and equal access to such services independent of private or public payer status. We adopt this proposition out of our concern for the dignity of the individual and recognition of the cost to society if we fail to adequately meet this need. This principal encompasses individuals covered under private health insurance plans, both fully-insured and self-funded, and those covered in the public sector. A minimum standard-of-behavioral health care includes the principle of mental health parity with medical and surgical coverage, readily available access to service information such as a single locator for substance use and mental health services, readily available access to crisis

intervention services, a continuum of care including an adequate number of inpatient psychiatry beds, residential treatment, extended day treatment, enhanced day treatment, and outpatient mental health services. We recognize that some components of treatment such as supported housing, therapeutic schools, and case management straddle the line between treatment and social services and are not likely to be paid for through a medical insurance policy. There must be a thoughtful integration of medical insurance and social services so that, for example, a patient in a group home will receive living support with public resources supplementing the ability to self-pay, but ongoing medical services through the patient's insurance. There must be reasonable standards for determining the amount of a co-pay for supported mental health assistance for a dependent.

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**7. The importance of providing and articulating a basic set of core principles that serve to guide behavioral health service delivery for children, adolescents, and young adults in Connecticut, including the following:**

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- **Provide individualized care** in accordance with the unique potentials and needs of each child, youth, young adult, and family, guided by a strengths-based, child, youth, young adult, and family team approach to a care planning process and the development of an individualized treatment plan.
- Ensure that care, services, and supports **include evidence-informed and promising practices**, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children, youth, young adults, and their families.
- **Deliver care, services, and supports within the least restrictive**, most normative environments that are clinically appropriate.
- **For adolescents and young adults, provide both acute clinical services and recovery oriented supports.**
- **Ensure that children, adolescents, young adults, and their families have readily available access to a full continuum of mental health care as needed and appropriate**, including crisis intervention services, inpatient psychiatry beds, residential treatment, enhanced outpatient and day treatment services, and outpatient treatment without requiring unreasonable income tests to qualify for services for a dependent. Please note that for young adults, federal and state privacy laws may present obstacles to sharing behavioral health information with their parents.
- **Ensure that families, other caregivers, youth, and young adults are full partners** in all aspects of the planning and delivery of their own care/services and in the policies and procedures that govern care for all children, youth, and young adults in their community.

- **Ensure that care, support, and services are integrated at the system level**, with linkages between child-serving and adult-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
- **Ensure that care, support, and services are integrated at the treatment level**, with linkages, communication, and coordination across mental health and primary care providers for all individuals as necessary and appropriate.
- **Provide care management** or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children, youth, young adults, and their families can move through the network of care in accordance with their changing needs.
- **Provide developmentally appropriate mental health care and supports** that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
- Provide developmentally appropriate care and supports, **to facilitate the transition of youth** to adulthood and to the adult service system as needed.
- **Incorporate or link with mental health promotion, prevention, and early identification** and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children, adolescents, and young adults.
- **Incorporate continuous accountability and quality improvement mechanisms** to track, monitor, and manage: the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child, youth, young adult, and family level.
- **Protect the rights of children, youth, young adults, and families** and promote effective advocacy efforts.

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**8. The importance of providing behavioral health services that are developmentally as well as culturally appropriate to the individuals, families, and populations being served.**

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- **Provide care, services and supports without regard** to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

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## **Section IV. Connecticut's Current System**

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This section reviews the current state of Connecticut's system for adolescent and young adult behavioral health care. Positive aspects are noted, along with some continuing problems and issues. Finally, the vital importance of improving the system in Connecticut and the costs of not doing so are discussed.

### **Existing Centers of Excellence**

Connecticut has examples of excellence in specific mental health programs. For example:

- The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) fund Mobile Crisis Teams and Emergency Mobile Psychiatric Services (EMPS)-Crisis Intervention respectively, which are often an access point to treatment for youth and young adults. EMPS and Mobile Crisis Teams provide a community response to psychiatric crises. Individuals are evaluated and clinicians assess the need for services on site. While beneficiaries of fully-insured and self-funded health plans benefit from the success of the Emergency Mobile Psychiatric Services, funded by DCF, and Mobile Crisis teams, funded through DMHAS, the health plans do not directly subsidize either of these programs through coverage under health plans. However, to be fair it is important to note that the commercial insurance industry supports the State through payment of premium taxes on its insured business, through income taxes on its non-insured business, through funding the Connecticut Insurance Department and Office of the Healthcare Advocate, through assessments to Connecticut's new insurance Marketplace, Access Health CT, and other charges that do support available resources for mental health crisis and other services.
- The DMHAS Young Adult Services (YAS) program was developed to help young adults transition successfully from DCF to the adult mental health system and to achieve the necessary skills for adulthood. The purpose of YAS is to improve the lives of young people by providing the highest quality services possible. DMHAS does this by forming a partnership with the individual, their family, identified significant persons, and with other community service providers. YAS creates a "community of care" that fosters mutual respect and individualized client centered treatment. In order to be considered for Young Adult Services, an individual must be between the ages of 18 and 25 years old. Individuals considered for this program are either referred from DCF and/or have a history of serious mental health problems. Other individuals between the ages of 18-25, who are referred to DMHAS for care and are medically indigent, are provided services through the traditional system with consultation from YAS staff to ensure that the services are developmentally and age appropriate.

- Additionally, the Connecticut Department of Mental Health and Addiction Services Prevention and Health Promotion (PHP) Unit manages Connecticut's Garrett Lee Smith Suicide Prevention grant, which funds development, enhancement and implementation of comprehensive, evidence-based suicide prevention/early interventions on college campuses and in communities across the state. The Connecticut Suicide Advisory Board, co-chaired by DMHAS and DCF, conducts a statewide campaign, *1 WORD, 1 VOICE, 1 LIFE...Be the 1 To Start the Conversation*, to promote awareness of suicide as a public health problem across the lifespan. This campaign promotes mental and emotional health and seeks to increase awareness of warning signs, risk factors, and state and national resources, including the National Suicide Prevention Lifeline. Expansion of the statewide campaign will assist Connecticut's youth in managing their behavioral health.
- The DMHAS PHP also manages the state's Local Prevention Councils in over 150 municipalities. These are locally-based alcohol, tobacco and other drug (ATOD) abuse prevention councils that facilitate the development of ATOD prevention initiatives at the municipal level to increase awareness of ATOD issues through prevention activities. In addition, the DMHAS PHP directs Connecticut's Statewide Healthy Campus Initiative (CSHCI) comprised of over 40 institutions of higher education, state government officials, and community organizations that promote safe and healthy campus communities focused on behavioral health and risk reduction.
- DMHAS funds and supports the Specialized Treatment Early in Psychosis (STEP) program model developed at the Yale School of Medicine. This program, begun in 2006, is a multi-disciplinary outpatient clinic that provides comprehensive care for those who are in the early stages of a psychotic illness, with a particular focus on youth and young adults. Treatment at STEP includes medication management, case management, therapy and an education group for family and friends. This program is not only about providing model care for clients but also the development of best practices and improving treatment options. Similarly, the Institute of Living's Young Adult program includes the POTENTIAL Early Psychosis program, an Intensive Outpatient/Partial Hospital program, a dual disorders intensive outpatient program, and outpatient and outreach services.
- Finally, DMHAS is developing a Behavioral Health Home (BHH) model for individuals diagnosed with Serious and Persistent Mental Illness (SPMI) in collaboration with the Departments of Social Services (DSS) and Children and Families, and other stakeholders, including providers, the Connecticut Behavioral Health Partnership (CT BHP) Oversight Council and individuals in recovery and their families. A Behavioral Health Home is an important option for providing a

cost-effective, longitudinal “home” to facilitate access to an inter-disciplinary array of behavioral health care, medical care, and community-based recovery and social services and supports for individuals with chronic conditions. The Connecticut model builds on the existing relationships between consumers of behavioral health services and their Local Mental Health Authority providers, by adding primary care professionals to the behavioral health team to assist in care management, care coordination, care transitions, and health promotion. Over the past year, a stakeholder workgroup has vetted the following components of BHH: inclusion criteria, provider standards and required infrastructure, service definitions, and quality measures. Connecticut is now entering discussions with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) and working toward a June 2014 implementation.

- Over the past 15 years, DCF has worked with community providers to build the community supports needed for families and young adults with mental health issues. In addition to the re-design of the EMPS program DCF has supported: the creation of the Enhanced Care Clinics for outpatient mental health services; the expansion of care coordination services; and the addition multiple evidence based in-home therapies. These services have supported many children and youth to remain with their family, in the community and in school while getting their mental health needs met. These services have also reduced the reliance on high cost residential treatment centers that historically were used to treat children and youth with serious emotional disturbance.

With the passage of P.A. 13-178, the Department of Children and Families will develop a comprehensive and integrated plan to meet the behavioral health needs of all children in the state and to prevent or reduce the long-term negative impact for children of mental, emotional, and behavioral health issues. The above initiatives offer hope that progress will continue in the development and implementation of a more effective, user-friendly, and integrated mental health system for Connecticut’s children, adolescents, young adults, and their families.

### **Activities of the Connecticut Department of Insurance**

The Connecticut Insurance Department (CID) is empowered by statute to regulate the activities of commercial payers in the State, exclusive of self-employed plans that are federally regulated and over which CID has no authority. Over the past two years, the Connecticut Insurance Department has been increasingly active in focusing on mental and behavioral health issues, and CID has been proactive in fostering collaborations with industry, providers and policymakers. The insurance department is now mandating that health insurers complete an annual mental health parity compliance survey in order to ensure practices and procedures are fully compliant with State and federal parity laws. The insurance department has also

implemented its statutory obligations mandated in Public Act 13-3, which are intended to enhance its consumer protection mission, particularly where it applies to mental health parity. Those actions are included in the comprehensive December 31, 2013 report CID provided to the legislature's Insurance and Real Estate and Public Health Committees.

Beyond its statutory obligations, CID has undertaken a number of initiatives in an effort to help support better access to behavioral health services. In collaboration with insurers and psychiatric staff at the UConn Health Center, CID developed a Behavioral Health Consumer Tool kit to facilitate pre-authorization and reimbursement. The Tool Kit has been shared with providers and carriers and is among several resources CID has included on its new Mental Health Parity Web page. The department has aggressively lobbied the state's congressional delegation to urge swift passage of final regulations implementing the federal parity law. In an effort to reduce coverage gaps, CID is collaborating with DMHAS on a list of mental and behavioral health treatments covered by Medicaid to review with commercial carriers. CID administers a third-party independent review of external appeals and works with the OHA on appeals of denials based on medical necessity.

At the same time, CID continues to help consumers daily with their health insurance issues. Each year, the department recovers more than \$4 million on behalf of policyholders. For example, the department stepped in swiftly in 2013 to reconcile a difference regarding reimbursement coding between Anthem and behavioral health providers. The insurance department's intervention resulted in Anthem reprocessing nearly 40,000 claims for over 800 providers, resolving payments totaling \$473,000.

The Connecticut Insurance Department's increasing focus on mental and behavioral health issues and collaborations with industry, clinical providers, and policymakers offers hope that initiatives to improve behavioral health will continue to make progress in the state.

## **Continuing Problems and Issues**

Although there exist pockets of excellence in specific programs and welcome and growing collaboration between regulators, industry, providers, and policymakers, Connecticut's overall system of behavioral health care for children, adolescents and young adults does not function well in providing for the needs of individuals and families, nor in providing effective and accountable care. A number of problem areas are identified by the Task Force.

### ***Inequalities in Access to Evidence-Based Mental Health Treatment Coverage***

Multiple payment systems under fully-insured commercial plans may differ from public sector coverage for evidence-based behavioral health services and care. For example, differences in coverage exist across private fully-insured plans versus public payers for available evidence-based mental health services such as Integrated Dual Disorder Treatment (IDDT), for people who have co-occurring mental health and substance use disorders in mental health treatment

settings, Intensive In-Home Child and Adolescent Psychiatric Services (IICAPs) and other community based services, Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Extended Day Treatment (EDT), Multi Systemic Therapy (MST), Functional Family Therapy (FFT), and Multi-Dimensional Family Therapy (MDFT). These evidence-based practices offer the potential to reduce emergency psychiatric admissions to emergency departments and psychiatric hospitals. It should be noted that commercial carriers are beginning to cover some of the same types of programs as covered by the public sector and that the Connecticut Insurance Department is continuing to work with commercial carriers on this issue pending a final list of “best practices” from DMHAS and DCF.

### ***Cost-Shifting***

A number of children and adolescents in private health plans also receive publicly funded behavioral health care through the state Department of Children and Families because necessary treatment is not available under private health plans. In another example, Connecticut’s use of Emergency Mobile Psychiatric Services has reduced the amount of treatment and costs in hospital emergency departments for both the privately insured and those insured by Medicaid. EMPS is funded exclusively through the public sector. Despite benefitting financially from reduced emergency psychiatric costs through EMPS, commercial insurers are not required to directly help support this publicly funded service. However, as noted above commercial carriers do contribute substantially to State revenues that indirectly support resource availability for these mental health services.

### ***Lack of Treatment Integration and Coordination of Care***

Children, adolescents, and young adults with behavioral health issues are often involved in multiple systems of care. These may include: the mental health system, the substance abuse treatment system, educational systems, the primary care system, DCF, DMHAS, and/or the courts. In order to facilitate optimum treatment, health care information must flow between providers and a seamless transition of care must be available when multiple systems of care are involved with the individual and family. Payers have not generally incentivized care coordination or communication across treaters, contributing to a fragmented and poorly coordinated mental health system. Current providers are frequently unable to access patients’ past psychiatric records in a timely manner which can contribute to care fragmentation. Improvements could be made to address continuity of care for individual patients. The state would do well to provide incentives for providers to communicate with one another to address the interests of the patients.

### ***Lack of Substance Use and Mental Health Service Integration***

Many adolescents and young adults with mental health disorders also have substance use disorders. Historically, mental health and substance misuse were treated in separate systems-of-care. Under federal and state parity laws and the Affordable Care Act there exists opportunity to

integrate mental health and substance use care into overall health care. The private insurance model is currently developing care delivery models that incentivize integrated mental health and substance use care into overall healthcare, although historically these have not been integrated.

### ***System Not User-Friendly for Those in Need***

Access to the behavioral health system of care can be frustrating and confusing for adolescents, parents, and young adults in need. The lack of easily accessible and up-to-date information about available services often leads to delays in treatment with adolescents, parents, and young adults often giving up before services are located. Further, if services are located the young adult may not fit “criteria” to be eligible for services, including “not being sick enough”. The current system is not only not user-friendly, it discourages prevention and/or early intervention. The behavioral health system requires a single locator for substance use and mental health services.

### ***Lack of Innovative Public/Commercial Insurance Models of Payment and Coverage***

The lack of innovative public sector and commercial insurance payment and coverage models that may reduce inequalities and discrepancies in behavioral health care results in many problems. *If* equal access to timely and effective mental health care is a public good benefiting not just the patient and family but the larger general society in terms of regained workforce productivity, increased public safety, diminished overall costs to society, and reduced overall burden on educational systems and the courts, *then* it is very important to reduce inequalities and discrepancies in access to and services available from multiple disparate behavioral health payer systems as an issue of public health and quality of life in Connecticut. The Task Force supports the ongoing efforts of the Insurance Department and DMHAS to convene the commercial carriers and work to address this issue.

### **Importance of Improving the Pediatric and Young Adult Behavioral Health System in Connecticut**

Improving the behavioral health system for Connecticut’s children, adolescents, and young adults is important for several reasons. First, given the continuity of childhood and adolescent behavioral health disorders across the lifespan, a robust and effective child and adolescent mental health system is necessary to reduce the morbidity, mortality, and economic burden of adult mental illness in Connecticut. Vulnerability to psychiatric disorders is frequently first noted in the pediatric years and may continue into the adult years. Recognition and effective management of disorders in childhood and adolescence with continuity of care into adulthood may prove an effective strategy to help reduce the severity and burden of mental health disorders and their associated costs in the 18-65 year old adult population.

Second, while accessible, affordable, and effective pediatric mental health care is important in helping children, adolescents, and young adults with behavioral health disorders and

their families, it is also important for Connecticut as a whole. Reducing the burden of early-onset mental health disorders benefits the larger general society in terms of regained workforce productivity, increased public safety, diminished overall costs to society, and reduced overall burden on educational systems, child welfare systems, the police, and the courts. For this reason alone it is important for Connecticut to invest in improving its fragmented pediatric and young adult behavioral health system.

Finally, there is great cost in doing nothing. Connecticut currently spends about one-half of a billion dollars yearly on the mental and behavioral health care costs for its 0-26 year-old citizens. (See Appendix B for source methodology.) It is generally agreed that the behavioral health care system bought for this money is difficult to access for those in need, fragmented, and does not deliver the necessary quality of care. Although there exist isolated centers of excellence, the child, adolescent, and young adult behavioral health care system in Connecticut is in need of repair. To not act to improve this system is to choose to accept our flawed system as the best we choose to do.

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## Section V: Recommendations

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### Introduction

At the initial meeting of the Task Force in August 2013, it was apparent that in order to address all of the 13 issues listed in P.A. 13-3, the Task Force would need data that described the current status of behavioral health services in Connecticut for children, adolescents, and young adults, wherever possible. The Task Force also realized that with 13 separate issues to tackle, it would be more efficient and productive for the Task Force to discuss the issues grouped into clusters of related content. We also realized this would allow the Task Force to make recommendations applying across a group of specific issues. Figure 1 shows the three clusters of related content and how the P.A. 13-3 issue areas were arranged under them.

**Figure 1. P.A. 13-3 Thirteen Issue Areas Grouped into Three Clusters**

- Cluster 1. The Capacity of the Service Delivery System (*Issue Areas 1, 3, 5, 8, 9, and 11*)
- Cluster 2. Access to Available Systems of Care (*Issue Areas 2, 4, 6, 7, and 13*)
- Cluster 3. Balancing Disclosure of Information, Mandating Services, and Patient Rights (*Issue Areas 10 and 12*)

Once these clusters were decided upon, the Task Force discussed the overarching subject of each cluster, as well as each individual issue within each cluster. We allocated a separate one and a half to two-hour meeting for each cluster. Discussions focused initially on the current situation, the services or arrangements currently available to address each issue, and the gaps or challenges regarding that issue. Wherever possible, we utilized background data and information from selected presentations in order to inform the discussion. (See Appendix C for presentation list.) Task Force members were also provided with additional background materials regarding most of the issues.

As a final step in the Task Force's work, after our discussions and reviews of the material, we re-addressed each cluster of related items specifically in order to state and agree upon the recommendations to make in the final report to the legislature. These recommendations were all included in a draft report that was distributed to each Task Force member, in order to obtain their input. In addition, as part of the democratic process of approving those recommendations to present in the final report to the legislature, each of the recommendations put forth was voted upon by the Task Force at the final meeting, and only those that received a majority vote have been included in the final report. Further, at this final meeting, the Task Force identified those recommendations that in our assessment represent the highest priority for immediate implementation by the legislature.

Thus, we are providing only those specific individual recommendations that, in our judgment as experts in our respective fields, should be implemented if we are truly to address the deficiencies in the provision of behavioral health services and begin to move towards an effective and proactive system of health care. We do anticipate that most of the recommendations will not be immediately implemented, but have provided a roadmap that can provide a mechanism for step-wise, incremental implementation, identifying those issues of highest priority for the youth and young adults in Connecticut. The Task Force felt strongly, however, that it is our responsibility to describe the most appropriate recommendations for each issue listed in P.A. 13-3.

We also chose to convene a panel of adolescents, young adults, and parents who were currently using behavioral health services, in order to hear their specific concerns and provide feedback to the Task Force as to the salience of our recommendations.

After a final review of the recommendations by the entire Task Force, the full report was reviewed and finalized prior to submission.

### **Overall Recommendation Impressions**

Looking at this group of 13 separate issues that the Task Force was asked to address by P.A. 13-3, it is clear that there needs to be in place a well-articulated framework for comprehensive behavioral health services (to include mental health services and substance use treatment services) that not only spans the adolescent and young adult age groups, but also includes those teens and young adults covered by both commercial and public health plans. A cohesive framework is needed in order for policies to be developed and implemented. Further, this framework can inform how the systems that are currently in place may need to be modified and strengthened in order to provide the mental health care that our children and youth of Connecticut need. Further, as Connecticut moves forward and takes advantage of this current opportunity, there are additional opportunities to expand and improve services provided through the federal Affordable Care Act, and anticipated increases in funding through efforts spearheaded by Vice President Joseph Biden.

### **Recommendations Format**

The 47 recommendations developed by the Task Force are enumerated below, organized into the three clusters that together address all thirteen issue areas set out in P. A. 13-3. Within each cluster, each Task Force recommendation is further organized under the specific P.A. 13-3 issue area with which it is most closely connected.

At certain points within the list of recommendations, many of the recommendations are explained further along with rationale for them. Table 1 in the Executive Summary includes all the recommendations as they are organized here, and identifies the page number where each is introduced.

## **Task Force Recommendations and Discussion**

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### **CLUSTER 1. THE CAPACITY OF THE SERVICE DELIVERY SYSTEM**

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#### **Addresses:**

- P.A. 13-3 Issue #1: Improving Behavioral Health Screening, Early Intervention and Treatment
- P.A. 13-3 Issue #3: Improving Behavioral Health Case Management Services
- P.A. 13-3 Issue #5: Improving the Delivery System for Behavioral Health Services
- P.A. 13-3 Issue #8: Providing Intensive, Individualized Behavioral Health Intervention Services in Schools for Students Who Are Exhibiting Violent Tendencies
- P.A.13-3 Issue #9: Requiring the State Department of Education to provide technical assistance to school districts concerning behavioral intervention specialists in public and private and pre-school program
- P.A. 13-3 Issue #11: Conducting behavioral health screenings of public school children

### **Recommendations 1 through 20**

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#### **P.A. 13-3 Issue #1: Improving Behavioral Health Screening, Early Intervention and Treatment**

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The Task Force recommends:

1. Mandate screening for behavioral health problems by primary care providers of children, adolescents, and young adults ages 0-25 years old in Connecticut in the setting of their primary medical care provider (the health care setting).
2. Increase support to primary care providers for the extra time and effort required to complete recommended behavioral health care screening in the primary care office setting.
3. Increase the accessibility and affordability of existing early intervention programs, particularly for those young children identified as at-risk through screening.
4. Scale-up existing food security guarantee programs for in-need and at-risk families of young children ages 0-6 years old.

5. Enhance housing and shelter security for in-need and at-risk children, adolescents, and young adults ages 7-25 years old, and for families of young children ages 0-6 years old.
6. Develop and fund seven specialized Centers of Excellence for consultation and educational training to mental health organizations and to professional practice organizations working in outpatient treatment with children, adolescents, and young adults in Connecticut.
7. Expand state appropriations for ACCESS MH CT to include young adults up to 25 years old, making ACCESS MH CT available for children, adolescents, and young adults ages 0-25 years old.
8. Enhance behavioral health care through the creation of models that co-locate behavioral health providers with primary care physicians independently of insurance type. Encourage memoranda of understandings (MOUs) between primary care physicians and behavioral health agencies to facilitate co-management models within local behavioral health system-of-care. [This model already exists and could be replicated across the state.]

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**P.A. 13-3 Issue #3: Improving Behavioral Health Case Management Services**

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The Task Force recommends:

9. Create regionalized networks of care and expand care coordination, in order to enhance integrated mental health care for children, adolescents, young adults, and their families. [Creating regionalized networks of care and expanding care coordination is currently proposed to be accomplished through the Behavioral Health Home model developed by DMHAS, DCF, and DSS that is currently under consideration by CMS. A similar model should be developed for individuals who are privately insured.]
10. Expand community collaboratives/systems of care into six regional networks of care that cut across town lines, state agencies, school systems, and private and public entities.
11. Expand and upgrade the current 2-1-1 Crisis Line in order to reach young adults by tying the DMHAS-funded Adult Mobile Crisis Lines to the 2-1-1 Crisis Line and promote this system for young adults in psychiatric crisis.
12. Create a “Pathways To Care” program including regional care navigators tied to the 2-1-1 Crisis Line who are knowledgeable about behavioral health services and supports in the caller’s local community.

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**P.A. 13-3 Issue #5: Improving the Delivery System for Behavioral Health Services**

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The Task Force recommends:

13. Consider that all provided behavioral health services be developmentally as well as culturally appropriate to the individuals and populations being served.
14. Create and enforce a set of uniform standards and definitions across all insurers (public and commercial) regarding: 1) the range of behavioral health services to be provided; 2) the criteria for receipt of services across the spectrum to include out-patient, community-based intensive outpatient services, and inpatient services; and 3) definitions of medical necessity that include behavioral health conditions. (This in effect should work towards alleviating problems such as: a) piecemeal information on service quality; b) geographic maldistribution of mental health services; c) difficult systems of pre-authorization for services in the private sector; d) the limitation of inpatient beds for psychiatric emergencies and appropriate inpatient psychiatric care; e) the tendency to truncate inpatient stays due to cost issues; and f) lack of patient improvement indicators.) (The Task Force recognizes that more than half of the commercial market consists of self-insured employers not subject to state jurisdiction.) The Task Force also recognizes that Connecticut already has a statutory definition of medical necessity for individual and group health insurance policies that should be consistent with the definition used by public payers.
15. Integrate evidence-based behavioral health treatment of adolescents and young adults with evidence-based substance use treatment. [This has been done through implementation of the Integrated Dual Diagnosis Treatment (IDDT) model that is required throughout the DMHAS system and, again, is one of the requirements for increased payment in the enhanced care clinic system but does not exist on the private insurance side.]
16. Enhance and facilitate better methods of transitioning youth from adolescent to young adult services by developing a specific mechanism where DCF and DMHAS create a comprehensive co-agency program specifically to address transition of youth with mild/moderate as well as severe behavioral disorders, in terms of their health care and human service needs. A leadership task force would facilitate continuing discussion and suggestions to address these two important unresolved issues in transitions of care for adolescents in Connecticut.
17. Support and adopt the recommendations of the Legislative Program Review and Investigations Committee reports of December 2012 and June 2013.<sup>3,4</sup>

18. Amend the public health statutes and/or regulations as needed to allow for combined licensure for adult mental health clinics and facilities for the treatment of substance abusing persons.
19. Amend the public health statutes and/or regulations as needed to allow for licensed psychiatric clinics for adults and licensed facilities for the treatment of substance abusing persons to provide “off-site” services in a similar fashion as is provided for in DCF licensed facility regulations, with specific reference to physician offices and other health care settings. [This proposal is consistent with the SIM Healthcare Innovation Plan.]
20. Review the suggested changes to the DSS Federally Qualified Health Centers (FQHCs) billing regulations, which could greatly affect mental health clinician access including the use of interns and unlicensed clinicians and reimbursement rates for group therapy.

## **Explanation of and Rationale for Cluster I Task Force Recommendations 1 through 20**

### **Overview**

Widely accessible and affordable *behavioral health screening* serves to help identify children, adolescents, and young adults at risk for developmental and mental health problems early in life, before behavioral health disorders can become chronic, entrenched, and cause serious impairment in life. Early identification enhances the possibility of early referral to treatment which may improve mental health and developmental outcomes for children, adolescents, and for young adults at risk. Behavioral Health screening should occur in a healthcare setting rather than a school setting. The medical home model could be used as an example of linkages between pediatricians and child/adolescent psychiatrists. It is important to try to accomplish these goals without labeling or stigmatizing the child or adolescent.

*Early intervention* programs provide vulnerable families with at-risk infants and young children ages 0-6 years old with treatment interventions designed to enhance parent-child bonding, parenting skills, family functioning, resilience to toxic psychological stress, nutrition, child safety, and child development. Children ages 0 to 6 years served by early intervention programs have been found to be significantly less likely to have language problems and aggressive and defiant behaviors, and to have fewer mental health problems than young children in usual care. Their mothers also have been found to have fewer mental health problems. At-risk families that receive early interventions are less likely to be involved with child protective services three years later.<sup>33,34,35</sup> Since vulnerability to mental and behavioral health disorders often begins early in life, robust early intervention programs may reduce risk for the later onset

of more severe mental health problems in at-risk children and families. Connecticut has a number of evidence-based early intervention programs.

The introduction to this report discussed many of the extant challenges facing the Connecticut child, adolescent, and young adult behavioral health treatment system. Challenges in improving behavioral health treatment overlap with those focused on behavioral health workforce development and capacity, closing gaps in commercial behavioral health insurance coverage, reducing barriers-to-care, improving the delivery system for behavioral health services, and improving payment models for behavioral health services. The Task Force recognizes that most of the recommendations to improve behavioral health treatment for children, adolescents, and young adults will be human capital intensive and require time, effort, and financial/resource support. Given the magnitude and costs of needed and comprehensive behavioral health care system reform targets for change will need to be prioritized and improvements will need to be staged as resources become available.

### **Explanation of Task Force Recommendation #1**

*Mandate screening for behavioral health problems by primary care providers of children, adolescents, and young adults ages 0-25 years old in Connecticut in the setting of their primary medical care provider (the health care setting).*

**Screening.** The Task Force feels strongly that behavioral health screening should occur primarily in the health care setting, as opposed to the educational/school setting. The Task Force supports the importance of the Medical Home pediatric model for children and adolescents 0-17 years old, and supports the importance of the primary care medical home model to screen for behavioral health issues in the 18 to 25 year old population. The primary care provider needs to be responsible for initiating any consultation to mental health professionals for the further evaluation and treatment of a patient suspected of having a behavioral health issue. Because children, adolescents, and young adults are at risk for the emergence of different mental and behavioral health problems at their progressive stages of development, one-size screening does not fit all and must be tailored for the individual's specific stage of development.

**Children ages 0-6 years:** At-risk children should be identified early in life by their pediatric primary care providers. Behavioral health screening should cover the following:

- Developmental disabilities (pervasive and specific: autism and intellectual disabilities)
- Traumatic/toxic stress
- ADHD
- Anxiety
- Parenting adequacy/Parenting stress
- History of family mental health disorders

**Children ages 7-12 years:** At-risk school-aged children should be identified early in life by their pediatric primary care provider. Behavioral health screening should cover the following:

- Developmental disabilities (pervasive and specific: autism and learning disabilities)
- Traumatic/toxic stress
- ADHD and Oppositional Defiant Problems
- Anxiety
- Depression
- Parenting adequacy/Parenting stress
- History of family mental health disorders

**Adolescents and young adults ages 13-25 years:** These young people should be screened by their pediatric, internal medicine, family medicine, or community medical primary care provider and referred to a psychiatrist for:

- Substance abuse
- Suicide risk/Self-harm risk
- Moderate to Severe Depression or Anxiety
- Bipolar Illness (manic-depressive illness)
- Psychosis and early-onset schizophrenia

This screening is particularly important when there is a strong family history of mental health or substance use disorders

### **Explanation of Task Force Recommendation #2**

*Increase support to primary care providers for the extra time and effort required to complete recommended behavioral health care screening in the primary care office setting.*

Because it is well known that one of the most significant barriers to primary care physicians performing timely and appropriate screening for behavioral or developmental problems is the lack of adequate support for the time needed to do these screening, the task force recommends identifying mechanisms to increase this support as a necessary step to insure that this screening take place in the primary care setting.

### **Explanations of:**

#### **Task Force Recommendation #3**

*Increase the accessibility and affordability of existing early intervention programs, particularly for those young children identified as at-risk through screening.*

#### **Task Force Recommendation #4**

*Scale-up existing food security guarantee programs for in-need and at-risk families of young children 0-6 years old.*

#### **Task Force Recommendation #5**

*Enhance housing and shelter security for in-need and at-risk children, adolescents, and young adults 7-25 years old, and for families of young children 0-6 years old.*



**Early intervention.** Early intervention in Connecticut can occur in a more robust fashion by scaling up existing evidence-based early intervention programs to make these programs more generally accessible and affordable to families in need across the State. At-risk families and young children 0-6 years old can be identified through screening by their primary care pediatric clinician and more readily be referred to these types of programs if they are more widely available and accessible in Connecticut. In order for early intervention programs to be most successful, food security and shelter security are very important.

**Treatment.** In regard to *improving behavioral health care treatment*, the Task Force focuses on specific areas of incremental improvement that include: 1) the creation of Centers of Excellence in pediatric and young adult behavioral health; 2) the expansion of ACCESS MH CT up to age 25 years, transitioning care across the adolescent to young adult years in the public sector (DCF responsibility to DMHAS responsibility); 3) substance abuse and addiction services; and 4) the very important issue of creating a regionalized system-of-care network of behavioral health care coordinators and case managers for Connecticut children, adolescents, and young adults with behavioral health care needs. The recommendations regarding pediatric and young adult behavioral health workforce education and development are also an essential part of improving treatment and are discussed separately under the section on workforce capacity.

#### **Explanation of Task Force Recommendation #6**

*Develop and fund seven specialized Centers of Excellence for consultation and educational training to mental health organizations and to professional practice organizations working in outpatient treatment with children, adolescents, and young adults in Connecticut.*

Clinical treatment research in child and adolescent mental health is increasingly demonstrating the importance of disorder-specific, specialized evidence-based evaluation and treatment methods for different age groups (infant versus preschool versus child versus adolescent versus young adult) and for various disorders such as autism, post-traumatic stress disorder, attention deficit/hyperactivity disorder, conduct and oppositional defiant disorder, childhood anxiety disorders, adolescent depression, adolescent bipolar disorder, early-onset obsessive-compulsive disorders, adolescent/young adult substance use disorders, and early-onset psychotic disorders. Generalized, one-size-fits-all mental and behavioral health approaches to clinical treatment usually fail to appreciate the complexity of individual behavioral health disorders and may fail to generate meaningful outcomes. The rapid pace of scientific advancement in child and adolescent mental health clinical treatment research is such that it cannot be assumed that routine professional training in child and adolescent psychology and/or psychiatry will result in an adequately trained professional workforce for Connecticut that is familiar with and able to effectively implement evolving evidence-based assessments and treatments.

These recommended Centers of Excellence could be located at universities, medical schools, children's hospitals, and/or teaching hospitals in Connecticut with expert faculty in the

areas of interest (clinical, educational, and research), or in behavioral health community organizations that will partner with universities. Duties will include consultation and educational outreach (not clinical services) to organizations requesting such assistance. The aim is to increase knowledge about and expertise in disorder-specific, effective and evidence-based behavioral health assessments and treatments; to increase clinical use of valid and behavioral health disorder-specific individualized outcome measures for children, adolescent, and young adults; and to increase clinician accountability, performance benchmarks, and transparency for behavioral health treatment outcomes. Centers of Excellence in pediatric and young adult mental health disorders will enhance behavioral health workforce education and development. Seven proposed Centers of Excellence include:

- Autism and Developmental Disorders
- Disorders of Traumatic Stress and Post-Traumatic Stress
- Externalizing Behavior Disorders (ADHD, CD, ODD)
- Substance Use Disorders
- Internalizing Disorders (anxiety, depression)
- Early-Onset Major Mental Illness (adolescent-young adult onset psychosis and bipolar disorder)
- Cultural competency in pediatric and young adult behavioral health

### **Explanation of Task Force Recommendation #7**

*Expand state appropriations for ACCESS MH CT to include young adults up to age 25 years old, making ACCESS MH CT available for children, adolescents, and young adults 0-25 years old.*

Based on the success of the Massachusetts Child Psychiatry Access Project (MCPAP)<sup>36</sup> and its precursor pilot program, Targeted Child Psychiatric Services (TCPS),<sup>37,38</sup> Connecticut has funded a similar program, ACCESS MH-CT. Due to roll out in early 2014, ACCESS MH-CT provides state appropriation funding to support pediatric primary care-child psychiatry collaboration for children and adolescents ages 0-17 years in the ambulatory care setting independent of healthcare coverage. This program effectively expands the pediatric mental health workforce in Connecticut by supporting an increased role for primary care in the evaluation and treatment of children and adolescents with behavioral health disorders presenting to the primary care setting. Expansion of ACCESS MH CT to support primary care medicine-adult psychiatry collaboration for young adults 18-25 years would help expand the existing behavioral health treatment system for young adults who have access to a medical provider.

Fiscal appropriations will be needed to increase the support of psychiatric consult support time, in the expanded model, and to support an additional young adult care coordinator, young

adult social worker, and increased administrative time at each of the chosen child and adolescent psychiatric teams under an expanded model of ACCESS MH CT.

### **Explanation of Task Force Recommendation #8**

*Enhance behavioral health care through the creation of models that co-locate behavioral health providers with primary care physicians independently of insurance type. Encourage memoranda of understanding (MOUs) between primary care physicians and behavioral health agencies to facilitate co-management models within local behavioral health systems-of-care. [This model already exists and could be replicated across the state.]*

The Task Force believes that we should capitalize on the recommendations of the Healthcare Innovation Plan under SIM to remove barriers to co-locating behavioral health providers with primary care physicians or other barriers to team-based practice. It should also be mentioned that Connecticut's emerging Behavioral Health Home (BHH) model is intended for individuals with Serious and Persistent Mental Illness (SPMI). However, were this concept expanded to include those adolescents and young adults with mild to moderately severe disorders, this program would be an excellent model for the treatment of youth and young adults with less serious behavioral health disorders, as a method to avoid the escalation of these individuals into more severe mental health problems, which require more intensive and costly services. The Connecticut SIM initiative may address this issue also.

### **Explanation of Task Force Recommendation #9**

*Create regionalized networks of care and expand care coordination, in order to enhance integrated mental health care for children, adolescents, young adults, and their families. [Creating regionalized networks of care and expanding care coordination is currently proposed to be accomplished through the Behavioral Health Home model developed by DMHAS, DCF, and DSS that is currently under consideration by CMS. A similar model should be developed for individuals who are privately insured.]*

An effective network of care is an integrated spectrum of effective, community-based services, support, and care for children, youth, and young adults with or at risk for behavioral health or other challenges and their families. This system is organized into a coordinated network; builds meaningful partnerships with children, youth, young adults, and their families; promotes health and wellness; and addresses their cultural and linguistic needs, in order to help them to function better at home, at work, in school, in the community, and throughout life.

The core values of a network of care include:

- Family and consumer-driven and youth-guided, with the strengths and needs of the consumer, child and family determining the types and mix of care, services, and supports provided;

- Community-based, with the locus of care, support, and services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level; and
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate care, services, and supports and to eliminate disparities in care.

Networks of care are designed to:

- Ensure availability and access to a broad, flexible array of effective, community-based care, services, and supports for children, youth, young adults and their families, that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports;
- Provide individualized care in accordance with the unique potentials and needs of each child, youth, young adult, and family, guided by a strengths-based, child, youth, young adult, and family team approach to a care planning process and an individualized Plan of Care developed in true partnership with the child, youth, young adult, and family;
- Ensure that care, services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children, youth, young adults and their families;.
- Deliver care, services, and supports within the least restrictive, most normative environments that are clinically appropriate;
- Ensure that families, other caregivers, youth, and young adults are full partners in all aspects of the planning and delivery of their own care/services and in the policies and procedures that govern care for all children, youth, and young adults in their community;
- Ensure that care, support, and services are integrated at the system level, with linkages between child-serving and adult-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management;
- Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that

children, youth, young adults, and their families can move through the network of care in accordance with their changing needs;

- Provide developmentally appropriate mental health care and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings;
- Provide developmentally appropriate care and supports, to facilitate the transition of youth to adulthood and to the adult service system as needed;
- Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children, adolescents, and young adults;
- Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage: the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child, youth, young adult, and family level;
- Protect the rights of children, youth, young adults, and families and promote effective advocacy efforts; and
- Provide care, services, and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

Over the past 15 years, Connecticut communities, in partnership with families, providers, and the Department of Children and Families have worked to implement the unfunded mandate legislated by P.A. 97-272 to create Community Collaborative/Systems of Care in every Connecticut community. The goal of this legislation is to ensure a comprehensive, coordinated network of care to promote social and emotional wellness and serve the ever growing and complex issues facing families who are raising children with mental and behavioral health issues. Networks of Care seeks to assist communities to avoid fragmentation in the local behavioral health care system by strengthening connections between local and state behavioral health care systems, promoting emotional and mental health wellness and working to ensure a seamless behavioral health network that is family driven, culturally and linguistically competent, and community based.

At the present time, Care Coordinators (funded by a variety of state agencies) work with individuals, and families with complex needs (both physical and behavioral) to create “wraparound” plans of care. Care coordination is available to a limited number of individuals

who have the greatest need. The need, however, greatly exceeds the availability of services and a public system that is subject to a stringent gatekeeper function is inherently unequal and unfair. In order to be eligible for these services, a child or youth must already have been identified as having significant behavioral health issues. This often means years of unsuccessful treatment, psychiatric hospitalizations and school failure before care coordination is sought or provided and paid for. In Connecticut, we can do better by increasing the number of care coordinators and offering care coordination BEFORE a family has experienced serious behavioral health difficulties.

A similar system is currently in place under the Department of Mental Health and Addiction Services through Local Mental Health Authorities and their affiliate providers that act as care coordinators and provide services for young adults with mental health diagnoses. These centers, however, are only available to young adults who are serviced through the public sector. That system could be replicated for individuals who are privately insured or paid for by private insurers.

#### **Explanation of Task Force Recommendation #10**

*Expand community collaboratives/systems of care into six regional networks of care that cut across town lines, state agencies, school systems, and private and public entities.*

Currently, Connecticut has 25 Community Collaboratives/Systems of Care that are part of a larger Statewide Network of Care. The goals of these Community Collaborative/Systems of Care are to ensure a coordinated network of care to serve the ever-growing and complex issues that face families who are raising children, adolescents, and young adults with significant emotional and behavioral health issues regardless of whether they are publicly or privately insured. In addition to providing direct support to families with children already identified with behavioral health needs, this collaboration of providers, families, and community members seeks to promote social and emotional wellness and awareness of behavioral health issues. This network of care is designed to meet the needs of all children, youth, and young adults with mental health issues regardless of whether they are involved with commercial payers, Medicaid, child protective services, juvenile justice, behavioral health, substance abuse, prevention, and/or early childhood intervention.

Expanded and adequately funded Community Networks of Care will bring communities together, break down silos that currently exist, and create communication vehicles that will allow for the promotion of social and emotional wellness and the early identification of mental health needs. These Regional Networks of Care cannot rely on “volunteer” resources. Instead, in order for them to be effective systems of change, the proposed regional systems of care must have an infrastructure that includes an effective community organizer who can serve as a local network champion who will facilitate communities to come together and build relationships across systems that serve children and families. These relationships will lead to knowing who to call and where to refer a family in need.

A commitment to relationship-building that directly translates into better coordination of care needs to be supported by investment. Coordination of care is critical to ensuring that children, adolescents, young adults, and their families receive the best service the first time, rather than “fitting a family into the next available slot in a mental health clinic.” No longer can we assume that coordination of care will occur without fiscal resources to support such activities. This is particularly important for multi-need complex family mental health situations but also will benefit those families who may need just a small source of guidance or support to prevent more costly mental and behavioral health needs from developing in the future.

### **Explanation of Task Force Recommendation #11**

*Expand and upgrade the current 2-1-1 Crisis Line in order to reach young adults by tying the DMHAS-funded Adult Mobile Crisis Lines to the 2-1-1 Crisis Line and promote this system for young adults in psychiatric crisis.*

The current fragmented behavioral health system is almost impossible for parents and for providers to navigate. It impedes those with the most involvement with children, youth and young adults (pediatricians, primary care, schools, family members) from accessing timely behavioral health help and individually-specific care information early in the evolution of mental health issues and before the situation reaches crisis proportions. Currently the 2-1-1 Crisis Line serves as the access point to EMPS – Crisis Intervention, which provides a mobile response for anyone seeking help for a child up to age 18 years in psychiatric crisis. For young adults beyond age 18, local mobile crisis response is available through the local mental health authorities but one must know who to contact locally. The utilization of 2-1-1 as the access point for children and adolescents in psychiatric crisis has been very successful in increasing utilization of this service and reducing psychiatric emergency room visits. This system holds similar potential for assisting those young adults, 18-24 years old who are experiencing psychiatric crisis. Thus, the Task Force recommends an expansion of the current 2-1-1 Crisis Line and increased funding so that it can be expanded to accommodate young adults in psychiatric crisis.

### **Explanation of Task Force Recommendation #12**

*Create a “Pathways To Care” program including regional care navigators tied to 2-1-1 Crisis Line who are knowledgeable about behavioral health services and supports in the caller’s local community.*

Access to the Regional Care Navigator begins with the family, provider, school, or youth telephoning 2-1-1. After brief, focused, and pertinent mental and behavioral information is gathered, the caller in need is transferred to a Regional Care Navigator who knows the local community behavioral and mental health environment and can respond to individual-specific inquiries from schools, pediatricians and families looking for behavioral and mental health services and supports.

### **Explanations of:**

#### **Task Force Recommendation #13**

*Consider that all provided behavioral health services be developmentally as well as culturally appropriate to the individuals and populations being served.*

#### **Task Force Recommendation #14**

*Create and enforce a set of uniform standards and definitions across all insurers (public and commercial) regarding: 1) the range of behavioral health services to be provided; 2) the criteria for receipt of services across the spectrum to include out-patient, community-based intensive outpatient services, and inpatient services; and 3) definitions of medical necessity that include behavioral health conditions. (This in effect should work towards alleviating problems such as: a) piecemeal information on service quality; b) geographic maldistribution of mental health services; c) difficult systems of pre-authorization for services in the private sector; d) the limitation of inpatient beds for psychiatric emergencies and appropriate inpatient psychiatric care; e) the tendency to truncate inpatient stays due to cost issues; and f) lack of patient improvement indicators.) (The Task Force recognizes that more than half of the commercial market consists of self-insured employers not subject to state jurisdiction.) The Task Force also recognizes that Connecticut already has a statutory definition on medical necessity for individuals with group health insurance policies that should be consistent with the definition used by public payers.*

Critical barriers to care exist in the delivery of behavioral health treatment to Connecticut's children, adolescents, and young adults. The net result is a fragmented behavioral health system that is difficult to access for families in need. Recognizing and reducing barriers-to-care will decrease system fragmentation and result in an improved delivery system for behavioral health services in Connecticut. There are a number of critically important deficits in how behavioral health services are currently delivered that significantly affect their overall effectiveness and quality. These specific deficits and barriers include the following:

- The lack of a developmental approach to early-onset behavioral health disorders. This creates barriers to developing and sustaining programs for prevention and early identification of at-risk children and families across significant portions of the child's developing years.
- Concern that many existing private healthcare plans have mental health care coverage that is not adequate to improve individual behavioral health outcomes, resulting in the increasing role of the public sector to assume the burden of supporting needed programs for these individuals. This cost-shifting has not been adequately addressed throughout the behavioral health services system.
- Volume-driven, fee-for-service models of payment to behavioral health providers, especially in the commercial sector, has led to an emphasis on increasing patient



volume per unit time per treater, instead of an emphasis on quality of care and measurable outcomes related to improved health and functioning. (See section on Payment Models.)

- An inadequate number of behavioral health care providers for the pediatric and young-adult population needing services in Connecticut, and a lack of transparent quality benchmarks for such providers. (See also Workforce Development section.)
- Long wait times for services in some areas of the state. Same day access models have been piloted for 18-25 year olds at some Local Mental Health Authorities and could be replicated.
- Uneven and inadequate geographical availability of services
- Limited provider hours and inconvenient locations of behavioral health treatment programs relative to families' daily demands (transportation issues, parent work demands, and child's school).
- Failure to provide an adequate number of high quality inpatient long-term psychiatric beds to sustain a continuum of care for Connecticut's most severely ill children, adolescents, and young adults. This lack leads to long wait times in hospital emergency departments for inpatient services and the frequency of adolescent placement in out-of-state residential treatment beds.
- Failure to ensure adequate social worker levels within our public school districts. The Department of Education reports about 15 percent of Connecticut's school districts do not employ a social worker, and in districts that do have a social worker, these professional are often overextended.<sup>6</sup>
- A lack of standardized and scaled up methods of transitioning youth in mental health treatment to adult mental health services, upon reaching age 18, often resulting in disruption in or loss of needed care.
- Inadequate mental health clinical provider transparency and accountability to measure and report outcomes of treatment, in terms of patient improved health, well-being, and functioning. (It is noted, however, that the Connecticut Insurance Department has published an insurer report card for the past 15 years. The report card rates important information on insurance provider coverage in various health related care areas. These materials are currently available to the public.)

In light of these deficits and challenges, the Task Force makes a number of specific recommendations regarding the delivery system for behavioral health services. Some of these recommendations are made under other issues, such as Workforce Development, Models of

Care, and overall recommendations regarding accountability for outcome measurement and reporting.

#### **Explanation of Task Force Recommendation #15**

*Integrate evidence-based behavioral health treatment of adolescents and young adults with evidence-based substance use treatment. [This has been done through implementation of the Integrated Dual Diagnosis Treatment (IDDT) model that is required throughout the DMHAS system and, again, is one of the requirements for increased payment in the enhanced care clinic system but does not exist on the private insurance side.]*

Many behavioral health disorders occurring in adolescence and in young adulthood have concomitant substance abuse as a comorbid condition. Adequate treatment requires clinical attention to both the behavioral health disorder and to the substance abuse disorder.

#### **Explanation of Task Force Recommendation #16**

*Enhance and facilitate better methods of transitioning youth from adolescent to young adult services by developing a specific mechanism where DCF and DMHAS create a comprehensive co-agency program specifically to address transition of youth with mild/moderate as well as severe behavioral disorders, in terms of their health care and human service needs. A leadership task force would facilitate continuing discussion and suggestions to address these two important unresolved issues in transitions of care for adolescents in Connecticut.*

A major challenge to providing services that span the age ranges from adolescence to young adulthood is providing assistance during the transition period when teens move from pediatric mental health providers to adult providers. An organized and thoughtful transition may not occur, with the result that young adults may fail to connect with adult providers on their own, and drop out of care, or find it impossible to maneuver through a new adult-focused system and find a new adult provider on their own. Cross-communication between pediatric and adult providers is often hampered by an overzealous interpretation of current HIPAA laws, with providers failing to recognize that they are able to speak with any new providers when continuity of care is involved, as well as the separation of publicly insured programs funded through either DCF versus DHMAS. While there may be a small number of transition programs shared by DCF and DHMAS, they are generally only for the most severely affected individuals and not the larger number of mildly or moderately affected individuals who are also using and needing behavioral health services. Further, these transition programs are virtually absent for any individual covered by a private healthcare plan.

As an example of publicly funded programs, DMHAS and DCF have been working for some years to develop an appropriate mechanism to aid in transitioning young adults from DCF to the DMHAS Young Adult Services (YAS) program. The agencies identified that many clients were being restricted from taking normal risks associated with development from childhood to adulthood and, therefore, were missing necessary life skills to survive in the adult community.

To address this issue the agencies modified an assessment tool for Life Skills (LIST), which consists of seven domains of necessary life skills to assess a client's readiness for community living as a young adult. DCF trained workers to perform these assessments and is in process of hiring Occupational Therapists to consult in the assessment; as a result transitions have steadily become more successful and clients' Transition Action Plans (TAP) have been more accurate in outlining real needs.

The Department of Children and Families and the Department of Mental Health and Addiction Services utilize a variety of evidence-based practices to facilitate the transition between adolescent and young adult behavioral health care. These include: Cognitive Behavior Therapy (CBT); Dialectical Behavior Therapy (DBT); Illness Management and Recovery (IMR); Motivational Interviewing; Trauma Specific Treatment Models; and the Twelve-Step facilitation practice which is embedded in the Department of Mental Health and Addiction Services (DMHAS) Assertive Community Treatment Program (ACT), Community Support Program (CSP)/Recovery Pathways Program (RP), Integrated Dual Disorder Treatment (IDDT) and the Dual Diagnosis Capability in Addiction Treatment (DDCAT).

There are a number of difficult issues that often arise during the process of transition from pediatric to adult services, such as those young adults who remain on their parents' private healthcare coverage, are privately insured themselves, or under employers' self-insured plans. Another issue is how to include schools in the conversation, when the school has been involved in educational or occupational planning. These issues are essential to a young adult's future functioning, particularly when the youth has a significant mental health problem, and these challenges point out the importance of dialogue and co-management across DCF and DMHAS, as well as real discussion about how this transition is accomplished when the youth is privately insured, and the pediatric and adult services are covered by private healthcare.

A leadership task force would facilitate continuing discussion and suggestions to address these two important unresolved issues in transitions of care for adolescents in Connecticut. A leadership task force consisting of representation from the commercial insurance industry, the Connecticut Department of Insurance, the Departments of Developmental Services, Children and Families, Education, and Mental Health and Addiction Services, Child and Families, and the Office of Program and Policy Management would be ideal. The leadership task force goal would be to make recommendations on facilitating transitions of care for (1) adolescents who remain on their parents' private commercial insurance or are privately insured themselves, and (2) are early dropouts from school.

### **Task Force Recommendation #17**

*Support and adopt the recommendations of the Legislative Program Review and Investigations Committee reports of December 2012 and June 2013<sup>3,4</sup>*

The PRI committee recommendations and rationale will not be repeated here.

### **Explanation of Task Force Recommendation #18**

*Amend the public health statutes and/or regulations as needed to allow for combined licensure for adult mental health clinics and facilities for the treatment of substance abusing persons.*

For providers who provide both mental health and substance abuse treatment the Task Force recommends creation of a combined license to treat both. Combined mental health and substance abuse treatment when it co-occurs is consistent with standards of best practice. Adult providers who provide substance abuse and mental health treatment are currently subject to two separate licenses which requires adherence to two separate set of regulations and duplication of site visits, time lines, etc. Given that we know it is best practice to treat mental health and substance use together, the regulations should reflect the current recommended standard-of-care. This would reduce redundancy for providers and reduce the regulatory burden on both providers and the Department of Public Health.

### **Explanation of Task Force Recommendation #19**

*Amend the public health statutes and/or regulations as needed to allow for licensed psychiatric clinics for adults and licensed facilities for the treatment of substance abusing persons to provide “off-site” services in a similar fashion as is provided for in DCF licensed facility regulations, with specific reference to physician offices and other health care settings. [This proposal is consistent with the SIM Healthcare Innovation Plan.]*

Co-location of behavioral health services in primary and other health care settings provides improved, integrated care for individuals with co-occurring physical and behavioral health conditions, and results in better outcomes. Current DPH licensure regulations restrict clinic practice to physical locations specifically approved by the department. There is no provision -- short of full licensing of a new site -- for the deployment of clinical resources from a licensed clinic to an “off-site” location in order to facilitate coordination of care and the delivery of services in the most appropriate setting for the patient. The SIM Healthcare Innovation Plan also recommends the allowance of co-location or “off-site” location to allow for integrated care.

Precedent for the provision of “off-site” services by a licensed clinic can be found in the Department of Children and Families’ licensure regulations for Outpatient Psychiatric Clinics for Children. In the DCF regulations “clinic off-site services” are defined as follows:

“Clinic services provided at a location which is not physically a part of the licensed clinic but whose services emanate from the licensed clinic. Such locations may include the recipient’s home, acute care hospital, school, recreational center or similar provisional location. Off-site services do not require separate licensing but shall be specified in the licensing process as locations where services are provided.”

## **Explanation of Task Force Recommendation #20**

*Review the suggested changes to the DSS Federally Qualified Health Center (FQHC) billing regulations, which could greatly affect mental health clinician access including the use of interns and unlicensed clinicians and reimbursement rates for group therapy.*

The Task Force has concerns that changes to the DSS FQHC billing regulations might diminish access to mental health trainees and access to group therapy. These include changes regarding the use of unlicensed clinicians under the supervision of a licensed supervisor. The new regulations suggest that FQHCs only hire individuals who have completed their requirements for licensure or are already licensed. There exists concern among Task Force membership that this requirement would strain the already inadequate mental health FQHC workforce as many FQHC therapists are interns, and clinicians working toward licensure. In addition, in the same regulation proposed changes to the amount of reimbursement for group therapy may increasingly make this form of therapy unavailable because providers may not be able to cover the cost of providing group forms of therapy.

## **Recommendations 21 through 29**

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### **P.A. 13-3 Issue #8: Providing intensive, individualized and in school behavioral health intervention services for students exhibiting violent tendencies.**

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The Task Force recommends:

21. Expand the current pool of in-school social workers so that all school districts have social worker capacity and the optimal ratio of one social worker for every 250 regular education students is achieved, compared with the current ratio of one social worker for every 530 students.
22. Expand the number of school psychologists to minimum national standards.
23. Provide “in-service training in mental health competencies” to school-based social workers and psychologists, as well as to other school personnel (administrators, teachers, and resource officers) so that they are able to: 1) provide needed assistance to teachers who may not be experienced enough to deal with behavioral problems or mental health concerns of their students as they occur; 2) change school protocols so that the response to children with behavioral problems is not out-of-school suspension, but in-school evaluation and treatment or mental health referral; and 3) identify and utilize appropriately available services in the community for mental health treatment (outpatient services, emergency mobile psychiatric services (EMPS), and case management services). There

should also be continued support and expansion of SAMHSA's Mental Health First Aid initiatives throughout the state by delivering the training to: A) college students by making it mandatory during freshman year orientation programs; B) newly hired public servants (all vocations) by making it mandatory within the first year of employment; and C) the public by offering it at Connecticut's community colleges free of charge.

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**P.A. 13-3 Issue #9: Requiring the State Department of Education to provide technical assistance to school districts concerning behavioral intervention specialists in public and private schools and for pre-school programs**

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The Task Force recommends:

24. Expand the presence of school nurses in elementary, middle, and high schools, and expand comprehensive school-based health centers, both in number and to support the inclusion of mental health services in all school-based health centers.
25. Make available to the behavioral health and developmental specialists located within each school, in each school district, a regional hub of mental health professionals under contract or memorandum of understanding (MOU). Private elementary and secondary schools as well as colleges and universities should also have access to this regional hub, so that services can be coordinated. This will require the development of MOUs between school mental health providers and any network of collaborating mental health professionals, in order to support any technical assistance activities.
26. Support the use of telemedicine in order to reach those districts that are geographically isolated.

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**P.A. 13-3 Issue #11: Conducting behavioral health screening for public school children**

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The Task Force recommends:

27. Expand the capacity of school mental health personnel to work and collaborate with teachers and administrators in identifying those children, adolescents, and young adults who are most at risk and in need of early screening and identification in order to refer to higher levels of mental health treatment, through specific, required training.
28. Require, as part of teacher preparation in undergraduate or graduate level education, coursework on the issues of mental health, early identification

and how to deal with safety and classroom management issues in the school setting.

29. Require statewide across all school districts a standardized component of health education classes in elementary, middle, and high school regarding the importance and elements of mental health and well-being.

## **Explanation of and Rationale for Cluster I Task Force Recommendations #21 through #29**

### **Overview of School Situation**

Schools represent an ideal setting in any community, where children, adolescents, and many young adults with behavioral health problems can be identified and where evidence-based practices for mental health care can be offered. The delivery of mental health services in schools -- where many children spend upwards of 6-8 hours each weekday -- is an important complement to any community-wide mental health system of care. There have been a number of published studies on the effectiveness of school-based health centers and well as the effectiveness of school nurses (RNs) in terms of providing acceptable, accessible and affordable health services. A recent publication in 2013<sup>6</sup> outlining the effectiveness of a mental health program in school settings, cited much of this literature and also presented a model for the effective location of mental health services in school settings, and the advantages of such programs for student's well-being and subsequent success in school performance and attendance.

Currently, the situation throughout Connecticut in terms of coverage by both school nurses and school-based health centers in that capacity is inadequate. There are many schools that do not even have a school nurse present for much of the school week, let alone a school-based comprehensive health center.

### **Overall Suggestions**

To avoid "reinventing the wheel," we commend legislative adoption of the model and recommendations in "Improving Outcomes for Children in our Schools," published recently by Child Health and Development Institute of Connecticut (CHDI), which addresses the need for expanded services and offers specific recommendations that address the three issues the Task Force has been charged with that directly involve school services.<sup>6</sup> Requiring or offering school social workers and school psychologists increased training on the timely identification of mental health disorders and increased knowledge and awareness of where to find relevant and timely access to effective community based services is paramount. Nationally, we have seen an increase in this type of initiative with programs such as "Mental Health First Aid." Requiring that schools incorporate this type of training and educational awareness program on screening and identification of mental health disorders into annual professional development and certification

requirements would be a tremendous step in enhancing the ability of school personnel to recognize and deal effectively with students who exhibit mental health problems, as well as violent and aggressive behaviors.

In addition, payers (including Medicaid) should allow licensed mental health providers in school settings to bill for services (when medically necessary). This would require the allowance of mobile and non-office based location codes to be used by mental health outpatient clinics.

**Explanations of:**

**Task Force Recommendation # 21**

*Expand the current pool of in-school social workers so that all school districts have social worker capacity and the optimal ratio of one social worker for every 250 regular education students is achieved, compared with the current ratio of one social worker for every 530 students.*

**Task Force Recommendation #22**

*Expand the number of school psychologists to minimum national standards.*

**Task Force Recommendation #23**

*Provide “in-service training in mental health competencies” to school-based social workers and psychologists, as well as to other school personnel (administrators, teachers, and resource officers) so that they are able to: 1) provide needed assistance to teachers who may not be experienced enough to deal with behavioral problems or mental health concerns of their students as they occur; 2) change school protocols so that the response to children with behavioral problems is not out-of-school suspension, but in-school evaluation and treatment or mental health referral; and 3) identify and utilize appropriately those services in the community available for mental health treatment (outpatient services, emergency mobile psychiatric services (EMPS), and case management services). There should also be continued support and expansion of SAMHSA’s Mental Health First Aid initiatives throughout the state by delivering the training to: A) college students by making it mandatory during freshman year orientation programs; B) newly hired public servants (all vocations) by making it mandatory within the first year of employment; and C) the public by offering it at Connecticut’s community colleges free of charge.*

**Task Force Recommendation #24**

*Expand the presence of school nurses in elementary, middle, and high schools, and expand comprehensive school-based health centers, both in number and to support the inclusion of mental health services in all school-based health centers.*

School-based mental health specialists (social workers, school psychologists,) need to be trained in the identification of mental health or behavioral concerns that indicate the need for evaluation and consultation with mental health professionals from these regional hubs.

School-based providers need to be trained in how to identify imminent problems, including risk assessments for violence and/or suicide and how to access and use of emergency



mobile psychiatry teams (EMPS), as well as where and how to refer children and teens who need additional mental/behavioral health evaluation (see above).

Schools should be required to incorporate this type of training and educational awareness programs on screening and identification of mental health disorders into annual professional development and certification requirements.

Current school requirements that mandate suspension of students with behavioral infractions due to a current mental health disorder should be changed to a standard of providing in-school evaluation and management of problems with appropriate parental consent and mental health referral as indicated.

**Explanation of:**

**Task Force Recommendation #25**

*Make available to the behavioral health and developmental specialists located within each school in each school district a regional hub of mental health professionals under contract or memorandum of understanding (MOU). Private elementary and secondary schools as well as colleges and universities should also have access to this regional hub, so that services can be coordinated. This will require the development of MOUs between school mental health providers and any network of collaborating mental health professionals, in order to support any technical assistance activities.*

The regional hub of mental health professionals to provide on-going technical and clinical assistance, and the training of required school personnel both need to be supported at the state level, in order to provide needed assistance for not-only middle, and high school children, but also pre-school, elementary, and college-level young adults within each Local Educational Authority.

It is essential that school districts and universities have required policies and collaborative agreements in place with community mental health providers that outline access to care, referrals to needed services, and the school's accessibility to Mobile Crisis programs, such as EMPS, through the state's 2-1-1 system. Students should be allowed to be referred to these services by school personnel without their having to have written or mandated oversight by the IEP process. Instead, this referral should be allowed on the clinical recommendation of any of the mental health providers present in the school settings, in response to an assessment of the mental health needs of that student.

In order to develop these regional mental health hubs, schools and universities need to be required to set up local and specific Memoranda of Understanding or agreements with local mental health providers (particularly Enhanced Care Clinics) to allow mental health experts (i.e., those in the community that are licensed or licensed eligible by Connecticut in social work, human services, psychology, or a related field) to provide on-site school screenings and risk assessments of identified children. School social workers and school psychologists who do not

have the appropriate background or training to provide effective mental health screening and risk assessments need to have available to them continuing training and technical assistance as necessary to maintain standards of care. Further, any MOUs that are developed need to insure that local consultants can operate as integrated school personnel, performing the tasks of screening, assessment, and referral without needing additional consent to evaluate an at-risk child or adolescent who the school has identified.

**Explanations of:**

**Task Force Recommendation #27**

*Expand the capacity of school mental health personnel to work and collaborate with teachers and administrators in identifying those children, adolescents, and young adults who are most at risk and in need of early screening and identification in order to refer to higher levels of mental health treatment, through specific, required training*

**Task Force Recommendation #28**

*Require, as part of teacher preparation in undergraduate or graduate level education, coursework on the issues of mental health, early identification and how to deal with safety and classroom management issues in the school setting.*

While universal behavioral health screening for public school children is not feasible, and the Task Force recommends screening be accomplished in the health sector, those educational professionals with whom a child or teen spends time, in the school setting, need to be trained in identification of specific behaviors that indicate the need for additional mental health referral and evaluation. This needs to be facilitated within the school setting, separate from any official medical/mental health evaluations that parents may request for their children or teen. When possible, consultation with parents about concerns and co-management of problems will be the best solution, but the school needs to have the ability to move forward with any child or teen whose behavior may signify a mental health or high-risk problem. School personnel thus need to be trained in terms of when there is a need for further referral, how to initiate referrals, and where the gateway is for additional referral and treatment, especially in an urgent situation.

**Explanation of Task Force Recommendation #29**

*Require statewide across all school districts that a standardized component of health education classes in elementary, middle, and high school include curricula on the importance and elements of mental health and well-being.*

While elements of health education programs required by the state of Connecticut include topics such as mental health and well-being, these elements of the health education curriculum are often left up to the discretion of each school district. Insuring that standardized core elements regarding physical as well as mental health and well-being are taught in health education classes across all school districts would enhance students' education as well as work to reduce the stigma of mental illness.

**The above recommendations are a more efficient way to utilize resources than universal behavioral health screening efforts.**

## **Recommendations 30 through 42**

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### **CLUSTER II. ACCESS TO AVAILABLE SYSTEMS OF CARE**

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#### **Addresses:**

- P.A. 13-3 Issue # 2: Closing gaps in private insurance coverage
- P.A. 13-3 Issue #4: Addressing the insufficient number of certain behavioral health providers, including psychiatrists who specialize in treating children and those offering specialized services
- P.A. 13-3 Issue #6: Improving payment models for behavioral health services
- P.A. 13-3 Issue #7: Creating a central clearinghouse with information for members of the public concerning behavioral health services
- P.A. 13-3 Issue #13: Reducing the stigma of mental illness as it presents a barrier to a person's receipt of appropriate mental health services

#### **Payment Models**

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##### **P.A. 13-3 Issue #2: Closing gaps in private insurance coverage**

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The Task Force recommends:

30. Increase efforts to enhance data-driven approaches to addressing the gaps in private behavioral health insurance that include: 1) mandating timely written responses; 2) third-party review of behavioral health data from private health plans; 3) requirements for specific data to be reported (as listed in explanation on pages 55-56 below); and 4) working towards addressing and bridging the gap between the menu of behavioral health services offered by commercial and self-funded plans and their financial support for the publicly funded programs from which their covered clients benefit. We suggest that this be a joint effort between commercial providers, the Connecticut Insurance Department, the Behavioral Health Care Partnership, and the Office of the Healthcare Advocate, with provided data to be de-identified and reported in aggregate to avoid HIPPA violations.
31. Invite the commercial healthcare and employer-based plans to participate with the Connecticut Behavioral Health Partnership in efforts to help insure a standard, uniform, and equitable system of behavioral health for youth 16 through 24 years of age.

32. Consider creating an *independent* Office within the current Office of Healthcare Advocate that is charged, as one of its responsibilities, with the task of monitoring whether data from both public and commercial insurers regarding behavioral health services is provided and outcomes are submitted and made available to the public in a timely and transparent manner. The Task Force recommends that this Office be called the Office of Behavioral Health Relations and Accountability. (See below for the additional proposed roles of this Office in reducing the stigma of mental illness and providing assistance to a clearinghouse. This Office could also monitor the compliance of all service providers with the new federal parity laws.)

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**P.A. 13-3 Issue #6: Improving payment models for behavioral health services**

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The Task Force recommends:

33. Incentivize innovative public-commercial partnership models to pay for child, adolescent, and young adult behavioral health care.
34. Incentivize the commercial behavioral healthcare plans to collaborate with public sector payers to develop innovative public-commercial models to reduce discrepancies between behavioral health coverage in the commercial versus public sectors.
35. Incentivize value-based behavioral health payments to clinicians based on quality and performance outcome measures to reduce volume-driven payments, as described in the SIM Healthcare Innovation Plan.
36. Improve reimbursement rates to clinical providers so that clinicians will more readily accept Medicaid patients through consideration of:
- i. loan forgiveness programs for social workers, psychologists, and psychiatrists who are qualified to assess and treat children, adolescents, and young adults;
  - ii. tax credits for accepting insurance payments and/or working with children, adolescents, and young adults in underserved areas of Connecticut;
  - iii. bonuses for equal access and quality of care based on performance outcome measures;
  - iv. malpractice coverage incentives; and

- v. free training on best practices, standards-of-care, and evidence-based clinical treatment interventions for children, adolescents, and young adults with mental health care needs.
37. Incentivize clinicians to communicate with one another about the behavioral health needs of patients through strategies such as reimbursement for coordination of care via multi-disciplinary provider meetings or telephone consultation, to address the issue of poor communication between providers, as described in the SIM Healthcare Innovation Plan.

### **Workforce Development (also a capacity issue)**

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#### **P.A. 13-3 Issue # 4: Addressing the insufficient numbers of certain behavioral health providers, including psychiatrists who specialize in treating children and those offering specialized services**

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The Task Force recommends:

- 38. Incentivize financially child and adolescent psychiatrists (CAPS) to work with the state populations designated as in need and in the geographic areas designated as in need in Connecticut.
- 39. Incentivize clinical psychologists, clinical social workers, and advanced nurse practitioners through similar tangibles as used for CAPS in order to increase the pool of trained clinicians willing to work in the public sector.
- 40. Address the work force concerns cited in this report through the Workforce Council in the SIM Governance Structure.

### **Awareness and Knowing Where to Get Help**

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#### **P.A. 13-3 Issue #7: Creating a clearinghouse with information for the public on behavioral health services**

#### **P.A. 13-3 Issue #13: Reducing the stigma of mental illness as it presents a barrier to people receiving appropriate mental health services**

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The Task Force recommends:

- 41. Using the mechanism of the *proposed* Office of Behavioral Health Relations and Accountability to be located within the Office of the Healthcare Advocate, and working with other offices charged with similar tasks, and working with existing State of Connecticut efforts, including

those put forth in Senate Bill 322 (2014 Session, Connecticut General Assembly), create a general information clearinghouse/website that is a single locator for information about behavioral health issues and mental health and substance abuse services available to adolescents and young adults in Connecticut. By expanding the scope of this clearinghouse to include electronic information via a well-advertised website, public information regarding behavioral health services will be more readily available and accessible to the public. It is also expected that this will increase the public's education about issues of mental health being part of overall well-being and will reduce the stigma associated with mental health problems.

42. Work with new and existing mechanisms to develop public service announcements directly aimed at informing the public about mental illness and behavioral health.

## **Explanation of and Rationale for Cluster II Task Force Recommendations #30 through #42**

### **Access to the Available Systems of Care**

#### ***Closing gaps in private insurance coverage***

There are significant discrepancies in the range and extent of behavioral health services that are covered by public as compared with commercial insurers, and there appears to be significant cost-shifting from the commercial to the public payer sector. This has resulted in numerous barriers to access to behavioral health care for those with private healthcare, ranging from out-patient psychological and psychiatric care, to more intensive day treatment and intensive outpatient programs, community based programs, and inpatient coverage. The Task Force believes that transparency is a necessary step towards accountability that, in turn, is a necessary step towards closing gaps in healthcare coverage.

In order to close gaps in coverage between private and publicly funded insurance, an initial step is to document the extent to which gaps in coverage occur and document where cost-shifting is occurring, in order to provide policy makers with concrete and specific data, much of which in the past has been very difficult to obtain from the private sector. The Task Force supports the current efforts of the Connecticut Insurance Department and the Department of Mental Health and Addiction Services to document the coverage options in private and publicly funded health coverage in Connecticut.

### **Explanations of:**

#### **Task Force Recommendation #30**

*Increase efforts to enhance data-driven approaches to addressing the gaps in private behavioral health insurance that includes: 1) mandating timely written responses; 2) third-party review of behavioral health data from private health plans; 3) requirements for specific data to be reported (as listed in explanation on pages 55-56 below); and 4) working towards addressing and bridging the gap between the menu of behavioral health services offered by commercial and self-funded plans and their financial support for the publicly funded programs from which their covered clients benefit. We suggest that this be a joint effort between commercial providers, the Department of Insurance, the Behavioral Health Care Partnership, and the Office of the Healthcare Advocate, with provided data to be de-identified and reported in aggregate to avoid HIPPA violations.*

#### **Task Force Recommendation #32**

*Consider creating an independent Office within the current Office of the Healthcare Advocate that is charged, as one of its responsibilities, with the task of monitoring whether data from both public and commercial insurers regarding behavioral health services provided and outcomes are submitted and made available to the public in a timely and transparent manner. The Task Force recommends that this office be called the Office of Behavioral Health Relations and Accountability. (See below for the additional proposed roles of this Office in reducing the stigma of mental illness and providing assistance to a clearinghouse. This Office could also monitor the compliance of all service providers with the new federal parity laws.)*

The Task Force recommends a series of efforts to enhance transparency through data-driven approaches to addressing the gap problem, to include:

- Requiring that private insurers respond in writing to data requests originating from CID working with the Behavioral Health Partnership in a timely manner (within one month of request)
- Empowering the Behavioral Health Partnership, in conjunction with the Office of Behavioral Health Relations and Accountability, and CID to review behavioral health data from the commercial insurance industry no less than once yearly, ensuring sharing of data and oversight, and to make recommendations to the legislature about improving care in the private commercial sector that are data-driven.
- Requiring that private healthcare plan behavioral health data provided include but not be limited to:
  - Number of child inpatient psychiatric beds in Connecticut (and trends over time)

- Number of adolescent inpatient psychiatric beds in Connecticut (and trends over time)
- Number of inpatient psychiatric beds for young adults up to age 25 years (and trends over time)
- Length of inpatient psychiatric treatment stay supported by commercials for ages 0-25 years (and trends over time)
- Length of residential treatment stay supported by commercials for ages 0-25 years (and trends over time)
- Number of Emergency Department visits for psychiatric care in commercially insured patients 0-25 years old (and trends over time)
- Wait time for inpatient and for residential bed placements in commercially insured 0-25 year olds (and trends over time)
- Percent of denials of care and reason for denial of care (and trends over time)
- Requiring that the commercial behavioral health insurers and employer health plans assist in the funding of publicly supported behavioral health programs for children, adolescents, and young adults to the extent that their enrollees access such services, including:
  - IICAPS
  - Emergency Mobile Crisis Teams
  - Extended Day Treatment
  - Substance Treatment Services for adolescents and young adults
- Considering assigning the proposed independent Office of Behavioral Health Relations and Accountability within the existing Office of the Healthcare Advocate, the task of monitoring compliance with federal mental health parity laws.

The Task Force also considered the challenge of enforcing requirements for data provision and transparency, and suggested that fines be levied for lack of compliance, with those funds used to offset the financial expansion of ACCESS MH CT up to age 25 and/or to support a more robust care management infrastructure.

It is apparent from the discussion above that the currently existing models of payment for behavioral health services do not work well at all for youth and young adults, or their parents,



trying to maneuver through the system. The system is fragmented and as a result has inefficiencies that reduce not only cost-effectiveness but also quality of care. Improving these payment models for the behavioral health care for children, adolescents, and young adults has been extremely challenging and difficult for a number of reasons.

1. There are multiple insurance payer systems in Connecticut. Multiple private commercial and public payers have differing covered services such that children who are publicly insured have more services than those covered under private commercial payers.
2. Many providers choose to “opt out of the system” and accept cash payment only for clinical mental health services. The extent of this practice and the reasons for it need to be clarified.
3. There are no incentives for behavioral health providers to communicate with one another, despite a team-approach standard-of-care in behavioral health treatment for children, adolescents, and young adults.

**Task Force recommendations #30 and #32 are intended to address the problems of multiple behavioral health insurance payer systems in Connecticut, improve low reimbursement rates clinical providers, and address the issue of poor communication between providers.**

**Explanations of:**

**Task Force Recommendation #33**

*Incentivize innovative public-commercial partnership models to pay for child, adolescent, and young adult behavioral health care.*

**Task Force Recommendation #34**

*Incentivize the private behavioral health insurance industry and public sector payers to develop innovative public-private models to reduce discrepancies between behavioral health coverage in the private payer versus public sectors.*

**Task Force Recommendation #35**

*Incentivize value-based behavioral health payments to clinicians based on quality and performance outcome measures to reduce volume-driven payments, as described in the SIM Healthcare Innovation Plan.*

**Task Force Recommendation #36**

*Improve low reimbursement rates to clinical providers so that clinicians will more readily accept Medicaid patients by considering:*

- *Loan forgiveness programs for social workers, psychologists, and psychiatrists who are qualified to assess and treat children, adolescents, and young adults.*

- *Tax credits for accepting insurance payments and/or working with children, adolescents, and young adults in underserved areas of Connecticut.*
- *Bonuses for equal access and quality of care based on performance outcome measures*
- *Malpractice coverage incentives*
- *Free training on best practices, standards-of-care, and evidence-based clinical treatment interventions for children, adolescents, and young adults with mental health care needs.*

### **Task Force Recommendation #37**

*Incentivize clinicians to communicate with one another about the behavioral health needs of patients through strategies such as reimbursement for coordination of care via multi-disciplinary provider meetings or telephone consultation, to address the issue of poor communication between providers, as described in the SIM Healthcare Innovation Plan.*

### **Task Force Recommendation #38**

*Incentivize financially child and adolescent psychiatrists (CAPS) to work with the state populations designated as in need and in the geographic areas designated as in need in Connecticut.*

### **Task Force Recommendation #39**

*Incentivize clinical psychologists, clinical social workers, and advanced nurse practitioners through similar tangible as used for CAPS in order to increase the pool of trained clinicians willing to work in the public sector.*

### **Task Force Recommendation # 40**

*Address the work force concerns cited in this report through the Workforce Council in the SIM Governance Structure.*

In 2013 there were just 7,482 board-certified child and adolescent psychiatrists (CAPs) practicing in the United States. A report by the U.S. Bureau of Health Professions in 2000 predicted a national need in the year 2020 for 12,624 CAPs. There are only 196 board-certified CAPs active in Connecticut in 2013 according to the American Board of Psychiatry and Neurology. Medical students are not entering the field because of the relatively low status and low reimbursement rates for psychiatrists within academic medical schools, compared with the higher salaries of invasive medical/surgical specialties, which are especially attractive given the high college and medical school educational debt burden facing students today. Given 804,238 children less than 18 years old in Connecticut (2011 Census data), overall there are 24.3 child psychiatrists per 100,000 children and adolescents in Connecticut.

These child psychiatrists are distributed unevenly in Connecticut with many practicing in private practice, cash-only payment, high income urban and suburban locations, and a paucity practicing in public-sector, low income, inner-city, or rural locales. For example, according to the Connecticut Chapter of the American Academy of Pediatrics the majority of CAPs practice

in the greater New Haven and greater Hartford areas (mostly suburban). There are almost no CAPs in New London and Litchfield Counties, or in the northeastern or western parts of the State. As a result, there is a shortage of child psychiatrists and high barriers to access child psychiatric care in much of Connecticut.

Incentives to work in underserved areas may include the following:

- (1) State appropriations to fund child and adolescent psychiatry fellowship training programs at the University of Connecticut School of Medicine (a publicly supported institution) focused on training for public sector work. Also, incentive programs may include medical school educational loan forgiveness or medical school stipends for training for medical students willing to commit to training in child and adolescent psychiatry and to direct-care public sector work in child and adolescent psychiatry ( $\geq$  50 percent time devoted to child, adolescent, and young adult mental health) in underserved areas of the state and/or to work in designated Connecticut Health Enhancement Communities within a medical home model in consultation with primary care for a designated period of time.
- (2) Incentivize CAP participation in Medicaid and working in underserved areas of Connecticut through the granting of tax credits, financial bonuses for benchmarks attesting to child psychiatric practices granting equal access and quality of care to underserved youngsters living in underserved areas of the state, free training on best practices, evidence based treatments and practices, and/or malpractice insurance incentives.

Behavioral health treatment for children, adolescents, and young adults ages 0-25 years old in Connecticut would be enhanced by behavioral health workforce education and development in culturally competent, family-centered, and evidence-based practices that emphasize continuities of behavioral health care across development (infant to adulthood).

**Incentives for Child and Adolescent Psychologists.** Child and adolescent trained psychologists could be incentivized to work in the public sector and for direct-care clinical work to underserved pediatric populations in underserved areas of the State ( $\geq$  50 percent time). Pediatric psychologists can support primary care mental health evaluation and treatment by use of co-location models of care. Child and adolescent psychologists are trained in and provide evidence-based psychotherapy treatments in the domains of cognitive-behavioral therapies, motivational interviewing for substance abuse, psychological testing for treatment planning, risk assessment, family therapies, behavioral therapies, and consultation to schools and the juvenile courts. Incentives may be similar to those noted above for CAPS.

**Incentives for Advanced Practice Child and Adolescent Mental Health Nursing.** Supporting Connecticut educational training programs in child, adolescent, and young-adult behavioral health Advanced Practice Nursing (APRN) is vital. Working with primary care

physicians in co-location practice models and with child and adolescent psychiatrists in ambulatory treatment settings, well-trained APRNs provide enhanced workforce capacity in routine (non-complex) mental health assessments and routine pediatric and young adult psychopharmacological services. Enhanced workforce capacity in this area may serve to reduce barriers-to-care and long wait times for routine psychopharmacological services in the ambulatory care setting, and free up child and adolescent psychiatry time for more complex and challenging cases. Incentives may be similar to those noted above for CAPS.

**Incentives for Child and Adolescent Clinical Social Work.** Supporting initiatives for social workers to specialize in pediatric mental health care and incentivize them to practice in geographically underserved areas or in co-location models in primary care pediatrics settings can also enhance the Connecticut mental health pediatric workforce. Well-trained clinical social workers can provide additional workforce capacity in routine mental health evaluations and family evaluations, and help access emergency mental health services when needed.

#### **Explanation of Task Force Recommendation #41**

*Using the mechanism of the proposed Office of Behavioral Health Relations and Accountability to be located within the Office of the Healthcare Advocate, and working with other offices charged with similar tasks, and working with existing State of Connecticut efforts, including those put forth in Senate Bill 322 (2014 Session, Connecticut General Assembly), create a general information clearinghouse/website that is a single locator for information about behavioral health issues and mental health and substance abuse services available to adolescents and young adults in Connecticut. By expanding the scope to of this clearinghouse to include electronic information via a well-advertised website, public information regarding behavioral health services will be more readily available and accessible to the public. It is also expected that this will increase the public's education about issues of mental health being as part of overall well-being and will reduce the stigma associated with mental health problems.*

**Awareness of where to go for help.** As described above, the Task Force has recognized that the public needs to have more readily available information about mental illness and substance abuse, as well as general information about behavioral health services and health care providers available throughout Connecticut. The Task Force recommends that one of the roles of the proposed Office of Behavioral Health Relations and Accountability would be to work with other offices charged with the tasks of providing such information, in order to develop a general information/clearinghouse that would be a single locator about the range of information on behavioral health. A single locator would be invaluable for families who are seeking knowledge about substance abuse and mental health services in their local community areas.

#### **Explanation of Task Force Recommendation #42**

*Work with new and existing mechanisms to develop public service announcements directly aimed at informing the public about mental illness and behavioral health.*

The Task Force recognizes that there are a number of mechanisms available that can be utilized to develop and disseminate to the public media messages aimed at dispelling the myths of mental illness and the stigma attached to such behavioral health issues and the need for treatment.

## **Recommendations 43 through 47**

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### **CLUSTER III. BALANCING DISCLOSURE OF INFORMATION, MANDATING CLINICAL SERVICES, AND PATIENT RIGHTS**

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#### **Addresses:**

- P.A. 13-3 Issue #10: Employing the use of assisted outpatient behavioral health services and involuntary outpatient commitment as treatment options
- P.A. 13-3 Issue #12: Requiring disclosure of communications by mental health professionals concerning persons who present a clear and present danger to the health or safety of themselves or other persons

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#### **P.A. 13-3 Issue #10: Employing the use of assisted outpatient behavioral health services and involuntary outpatient commitment as treatment options**

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The Task Force recommends:

43. Given the scope and complexity of the issue of involuntary outpatient commitment, and the wide variety of individuals who may need to have input regarding this issue, a separate Task Force should be appointed specifically for further discussion and possibly to make final recommendations regarding this issue. The Task Force would specifically address the use of psychotropic medications for adolescents and young adults who refuse such treatment. This Task Force would also address the question of allowing legally appointed conservators for adolescent and young adults with severe mental illness to consent to medication on behalf of their conservatees.
44. DMHAS scale up Assertive Treatment Programs that provide aggressive outpatient services, shy of forced medication, to clients with severe illness in Connecticut.
45. Increase the age of majority to 18 years old for making decisions regarding one's mental health and substance abuse treatment, given the current understanding of mental illness to be a biologic disease. The Task Force wishes to emphasize that nothing said here is to infer that this is intended to contradict current access to care laws for minors or to diminish the rights of

minors to consent to and obtain any medical or mental health treatment on their own without parental consent that is authorized by current state laws or precedents.

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**P.A. 13-3 Issue #12: Requiring disclosure of communications by mental health professionals concerning people who present a clear and present danger to the health or safety of themselves or other persons**

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The Task Force recommends:

46. Clarify, and educate all those providers involved in clinical care of adolescents and young adults regarding, current patient privacy rights in order to allow communication between providers across both inpatient and outpatient settings, and when patients are being transitioned from higher to lower levels of medical care, in order to ensure continuity of treatment and safety of providers. Definitions for when this is necessary also need to be carefully elucidated and clarified.
47. Clarify, and educate all health care providers regarding, the current HIPAA and FERPA laws that address communication between clinical providers and school, college, and university settings where adolescents and young adults study in order to allow enhanced and timely communication when safety due to a mental illness (threat to self or others) is an issue.

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**Explanation of and Rationale for Cluster III Task Force Recommendations #43 through #47**

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**Assisted Behavioral Health Services and Involuntary Outpatient Commitment**

There are currently more than 44 states in the United States that have adopted outpatient commitment or conditional discharge from commitment laws for severely mentally ill individuals who otherwise would refuse treatment or who would not be able to secure needed outpatient treatment. Connecticut's lack of such a legal mandate has resulted in a number of severely affected individuals either not receiving needed treatment, or being admitted for short stays while under a Physician's Emergency Certificate (PEC), discharged prematurely, and then requiring almost immediate readmission when they fail outpatient treatment (either counseling or medication use).

This Task Force recognizes that it is only in the more serious but rare circumstances that people with mental illness represent a true, lethal threat to community citizens. More often however, these patients are a serious threat to themselves, and often a threat to their family members, and others in their immediate surroundings, especially when it is not possible, given current laws that protect the rights of individuals, to mandate treatment (inpatient care) except in

specific and very limited, short-term settings), and insure that treatment continues when needed. The burden on these individuals and their families cannot be underestimated.

On the other side of this issue, the Task Force acknowledges that in the states where outpatient commitment laws do exist, there is little ability to enforce the laws, often leaving families with a false sense of security when a person is mandated to outpatient treatment. The question then arises: Do the actual benefits of outpatient commitment justify the cost of abridgment of individual autonomy and liberty for the subset of individuals with severe mental health needs mandated to outpatient commitment?

**Given the complexity of these issues the Task Force recommends a separate task force committee for studying the use of assisted outpatient behavioral health services and involuntary outpatient commitment as treatment options.**

DMHAS instituted, then abolished, Assertive Treatment Programs that provide aggressive outpatient services, shy of forced medication, to clients with severe illness. Currently, the department is reinstituting a limited ACT program in Hartford and New Haven. These programs are important in providing encouragement to patients to participate in outpatient treatment and protection of the client and other state residents from behaviors that may accompany serious decompensation when a patient is ignoring treatment. DMHAS acknowledges the value of these programs and the Task Force strongly recommends their immediate expansion statewide.

There is also lack of parity in definitions of majority between medical and mental health concerns. More specifically, adolescents can generally not decide for themselves courses of medical therapy and whether to remain in the hospital until the age of 18 years, which is the accepted age of majority across most states in the U.S.

However, the situation for mental health disease is different and the age of majority is determined to be 16 years of age for mental health treatment in Connecticut. Thus, a teen who has decided not to remain in inpatient treatment for a behavioral health disorder can decide at the age of 16, not 18 years as for medical issues, to discharge himself against medical advice, and the parents and physicians have only strict legal recourses to this decision by the adolescent. It is not clear why there is such lack of parity in consent to treatment across mental health and medical/surgical disorders. It has been suggested that this age of consent in mental health was more consistent with the age that youth used to be considered adults in the criminal justice system (a situation that has fortunately been changing in Connecticut in recent years). However, this lack of parity remains, and is not currently justified by recent developmental neurobiological research demonstrating incomplete brain maturation in adolescents, which increases risk for immature and present-driven decision-making and decreased impulse control in adolescents compared with adults.<sup>39</sup>

The current situation places undue burden on both families and medical providers who are attempting to provide care for their adolescent, as well as for that adolescent who may not have adequate judgment to realize that such mental health inpatient care is necessary for their health and well-being. *It must be understood that this parity with medical conditions in no way conflicts with the laws and precedents that understand that by age 15 years, many adolescents are able to make decisions and consent for their own healthcare, as well as understand the risks and benefits of consenting to medical care on their own, especially for issues such as mental health treatment and reproductive health issues.* However, this change addresses only those situations when the teen is clearly presenting a danger to him or herself, or is assessed as not competent to make decisions for him/herself. In these rare cases, having the age of majority be increased to 18 years, allows the parents to act on behalf of their teen, rather than having this situation need to be resolved a high cost in a probate court setting.

## **Disclosure of Relevant Mental Health Information and Enhancing Communications Concerning Persons Who Present a Clear and Present Danger to the Health or Safety of Themselves or Others**

### **Rationale in School Setting**

School employees in Connecticut are the professionals most likely to learn that a child or adolescent has thoughts or intentions to threaten or harm another person. School employees often will learn of threats either through direct interaction with a particular student or through information they receive from concerned classmates or family members. Mental health providers in school settings who include school psychologists, social workers, and school counselors can perform screening assessments of these students who make threats with the urgency and efficiency that is required, and contact EMPS as needed. After the screening assessment is completed, many students will be identified as needing a more comprehensive evaluation of their mental health status, which must be conducted at a medical facility or other clinical setting.

Regarding the issue of disclosure of communication between mental health professionals and school systems, it is imperative that those providers in the clinical setting have all the pertinent information from the school related to the precipitating event(s) that led up to the referral for an emergent and comprehensive mental health evaluation. To meet this goal it is recommended that mechanisms be explored to facilitate disclosure of relevant mental health information and enhance communication across the school and mental health systems for emergency mental health situations as necessary and appropriate.



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## Endnotes

<sup>1</sup>The Task Force met 13 times: August 14, 2013; September 11, 2013; September 24, 2013; October 8, 2013; October 22, 2013; November 5, 2013; November 19, 2013; December 3, 2013; December 31, 2013; January 7, 2014; January 14, 2014; March 18, 2014; and April 8, 2014.

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<sup>3</sup> Legislative Program Review and Investigations Committee, CGA. Access to Substance Use Treatment for Insured Youth: Phase I. Hartford, CT: PRI; 2012.

<sup>4</sup> Legislative Program Review and Investigations Committee, CGA. Access to Substance Use Treatment for Insured Youth: Phase II. Hartford, CT: PRI; 2013.

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<sup>15</sup> Legislative Program Review and Investigations Committee, CGA. Access to Substance Use Treatment for Insured Youth, Phase I. Hartford, CT; PRI, 2012.

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<sup>31</sup> Honigfeld L, Meyers J. *The Earlier the Better: Developmental Screening for Connecticut's Young Children. Impact*. A publication of the Child Health & Development Institute of Connecticut, Inc. 2013 (October).

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<sup>33</sup> Lieberman AF, Ippen CG, Van Horn P. 6-Month Follow-Up of a Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2006; 45(8):913-918.

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**TASK FORCE TO STUDY THE PROVISION OF  
BEHAVIORAL HEALTH SERVICES FOR YOUNG ADULTS**

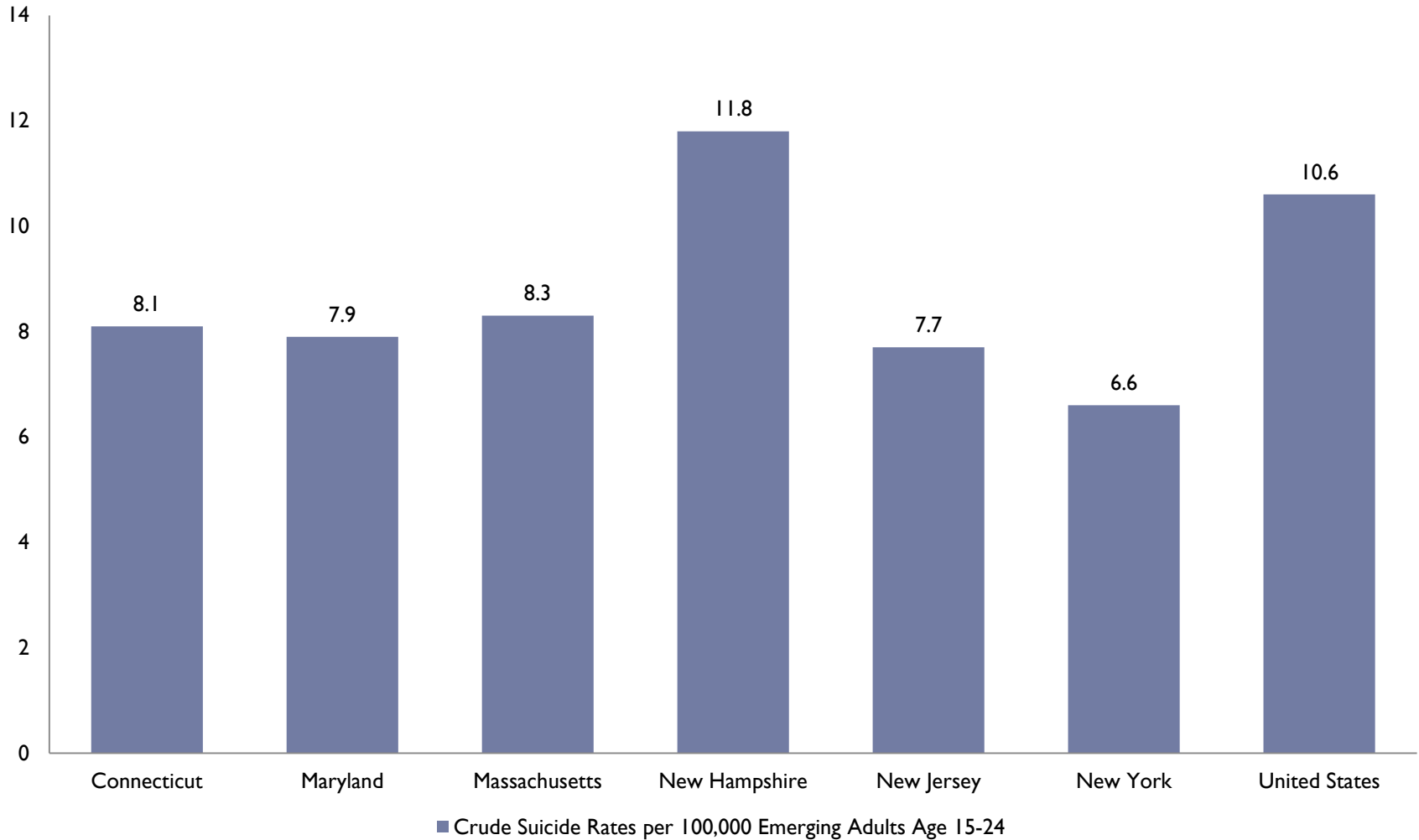
Background Data

# NOTES:

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# Comparison of Connecticut Emerging Adult Suicide Rate with Selected States\*



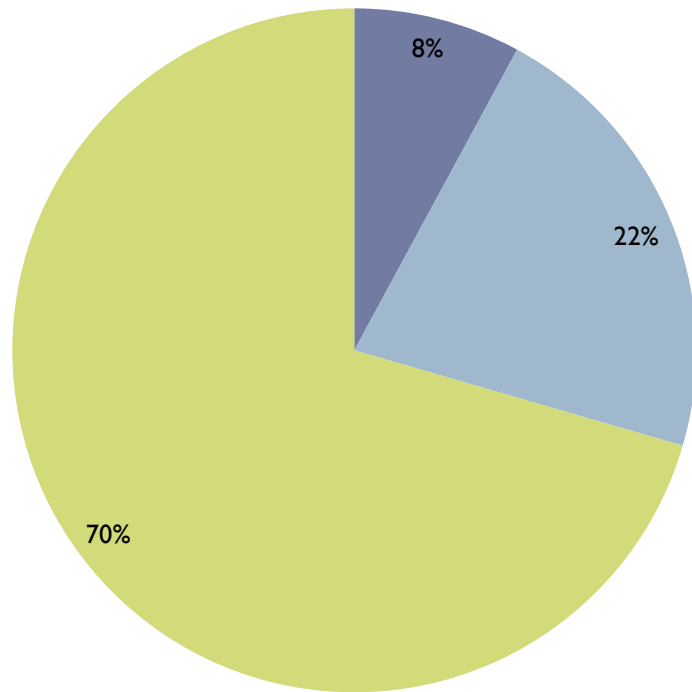
# Notes: Emerging Adult Suicide Rate

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- ▶ National rate per 100,000 is 10.6.
- ▶ Rates per 100,000 tend to be higher in states with large geographic areas and low populations.
  - ▶ Alaska: 46; Wyoming: 31.9; South Dakota: 26.9
- ▶ Rates per 100,000 tend to be lower in states in which large portions of the population is concentrated in urban/suburban areas.
  - ▶ New York: 6.6; New Jersey: 7.7; Maryland: 7.9
- ▶ RI, DE and VT cannot be included because the small population and low number of deaths render calculation of crude suicide rate per 100,000 unreliable.
- ▶ Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Sep 16, 2013 4:22:34 PM

# Rates of Past Year Mental Illness in Connecticut Residents Ages 18-26 (2010)

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- Serious Mental Illness in Past Year
- Mental Illness other than Serious Mental Illness in Past Year
- No Mental Illness Reported in Past Year

- ▶ About 30% of emerging adults report mental illness in the past year both nationally and in Connecticut.
- ▶ About  $\frac{1}{4}$  of this total, in both the U.S. and Connecticut, report serious mental illness.
- ▶ These rates are similar to those in DE, MA, MD, NJ and RI.

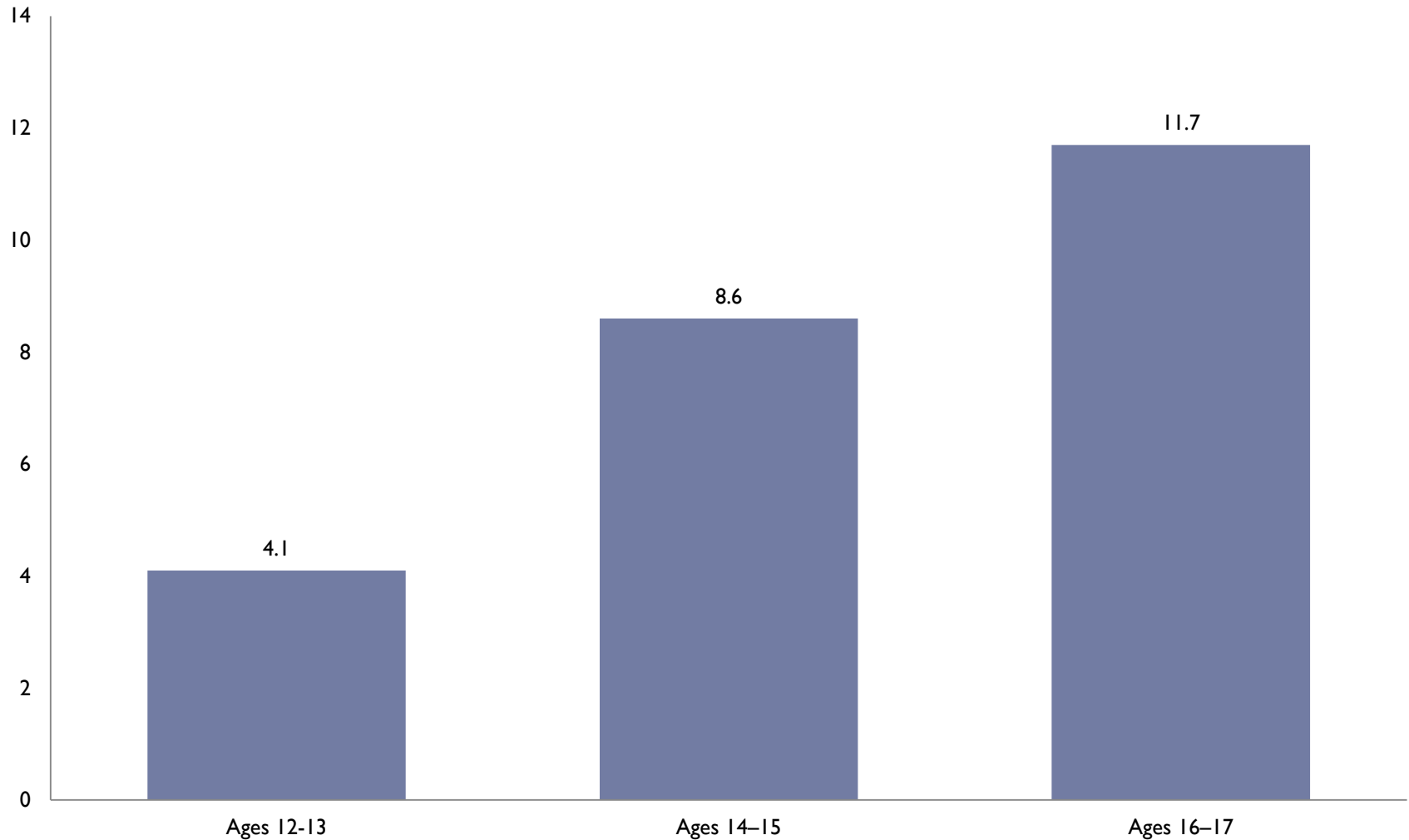
# NOTES: Past Year Mental Illness

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- ▶ Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the DSM-IV.
- ▶ Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder other than a developmental or substance use disorder that met the criteria found in the DSM-IV **and resulted in serious functional impairment.**
- ▶ Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2010 and 2011 (2010 Data – Revised March 2012).

# Percent of Adolescents by age group with one or more Major Depressive Episodes (U.S. - 2011)

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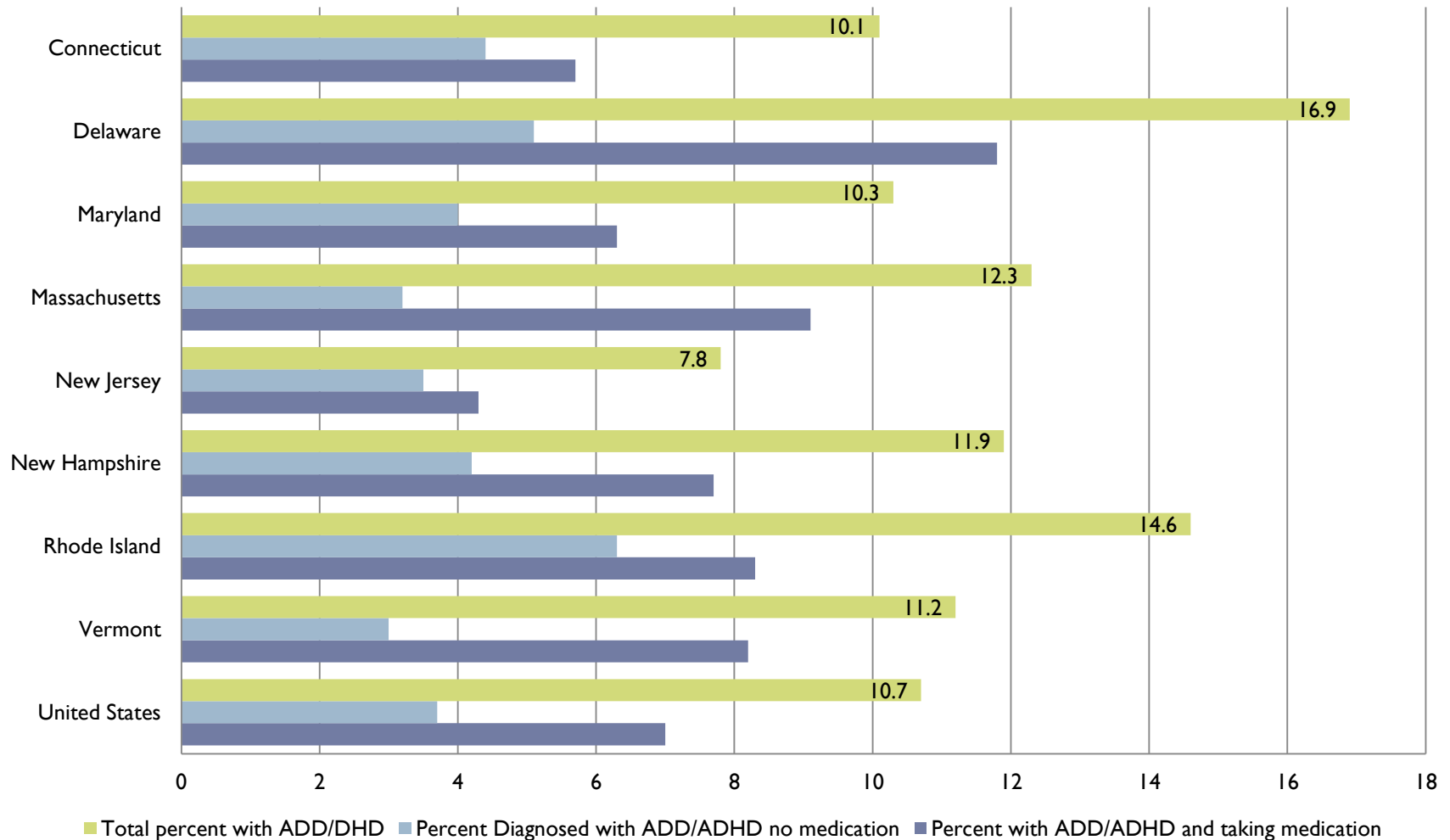


# NOTES: Major Depressive Episodes

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- ▶ \*Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had at least four additional symptoms (such as problems with sleep, eating, energy, concentration, and feelings of self-worth) as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.
- ▶ SOURCE: Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2013* (Tables 4A, 4B and 4C utilizing data from the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health).  
<http://www.childstats.gov/americaschildren/index.asp> accessed on September 18, 2013

# ADD/ADHD Rates for ages 3-17 (2011)



## NOTES: ADD/ADHD Rates

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- ▶ Source: 2011 National Survey of Children's Health data accessed through the Data Resource Center for Child & Adolescent Health on September 20, 2013



# Substantiated Child Victimization Rates, United States and Connecticut (2011)

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	Child Population (Birth through 17)	Number of unique substantiated victims	Victimization rate per 1,000
United States	73,946,999	676,569	9.1
Connecticut	803,314	10,012	12.5

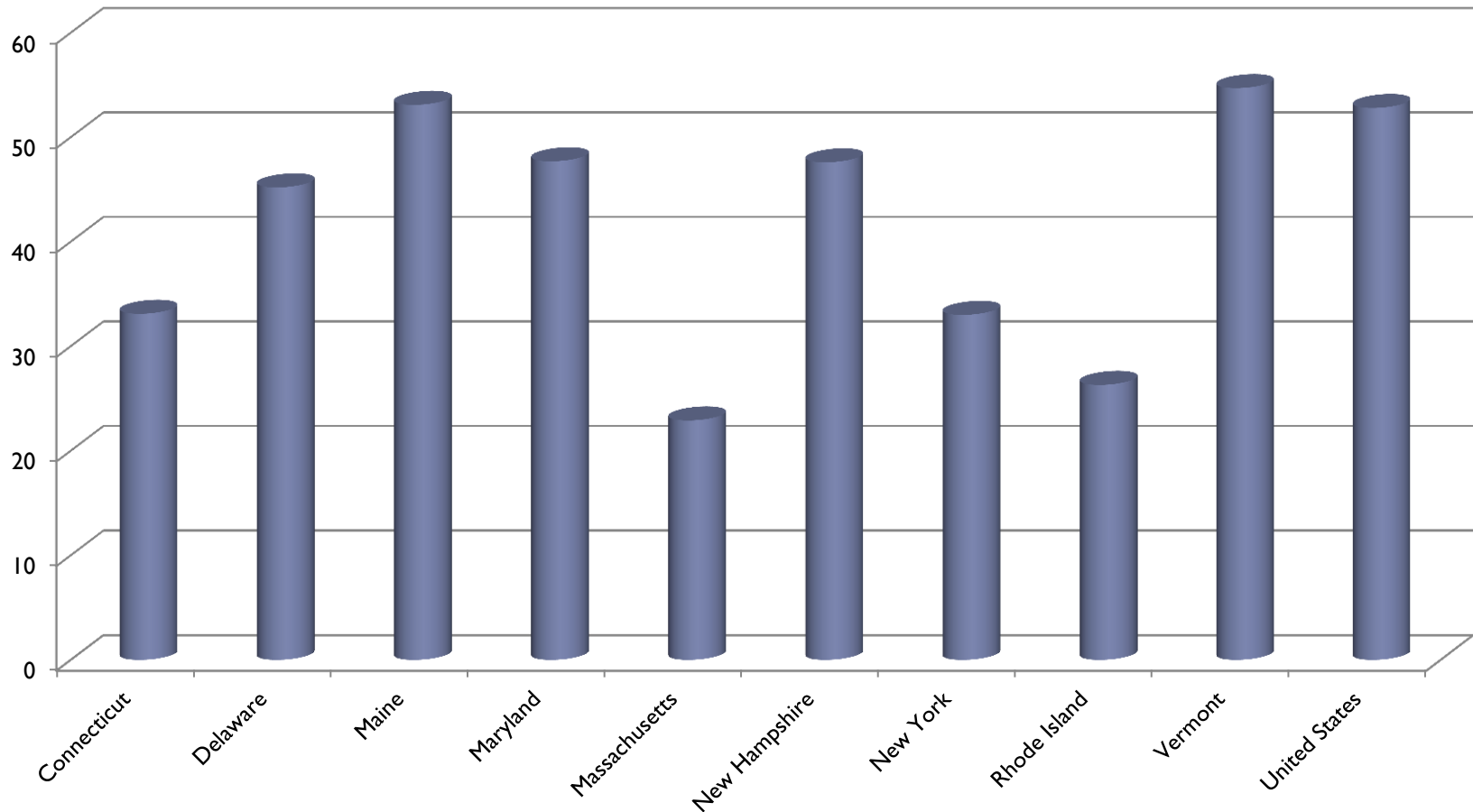
# NOTES: Child Victimization Rates

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- ▶ Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). Child Maltreatment 2011 (Tables 3-D and 3-3). Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>
- ▶ The Children's Bureau report is based on CPS substantiated abuse/neglect as reported by the states in the National Child Abuse and Neglect Data System (NCANDS).
- ▶ The National Incidence Studies of Child Abuse and Neglect (NIS-1, 2, 3 and 4), which have been provided to the U.S. Congress pursuant to legislative mandate in 1981, 1988, 1996 and 2010, have employed a broader approach, attempting to capture rates of child abuse and neglect including, but not limited to, cases in which abuse and neglect were substantiated by child protection agencies. **The NIS-4, published in 2010 and reflecting data collected in 2005-2006, estimated a rate of maltreatment of 17.1 per 1,000 nationwide.** This compared to an estimated victimization rate of 12.1 per 1,000 for federal fiscal year 2006 as reported by the Children's Bureau based on that year's NCANDS' data. The NIS-4 does not provide estimates broken down by state.

# Gun Ownership in the U.S. and Selected States by Decade

**Average Rates of Gun Ownership 2001-2010**



# NOTES: Gun Ownership

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- ▶ These percentages reflect the proxy measure of suicides using firearms as a percentage of total suicides. A discussion of the validity of this proxy measure can be found in Seigel, M, Ross, C, and King, C. (2012).
- ▶ There has been a decline in rates of gun ownership in the U.S. between the decade 1981-1990 to the decade 2001-2010. In the U.S. the decline was from 60.6% to 52.8% and in Connecticut the decline was from 42.6% to 33.1%.
- ▶ **Source:** Data from Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting Systems: Fatal Injury Reports*. As reported as Appendix A in Seigel, M, Ross, C, and King, C. The Relationship Between Gun Ownership and Firearm Homicide Rates in the United States, 1981-2010. *American Journal of Public Health*. Published online ahead of print September 12, 2013: e1-e8. Doi:10.2105/AJPH.2013.301409

# Connecticut's Adolescent Behavioral Health Work Force

Occupation/Specialty	Number	Source
Primary Care Pediatricians	1,246 (842 with no reported subspecialty)	Correspondence from DPH to PRI dated 9/16/2013 reporting data from American Board of Medical Specialties
Child & Adolescent Psychiatrists	120*  251**	*"Find a provider" resource on AACAP website  ** Correspondence from DPH to PRI dated 9/16/2013 reporting data from American Board of Medical Specialties
Developmental and Behavioral Pediatricians	11	Correspondence from Connecticut State Medical Society to Public Health Committee dated 10/2/2013
Adolescent Medicine MDs	26	Correspondence from DPH to PRI dated 9/16/2013 reporting data from American Board of Medical Specialties
Pediatric Neurologists	4	Correspondence from DPH to PRI dated 9/16/2013 reporting data from American Board of Medical Specialties
Child Psychologists (Psy.D. or Ph.D.)	1,912	Total licensed psychologists in CT per DPH – not specific to child/adolescent/young adults
Child Mental Health APRNS	Not Yet Available	

# NOTES:

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## Care accessed in follow up to ED admission for primary behavioral health diagnosis 2011 for CT Medicaid population

	Ages 0-17 (N=6,176 ED admits)		Ages 18+ (N=41,049 ED admits)	
	Number	Percent of total BH ED visits	Number	Percent of total BH ED visits
Admits to Inpatient from ED	2,377	38.5	13,814	33.7
Follow up within 7 days to intermediate level of care*	329	5.3	1,949	4.8
Follow up within 7 days to congregate care setting	354	5.7	N/A	N/A
Follow up within 7 days to home based mental health treatment	293	4.7	N/A	N/A
Follow up within 7 days to routine outpatient care	725	11.8	4,079	9.9
Follow up within 30 days to intermediate level of care*	505	8.2	3,098	7.6
Follow up within 30 days to congregate care setting	362	5.9	N/A	N/A
Follow up within 30 days to home based mental health treatment	389	6.3	N/A	N/A
Follow up within 30 days to routine outpatient care	1,110	18.0	5,888	14.3
<b>No follow up care within 30 days of ED visit</b>	<b>1,198</b>	<b>19.4</b>	<b>15,504</b>	<b>37.8</b>

\*Access to an intermediate level of follow up care was determined based on the presence of a paid claim for PHP, IOP or EDT service within the applicable time frame. For the 0-17 population only, intermediate level of care is separate from return or new admission to a congregate care setting for which Medicaid paid a claim (group homes, residential treatment) and/or home based care which is presumably IICAPS, FST, MDFT, etc.

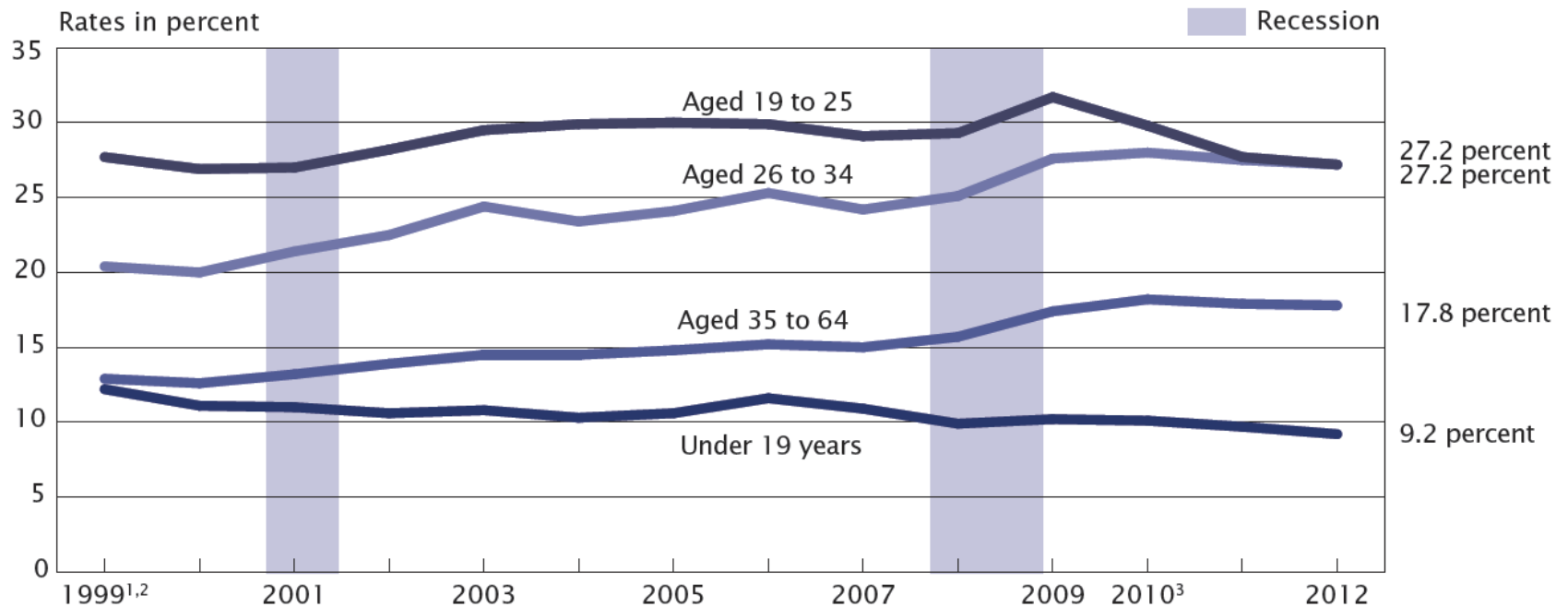
# NOTES: Post-ED Visit Follow-Up MH Care

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- ▶ This data was provided by Program Review & Investigations in connection with its current study on Emergency Department utilization and costs for Medicaid users.
- ▶ In terms of the difference between intermediate level of care, congregate care, and home based mental health treatment for the under 18 and 18+ populations, only the first of these categories (follow up to intermediate level of care) is tracked for the 18+ population. Thus, the 4.8% of 18+ year olds receiving intermediate level of care within 7 days can be contrasted to the 15.7% of those ages 0-17 receiving any of those three types of post-ED services within that time frame and the 7.6% of 18+ years olds receiving intermediate level of care within 30 days can be contrasted to the 20.4% of those under age 18 who receive any of those services.



# Uninsured Rates by Age 1999-2012 (U.S.)



U.S. Census Bureau, Current Population Reports, P60-245, Figure 9 from *Income, Poverty, and Health Insurance Coverage in the United States: 2012*.

## NOTES: Uninsured Rates 1999-2012 (U.S.)

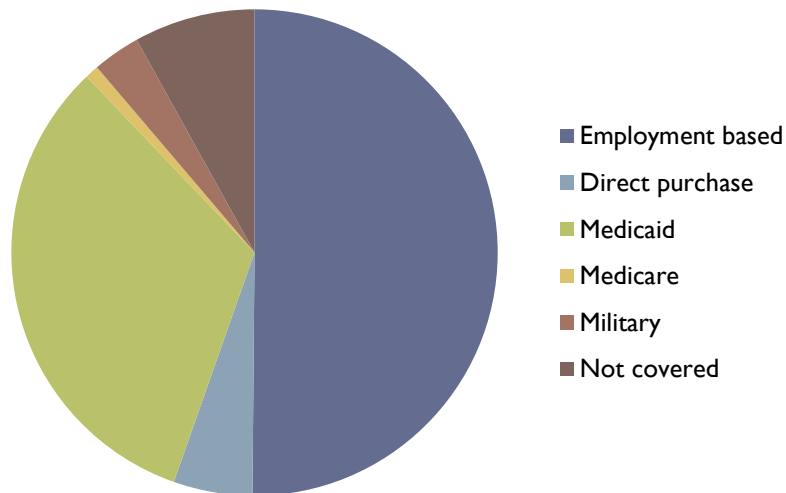
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- ▶ DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-245, *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Government Printing Office, Washington, DC, 2013.

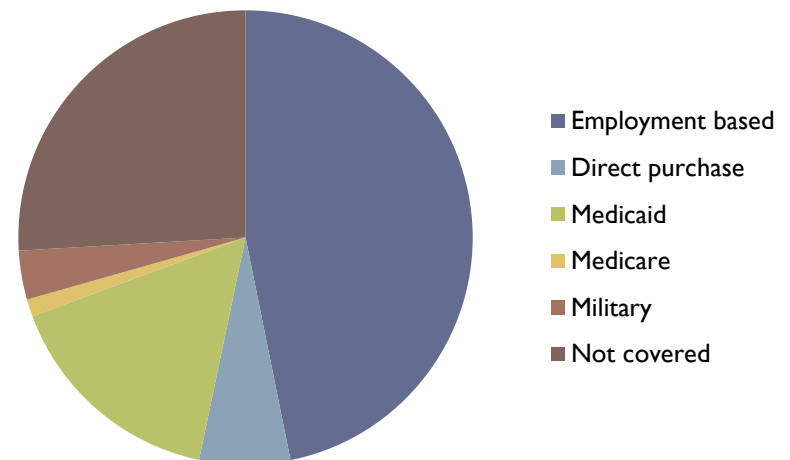
# 2012 Type of Health Insurance Coverage (U.S.)

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## Population Under Age 18: Type of Health Insurance Coverage



## Population Ages 18 through 24: Type of Health Insurance Coverage



# NOTES: Type of Health Coverage

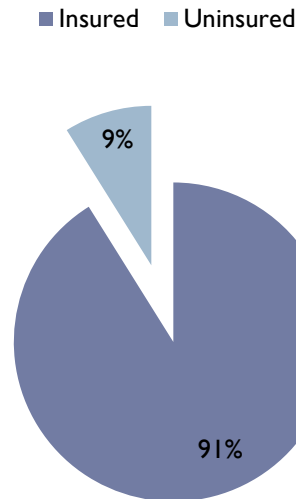
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- ▶ The data regarding percent of individuals with each type of coverage for these pie charts is taken from Table C-3 in U.S. Census Bureau, *Current Population Reports, P60-245, Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Government Printing Office, Washington, DC, 2013. For those under age 18, total percentages summed to 110.5% (presumably because some insured individuals have more than one type of coverage). For individuals aged 18-24 total percentages summed to 97.6%. Thus, although these charts are helpful for understanding the shift in type of health insurance coverage between these two age groups, particularly the decrease in the percent covered by Medicaid and the increase in the percent uninsured, they should not be relied upon as reflecting accurate percentages of uninsured as compared to insured individuals. That is done on the next slide.

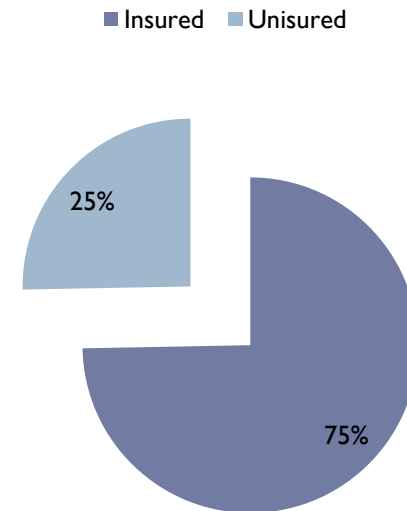
# Comparison of Insured to Uninsured 2012 (U.S.)

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## Percentages of Population Under Age 18 with and without Health Insurance Coverage



## Percentages of Population Aged 18-24 with and without Health Insurance Coverage



# NOTES: Rates of Insured vs. Uninsured

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- ▶ Source: DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-245, *Income, Poverty, and Health Insurance Coverage in the United States: 2012* (Table C-3), U.S. Government Printing Office, Washington, DC, 2013.

# COSTS OF BEHAVIORAL HEALTH IN CONNECTICUT

A Rough Estimation

# What should be measured?

Table 1. The overall economic burden of mental disorders

	Care costs	Productivity costs	Other costs
Sufferers	Treatment and service fees/payments	Work disability; lost earnings	Anguish/suffering; treatment side-effects; suicide
Family and friends	Informal care-giving	Time off work	Anguish; isolation; stigma
Employers	Contributions to treatment and care	Reduced productivity	–
Society	Provision of mental health care and general medical care (taxation/insurance)	Reduced productivity	Loss of lives; untreated illnesses (unmet needs); social exclusion

Source: World Health Organization (2003). *Investing in Mental Health*. Geneva. Accessed online October 28, 2013 at [http://www.who.int/mental\\_health/media/investing\\_mnh.pdf](http://www.who.int/mental_health/media/investing_mnh.pdf)



# What can be measured?

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Table 2. Types of measurable costs

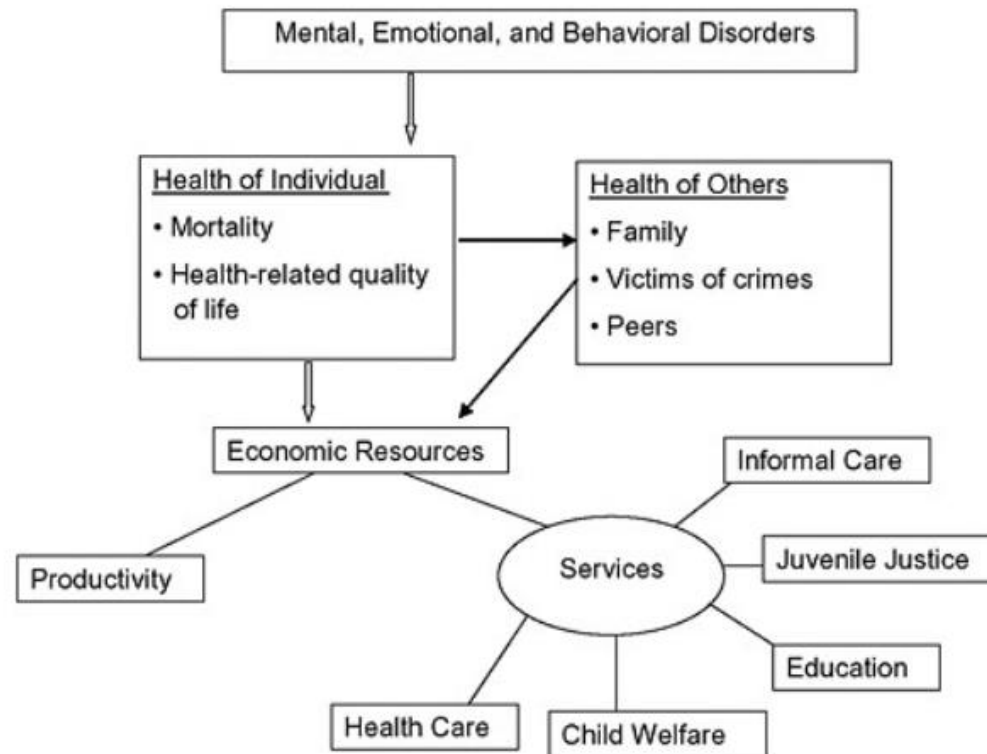
	Core costs	Other non-health costs
Direct costs (payments made)	<ul style="list-style-type: none"><li>• Treatment and service fees/payments</li></ul>	<ul style="list-style-type: none"><li>• Social welfare administration</li><li>• Public and private criminal justice system</li><li>• Transportation</li></ul>
Indirect costs (resources lost)	<ul style="list-style-type: none"><li>• Morbidity costs (in terms of value of lost productivity)</li><li>• Mortality costs</li></ul>	<ul style="list-style-type: none"><li>• Value of family caregivers' time</li></ul>

Source: World Health Organization (2003). *Investing in Mental Health*. Geneva. Accessed online October 28, 2013 at [http://www.who.int/mental\\_health/media/investing\\_mnh.pdf](http://www.who.int/mental_health/media/investing_mnh.pdf)

## How to visualize range and distribution of costs?

Although outcomes of most interest are likely health and productivity, these are most difficult to quantify.

Focusing on population aged 0-25, approach taken by Eisenberg & Neighbors for IOM was to estimate service costs, and add in health, productivity and crime costs by diagnostic category.



Source: National Research Council and Institute of Medicine. (2009). Benefits and Costs of Prevention, Chapter 9 in *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

# 2007 IOM National Estimate of Direct Costs: **\$45 Billion**

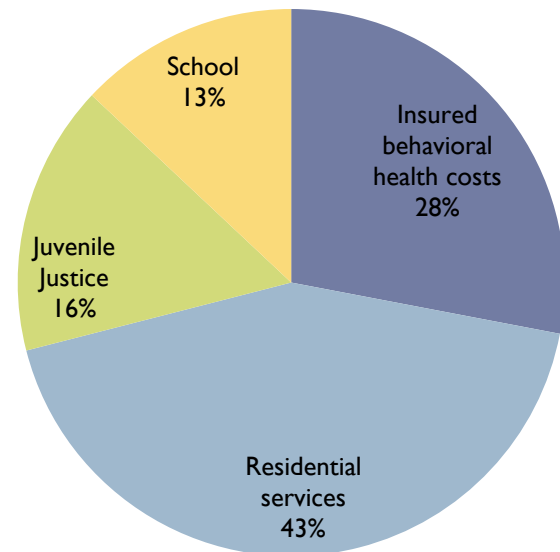
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- ▶ Eisenberg & Neighbors started with a 1998 estimate prepared by Ringel & Sturm for the NIMH using 1998 data, that included only direct and insured costs of behavioral health care for individuals 0-17 (\$11.7 billion)
- ▶ Increased estimate to reflect:
  - ▶ Inclusion of ages 18 through 24
  - ▶ Increase in population between 1998 and 2007
  - ▶ Conversion from 1998 to 2007 dollars ( ≈ \$22.5 billion)
- ▶ Multiplied by 2 to reflect costs outside of direct insured behavioral health care costs (juvenile justice, school, residential, etc...) (\$45 billion)

# Justification for IOM Estimate 2x Multiplier

- ▶ Mental health costs as covered by insurers reflect only a portion of total mental health costs.
- ▶ Costello, Copeland, Cowell & Keeler (2007) found this portion was less than 1/3 of total mental health costs across systems.

Proportional costs by type of service for 13-16 year olds with behavioral health diagnoses in western North Carolina 1993-2000

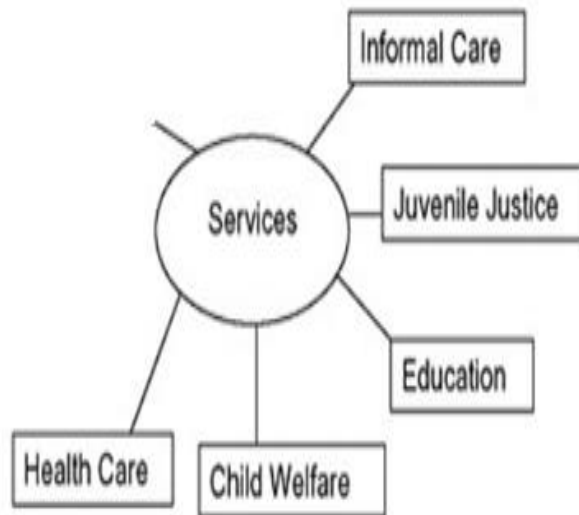


Source: Costello, E.J., Copeland, W., Cowell, A., Keeler, G. (2007) Service costs of caring for adolescents with mental illness in a rural community, 1993-2000. American Journal of Psychiatry, Volume 164, pages 36-42 (January 2007). Accessed on line November 1, 2013 at <http://ajp.psychiatryonline.org/data/Journals/AJP/3791/07aj0036.PDF>

# Apply IOM Methodology to Connecticut

Convert to 2012 USD\$ and apply to Connecticut's 0-25 population

Use IOM's \$45 Billion

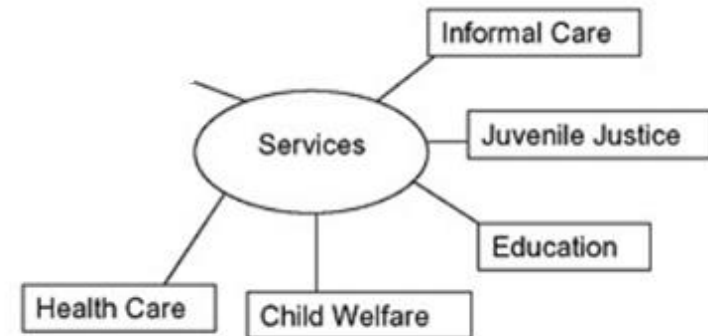


- ▶  $\$45 \text{ billion} / 104,000,000$  population aged 0-25 in 2007 = \$432 per person per year
  - ▶ Adjust to 2012 USD\$ (\$466)
  - ▶ Multiply by Connecticut 0-25 population in 2012 ( $\approx 1,130,000$ )
- ▶  $\$466 * 1,130,000 = \$526 \text{ million}$

# Direct Connecticut Expenditure Approach

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- ▶ Can we get better data to flush out economic costs for state of Connecticut?
- ▶ Behavioral Health Care/Related Living Expenses/  
Child Welfare
- ▶ Juvenile and Adult Justice System
- ▶ Education



# Direct Behavioral Health Care Costs Estimate Components

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- ▶ Privately insured behavioral health expenses
- ▶ Publicly insured behavioral health expenses
- ▶ Behavioral health services provided by DCF
- ▶ Behavioral health services provided by DMHAS

Will include residential costs for those not living at home.

## Private Insurance Behavioral Health Expenditures

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- ▶ According to the Consumer Report Card for calendar year 2012, the mean cost per member per month for inpatient and outpatient mental health and substance abuse services (including both HMOs and IMCCs) was \$10.35 per month.
- ▶ Assuming 60% of the 0-25 population is covered by private insurance and that the \$10.35 per member per month is a reasonable estimate for the entire 60%, private insurance expenses for just in- and out-patient mental health and substance abuse services are \$84.2 million.



# Connecticut BHP Expenditures

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- ▶ Per Value Options presentation on 9/11/2013 there were 165,588 Medicaid subscribers ages 13-24 in 2011.
- ▶ Per 2009 Annual Report by BHP to the BHP Oversight Council in December 2010, the average Per Member Per Month cost was \$36.26.
- ▶ This yields Per Member Per Year cost of \$435
- ▶ Multiplied by 173,353 subscribers yields \$75.4 million

# Connecticut DCF Expenditures

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Department of Children and Families	
Summary By Account	2012
Board & Care For Children Res	\$169,013,481.00
CMHS Block Grant	\$1,160,043.08
DCF Grant to Mental Hlth Clin	\$60,998.87
Gr Psychiatric Clin For Chldrn	\$13,920,319.00
Local Systems Of Care	\$2,009,252.83
Mental Health Srvcs Info Syst	\$21,003.56
MultiDimenFamTher CSSD Grant	\$515,560.00
Short Term Res Treatment	\$713,129.00
<b>Total</b>	<b>\$192,726,199.47</b>

# Connecticut DMHAS Expenditures

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- ▶ DMHAS spends about \$34 million per year on Young Adult Services (YAS).
- ▶ BUT only 5% of all 18-25 year olds receiving DMHAS services are in YAS (and thus less than 1% of the DMHAS population is served by YAS), there are many more services being provided to emerging adults by DMHAS.
- ▶ These include other Mental Health Services, Substance Abuse Services, Forensic Services or a combination.
- ▶ A rough computation would be to take total DMHAS expenditures of \$766,366,727.42 for fiscal 2012 and multiplying it by 16.8% reflecting the percentage of DMHAS clients who are ages 18-25.
- ▶ This yields an estimate of \$128,749,610 expended by DMHAS to serve this age group.

# Estimating Justice Expenditures to Provide Behavioral Health Services

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- ▶ The challenges to estimating justice system expenditures:
  - ▶ Cannot say that any individual would not have been arrested/incarcerated “but for” his or her behavioral health needs.
  - ▶ There clearly are individuals who might not be arrested/incarcerated if their behavioral health issues were being addressed.
  - ▶ Swanson, et al. (2013)
    - utilizing 2006-2007 data from CT Medicaid, and the Judicial, Corrections and Public Safety Departments
    - find that among DMHAS clients with schizophrenia or bipolar disorder approximately 1/4 also have criminal justice involvement
    - the total average annual cost of care for a dually involved individual is over \$48,980 as compared to \$24,728 for individuals not involved in the justice system
- ▶ Estimates here are flawed, little more than a placeholder, but reflect importance of this expenditure category.

# Judicial and Corrections: Direct Behavioral Health Expenditures for those under age 25

Item	Actual Expenditures	Multiplier	Total
Judicial Forensic Sex Evidence Exams	909,036.15	.24	\$218,169
Judicial Juvenile Alt Incarceration	28,264,796.79	.60	\$16,958,878
Judicial Juvenile Justice Centers	3,104,877.00	.60	\$1,862,926
Judicial Youthful Offender Status	8,718,151.00	.60	\$5,230,891
Corrections Addiction Services	5,533,914.10	.21	\$1,162,122
Corrections Counselor Services/Other Facilities	12,942,908.70	.21	\$2,718,011
Corrections Counselor Services/Manson	1,104,196.24	1.0	\$1,104,196
<b>TOTAL</b>			<b>\$29,255,193</b>

# Direct Special Education Costs for Those Identified as Emotionally Disturbed

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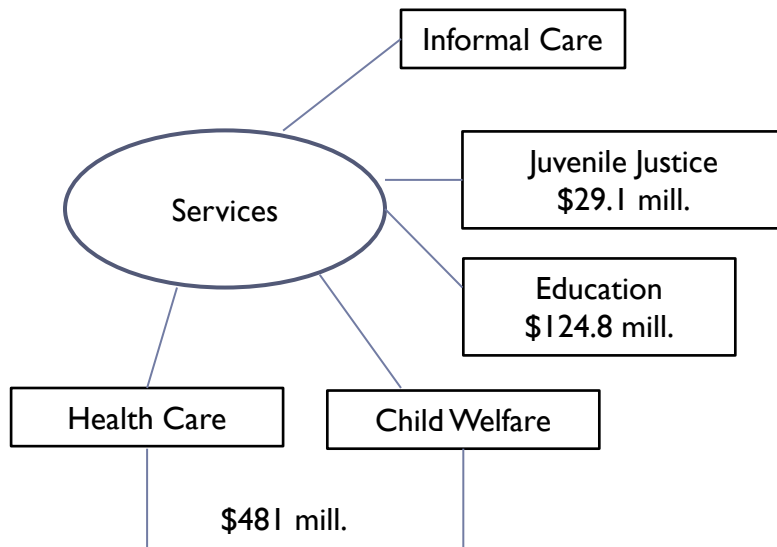
- ▶ Using publically accessible CEDAR data for special education for 2008-2009
  - ▶ Total spending on public education= \$7.5 billion
  - ▶ Total spending on special education = \$1.56 billion (≈20% of total)
  - ▶ Total number of students = 565,817
  - ▶ Total number of students with disabilities = 68,853 (≈12% of total)
  - ▶ Percentage of all students with disabilities receiving services under label emotional disturbance = 8.1% (≈ 5,577 students ≈1% of all students)
  - ▶  $\$1,560,000,000 * .08 = 124,800,000$  or \$124.8 million

# Estimated Connecticut Expenditures for Behavioral Health for Ages 0-25 - 2012

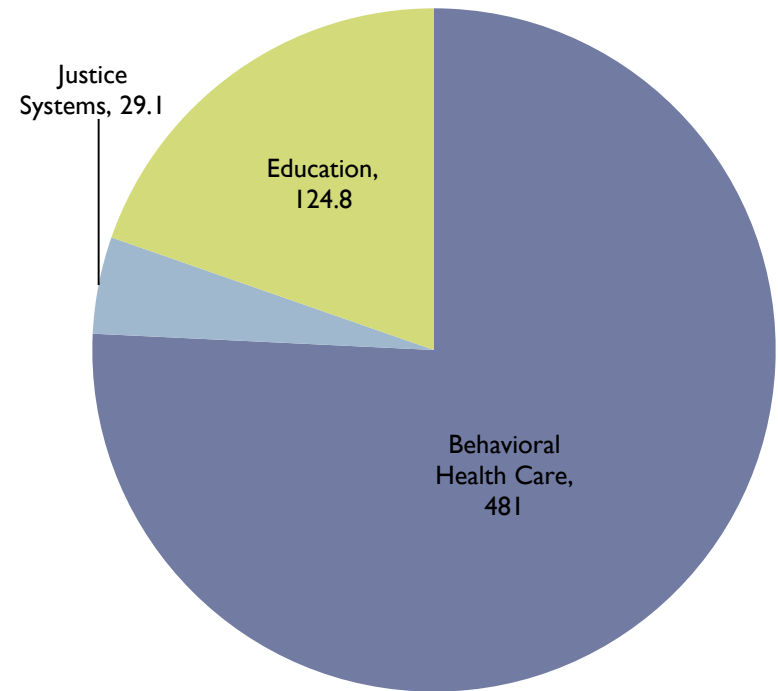
SUMMARY OF ESTIMATED CONNECTICUT COSTS OF BEHAVIORAL HEALTH FOR AGES 0-25		
Behavioral Health Care and Related Living Expenses = \$481 million		Expenditures in millions
	Privately Insured BH Services (ages 0-25) (2012)	\$84.2
	Medicaid BH Services (ages 13-24 only) (2009 PMPM estimates)	\$75.4
	DCF Provided BH Services (2012)	\$192.7
	DMHAS Services (2012)	\$128.7
Justice System Costs = \$29.1 million		
	DOC (2012)	\$4.9
	Judicial (2012)	\$24.2
Special Education Costs = \$124.8 million		
	Special Education for ED Category (2008-2009 school year)	\$124.8
TOTAL		\$635

# Two Illustrations of \$635 Million Estimate

## IOM Graphic



## Pie Chart



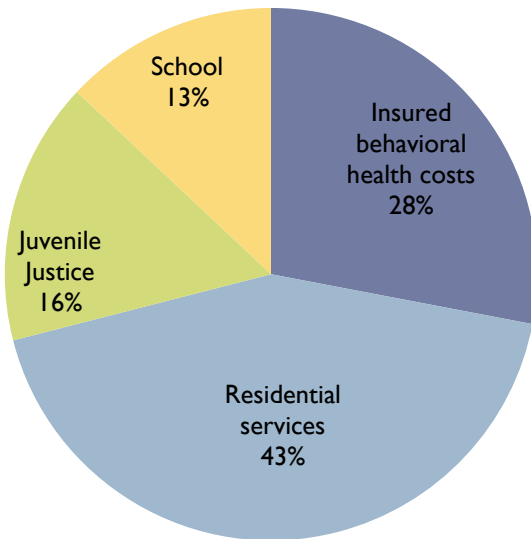


# Comparison of CT Proportional Estimates to NC Study Estimates

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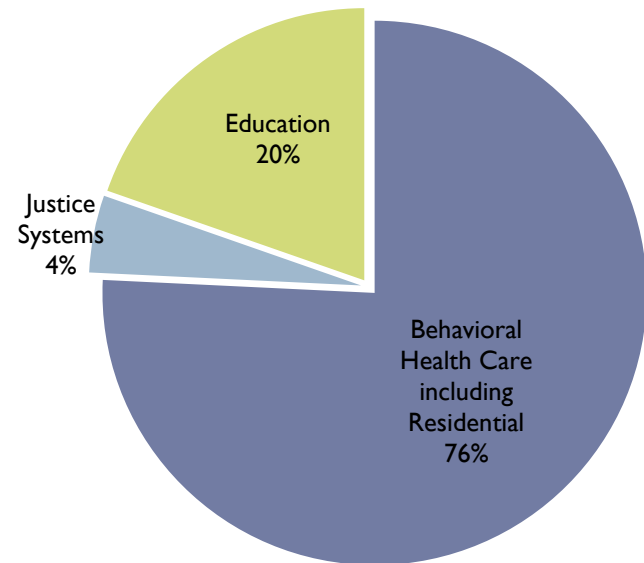
## Western North Carolina

**Proportional costs by type of service for 13-16 year olds with behavioral health diagnoses in western North Carolina 1993-2000**



## Connecticut

**Proportional costs by type of service for 0-25 year olds receiving direct behavioral health services 2012**



# POSSIBLE ESTIMATES

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- ▶ Limiting estimate to expenditures to those for direct behavioral health services (by private insurers, CTBHP, DCF and DMHAS):
  - ▶ \$481 million
- ▶ Updating IOM 2007 estimate and applying it to Connecticut:
  - ▶ \$526 million
- ▶ Including estimated justice and education system expenditures:
  - ▶ \$635 million

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# A Rough Estimate: Direct Behavioral Health Costs for Ages 0-25 in Connecticut in 2012

\$526,000,000



## **APPENDIX C**

### **Task Force to Study the Provision of Behavioral Health Services for Young Adults Presentations**

#### **September 11, 2014: Presentations**

1. Program Review & Investigations Committee: *Carrie Vibert, Director; Janelle Stevens, Principal Analyst*
2. Department of Mental Health & Addiction Services: *Cheryl Jacques, Director, Young Adult Services Program*
3. Connecticut Judicial Branch: *Catherine Foley-Geib, Manager, Clinical & Educational Services and Barbara Lanza, Program Manager, Court Support Services Division*
4. Department of Children & Families: *Robert McKeagney, Administrator, Clinical and Community Services; Tim Marshall, Clinical Director, Community Behavioral Health*
5. Behavioral Health Partnership/ValueOptions, Inc.: *Lori Szczygiel, Chief Executive Officer and Laurie Van der Heide, ValueOptions, Inc. Connecticut*
6. Child Health and Development Institute of Connecticut: *Judith Meyers, President and CEO*

#### **October 8, 2014: Presentations**

1. State Department of Education: *Scott Newgass*
2. Connecticut Association of Health Plans: *Susan Halpin*
3. Connecticut Chapter American Academy of Pediatrics: *Sandra Carbonari, MD*  
Connecticut Council of Child & Adolescent Psychiatry: *Laine Taylor, DO*