

The Connecticut General Assembly

Task Force To Study The Provision Of Behavioral Health Services For Young Adults

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MEETING SUMMARY AND NOTES

TASK FORCE TO STUDY THE PROVISION OF BEHAVIORAL HEALTH SERVICES FOR YOUNG ADULTS (16-25 YEARS OLD)

Submitted by Task Force Co-Chairs: Daniel Connor and Sheryl Ryan

September 11, 2013

Members present: Daniel Connor, M.D.; Sheryl Ryan, M.D.; Aura Ardon, M.D.; Marcy Kane, Ph.D.; Judge Robert Killian, Jr.; Sarah Eagan; Katharine Kranz Lewis, Ph.D.; Tim Marshall; Scott Newgass, LCSW; Ted Pappas, M.A.; Kelly Phenix, Ashley Saunders; Laura Tordenti, Ed.D.; Cara Lynn Westcott

Members Absent: Stacey Adams, Anton Alerte, M.D.; Anne Melissa Dowling; Patricia Rehmer, MSN; Victoria Veltri, JD., LLM

Others present: Jill Hall, representing Victoria Veltri, JD, LLM; Cheryl Jacques, representing Patricia Rehmer, MSN

The Young Adult TF received presentations on the following:

1. The CT Program Review & Investigations Committee (Carrie Vibert and Janelle Stevens)
 - a. Report on adolescent and young adult substance use screening, intervention, and treatment in Connecticut.
 - i. Need for screening
 - ii. Need for provider training and education

- b. Gaps in private commercial mental health insurance coverage for adolescents and young adults in Connecticut
 - i. Coverage for evidence-based services: (e.g. MDFT)
 - ii. In-home services
 - 1. To what extent are youths who have commercial mental health insurance using in-home services paid for by DCF?
 - iii. Case management services
 - iv. Supervised living services
 - v. Long-term residential treatment services (> 4 weeks)
 - vi. Lack of information on In-service versus Out-of-Network coverage
 - c. Adolescent and young adult MH provider capacity
 - i. Shortage of child & adolescent psychiatrists resulting in diminished access and long wait times for services
 - 1. ACCESS MH Connecticut-CAP-Peds consult model. On-line Winter 2014
 - 2. State Urgent Care Center?? No action as of yet.
2. Department of Mental Health and Addictions Services (DMHAS): Report of Young Adult Services (Cheryl Jacques)
- a. Population characteristics
 - i. Normal difficulties of adolescence
 - ii. Early deprivation and out-of-home placement during developing years
 - iii. Emergent mental illness
 - iv. Developmental disorders: Autism, Learning Disability (LD), Attention Deficit Hyperactivity Disorder (ADHD)
 - v. Complex psychiatric illness
 - vi. Sexual behavior problems
 - vii. Trauma and Post Traumatic Stress Disorder (PTSD)
 - viii. Legal involvement

- b. Service Delivery
 - i. Multiple services provided
 - c. Outcomes (provided):
 - i. 37% achieve independent living in school/occupation after DMHAS young adult treatment.
 - ii. 2% incarcerated
 - iii. 40%-45% continue in some way with DMHAS
3. Connecticut Judicial Branch (Catherine Foley-Geib and Barbara Lanza)
- a. Population characteristics
 - i. 70% of juvenile detainees in CT have a diagnosable MH disorder
 - 1. ADHD
 - 2. Depression
 - 3. PTSD and exposure to developmental traumatic stress
 - ii. High rates of substance misuse in juvenile detainees in CT.
 - iii. Complex psychiatric disorders in juvenile detainees.
 - iv. Unclear data on 18-25 year-old detainees.
 - b. Service delivery
 - i. Multiple services provided
4. Department of Children & Families (Robert McKeagney and Tim Marshall)
- a. Implementation of PA 13-178
 - i. The Young Adult Behavioral TF should work with DCF as PA 13-178 is implemented
 - b. Service delivery
 - i. Multiple services provided
 - c. Outcomes
 - i. Reportedly, a sophisticated outcomes methodology is in place at DCF-details unclear.
5. Behavioral Health Partnership/ValueOptions, Inc. (Lori Szczygiel and Laurie Van der Heide)

- a. Report on the Legislative Task Force on MH Service Utilization of Medicaid Youth Aged 13-24 (For Medicaid enrolled youth only)
 - i. 20% of youth 13-24 enrolled in Medicaid access MH care on a yearly basis
 - ii. 8-9% of all ED visits are for MH in this age range
 - iii. Over the past 10 years for Medicaid enrolled youth in this age-range
 - 1. Number of inpatient psychiatry beds have roughly doubled
 - 2. Lengths of inpatient psychiatry days have decreased. Result is shorter wait times for psychiatry beds.
 - 3. Day treatment capacity for 13-24 year-olds has grown in CT over the past decade.
- 6. Child Health and Development Institute of Connecticut (Judith Meyers)
 - a. Over the past decade MH services for children and adolescents have become more robust in Connecticut.
 - b. Report of CHDI initiatives:
 - i. Child psychiatry-primary pediatric care co-management initiative and toolkit
 - ii. Trauma network evidence-based training initiative

Committee Discussion

- 1. Need to define Committee working structure:
 - a. Agreed to meet every 2 weeks. Day will have to change. Beverley to Doodle membership for new day and time.
 - b. Need to condense the 13 Committee charges down to a manageable number.
 - c. For now, it appears that the Committee has decided to continue to work as a whole group, and not break up into sub-groups that report back to the Committee.
- 2. Domains of Committee Consensus:
 - a. Need to identify existing programmatic areas of excellence, identify what specific programs do that are excellent, and scale up to a state-wide level. Do not reinvent the wheel.
 - i. Service delivery

- ii. Quality Assurance
 - iii. Outcomes methodology that informs programmatic planning and structure
 - iv. High risk populations
- b. Need more Child & Adolescent Psychiatry providers
 - c. Need to hear from the private commercial MH insurance industry about what they offer in the care of MH needs in the 16-25 yo population.
 - d. Need to incentivize approaches to de-fragment the existing MH system and facilitate communication across educational, institutional, outpatient, and pediatric providers. Relevant and important patient MH care information must flow more freely to providers to facilitate personalized MH care. New models of payment structure needed to facilitate this.
 - e. Should DCF and DMHAS work more collaboratively to develop policies/procedures that facilitate and help bridge the transition of care from the pediatric age range to the young adult age range?
 - f. Should ACCESS MH CT be expanded (increased funding) to include 18 to 25 year-olds?
 - g. How should MH Barriers-to-Care be addressed?
 - h. The Committee needs to hear more about existing school-based health and mental health care initiatives in Connecticut.

3. Domains of Committee Non-Consensus:

- a. Should we discuss Outpatient MH Involuntary Treatment?

Next Task Force Meeting: to be decided upon in two weeks