Staff Findings
and Recommendations

# Access to Substance Use Treatment for Insured Youth: Phase II

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Legislative Program Review
& Investigations Committee

CONNECTICUT GENERAL ASSEMBLY

Committee Staff on Project

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# PRI Staff Report Highlights

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## Background

In April 2012, the program review committee authorized a study to assess insurer coverage and enrollee utilization of substance use treatment. In addition, the project aims to examine availability of those treatment services. The study is limited to youth ages 12-25 who have private (i.e., commercial) or Medicaid insurance.

In Connecticut, about 7% of youth ages 12-17 and 21% of those ages 18-25 have met the clinical criteria for abuse or dependence on alcohol or an illicit drug within the past year, according to a recent federal survey. Research estimates indicate a substantial portion of those needing treatment do not receive it, perhaps partly due to insurance coverage and capacity issues.

Commercial health plans that are fully insured generally are regulated by the state, while self-insured plans (in which the employer assumes the financial risk of coverage) and Medicaid are subject to federal oversight. Plan coverage of substance use treatment is affected by both federal and state mental health parity laws.

A Connecticut resident with a health plan coverage complaint may seek assistance from the state's insurance department, Office of the Healthcare Advocate, and/or Office of the Attorney General. If the plan is self-insured or a government plan, certain federal or state agencies may be more appropriate venues for grievances.

This report, which focuses on treatment services capacity and overarching issues, is based on: interviews with staff from multiple state agencies and offices, advocates, treatment providers, and researchers; review of state and federal laws, as well as literature on substance use treatment; and treatment provider and college counseling center survey results.

An earlier report, approved by the committee in December 2012, involved utilization review, mental health parity laws, and state oversight and consumer assistance.

## Main Staff Findings

**There has been little lasting attention to improving access to substance use treatment for people outside the state service system**. A cross-agency council has focused mainly on policies affecting state clients, and there have not been strong laws regarding commercial insurers' behavioral health (substance use and mental health) provider network adequacy.

**Screening youth for behavioral health problems by medical providers appears to be done on a limited basis, for multiple reasons**. Screening can help connect people to needed treatment early on.

**Several substance use treatment locators exist, but they are sub-optimal**. There are some inconsistencies, and more problematically, there is no information on availability and insufficient detail on insurance acceptance.

**Multiple evaluations have found substantial waits for inpatient, residential, in-home, and outpatient counseling behavioral health treatment**. Hospitals are burdened by an increasing volume of behavioral health (substance use and mental health) needs, and the wait for adolescent in-home evidence-based models is especially long. Substance use treatment needs to be available promptly.

**Age-appropriate services appear to be lacking**. Some data indicate the youth who do receive treatment are not served by age-specific services. Recovery supports could help sustain treatment gains but there are few available to Connecticut youth. Age appropriateness helps treatment be maximally effective.

## PRI Staff Recommendations

**Several recommendations are made with the overall goal of improving insured youth's access to appropriate treatment**. This is a critical goal because substance use has tremendous costs to society, families, and individuals. It can and does result in direct and indirect cost-shifting from the private to public sector.

This report's recommendations aim to:

1. **Improve people's ability to find treatment**, by directing people to a single useful treatment locator, easing capacity problems (see below), and taking steps to develop a behavioral health urgent care center
2. **Ensure youth receive and benefit from needed, appropriate treatment**, by asking state agencies to work with all youth treatment providers, establishing a behavioral health consultation phone line for primary care providers - in part to encourage screening, and moving forward with an initiative to establish youth-specific recovery supports
3. **Increase attention to substance use treatment access**, by requiring commercial insurers to submit an access plan and assigning general oversight of access to care to a cross-agency entity that includes treatment providers and people in recovery

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# Acronyms

| | |
|---|---|
| ACA | Patient Protection and Affordable Care Act of 2010 |
| ADPC | Alcohol and Drug Policy Council |
| BHP | Behavioral Health Partnership |
| CBT | Cognitive Behavioral Therapy |
| CID | Connecticut Insurance Department |
| DCF | Department of Children & Families |
| DMHAS | Department of Mental Health and Addiction Services |
| DPH | Department of Public Health |
| FFT | Functional Family Therapy |
| HMO | Health Maintenance Organization |
| IICAPS | Intensive In-Home Child and Adolescent Psychiatric Services |
| MCO | Managed Care Organization |
| MDFT | Multidimensional Family Therapy |
| MST | Multisystemic Family Therapy |
| NAIC | National Association of Insurance Commissioners |
| N-SSATS | National Survey of Substance Abuse Treatment Services |
| NCQA | National Committee for Quality Assurance |
| NSDUH | National Survey on Drug Use and Health |
| OHA | Office of the Healthcare Advocate |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| URAC | Formerly known as the Utilization Review Accreditation Commission |

# Introduction

## Access to Substance Use Treatment for Insured Youth: Phase II

In Connecticut, about one in 13 adolescents (ages 12 through 17) and one in five young adults (18 through 25) have abused or become dependent on alcohol or an illicit drug within the past year, according to a recent estimate. These youth, who are said to have a substance use disorder, can enter into a range of treatments and settings. However, less than 13 percent of youth needing treatment for a substance use disorder have received care from a licensed treatment provider – and only four percent of those needing treatment for a substance use disorder involving alcohol have received it.[1]

There are many potential reasons for this treatment gap, including a person's denial that a problem exists, under-detection of the disorder by healthcare professionals, the social stigma surrounding substance use, and difficulty accessing care even when someone is seeking treatment. [2]

**Study focus**. The Legislative Program Review and Investigations Committee (PRI) sought to examine access to substance use care, focusing on accessibility for youth with either private (i.e., commercial) or public insurance, through a study authorized in April 2012. The public insurance component of the study is limited to the state's Medicaid program for mental health and substance use services (the Behavioral Health Partnership), while the commercial insurance aspect is restricted to fully-insured plans.[3] (Self-insured health plans are not governed by state law.)[4]

Phase II of the study focused on determining whether Connecticut's youth substance use treatment system capacity is sufficient. In undertaking the assessment, it became clear that capacity is affected by a variety of factors. This report addresses those factors as well as capacity by evaluating the ability of Connecticut youth to access available, appropriate treatment at an early stage of problematic substance use. In addition, the roles of various state agencies and councils that can influence access to substance use treatment were examined.

An earlier report, which reviewed and made recommendations concerning Connecticut's agencies and laws involved in regulating or contesting health insurance plan offerings and decisions, was approved by the program review committee in December 2012.

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[1] National Survey on Drug Use and Health (NSDUH) 2010-2011 State Estimates. See Appendix A for more information on youth and adolescent substance use disorder prevalence and treatment received.

[2] "Access to Treatment for Adolescents with Substance Use and Co-Occurring Disorders: Challenges and Opportunities," Stacy Sterling, Constance Weisner, Agatha Hinman, and Sujaya Parthasarathy, *Journal of the American Academy of Child & Adolescent Psychiatry 49*(7): 637-646, July 2010.

[3] A fully-insured plan is one whose financial risk is borne by a health insurer (instead of by the employer).

[4] The U.S. Department of Labor, the U.S. Department of Health and Human Services (HHS), and the Internal Revenue Service have oversight of self-insured and government plans. The labor department receives complaints and inquiries, conducts investigations when necessary, and has enforcement authority for self-insured plans. The Centers for Medicare and Medicaid Services (CMS), which is part of HHS, has the same role for government plans.

**Key findings**. There has been little prolonged attention to improving access to substance use treatment for people outside the state service system. The Alcohol and Drug Policy Council is statutorily charged with formulating and improving state substance use-related policies, but the group's work has focused mainly on state agency clients, much like the state agencies themselves. Within the insurance department, additional health insurance carrier reporting and planning requirements could be instituted to better assess and ensure access to covered treatment for enrollees of fully-insured commercial health plans.

Medical health provider screening for substance use is one way in which problems can be discovered early, because most youth have periodic check-ups. Substance use screening in a primary care setting makes sense because behavioral health is a part of overall health, most youth have periodic check-ups, and substance use disorders have physical health manifestations and implications. In Connecticut, however, behavioral health screening appears to be done for youth on a limited basis, for multiple reasons.

When someone needs treatment, it is important to be able to quickly find feasible treatment options at the appropriate level of care. Multiple Connecticut-specific treatment locators can aid in finding treatment, but these are inconsistent. The locators also lack crucial information on payment methods and ability to take new clients.

Although the precise capacity of substance use treatment in Connecticut is unknown, it is probable that a person would have difficulty promptly accessing inpatient, detoxification, residential, in-home evidence-based models, and regular outpatient counseling treatments, according to various assessments. The wait to receive in-home care is especially long.

Treatment received should be appropriate to the person's circumstances and characteristics. There is some indication, however, that a portion of the adolescents and young adults who do receive treatment might not be getting services appropriate to their developmental and life stage.

When intensive treatment has been completed, ongoing care or case management as well as recovery supports help maintain gains and facilitate a return to more intensive treatment when relapse occurs. Generally, there is little availability in Connecticut of youth-specific recovery supports, which could help sustain treatment gains and, for people of any age, are not covered by insurance. Care management is available to a portion of commercially insured people with substance use disorders, and for the most part is of limited duration.

**Recommendations: Rationale and goals**. This report, like the committee's previous one, makes several recommendations with the overall goal of improving insured youth's access to early and appropriate substance use treatment.

This is a critical goal from a fiscal policy perspective because substance use has tremendous costs to society, families, and individuals – and especially government. The financial burden of substance use treatment falls to government in a unique way. State and local governments are the biggest payor of these services, accounting for 36 percent of substance use

treatment expenditures (excluding Medicaid) but only six percent of all healthcare spending.[5] In contrast, commercial (i.e., private) insurance pays for 37 percent of all healthcare spending but only 12 percent of substance use treatment expenditures.[6]

There are many potential reasons for the substantially lighter treatment cost load carried by commercial insurance, including some that have little to do with the terms or management of insurance coverage. While acknowledging that, it is important to recognize and attempt to remedy the difficulties some Connecticut residents have experienced in promptly getting covered behavioral health treatment. The study's recommendations aim to ensure that insured enrollees who attempt to obtain appropriate substance use treatment coverage are able to do so.

This report's recommendations, taken together, more broadly intend to boost access to needed substance use treatment by:

1. increasing detection of substance use problems at routine medical appointments;
2. improving practitioners' and the general public's ability to quickly and easily locate treatment;
3. ensuring youth in particular receive and benefit from appropriate treatment; and
4. calling for efforts to oversee and work to improve, at the state level, access to substance use treatment, focusing on but not limited to treatment for insured youth.

**Report structure**. Various ways in which state agencies and councils can affect access to care are explained in Section I. How youth become connected to substance use treatment is described briefly and then followed by an assessment of Connecticut's system for helping youth access and benefit from care, in Section II. Appendix B contains an overview of the study's methods. Other appendices provide supporting material to the main body of the report.

[5] When all types of government funding are included, 80 percent of treatment expenditures are borne by the state, local, and/or federal governments.

[6] 2005 data. From: "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011. Accessed February 6, 2013 at: http://www.kff.org/medicaid/upload/8182.pdf.

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# Section I

## State Government's Roles

Various state agencies and councils play roles that can influence access to treatment. As described in this section, this influence can be exerted through licensure requirements, funding, and oversight responsibility, including for health insurance carrier network adequacy. The entities involved and their roles are conveyed in the figure on the next page. No single entity, however, is in charge of overseeing access to substance use treatment for the entire state's adolescents and young adults.

One recommendation would give that oversight to an existing cross-agency council that is focused on substance use. Two other recommendations would result in greater information and attention to substance use treatment access for people insured by commercial health plans.

### Provider Licensure

The supply of facilities, clinics, and individual healthcare practitioners can be influenced by licensure requirements. In Connecticut, the Department of Children and Families (DCF) and the Department of Public Health (DPH) each license one or more types of behavioral health (substance use and mental health) care providers, as shown in the table below. The purpose of licensure is to ensure a minimum level of health and safety.

The Department of Public Health licenses practitioners and nearly all types of substance use treatment facilities. Children's residential facilities are licensed by DCF. Multiple licenses are required for facilities delivering both substance use and mental health treatment.

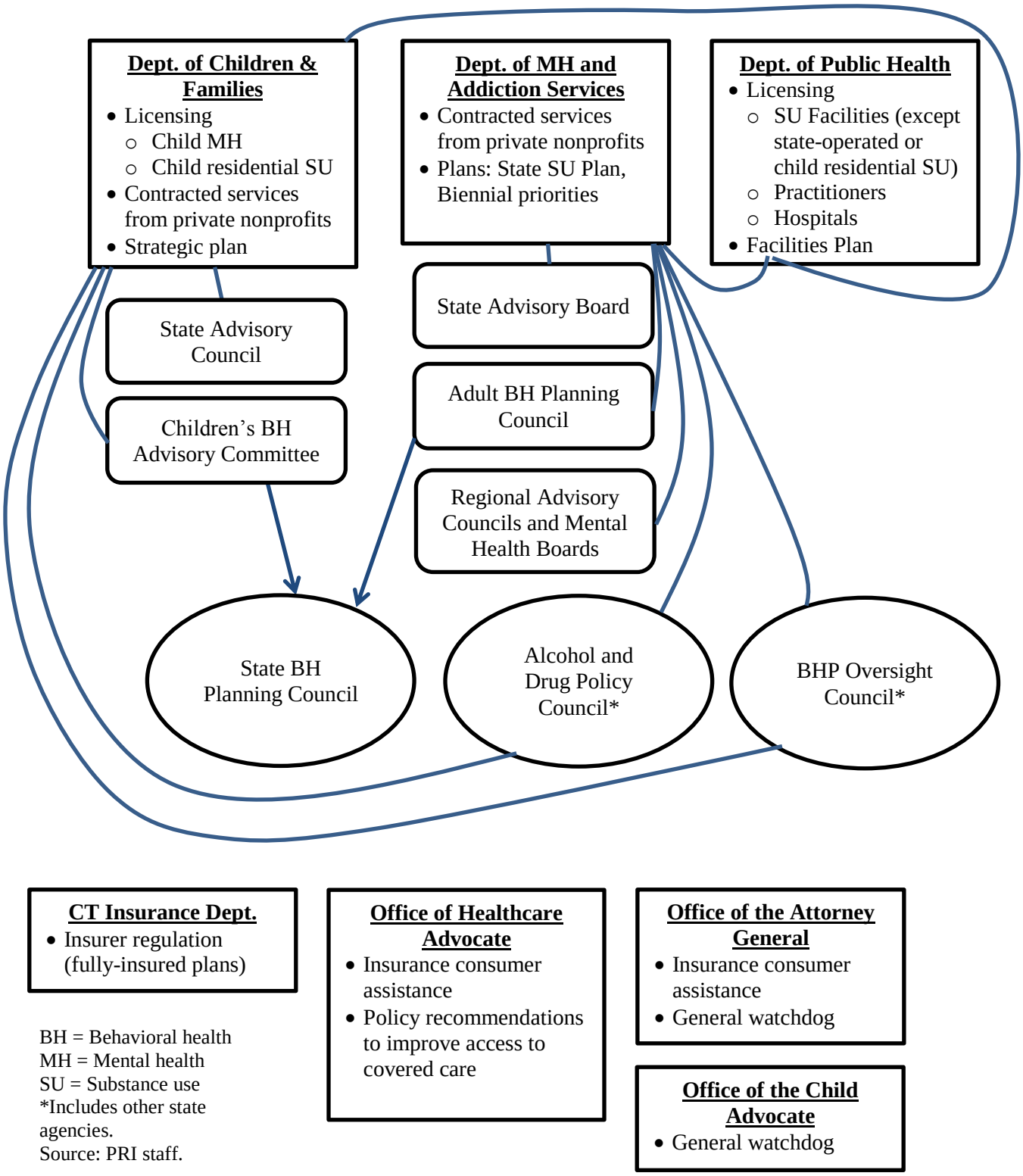
The Department of Mental Health and Addiction Services (DMHAS) does not conduct licensing but all its contracted facility providers giving clinical services are DPH-licensed.

**Table I-1. Licensure of Connecticut Behavioral Health Treatment Providers**

| ***Agency*** | ***Provider Types Licensed*** | |
|---|---|---|
| | ***Substance Use*** | ***Mental Health*** |
| DCF | Residential: Child | Residential: Child<br>Outpatient: Child – *optional** |
| DPH** | Inpatient: Child and adult<br>Residential: Adult<br>Outpatient: Child and adult | Inpatient: Child and adult<br>Residential: Adult<br>Outpatient: Adult |
| | • Individual behavioral and physical healthcare practitioners<br>• General and children's hospitals | |

*Optional, unless receiving DCF funding.
**State-operated facilities are not licensed by DPH.
Source: PRI staff analysis of information provided by DCF and DPH.

**Figure I-1. State Agencies, Offices, and Councils With Potential Roles in Influencing Access to Treatment for Insured Youth**




BH = Behavioral health
MH = Mental health
SU = Substance use
*Includes other state agencies.
Source: PRI staff.

DPH has for several years been in the process of developing regulations that would no longer require providers who treat both mental health and substance use under certain licenses to hold multiple licenses.[7] An existing law, passed in 2009, requires this dual licensure to have been implemented by January 1, 2011 – more than two years ago.[8] DPH personnel stated in a fall 2012 conversation with program review committee staff that it likely will be another 12 to 18 months until the regulations can successfully proceed through the review and adoption process. They indicated the process would not be sped up through further legislative mandate. There simultaneously are other efforts being considered within the executive branch that would ease licensure's administrative burden on the state's contracted nonprofit providers without compromising standards.

**Funding**

DMHAS and DCF both fund contracted private nonprofits that provide substance use treatment services to the departments' clients, people with insurance, and those who are uninsured. The payments are meant to cover state agency clients who are unentitled or uninsured, and defray part of the cost for uninsured people who are not state agency clients.

Due to the timeframe of this study, data on this funding was not examined;[9] however, generally it is acknowledged that state-supported nonprofits are experiencing deteriorating financial conditions.[10] Financially stretched providers would be unable, at current resource levels, to help better meet service demand through expansion.

**Coordination & Oversight of Treatment**

Several state agencies and councils play a role in overseeing access to substance use treatment for adolescents and/or young adults, described below.

**Alcohol & Drug Policy Council (ADPC)**. The council, formed in 1996 via executive order and then established in statute in 1997, is responsible for coordinating and planning efforts that involve the numerous state agencies whose activities involve substance use services. The authorizing statute specifically focuses on state agency programs and policies.[11] Its members include nonprofit providers, healthcare practitioners, state personnel from all three branches of

[7] The following facility licenses would be combined into a single license: Mental Health Day Treatment, Community Residence, and Residential Living Center; Psychiatric Outpatient Clinics for Adults; and Private Freestanding Facilities for the Care or the Treatment of Substance Abusive or Dependent Persons.

[8] Required by C.G.S. Sec. 19a-902, per Public Act 09-149, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning Substance Abuse Treatment for Adults.

[9] Part of DMHAS and DCF substance use-related funding comes from federal sources. For example, Connecticut received $16,883,413 from the Substance Abuse Prevention and Treatment Block Grant and $4,464,764 from the Community Mental Health Block Grant. (These amounts are based upon the Federal Fiscal Year (FFY) 2012 amounts; as of February 14, 2013, there was no final FFY 2013 appropriation.) Historically – and continuing through the current grant cycle – none of the substance use treatment grant has been used for adolescent services.

[10] See, for example: "Governor's Cabinet on Nonprofit Health and Human Services Report to Governor Dannel P. Malloy," October 1, 2012. Accessed February 6, 2012 at:
http://www.ct.gov/opm/lib/opm/assets/temp/governors_np_cabinet_annual_report_final_2012-10-01.pdf

[11] C.G.S. Sec. 17a-667

government, and persons in recovery. The council is co-chaired by the DMHAS and DCF commissioners.

The council has not been very active recently, due in part to turnover among key state agency personnel. There were four meetings across 2011 and 2012, with no annual report issued in either year. In earlier years, the council's reports have extensively discussed adolescent substance use (especially in 2007), largely in terms of how state agencies could improve services to their clients. State agency personnel reported that the council had been useful most recently in the effort to address prescription drug misuse. The future direction of the ADPC is under consideration by DMHAS and DCF.

**State Behavioral Health Planning Council**. Begun in 1992, the council was formed to provide overall advice and direction for the state's mental health efforts but has since been expanded to also include substance use. The children's representatives to the council are DCF's Children's Behavioral Health Advisory Committee, while the adult segment is DMHAS's Adult Behavioral Health Planning Council. The adult council concerned only mental health until it was expanded in fall 2012 to include substance use stakeholder representation (e.g., people in recovery, advocates, providers). Consequently the joint child-adult council was re-named to reflect its broadened mission.

The entire council meets quarterly. In 2012, its meetings involved updates on DCF and DMHAS initiatives, as well as on the federal mental health and substance use block grants.[12]

**Behavioral Health Partnership (BHP) Oversight Council**. The council oversees the state's Medicaid behavioral health program, the BHP. The group is statutorily required and includes providers of substance use and mental health treatment, people in recovery from behavioral health disorders, and representatives of numerous state agencies.[13] The council meets monthly and has been active in trying to improve access to behavioral health services for BHP enrollees.

**DMHAS**. The department – the behavioral health state agency for adults – assumed a key role in coordination and oversight with the enactment of Public Act (P.A.) 09-149, which was based on recommendations from a program review committee study. The law, found at C.G.S. Sec. 17a-451(j), makes the department responsible for creating and implementing a state substance abuse plan. The plan, to be updated periodically, is to include prevention and treatment, but due to the agency's jurisdiction, is limited to adults (including young adults 18 through 25, who are part of this study's focus). Issued in September 2010, the plan's major strategies generally address state agency services, although one involved making the Connecticut Clearinghouse website's treatment locator function more consumer-friendly.

The department is advised by multiple councils and boards. Pertinent to substance use, there are: the Behavioral Health Planning Council, the State Board of Mental Health and Addiction Services, Regional Action Councils, and Regional Mental Health Boards.

[12] Based on program review committee staff review of meeting minutes.
[13] C.G.S. Sec. 17a-22j

DMHAS oversees services given by the private nonprofits it funds, through contracting requirements, but not those of other treatment providers.

**DCF**. The Department of Children and Families is the behavioral health state agency for children[14] and has other roles regarding child protection, juvenile justice, and prevention. As such, DCF participates in the ADPC and works with DMHAS; furthermore, its strategic plan must include behavioral health services (both mental health and substance use). It is advised by the State Advisory Council on Children and Families and by the Children's Behavioral Health Advisory Committee.

DCF oversees the substance use treatment services given by its contracted private nonprofit providers, similarly to DMHAS, and also, through licensure, all adolescent residential substance use treatment.

**DPH**. The Department of Public Health is involved in access to treatment in two ways. First, it is involved with regulation of facilities and practitioners, except for facilities that are state-operated or provide certain types of children's behavioral healthcare.

Second, the department must issue a Statewide Health Care Facilities and Services Plan. The plan focuses on data that are useful to the certificate of need process but also incorporates other information that can help policymakers and others improve access to and quality of healthcare. The first plan was issued in October 2012. Its behavioral health section mainly explains the types of services offered directly by the state, the number of providers funded by the state, and trends in behavioral healthcare (recovery-focused and integration with primary care).

Specific to substance use, the plan's assessment of the overall level of need for services and existing treatment settings available rely on federal data also used in this study. The pertinent recommendations focus largely on developing better information on the accessibility of treatment services to the state's whole population. Review of the behavioral health subcommittee meeting minutes indicates that a more ambitious assessment of capacity was considered; ultimately, it seems that idea was not pursued due to resource constraints. This and all other subcommittees will be reconvened in spring 2013 to explore implementing the plan's recommendations.

**Office of the Healthcare Advocate (OHA)**. The office has dual roles of assisting healthcare consumers in understanding and accessing insurance coverage, and issuing policy recommendations to improve access to insurance-covered healthcare. It also is charged more specifically with overseeing access to mental health care by facilitating communication among mental health care consumers, providers, and insurers surrounding best practices and mental health (and similar) parity, and annually reporting to the legislature on those activities.[15]

[14] C.G.S. Sec. 17a-3(a)
[15] C.G.S. Sec. 38a-1041(e)

Under this latter charge, OHA held an October 2012 hearing on access to behavioral healthcare. Subsequently the office issued a January 2013 report, calling for several steps to improve access to mental health and substance use care.[16]

**Others**. The Office of the Child Advocate and the Office of the Attorney General fill watchdog roles and at times have investigated and spoken out about access to behavioral healthcare.[17]

**Overall**. *There has been little sustained attention to ensuring access to substance use treatment for the state's whole population.* DMHAS and DCF, along with their councils,[18] largely – and understandably – have been focused on improving services to their clients. It would be appropriate for a cross-agency entity that involves providers, advocates, and people in recovery to have as a main goal ensuring access to treatment. The ADPC may be best suited for this role, but it has lost momentum recently and its future direction is unclear. A reinvigorated ADPC could serve the state well in this capacity.

**Recommendation**. The program review committee staff recommends:

**1. The Alcohol and Drug Policy Council should include as one of its main missions the goal of ensuring access to appropriate substance use treatment for the entire state's population, including adolescents and young adults. The group should explore, develop, and advance comprehensive strategies for improving access to treatment for all Connecticut residents.**

**Insurer Network Adequacy**

The Connecticut Insurance Department (CID) conducts some activities to monitor whether fully-insured plans within the state have sufficient in-network services availability. These activities involve enforcement of a few state laws and publication of certain network information, as described below. (The insurance policies to be available on state insurance exchanges will have to meet certain other network adequacy requirements, as explained in Appendix C.) The department also tracks adequacy through complaints, by methods described in the program review committee's December 2012 report.

The extent of a health insurer's network has a substantial impact on whether enrollees can access needed, covered services in a timely way that is also affordable. (Some plans cover out-of-network benefits but at a higher cost-sharing rate; others do not, placing the full financial burden on the enrollee.) Ideally a network would include sufficient numbers of various types of providers accepting new patients who are within a reasonable distance from all plan enrollees. Technological tools (e.g., GeoAccess) and numerical benchmarks (such as provider-to-enrollee

[16] "Findings and Recommendations: Access to Mental Health and Substance Use Services," Victoria Veltri, Office of the Healthcare Advocate, January 2, 2013. Accessed January 3, 2013 at: http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.

[17] For example, see: "Connecticut Children Losing Access to Psychiatric Care; A Report of the Attorney General and Child Advocate's Investigation of Mental Health Care Available to Children in Connecticut," Richard Blumenthal and Jeanne Milstein, April 12, 2007.

[18] Based on program review committee staff review of recent meeting minutes for the Joint Behavioral Health Planning Council, the Child Behavioral Health Advisory Council, and the Alcohol and Drug Policy Council.

ratios) can assist a plan, accrediting agencies, or insurance regulators in determining whether a network is adequate. However, geographical provider shortages may mean that even if a plan makes an earnest attempt to have an adequate network, one cannot be maintained. In such a situation, a national accrediting organization and an insurance regulator would certify a health plan as having a sufficient network.

**Laws**. In Connecticut, network adequacy is regulated by two different statutes. The first has long required preferred provider networks contracting with managed care organizations (MCOs) to demonstrate adequacy to the satisfaction of the MCOs.[19] The other, effective January 1, 2012, requires MCOs and preferred provider networks to meet the network adequacy standards of either major health accrediting organization (the National Committee for Quality Assurance, NCQA, or URAC).[20] Detailed explanations of both standards are found in Appendix C. The standards are not numerical (e.g., no set provider-to-enrollee ratio). Instead, they require health plans to set and assess progress toward reasonable goals incorporating geographical and ease of appointment aspects, among others.

The Connecticut Insurance Department is enforcing the more recent network adequacy law by asking carriers to certify compliance as part of an existing annual reporting process (for the Consumer Report Card, which is described below). The department is not requiring supporting documentation be submitted for the certification, even for companies lacking NCQA or URAC accreditation. As of fall 2012, ten of the fifteen indemnity MCOs had not applied for NCQA accreditation.[21] (URAC accreditation information is not included in the report card.)

Of note, while the statute was effective January 1, 2012, which means that sometime after that compliance was required, the department decided to implement it based on calendar year 2012 data, to coincide with the Consumer Report Card timeframe. This effectively gave the health carriers until the end of 2012 to comply, and until May 2013 to report compliance to CID, which seems to be an overly lengthy period of time.

**Information**. The insurance department's Consumer Report Card contains a limited amount of other information relevant to network adequacy. The mandated publication is annually issued to help people understand utilization review results, enrollee satisfaction, and number of providers regarding the state's fully-insured plans.

The report card gives two types of network adequacy information. First, it presents, for each HMO and indemnity managed care organization, the numbers of different types of providers – primary care physicians, physician specialists (generally), hospitals, and pharmacies – by county. Notably there is no break-down by types of specialists or ratio of providers to enrollees. Second, the report includes for each plan selected member satisfaction survey data,

[19] C.G.S. Sec. 38a-479bb(d)(1). (Enacted via P.A. 03-169, effective May 1, 2004.) The statute provides that the adequacy determination takes into account "geographic distribution of enrollees and participating providers and whether participating providers are accepting new patients."

[20] C.G.S. Sec. 38a-472f. (Enacted via P.A. 11-58.) URAC formerly was known as the Utilization Review Accreditation Commission.

[21] Five indemnity MCOs and all health maintenance organizations were NCQA-accredited. ("Consumer Report Card on Health Insurance Carriers in Connecticut," Connecticut Insurance Department, October 2012. Accessed February 1, 2013 at: http://www.ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf.

including ease of access to specialist and other appointments. There is no survey information specific to behavioral health, due to limitations of the dataset.[22]

Data received by the program review committee from the five major carriers of Connecticut fully-insured health plans indicates variation in the number of in-network substance use or behavioral health treatment providers at a few levels of care (shown in Appendix C, Table C-5). The precise reasons for the network differences and the implications of them are unclear.

**Overall**. *Connecticut's network adequacy laws and information collected from plans are weak*, compared to what is done by about 20 other states or recommended by the National Association of Insurance Commissioners (NAIC), described in Appendix C. For example, health carriers are not required to file data (beyond limited counts of certain types of providers) or written plans demonstrating in-network provider accessibility. Information on the number of behavioral health or substance use treatment in-network providers is not collected; data given to program review committee staff show some differences among the major carriers.

*It is unclear if stronger traditional network adequacy laws would be an effective way to improve access to covered substance use treatment*, for a few reasons. First, the impact of traditional network adequacy standards on enrollee access to any type of care is not well-researched. No such evaluations were located by program review committee staff. Second, in public hearings recently held by OHA and multiple legislative committees, families seeking behavioral healthcare and practitioners themselves have testified mainly about issues that would not be remedied by typical network adequacy laws. Particular complaints have been about difficulty and work involved in receiving coverage authorizations (i.e., utilization review), onerous requirements to be admitted to the network, and, for both Medicaid and commercial insurance, low reimbursement rates.

While the committee's December 2012 report made recommendations regarding one area of access complaints (utilization review), *additional steps should be taken to address access to covered substance use treatment.* Some behavioral healthcare providers, individual practitioners, and clients have expressed growing frustration – through the committee survey, public hearing, and staff's interviews – with clients' difficulty accessing covered substance use treatment, especially for those with commercial insurance. Their frustration with managed care's role in accessing substance use treatment is found beyond Connecticut, [23] and within this state, extends to mental health treatment.[24]

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[22] The survey data are drawn from the national Healthcare Effectiveness Data and Information Set (HEDIS) database, in which all the MCOs participate.

[23] As noted in the committee's December 2012 report, Pennsylvania in 1986 removed the ability of insurers to conduct utilization review on substance use treatment prescribed by a licensed physician or psychologist. The law was challenged in the 2000s by health carriers but court decisions upheld the laws and their enforcement. More recently, there has been press coverage of insurer restrictions in New Jersey. (See: "Insurance Companies Frustrate N.J. Families Seeking Addiction Treatment," Dan Goldberg, The Star-Ledger, February 17, 2013. Accessed February 20, 2013 at: http://www.nj.com/news/index.ssf/2013/02/new_jersey_heroin_insurance_tr.html.)

[24] See: "Findings and Recommendations: Access to Mental Health and Substance Use Services," Victoria Veltri, Office of the Healthcare Advocate, January 2, 2013 at: http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf. Also: "Waiting for the Next Crisis: Parents Struggle with Children's Mental Health Needs," Arielle Levin Becker,

*One way to begin to better understand and address access to treatment is through an approach similar to that of a model law developed by a national bipartisan group.* The President's Commission on Model State Drug Laws in 1993 recommended that states require each health carrier to submit plans and data describing access to substance use treatment and how the carrier intends to increase access.[25] The proposed model law includes provisions for a network adequacy and outreach plan, and thorough information (e.g., length of stay by level of care) on utilization.[26]

**Recommendations**. Drawing on the substance use treatment access plan and data proposed by The President's Commission on Model State Drug Laws, the program review committee staff recommends:

**2. C.G.S. Sec. 38a-478c shall be amended to require health carriers to annually report on:**

**a. By county, for inclusion in the Consumer Report Card:**

- **i. The estimated prevalence of substance use disorders among child, young adult, and other adult enrollees;**
- **ii. The number and percent of child, young adult, and other adult enrollees who received covered substance use treatment, by level of care;**
- **iii. The median length of substance use treatment for child, young adult, and other adult enrollees, by level of care;**
- **iv. The per member per month child, young adult, and other adult claim expenses for substance use treatment;**
- **v. The number of in-network substance use treatment providers, by level of care, showing the percentage of in-network providers that are taking new clients with that insurance;**

**b. For the entire state:**

- **i. The number, by licensure type, of behavioral health practitioners and, by level of care provided, facilities that have applied for in-network status, and for each, the percent that were accepted; and**
- **ii. The number and percentage of behavioral health practitioners by licensure type and, by level of care, facilities that have halted participation in the network.**

**c. Identification and explanation of factors that may be impacting access to substance use care, including but not limited to screening, statewide supply of certain practitioner types, provider capacity limitations, and reimbursement rates.**

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The CT Mirror, February 15, 2013 at: http://www.ctmirror.com/story/19136/waiting-next-crisis-parents-struggle-childrens-mental-health-needs.

[25] "Model Managed Care Consumer Protection Act," The President's Commission on Model State Drug Laws, December 1993. Accessed March 7, 2013 at: http://www.namsdl.org/resources/v4d%20model%20managed%20care%20consumer%20protection%20act-.pdf.

[26] Ibid, Sections 14 and 15

**d. Plans and ongoing or completed activities to address the identified factors that may be negatively impacting access to care.**

**The health carrier may request the commissioner to deem any of the information in (b), (c), or (d) above proprietary and unavailable to the public. The commissioner may approve or deny such request. If any information is deemed proprietary, the insurance department and the Office of the Healthcare Advocate may view the information but not make it public.**

To further assist the insurance department in evaluating access to care, the program review committee staff recommends:

**3. The Connecticut Insurance Department should, for the Consumer Report Card, request fully-insured health carriers to submit behavioral health utilization review (including coverage requests and adverse determinations) data:**

**a. according to specific levels of care (for example, inpatient, residential, partial hospitalization, et cetera);**

**b. separately for mental health treatment, substance use treatment, and co-occurring disorders;**

**c. separately for children, young adults, and other adults; and**

**d. including, separately, internal appeals and external appeals information.**

These data will result in report card information that more closely matches the information presented in the committee's phase one report. It will enable not only the insurance department but also the public to better understand utilization review outcomes for behavioral health and how they may change over time – particularly if the study's recommendations regarding utilization review and/or the insurer access plan are enacted.

# Section II

## Substance Use Treatment Services for Insured Youth

This section explains how youth can become connected to treatment services. It then describes elements of an ideal system for helping insured youth access and engage in needed substance use treatment, drawing largely on a 2012 report from the National Center for Addiction and Substance Abuse at Columbia University.[27] The elements are:

- screening within primary care;
- locating available treatment;
- receiving appropriate treatment; and
- receiving support for recovery.

Within each element, Connecticut is compared to the ideal. Recommendations in a variety of areas collectively would move Connecticut toward an ideal system.[28]

### Background: How Youth Reach Treatment

Youth can become connected to substance use treatment through the initiative or requirement of a range of people or institutions. These include family, school, healthcare practitioners, community organizations, and – though not addressed by this study – state systems (e.g., justice, child welfare). The justice system is by far the most common referral source, accounting for nearly half of all adolescent admissions to substance use treatment.[29]

Youth also can independently choose to search for treatment options or seek out counseling at school. Some may first turn to mutual assistance groups like Narcotics Anonymous or Alcoholics Anonymous, although committee staff heard during the study that it is unlikely most youth will feel comfortable with and persist in such groups, unless the group is connected with a school or geared to their age group.

Parents or guardians may seek guidance from clergy or their child's pediatrician, or choose to independently search for treatment options. Frequently, parents will not request assistance from or notify school due to the possibility of sanctions, such as suspension, on their child. Parents may also present, with the youth, at an emergency department within a general hospital.

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[27] "Addiction Medicine: Closing the Gap Between Science and Practice," National Center on Addiction and Substance Abuse, June 2012, pp. 107-109. Accessed June 29, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf.

[28] In some instances, recommendations address behavioral health (i.e., both substance use and mental health) because of the close relationship between substance use and mental health disorders (e.g., co-occurring disorders, practitioners and facilities may treat both, state agencies' roles encompass both).

[29] Adolescent referral sources were, according to CASA (based on federal survey data): criminal justice (48 percent), themselves (16 percent), school (11 percent), healthcare provider (5 percent), and other community providers (12 percent). ("Adolescent Substance Use: America's #1 Public Health Problem," The National Center on Addiction and Substance Use at Columbia University, June 2011. Accessed May 23, 2012 at: http://www.casacolumbia.org/upload/2011/20110629adolescentsubstanceuse.pdf.)

## Element 1: Screening Within Primary Care

**Ideal**. Primary care providers screen adolescent, young adult, and older adult patients for risky substance use periodically – at routine check-ups – and upon trauma admissions. Screening helps providers identify those needing treatment. In some cases, providers can give a brief intervention, which has been proven by several studies to be an effective method at reducing risky use and possible effects (e.g., hospitalization, arrest). In others, a referral to treatment is necessary. Providers administer screens when they are comfortable with the idea of screening, the tool used, and what to do when a positive result is obtained.

**Connecticut**. *Trauma patients are screened for substance use, per C.G.S. Sec. 19a-490h,*[30] *and generally adult physicals include at least a cursory alcohol screen. Adolescents, however, might not be routinely screened – as is recommended – for risky substance use, although screening tools are available.* Recent public hearing testimony indicated that a limited portion of pediatricians and other primary care providers uses a standardized, formal method to check child and adolescent behavioral health. There are a few substance use screening tools meant for primary care, such as CRAFFT, which consists of six questions.[31] Routine substance use screening for adolescents, using a validated tool, was recommended by the American Academy of Pediatrics in October 2011.[32]

*There are many possible reasons for why screening is not uniformly conducted*. Some providers have indicated being reluctant to screen because it was not part of their training and therefore feel unprepared to do so. However, state law implies these activities, related to substance use, should be included in Connecticut training programs: Public Act (P.A.) 98-201 required a variety of behavioral and primary care practitioner preparation programs to create plans to implement substance use screening and referral into their curricula. The program review committee staff was unable to locate any information on whether these plans had been submitted to the Board of Governors of Higher Education as required by the law.[33]

For practicing adolescent providers, free behavioral health screening training (among other types of education) is made available by the Child Health and Development Institute. This

[30] Enacted by Public Act 98-201. The national trauma center accrediting organization also requires certain trauma centers to screen for substance use.

[31] CRAFFT's acronym is based on the six questions. One other tool is the GAIN-SS (Short Screen), which is widely used by behavioral health agencies, including Connecticut's Department of Children and Families. It takes three to five minutes and involves a range of behavioral health disorders. As it requires minimal training, it could perhaps be used in primary care settings. (See: "Brief Introduction to the GAIN-SS and Assessments.com," Assessments.com. Accessed March 1, 2013 at: https://www.assessments.com/assessments_documentation/gain_ss/GAIN%20SS%20Fact%20Sheet.pdf.) Additional tools are described at the Centre for Addiction and Mental Health's website, accessed March 8, 2013 at: http://knowledgex.camh.net/amhspecialists/screening_assessment/screening/navigating_screeningcd/pages/api_screen_substance.aspx.

[32] "Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians," From the American Academy of Pediatrics with lead authors Sharon Levy and Patricia Kokotailo, Pediatrics 128(5):e1330-e1340, October 31, 2011. Abstract accessed March 1, 2013 at: http://pediatrics.aappublications.org/content/128/5/e1330.full.

[33] The Board of Governors of Higher Education was replaced by the Board of Regents for Higher Education on July 1, 2011. At that time, the administrative higher education agency changed from the Department of Higher Education to the Office of Higher Education.

independent organization (associated with a foundation) has indicated low participation in this particular training.

Other providers may be unaware of the treatment resources available, uncertain which service would be most appropriate, or reluctant to widely screen when they perceive it is difficult for patients to access needed treatment for substance use.

Finally, time and/or financial pressures may impact screening practices. It is unclear whether commercial insurers will give additional reimbursement for very brief screens, as part of routine care, and providers may feel they lack the time or income cushion to perform additional duties without extra pay.

It is possible to mandate substance use or (more comprehensively) behavioral health screening;[34] however, most people with whom committee staff spoke are reluctant to embrace that step. There is doubt that primary care providers would embrace screening if not sufficiently comfortable with the tool or what to do if a need for treatment is found.

*Connecticut lacks a behavioral health consultation service for children's primary care providers, a program that may increase screening rates through giving providers training, information, and referral assistance*. Twenty-four states – including Maine, Massachusetts, New Jersey, New York, New Hampshire, and Vermont – have a consultation program.

In Massachusetts, the program involves active outreach to and training for all providers of care to children, a telephone consultation line, referral assistance, and in-person evaluations when necessary. It has yielded a higher rate of comfort with mental health screening[35] and better provider satisfaction with ability to meet children's behavioral health needs.[36] The program is

[34] Massachusetts's Medicaid program recently began requiring a behavioral health screening at routine children's physical healthcare appointments, due to a 2006 court ruling. (See, for a description of the case and results of the screening requirement: "*Rosie D.* and Mental Health Screening; A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit," Julianna Belelieu, TeenScreen National Center for Mental Health Checkups at Columbia University. Accessed February 5, 3013 at: http://www.mass.gov/eohhs/docs/masshealth/cbhi/rosie-d-white-mhscreening.pdf.) Legislation pending in the Connecticut General Assembly (Senate Bill 169) would require behavioral health screening among the health-oriented mandates for public school children.

[35] Fifty-seven percent of pediatric primary care providers indicated their ability to use behavioral health screening tools had improved (with one-quarter not giving an opinion), according to a recent presentation during a Connecticut legislative meeting. (Presentation of John Straus and Barry Sarvet, March 4, 2013.) There is some indication that a strong increase in screening was due largely to a judicial mandate for screening of children with Medicaid insurance, which also ultimately yielded better Medicaid billing terms for this screening. ("Increases in Behavioral Health Screening in Pediatric Care for Massachusetts Medicaid Patients," Karen Kuhlthau et. al, *Archives of Pediatric Adolescent Medicine 165*(7):660-664, 2011. Accessed February 5, 2013 at: http://archpedi.jamanetwork.com/article.aspx?articleid=1107548.)

[36] Once the program was implemented, the percent of primary care providers agreeing they are able to meet the needs of children with psychiatric problems increased nearly 8-fold (from 8 percent pre-program, to 63 percent). ("The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care," Wendy Holt, DMA Health Strategies for The Commonwealth Fund, March 2010. Accessed February 5, 2013 at: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Mar/1378_Holt_MCPAP_case_study_32.pdf.)

now aiming to expand substance use screening; previous efforts focused on mental health. About 95 percent of the children in the state are seen by providers participating in the program.[37]

While patients with commercial insurance have benefited from the Massachusetts program, private insurers have played no role. The majority of patients for whom providers have sought consultation are covered under private insurance, but the program's operations are funded solely by government sources. Commercial insurance has neither contributed to operations costs nor reimbursed providers calling for consultations with the program.

Implementation of a similar model within Connecticut – which may happen soon – likely would both help primary care providers become comfortable screening for behavioral health concerns and alleviate the shortage of child and adolescent psychiatrists. In early March 2013, creation of a comparable program in Connecticut was unanimously recommended by the legislature's Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety.

*The extent to which adult primary care providers routinely screen for substance use or other behavioral health needs is unclear. There is, however, a burgeoning interest in integrated or collaborative care, of which screening for problems with the other aspect of health is just one of many models.*[38] As this interest grows – fed through government grants and requirements, as well as initiative of insurers, providers, and professional associations – it is likely that screening for and connection to behavioral healthcare will improve.

**Recommendations**. The Massachusetts consultation program model could be strengthened, when it is adapted for use in Connecticut, by incorporating substance use and commercial insurance participation. The program review committee staff recommends:

> **4. The State of Connecticut should have a comprehensive pediatric behavioral health consultation program. The consultation line's screening, training, consultation, and referral activities should include both mental health and substance use. The program should work with commercial insurers to explore how those insurers can play a role in the project.**

The consultation program likely will yield higher behavioral health screening rates among primary care providers serving children and adolescents. It would make sense to simultaneously expand screening training to students in medical preparation programs. The extent to which these preparation programs offer screening training is unclear. The program review committee staff recommends:

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[37] "The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care," Wendy Holt, DMA Health Strategies for The Commonwealth Fund, March 2010. Accessed February 5, 2013 at: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Mar/1378_Holt_MCPAP_case_study_32.pdf.

[38] For a description of the various meanings and types of integrated and collaborative care, see: "Evolving Models of Behavioral Health Integration in Primary Care," Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade, Milbank Memorial Fund, 2010. Accessed March 6, 2013 at: http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.

**5. The Alcohol and Drug Policy Council should assess whether Connecticut's physician, nurse, and physician assistant preparation programs include training on behavioral health screening, administering a brief intervention for substance use, and referring to treatment. The council then should encourage and assist the preparation programs not offering the training, to do so, on at least a voluntary basis.**

## Element 2: Locating Available Treatment

**Ideal**. An appropriate substance use treatment program is easily found and quickly entered. Treatment must be available when a person (or provider, or family member) seeks it because many are uncertain about entering.[39]

**Connecticut treatment locators**. Multiple substance use treatment locators are available to help people find treatment options. Six major substance use treatment locators, detailed in Appendix D, were found. Of these:

- three are affiliated with the Department of Mental Health and Addiction Services (DMHAS), including one listing town-specific telephone numbers for crisis services;
- one is operated by the federal behavioral health services agency;
- another is run by the United Way; and
- one is funded by a variety of government and private partners.

All but one enable the user to locate treatment options using only the Internet; two additionally offer a telephone option. Several link to each other. Most, if not all, do not include small private behavioral healthcare practices.

In addition to these tools, there are online locators specific to some types of treatment (e.g., residential facility, buprenorphine, recovery housing) and behavioral health practitioners (e.g., social worker). General search engines or tools - such as Google, Yellow Pages, and insurer in-network provider listings - may also be a resource. Some healthcare providers or other community resources keep their own lists of possible treatment options.

*The major substance use treatment locators' program listings are deficient in two ways.* First, the locators are inconsistent. Program review committee staff conducted basic searches for a variety of care levels, using three locators, and found discrepancies in the number of options produced for various care levels, as described in Appendix F. Second, none of the locators shows whether treatment providers are accepting new clients. This information would make it easier for

[39] National Institute on Drug Abuse, National Institutes of Health Publication No. 09-4180, *Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)*, April 2009. Accessed June 11, 2012: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment.

healthcare providers, families, people with a substance use disorder, and others to easily and quickly find an appropriate placement.[40]

*While maintaining multiple locators could be helpful in trying to reach as many people as possible, it may be more cost-effective and consumer-accessible if one up-to-date, comprehensive locator were maintained.* Then, other sites could link to this single listing.

**Recommendation**. To improve the ease of finding available treatment, the program review committee staff recommends:

> **6. The Alcohol and Drug Policy Council should assess the various substance use treatment locators maintained at the state level. The assessment should be used to select one of the locators to be Connecticut's primary source of information on substance use treatment options. The relevant state agencies should publicize this locator online and encourage private nonprofits to do the same.**
>
> **The locator should contain information on whether each treatment program is accepting new clients – updated at least daily – and what insurance plans, if any, are accepted. An effort should be made, working through the healthcare practitioner associations, to include in the locator private behavioral healthcare practices.**

**Connecticut's treatment capacity**. *For most levels of care, the precise capacity of the state's substance use treatment system is unknown.* This is due in part to the fragmented nature of the system.

Treatment services may be obtained at facilities or practices with or without specialty substance use treatment licenses, depending on the level of care and size of the practice. To assess the capacity and availability of substance use treatment services, program review committee staff reviewed a variety of state agency documents. Surveys of licensed treatment providers and colleges also were completed. Appendix E contains information on the provider survey results and methods, and Appendix F discusses the capacity information available by source.

***Specialty licensed facilities***. There are 205 licensed, private substance use treatment facilities in Connecticut. Of these:

- 199 are private substance use treatment facilities licensed by the Department of Public Health (DPH);[41]
- two are specialty psychiatric hospitals, also licensed by DPH;[42] and

[40] The emergency department focus groups convened for the Department of Public Health's Office of Health Care Access's 2012 Statewide Health Care Facilities and Services Plan included among their recommendations an up-to-date source of information on behavioral health treatment programs' availability.
[41] DMHAS-operated facilities are not licensed.

- four provide residential substance use treatment for children, and are licensed by the Department of Children and Families (DCF).

The number of substance use treatment facilities likely has declined over the past decade, according to a federal survey.[43]

*Levels of care*. The entire range of substance use treatment levels of care is represented among the DPH-licensed facilities:

1. Inpatient, involving medically managed or monitored care
2. Residential rehabilitation, which can have stays that are short (30 days or fewer), intermediate, or long-term (90 days or more)
3. Supervised community living arrangement with clinically managed services, such as a halfway house[44]
4. Partial hospitalization (involving medical management) or day or evening treatment, usually for someone who is transitioning out of residential care
5. In-home treatment using evidence-based models
6. Intensive outpatient, with at least nine hours weekly of clinical (e.g., individual and group counseling) services
7. Outpatient, which can be individual or group counseling

Detoxification can be done on an inpatient or outpatient basis, depending on the level and substance(s) of use.

The majority of facilities offers – and most clients engage in – some type of outpatient (broadly) treatment. Among specialty licensed providers responding to a federal survey, methadone maintenance served the largest portion of all people in treatment (45 percent), while regular outpatient counseling was the second most popular care (37 percent).[45]

The precise capacities for the various types of outpatient care available in DPH-licensed facilities are not known, but collectively they far exceed 36,000 spaces for substance use and mental health outpatient care overall.[46] The DPH licensure process does not collect information on the number of slots for any type of outpatient treatment.

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[42] "Statewide Health Care Facilities and Services Plan," Connecticut Department of Public Health Office of Health Care Access, October 2012.

[43]The number of facilities known to an annual federal survey of treatment facilities (N-SSATS) declined by 24 percent between 2002 and 2011 (from 263 to 201 facilities). See Appendix F for more information.

[44] A halfway or recovery house that does not provide clinically managed services is not required to be licensed as a substance use treatment provider.

[45] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf.

[46] DPH licensure information shows capacity for residential treatment and inpatient care, but not for outpatient (e.g., day/evening treatment) services. N-SSATS indicates 24,294 clients were receiving some type of outpatient service in March 2011 (including 9,663 in regular outpatient counseling and 11,647 in methadone maintenance) but the number of behavioral health (i.e., not specific to substance use) treatment spaces well exceeds 36,000, based on the

Residential and inpatient treatment capacity is much smaller than outpatient capacity. There are about 1,570 residential treatment beds and under 200 specialty hospital inpatient beds, among DPH-licensed substance use treatment providers. Most (64 percent) of the state's DPH-licensed adult residential treatment slots are in programs that offer only long-term (three to six month) stays. These programs likely are for only state agency or Medicaid clients, as commercial insurance generally will not pay for residential treatment of that duration.

In Connecticut, there has been over the past decade a slight capacity shift away from long-term residential care and day/evening treatment or partial hospitalization, and toward intensive and regular outpatient counseling treatment.[47] This shift has been occurring across the country, and over a longer period of time than for which data were examined.[48] The change is due to various factors, including the cost of residential treatment compared to outpatient, some research questioning the effectiveness of residential treatment in certain circumstances, and a movement to serve people needing behavioral health treatment within their communities, instead of in residential settings.

*Payment*. A large majority of specialty treatment facilities accepts private insurance, and an even larger share accepts Medicaid.[49] A portion of those taking private insurance – roughly one-third of program review committee's survey respondents – are not in-network providers for all the major insurers (entailing higher patient out-of-network cost-sharing, if applicable).

*Youth services*. Fewer providers at every level of care appear to offer substance use treatment to adolescents than to adults, based on the committee's survey results. DPH and DCF licensing data show that adolescent residential treatment capacity is about one-tenth of the state's adult residential treatment capacity.[50]

***Non-specialty-licensed services***. Some treatment-related services or facilities do not need to be DPH-licensed for substance use care, such as those given by certain providers or practitioners primarily giving medical healthcare. Each of the state's 29 general and children's hospitals can provide substance use treatment under its hospital licensure. The treatment may be for any level of care (e.g., inpatient, outpatient); more than one-third offer at least one type of outpatient substance use treatment, according to the Connecticut Clearinghouse treatment locator. In addition, school-based health centers provide counseling, though the portion that has

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program review committee staff's provider survey. These spaces for many providers are shared between clients who have only mental health disorders and those with disorders involving substance use.

[47] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf.

[48] "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011. Accessed February 6, 2013 at: http://www.kff.org/medicaid/upload/8182.pdf.

[49] Among the N-SSATS 2011 survey respondents, 71 percent accepted private insurance and 79 percent took Medicaid. These percentages were even higher among the program review committee staff survey respondents (which, unlike N-SSATS, excluded government-operated facilities): 89 and 94 percent, respectively.

[50] Including only adult facilities offering treatment stays of four weeks or less, to ensure a reasonable comparison to adolescent residential treatment, which generally – for a center setting – does not exceed that timeframe.

actually provided substance use-related counseling is small.[51] Finally, non-behavioral healthcare licensed practitioners may deliver very brief interventions when routine or other examinations indicate there is a substance use problem.

Outpatient counseling also can be given by small independent behavioral healthcare practices and, on most of the state's baccalaureate-level campuses, college counseling centers.

**Connecticut's treatment availability**. *Currently, there is no comprehensive assessment of Connecticut substance use treatment sites or programs that systematically examines service capacity and whether it is sufficient.* There have been, however, a few efforts to examine one or both aspects, usually for behavioral healthcare (i.e., not specific to substance use), as described in-depth in Appendix G.

*Combined with the results of the program review committee's survey of licensed providers, these information sources indicate that there is inadequate behavioral health capacity at several levels of treatment:*

- *inpatient care;*
- *detoxification;*
- *residential treatment, especially for youth;*
- *in-home treatment models; and*
- *outpatient individual counseling.*[52]

In addition, some of these sources found a need for: treatment facilities that would accept new clients outside of normal business hours; youth-specific services (including young adults); and greater capacity for programs to serve Spanish-speaking clients.

Within college behavioral health outpatient counseling services, there could also be a shortage, with half of the survey respondents indicating a wait for treatment of at least four days. As noted in this study's prior report, it is important that substance use treatment be available very quickly.

*Adolescents' access to effective in-home treatment models is limited.* These models – Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) – are described in Appendix H. Each has been proven effective for adolescents, according to the National Center on Addiction and Substance Use at Columbia University.[53] In Connecticut, the Department of Children and Families grew these services through an intentional effort to make its substance use care community-based and, to the extent

[51] In FY10, six state-funded SBHCs (of about 71) – located in middle and high schools – provided substance use counseling, with an additional 13 (including a few elementary schools) providing "other counseling" that may have included care for substance use issues, according to data provided by DPH.

[52] These are the levels of care cited by at least two sources discussed in Appendix G as having substantial waitlists or generally inadequate capacity.

[53] Cognitive Behavioral Therapy (CBT) integrating family members has also been proven effective for adolescents. The aim of this therapy is to change unhealthy patterns of thinking and beliefs. CBT, more generally, is an evidence-based approach for many behavioral health disorders. It is not a model that is offered, as a distinct program, by the Department of Children and Families, though certain applications (e.g., Trauma-Focused CBT) are.

possible, evidence-based. Children may seek access to these services – which are covered for BHP enrollees – through methods that vary among the programs (as described in the appendix). The services generally are in high demand; an adolescent can wait longer than a month.

DCF contracts with providers to support these and other services for all adolescents, but it is not clear to what extent these programs serve those who are commercially insured.[54] A few providers told program review committee staff that, for the most part, there is limited accessibility to in-home models for children without Medicaid or DCF involvement. In addition, these providers noted that these evidence-based models are expensive to implement and maintain, with Medicaid reimbursement falling short of the actual costs. The precise expense of an in-home model varies among the options, but the full-length course of MDFT, for example, requires about $13,000 for one family. For commercially insured youth, providers attempt to bill commercial insurance for these services, reportedly with varying degrees of success. Two of the five Connecticut commercial health plans told committee staff that models such as MDFT are covered; an additional plan indicated an intention to explore such coverage.[55]

The Department of Children and Families noted that adolescents are to have equal access to the in-home programs, regardless of involvement with state agencies or insurance coverage. The contracted providers are to use their state funding to both: 1) serve adolescents who are uninsured, under-insured, or state agency clients; and 2) fill the gap between any reimbursement from Medicaid or commercial insurance and the true cost of delivering an evidence-based model.

*Even if a commercial insurer agrees to cover in-home services, the cost-sharing most plans require could make these treatments prohibitively expensive for a portion of enrollees, without the state paying for some or all of the remainder.* At the same time, in-home services are both evidence-based and, providers reported, less costly than either short-term residential treatment combined with appropriate after-care or the traditional 28-day stay in residential treatment.

If the state is serving a large number of commercially-insured youth through its evidence-based in-home behavioral health treatment models, it is spending a substantial amount to do so. Without data, however, it is difficult to accurately assess either the true accessibility of these models to privately insured youth, or the extent of the cost-shifting to the public sector and its nonprofit providers.

*There is indication that certain additional types of care are strained. First, Connecticut hospitals have reported struggling with an increased volume of behavioral health patients of all ages, particularly those seeking care from emergency departments.* For visits involving

[54] It is known, however, that commercially insured children are about one-third of DCF's Emergency Mobile Psychiatric Services (EMPS) participants.

[55] The other two plans indicated via the Connecticut Association of Health Plans that certain in-home behavioral health treatments, such as Applied Behavior Analysis for autism, are covered, but not MDFT and other, similar models.

behavioral health, emergency department presentations not resulting in an inpatient admission increased 40 percent from FY 2008 to FY 2012, while inpatient discharges rose 13 percent.[56]

One way to relieve hospitals and improve people's access to behavioral healthcare would be to open a 24-hour behavioral health urgent care center. This has been done in a few states[57] and was endorsed by the emergency department focus groups convened by DPH for the facilities plan. Because Connecticut is geographically small, this could be an option that would increase quick access to care for people statewide.

*Second, child and adolescent psychiatrists are difficult to access*, according to parents, pediatricians, and private nonprofits, with a statewide shortage that may be reflective of a national deficiency. In some situations, cost may be a barrier – with either particular insurance accepted or none at all – while in others, practices are full, with waits of weeks or even months.[58] While other types of practitioners can provide behavioral healthcare, child and adolescent psychiatrists are sought by most parents who seek psychiatric medication for their offspring.[59] This issue affects children with mental illnesses most deeply, but a portion of them have or will develop a co-occurring substance use disorder in adolescence – particularly if unable to receive appropriate treatment for mental illness.

The consultation program recommendations above would aim to ease this shortage. Massachusetts and other states have found that having a consultation and referral line has helped alleviate long waits for child psychiatrists by helping primary care providers shoulder some medication responsibilities, referring children who need counseling but probably not medication to non-psychiatrist therapists, and reserving psychiatry referrals for those with the most severe needs.

***Other factors impacting capacity adequacy***. Capacity adequacy from the perspective of a person seeking treatment may be impacted by payment method. From a macro view, an adequacy assessment is most accurate when the true need for services and referral patterns are considered.

*Payment method*. A share of private behavioral healthcare practices – including a small portion of specialty substance use treatment providers – does not accept commercial insurance.[60]

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[56] "Testimony of Carl Schiessl; Director, Regulatory Advocacy; Connecticut Hospital Association Before the Office of the Healthcare Advocate," October 17, 2012.

[57] The Olive View Community Mental Health Urgent Care Center in Sylmar (Los Angeles County) opened in August 2011. The project, which cost $10.8 million to build, was funded by both private and public contributions. (News release accessed on February 6, 2013 at: http://dmh.lacounty.gov.) In St. Paul, the Urgent Care for Adult Mental Health clinic was launched one month later through collaboration among hospitals, health plans, consumer groups, and state agencies. (Television news report accessed on February 6, 2013 at: http://www.kare11.com/rss/article/985970/20/Urgent-care-for-mental-health-opens-in-St-Paul.)

[58] See, for example, Dr. Kenneth Spiegelman's testimony at the Mental Health Working Group's January 29, 2013 public hearing (accessed February 15, 2013 at: http://www.cga.ct.gov/ASaferConnecticut/docs/2013MHWG00129-R001030-INF.pdf ).

[59] Pediatricians and Advanced Practice Registered Nurses (A.P.R.N.s) may prescribe medication. Interviewees indicated that pediatricians have grown comfortable with prescribing attention-deficit medication but not with doing so for other types of pharmaceuticals designed to treat mental health disorders.

[60] For example, nearly half (47 percent) of the 147 Connecticut child and adolescent psychiatrists who responded to a 2007 survey indicated they do not accept any major managed care health plan. The survey was conducted for a

Individuals with commercial insurance receive substance use treatment at lower rates than others, for unclear reasons.[61]

Someone seeking to pay for treatment with insurance may also be delayed in receiving care due to insurance utilization review (i.e., the process used to determine if requested or received treatment will be covered). The committee's December recommendations regarding commercial fully-insured plans' substance use treatment utilization review requirements, contained in Raised Bill 6557, aim to help ensure that commercial insurer coverage determination practices are not a barrier to prompt and appropriate treatment.

*Need for treatment*. The capacity assessment given above is limited because it includes only provider and family experiences of those who have sought treatment. A substantial share of the population needs but does not receive substance use care. According to a federal estimate, ina recent year more than 87 percent of non-institutionalized Connecticut youth who needed treatment for a substance use disorder involving illicit substances did not receive it (at least, from a specialty facility),[62] and the figure rises to 96 percent for a disorder involving alcohol. If all youth needing treatment were to seek it out, it is likely the current specialty substance use treatment system would be unable to handle the influx of patients; however, it is possible a portion could be appropriately treated by private counseling practices. Wider screening, as discussed above, would translate into more accurate adequacy information.

*Appropriate care level*. Capacity adequacy is influenced by referral patterns – not only which providers frequently receive referrals, but also whether certain levels of care are more often sought. There is some concern among state agency personnel and insurers that residential treatment in particular is requested when it might not be the most appropriate level of care. At the same time, it is clear that certain clients need residential treatment. The committee's December recommendations regarding commercial fully-insured plans' substance use treatment utilization review protocols (i.e., criteria) – which are contained in Raised Bill 6557 – would ensure that these criteria are not a barrier to appropriate treatment. This report's screening-related recommendations would help ensure providers know what treatment level is necessary.

**Recommendations**. To improve quick access to urgent behavioral healthcare, the program review committee staff recommends:

**7. The Departments of Mental Health and Addiction Services, Public Health, and Children and Families should develop a proposal to launch an urgent care center for behavioral health, bringing in both public and private partners.**

To understand whether DCF's in-home treatment models for behavioral healthcare are accessible to adolescents with commercial health insurance, and to determine if there is cost-shifting, the program review committee staff recommends:

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study of access to mental health care completed by two state offices. ("Connecticut Children Losing Access to Psychiatric Care; A Report of the Attorney General and Child Advocate's Investigation of Mental Health Care Available to Children in Connecticut," Richard Blumenthal and Jeanne Milstein, April 12, 2007.)

[61] "Type of Health Insurance and the Substance Abuse Treatment Gap," Ellen Englert Bouchery, Henrick J. Harwood, Joan Dilonardo, and Rita Vandivoert-Warren, 2012, *Journal of Substance Abuse Treatment* 42:289-300.

[62] Illicit substances are either illegal substances or legal substances used improperly.

**8. The Department of Children and Families should instruct its funded providers to keep data, for a short period (e.g., three to six months), on:**

**a. the name of the insurance carrier (if any) of each child whose parent(s) seeks treatment in an in-home behavioral healthcare model, including the employer if the plan is self-insured;**

**b. whether the child was accepted into the program;**

**And for those children accepted:**

**a. whether the insurance carrier agreed to cover the treatment;**

**b. for those parents whose commercial insurance agreed to cover the treatment,**

**i. voluntary reporting on the terms of the cost-sharing, and**

**ii. whether the child did in fact then participate in the program; and**

**c. for those children who had commercial insurance that did not agree to cover the treatment, the per-child cost of the treatment and voluntary reporting by the parent on whether the coverage denial was due to exceeding insurance spending limits.**

**The Department of Children and Families should use this information to assess the accessibility of these models to commercially insured youth and the extent of cost-shifting to the state and its contracted nonprofit providers. If the department finds extensive cost-shifting, it should propose ways to alleviate the burden on the state and its providers.**

Finally, the program review committee staff's Section I recommendations are intended to further help the state assess and address capacity problems.

**Element 3: Receiving Appropriate Treatment**

**Ideal**. A person receives treatment that is sensitive to his or her characteristics. For example, an adolescent or a young adult receives treatment that is appropriate to developmental and life stage. If there is a co-occurring mental health disorder, treatment for both is simultaneously given, in an integrated way.

**Connecticut**. *There are some indications that a portion of Connecticut adolescents and young adults are not receiving age-appropriate substance use treatment services.* Federal data indicate that Connecticut lags the nation in adolescent substance use treatment. Compared to the national average, the state has had smaller shares of adolescents being treated by a facility that offers an adolescent-focused program and facilities offering adolescent-focused programs, despite similar need.[63]

While young adults generally can access services that are open to adults, services rarely are tailored to this specific group.[64] There has been some recognition by DMHAS that its

[63] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf. See Appendix F for details.

[64] Based on program review committee staff interviews and survey data (presented in Appendix E).

services for young adults (even beyond those given to youth transitioning to that agency from DCF) could be more age-specific, in order to increase treatment persistence and benefit.[65]

*Co-occurring disorders generally are treated in an integrated way*, according to program review committee provider survey respondents.

**Recommendation**. To improve the appropriateness of substance use treatment received by adolescents and young adults, the program review committee staff recommends:

> **9. The Department of Children and Families and the Department of Mental Health and Addiction Services should offer training and/or other resources to substance use treatment providers – including those who are not state-contracted – to ensure that adolescents and young adults receive developmentally appropriate substance use treatment.**

**Element 4: Receiving Support for Recovery**

**Ideal**. After intensive substance use treatment, a person is connected with less-intensive clinical services and appropriate recovery supports.[66] These services can help maintain treatment gains and, if relapse occurs, facilitate quick re-entry into intensive treatment. Ongoing care management involves check-ins and connections to services, while recovery supports are nonclinical things or programs that provide assistance in dealing with life stressors that can trigger relapse. Recovery supports can include housing (group or independent), transportation, and peer coaching.[67] Both care management and recovery supports are supported by research and reflect the chronic nature, for many, of a substance use disorder.

**Connecticut: Care management**. *People with substance use disorders who are enrolled in the BHP or are DMHAS clients have access to case management services, while similar services are available with coverage to only a subset of commercially insured people*.[68] All five Connecticut commercial health plans indicated that care management services of two to five months are provided directly by plan staff. For two plans, these services are given to about 30 percent of enrollees who are admitted to inpatient substance use treatment – not to everyone in inpatient care, or to enrollees participating in lower levels of care. The other plans indicated a wider scope of potential care management participants, though not everyone with a substance use disorder necessarily would be included. Most, if not all, plans use data analysis to identify

[65] "2012 Report on Statewide Priority Services," Connecticut Department of Mental Health and Addiction Services, September 2012.

[66] Recovery itself is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential," according to SAMHSA (http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/, accessed February 26, 2013.)

[67] Other recovery supports are: case management, childcare, faith support services, financial support, mutual support groups, recovery check-ins, recovery-specific schools and vocational programs, and wellness services.

[68] See, for example, DMHAS Commissioner Patricia Rehmer's testimony to at the Mental Health Working Group's January 29, 2013 public hearing (accessed February 15, 2013 at: http://www.cga.ct.gov/ASaferConnecticut/docs/2013MHWG00129-R001030-INF.pdf ). Case management can include assessing, planning, referring and linking to services, coordinating services, and monitoring.

enrollees for care or case management. Generally commercial health plans do not reimburse providers for case management.[69]

Some substance use treatment advocates are frustrated with the disparity between disease management services provided to people with medical ailments and those given to people with substance use or other behavioral health disorders. In Connecticut as nationally, substance use and other behavioral health disorders generally are not included in ailments targeted by chronic disease management programs offered by or mandated for some insurers (private and public).[70,71]

However, it is unclear whether people with substance use disorders would benefit from inclusion in typical disease management programs. The evidence on the cost-effectiveness of chronic disease management programs is mixed.[72] Research suggests chronic disease management programs most likely to lower healthcare costs involve an individualized plan, in-person check-ins with a care manager, a focus on reducing hospital utilization, and low cost-sharing for recommended care.[73]

In contrast, there is research to support care or case management for people with substance use disorders.[74] Short of mandating health plans cover or directly provide care / case management services for people with a substance use disorder, or the state funding these services directly, it is unclear how to uniformly expand these services to commercially insured youth.

**Connecticut: Recovery supports**. *Youth in Connecticut who have substance use disorders generally do not have insured access to the recovery supports that also can help maintain treatment effects*. As nonclinical services, recovery supports generally fall outside traditional private insurance coverage, although insurance pays for sustained outpatient counseling for a person in recovery and may cover or subsidize some wellness services. Other recovery supports may be provided or funded by family members, friends, or others, when there is a desire and means.

Some support services – such as weekly telephone peer check-ins and recovery drop-in centers – are available free to the general public, largely through the Connecticut Community for

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[69] "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011.

[70] The ACA requires small group and individual health plans to include chronic disease management, beginning in 2014 (i.e., it is defined by the law as an essential health benefit).

[71] For example, the State Employee Health Plan's Health Enhancement Program does not include behavioral health disorders in the list of maladies that require chronic disease management components. The included ailments are diabetes, heart disease/heart failure, asthma and chronic obstructive pulmonary disease, hyperlipidemia, or hypertension. ("Health Enhancement Program Chronic Condition Tracker," accessed February 20, 2013 at: http://www.osc.ct.gov/empret/healthin/2011hcplan/HEPprogress/HEPChronicConditionRequirements.pdf .)

[72] "Chronic Disease Management," Lara Cartwright-Smith. HealthReformGPS (a project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation), February 23, 2011. Accessed January 29, 2013 at: http://healthreformgps.org/resources/chronic-disease-management/.

[73] "Issue Brief; Disease Management: Does It Work?" Jill Bernstein, Deborah Chollet, and G. Gregory Peterson. Mathematica Policy Research, May 2010, Number 4. Accessed January 29, 2013 at: http://www.mathematica-mpr.com/publications/PDFs/health/reformhealthcare_IB4.pdf.

[74] "Addiction Medicine: Closing the Gap Between Science and Practice," National Center on Addiction and Substance Abuse, June 2012, pp. 107-109. Accessed June 29, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf.

Addiction Recovery and mutual support groups.[75] In addition, comprehensive recovery support services are available to some DMHAS clients, largely through a federal grant.[76]

*Few recovery supports specific to youth, however, are available in this state, even for DMHAS clients or BHP enrollees.* For example, there is no high school for youth in recovery, unlike in 16 other states.[77] Only one college participating in the committee's survey indicated having a recovery program for its students. Some adult recovery supports – such as mutual support groups or telephone check-ins with adults in recovery – might not be appropriate for youth, because adolescents and young adults are different in several ways from mature adults (e.g., still developing, shorter substance use history).

The creation of youth recovery support services is sought by a relatively new youth recovery advocacy organization.[78] At the group's urging, recently there has been some state agency collaboration around this goal. There have been no concrete outcomes of that effort yet; the agencies have been awaiting state budget information because that will shape what is feasible. Although state funds are scarce, even if no funding is obtained this year, it would be helpful to have a concrete action plan ready to aid in grant application submissions and identification of priorities for future state budget cycles.

**Recommendation**. To help maintain the treatment investments made by the BHP, commercial insurers, state agencies, youth in recovery, and their families, the program review committee staff recommends:

**10. The Department of Children and Families and the Department of Mental Health and Addiction Services, as well as other state agencies, should continue the effort to develop youth recovery supports that are reasonably accessible statewide to adolescents and young adults both in and out of state agency systems.**

**The interagency group should set a date by which it will complete a plan describing:**

**a. the supports to be built (including using existing advocacy or mutual support groups as a foundation);**
**b. how the supports will be found by and accessible to youth; and**
**c. options for implementation, including but not limited to funding.**

[75] The Connecticut Community for Addiction Recovery is a recovery advocacy group that has been supported in part through DMHAS funding. It was created in 1998.
[76] DMHAS recovery supports are funded by the federal Access to Recovery grant and a small portion of its federal Substance Abuse Prevention and Treatment Block Grant.
[77] "High Schools," Association of Recovery Schools. Accessed February 28, 2013 at: http://www.recoveryschools.org/schools_highschool.html.
[78] Connecticut Turning to Youth and Families is a recovery advocacy organization that was launched in 2008 through a DCF-received federal grant.

# Appendices

A: Estimate of Youth Substance Use Treatment Need
B: Study Methods
C: Network Adequacy
D: Treatment Locators
E: Licensed Substance Use Treatment Provider Survey
F: Available Treatment Services
G: Examinations of the State's Substance Use Treatment Capacity Adequacy
H: Adolescent In-Home Treatment Models

# Appendix A

## Estimate of Youth Substance Use Treatment Need

| Table A-1. Youth Substance Use Disorder Treatment Need and Receipt of Treatment, 2010-2011 Estimates | | | | |
|---|---|---|---|---|
| | ***Ages 12-17*** | | ***Ages 18-25*** | |
| | ***CT*** | ***US*** | ***CT*** | ***US*** |
| Illicit substances | | | | |
| Had abuse or dependence disorder in last 12 months | 4.6% | 4.7% | 7.9% | 7.7% |
| Received treatment | 0.6% | 0.4% | 0.9% | 0.6% |
| Needed, did not receive | 4.0% | 4.3% | 7.0% | 7.1% |
| Of those needing treatment, percent who did not receive it in specialty facility | 87.3% | 92.5% | 88.4% | 91.8% |
| Alcohol | | | | |
| Had abuse or dependence disorder in last 12 months | 4.2% | 4.2% | 17.2% | 15.0% |
| Received treatment | 0.1% | 0.1% | 0.7% | 0.6% |
| Needed, did not receive | 4.1% | 4.0% | 16.5% | 14.5% |
| Of those needing treatment, percent who did not receive it in specialty facility | 96.7% | 96.6% | 96.2% | 96.2% |
| Had either substance or alcohol abuse or dependence in last 12 months | 7.3% | 7.1% | 21.2% | 19.3% |

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data – Revised March 2012); and PRI staff analysis of the data (Received treatment, Percent needing treatment that did not receive it in specialty facility). Accessed February 21, 2013 at: http://www.samhsa.gov/data/NSDUH/ 2k11State/NSDUHsaeTables2011.pdf.

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# Appendix B

## Study Methods

This report draws upon a variety of information sources. Program review committee staff had conversations and electronic communications with: youth in recovery, and parents of some; substance use treatment providers; commercial insurance staff and representatives; personnel from numerous state agencies and offices - the Insurance Department, the Department of Social Services, the Department of Mental Health and Addiction Services, the Department of Children and Families, the Department of Public Health, the Office of the Attorney General, the Office of the Child Advocate, and the Office of the Healthcare Advocate (OHA); former state agency employees; advocates for substance use treatment, nonprofit providers, healthcare professional associations, and children's health; and researchers.

Committee staff also listened to or read testimony from the study's June 2012 public hearing, a May 2012 forum on the experiences of youth in recovery, the OHA-sponsored October 2012 hearing on mental health parity, the January 2013 hearing held by the Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety, and the March 2013 public hearing on bills containing recommendations from this study's phase one report.

These communications and events informed all aspects of this report. The following table lists information sources (other than those mentioned above) specific to particular areas.

| Table B-1. Additional Information Sources | |
|---|---|
| **Section 1** | |
| State agency and council activities | • Council reports and meeting minutes |
| Insurer network adequacy | • State and federal laws<br>• National health plan accrediting organization staff<br>• National health plan accrediting standards<br>• State agency personnel in nearby states (as well as Connecticut)<br>• Literature |
| **Section II** | |
| Connection to treatment | • Department of Public Health (DPH) facilities plan<br>• Reports from the National Center on Addiction and Substance Use |
| Screening within primary care | • Independent nonprofit staff<br>• Massachusetts Child Psychiatry Access Project staff, and project's March 2013 presentation to Connecticut legislature<br>• Literature |
| Locating available treatment | • Plans produced by the Departments of: Children and Families (DCF), Mental Health and Addiction Services (DMHAS), and Public Health<br>• Program review committee surveys of licensed treatment providers and college counseling centers<br>• Federal substance use treatment facility and treatment need data<br>• Online treatment locators<br>• Information from DPH and DCF on school-based health center services and in-home treatment models |
| Receiving appropriate treatment | • Federal substance use treatment facility data |
| Receiving support for recovery | • Connecticut Association of Health Plans data and information<br>• Literature |

# Appendix C

## Network Adequacy

Health plans, insurance regulators, or accrediting agencies may aim for or require certain standards regarding access to in-network providers. These are called network adequacy standards, and generally include assessment of: whether the number of in-network providers is sufficient; if in-network providers are reachable by health plan enrollees within a certain amount of time or distance; and if in-network appointments are available.[79]

### Affordable Care Act (ACA)

The ACA has several provisions that aim to ensure the plans available on insurance exchanges – called "qualified health plans" (QHPs) – have sufficient networks. A plan must:

- post its provider network directory online, with identification of providers not accepting new patients;
- include essential community providers in their network;[80] and
- have a network sufficiently diverse – including providers specializing in mental health and substance use services – and large to make services available "without unreasonable delay."

QHPs must be accredited as an attestation to compliance with certain quality measures, including "network adequacy and access." For an interim first phase (until a rule establishing phase two is issued), accreditation by either the National Committee for Quality Assurance (NCQA) or URAC is required.[81]

In addition to this accreditation, each exchange board must certify all the plans offered within it, monitor to ensure that all standards are being met (including accreditation standards), and publicize each QHP's standards data to inform consumers. The Office of the Healthcare Advocate has indicated that Connecticut's exchange board (on which the advocate sits) will require a QHP to provide and make publicly available its network adequacy measures and data.

[79] See, for example: "Network Adequacy in the Commonwealth Care Program," Bailit Health Purchasing for the Blue Cross Blue Shield of Massachusetts Foundation, April 2009. Accessed January 10, 2013 at: http://bluecrossmafoundation.org/sites/default/files/090422NetworkStandardsFINAL.pdf.

[80] Essential community providers are those that serve mostly low-income, medically underserved people, including FQHCs, Indian Health Centers, rural health clinics, and disproportionate share and critical access hospitals. An exchange may require that a QHP contract with all willing essential community providers.

[81] When phase two commences, the accrediting entities will be selected through an evaluation based on criteria set out in future federal rules. (45 CFR Part 156. Friday, July 20, 2012 Federal Register, Vol. 77, No. 140)

**Standards at the National and State Levels**

Existing standards available at the national level include those of the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act; URAC; NCQA; Medicaid; and Medicare.[82] The URAC and NCQA standards are discussed in-depth below, given their recognition by the federal government for exchange health plan purposes and prominent role in Connecticut's network adequacy law. The NAIC model act is also described.

**NAIC**. The NAIC model act on network adequacy calls for, among many things, each health insurance carrier to submit an access plan to the insurance department.[83] The act does not explicitly state whether the department shall have approval power, but embedded drafting notes explain that such power may be given to that or another department.

In NAIC's June 2012 guidance on how insurance regulators may handle determining exchanges' qualified health plans' network adequacy, it is implied that at least some states actively check for commercial plans' adequacy through formal analysis. The purpose is to ensure that covered services "accessible without unreasonable delay." The paper enumerates that included in the analysis are reviews – at least annually – of:

- geographical considerations, including population, density, provider willingness to participate under reasonable terms, and geographical barriers;
- medical care referral patterns and hospital admission privileges;
- whether hospital-based providers are in the hospital's same network;
- access to medically intensive and critical care services (e.g., burn units, transplants);
- availability of different provider types; and
- ability of providers to accept new patients.

The guidance notes proprietary tools (e.g., OptumInsight, Quest Analytics) may be used to evaluate a plan's network. It also notes that an analysis of provider willingness to participate under reasonable terms and conditions could be done, but unaddressed is how to resolve whether terms and conditions are reasonable. If a plan or actual network is found insufficient by the insurance department, corrective action can be required.[84]

**URAC**. The URAC standards are not easily available to the public; however, the organization provided a copy to program review committee staff upon request. The standards directly relating to enrollee access – as well as what URAC expects to see for each standard – are

[82] "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.
[83] Other components of the Model Act address: various aspects of the relationship between in-network providers and the health carrier; provider network admission standards; and insurance department review of forms and contracts.
[84] "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf .

| Table C-1. URAC Accreditation Measures Related to Network Adequacy | | | | |
|---|---|---|---|---|
| ***Title*** | ***Number*** | ***Reqd?**** | ***Standard's Description*** | ***URAC Expectations (beyond standard's language)*** |
| Scope of Services | P-NM 1 | No | Define network's types of services and geographic area served | Census data (e.g., age, rural vs. urban, ethnicities) |
| Provider Network Access and Availability | P-NM 2 | No | Regarding access and availability:<br>• Set goals<br>• Monitor performance and report to organization's quality management committee<br>• Make improvements where necessary to maintain network and meet contractual requirements | 1. Accessibility goals: (could vary based on geography)<br>• Primary care: Providers within 25 miles or minutes<br>• Specialists: within 50 miles<br>2. Availability goals:<br>• Appointments possible<br>• Wait times for emergent, urgent, symptomatic, preventive visits<br>• Business hours<br>3. Compare network to universe of providers in area<br>4. Provider-enrollee ratio<br>5. Monitor through software, secret shoppers, surveys, complaints, out-of-network use, ER use |
| Out of Network and Emergency Services | P-NM 4 | Yes | Ensure access to covered services not available in-network and emergency care | --- |

*URAC accreditation, like NCQA's, is based on weighted scores on a variety of performance measures. Failure to perform or submit documentation on a standard will negatively impact the overall score and therefore harm the chance for / level of accreditation; therefore, it is likely that health plans aim to gather as many points as possible by completing both mandatory and non-required measures.

Source: PRI staff analysis of URAC's *Health Plan Standards, Version 7.1* and URAC powerpoint presentation to Hawaii regulators, entitled "URAC Accreditation & Network Adequacy," Christine Leyden and Mark Gorden, 2012.

described in Table C-1. As part of the accreditation process, URAC's staff is to confirm that the network composition plan and network itself is sufficient and evaluate whether the plan is on track to meet its self-set goals. If a problem is found during that process, then the health plan must create a plan to solve it, with follow-up by URAC.[85]

**NCQA**. NCQA standards similarly are not freely accessible to the public; however, the organization provided a copy to program review committee staff upon request. The standards involve an examination of whether there are sufficient primary and specialty care providers given plan enrollment, the plan's performance against self-set standards, and if patients report problems accessing care.

The standards directly relating to enrollee access – as well as what NCQA expects to see for each standard – are described in the table below. There is particular emphasis on access to behavioral health care.

**Medicaid and Medicare**. Federal law requires Medicaid managed care plans and Medicare Advantage plans to meet certain standards, including provider to enrollee ratios – which can be specific to types of providers (e.g., obstetrician-gynecologist, behavioral health) and time / distance requirements.[86]

[85] Correspondence from URAC President & CEO Alan P. Spielman to CMS Acting Administrator Marilyn Tavenner, RE: Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans; July 5, 2012.
[86] "Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges," Sabrina Corlette, JoAnn Volk, and Kevin Lucia, Report from the Study Panel on Health Insurance Exchanges Created Under the Patient Protection and Affordable Care Act, May 2012. Accessed February 1, 2013 at: http://www.healthreformgps.org/wp-content/uploads/Plan_Management_Issues_for_Exchanges.pdf.

| Table C-2. NCQA Accreditation Measures Related to Network Adequacy | | | | |
|---|---|---|---|---|
| ***Title*** | ***Number / Element*** | ***Reqd?**** | ***Standard's Description*** | ***NCQA Expectations (beyond standard's language)*** |
| **Availability of Practitioners** | **QI** 4** | **No** | **Ensures its network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care** | **Intent: Maintain an adequate network in each care area and monitor how effectively members' needs and preferences are met** |
| Cultural Needs and Preferences | QI 4: Element A | No | • Assesses members' cultural, ethnic, racial and linguistic needs<br>• Adjusts practitioner availability within network, if necessary | 1. Identify members' language needs and cultural background, as well as expressed preferences, through survey / Census / employer / complaint data<br>2. Identify those of practitioners and compare to members<br>3. Adjust the network if members' needs / preferences not met, through recruitment and credentialing of new providers / requiring provider cultural competency training; also facilitate linking members to practitioners meeting preferences |
| Practitioners Providing -- | QI 4: | No; Equal weight per element | • For specialty and behavioral care, defines the types of practitioners who are high-volume; for primary care, those are GPs, internists, pediatricians<br>• Establishes quantifiable and measurable standards for the:<br>  • Number of each high-volume / primary care type<br>  • Geographic distribution of each high-volume / primary care type<br>• Analyzes performance against the standards (at least) annually | • Standards realistic for community, delivery system and clinical safety<br>• Number and distribution expressed through (e.g.) –<br>  • Ratio of members: practitioners in each area<br>  • Ratio of providers taking new patients: practitioners in each area<br>  • Percentage of members with practitioner of each type available within certain miles or (to those taking new members) driving times |
| Primary Care | Element B | | | |
| Specialty Care | Element C | | | |
| Ensuring Availability of Behavioral Healthcare Practitioners | Element D | | | |
| **Accessibility of Services** | **QI 5** | **No** | **Provides and maintains appropriate access to primary care, behavioral healthcare and member services.** For each element, using valid | **Intent: Maintain an adequate network in each care area and monitor how effectively members' needs and preferences are met** |

| Table C-2. NCQA Accreditation Measures Related to Network Adequacy | | | | |
|---|---|---|---|---|
| | | | methodology, organization collects and performs annual analysis to measure performance against standards of access. | |
| Assessment Against Access Standards | QI 5 Element A | No | Access to:<br>1. Regular and routine care appointments<br>2. Urgent care appointments<br>3. After-hours care<br>4. Member services, by phone | • Member satisfaction with appointment / care timeliness in various ways<br>• Practitioner timeliness in responding to after-hours calls |
| Behavioral Healthcare Access Standards | QI 5 Element B | No | Access to:<br>1. Care for non-life-threatening emergency within 6 hours<br>2. Urgent care within 48 hours<br>3. Appointment for routine office visit within 10 days | Can be supplemented by member surveys and complaints (as with other elements) |
| Behavioral Healthcare Telephone Access Standards | QI 5 Element C | No | 1. Quarterly average for screening and triage calls shows that phones are answered by live voice within 30 seconds<br>2. Quarterly average for those calls reflects a phone abandonment rate within 5% | (Only applicable if there is centralized screening and triage) |

*NCQA accreditation, like URAC's, is based on weighted scores on a variety of performance measures. Failure to perform or submit documentation on a standard will negatively impact the overall score and therefore harm the chance for / level of accreditation; therefore, it is likely that health plans aim to gather as many points as possible by completing both mandatory and non-required measures.
*Quality Improvement
NCQA accreditation relies on a plan's score. Half the score derives from a plan's score on accreditation standards performance, such as those described in this chart, while the other portion is based on the plan's performance on certain health insurance industry measures (HEDIS and CAHPS).
Source: NCQA's accreditation standards "QI 4: Availability of Practitioners" and "QI 5: Accessibility of Services", and PRI staff review of NCQA powerpoint presentation entitled "Quality Improvement Standards in Access and Availability; Introduction to NCQA Accreditation for Health Plans and MBHOs," 2011.

**State Laws**

Several states have adopted laws incorporating the NAIC model act's network adequacy provisions, as shown by the table below. At least a few additional states have other, non-Model Act network adequacy standards; some states rely on solely the insurance department to determine compliance, while others draw in the state health agency.[87]

| Table C-3. State Adoption of NAIC Model Act on Network Adequacy | | | |
|---|---|---|---|
| ***Entire Act: 5*** | ***Portions: 2*** | ***Related / Similar: 13*** | |
| Colorado | New Jersey | Alabama | New York |
| Missouri | Tennessee | Florida | North Carolina |
| Montana | | Georgia | Oregon |
| Nebraska | | Illinois | Pennsylvania |
| South Dakota | | Kansas | Rhode Island |
| | | Maine | Washington |
| | | New Hampshire | |
| Source: PRI staff analysis of *Managed Care Plan Network Adequacy Model Act; Model Regulation Service – October 1996* (Rev. 2010), NAIC. | | | |

Several states have specific quantitative provider-to-enrollee and time or distance-to-provider requirements in law or regulation.[88]

It is unclear to what extent other states' insurance regulators actively examine fully-insured plans' network adequacy and access to care. One report, issued in 2000, indicated that a few states did at that time examine network adequacy through investigating provider network listings. Although these states found substantial inaccuracies, the report noted that other states had chosen not to engage in such resource-intensive efforts.[89]

**Northeastern states**. Several northeastern states have network adequacy requirements. Regulating entities in four states provided program review committee staff with information on the extent of their laws and oversight. Highlights are provided below.

[87] Arizona, Minnesota, and Wisconsin were cited in one report reviewed for this study as having adequacy laws that differ from the Model Act; however, these - along with Tennessee's Model Act-type law – apply their laws solely to HMOs and closed network plans. ("Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges," Sabrina Corlette, JoAnn Volk, and Kevin Lucia, The Center on Health Insurance Reforms at Georgetown University Health Policy Institute and the National Academy of Social Insurance, May 2012. Accessed February 1, 2013 at: http://www.healthreformgps.org/wpcontent/uploads/Plan_Management_Issues_for_Exchanges.pdf)

[88] "Background Paper on Network Adequacy and Essential Community Providers," Prepared by Exchange staff, June 2012. Accessed January 10, 2013 at: http://mn.gov/commerce/insurance/images/ExchPlanBkgndPaper6-27-12.pdf. See also: "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. Accessed January 10, 2013 at: http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[89] "Consumer Protection in Private Insurance: State Implementation and Enforcement Experience," Stephanie Lewis and Karen Pollitz, Institute for Health Care Research and Policy at Georgetown University for the Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 2000. Accessed February 19, 2013 at: http://aspe.hhs.gov/health/reports/consumer/stateimp/private.htm.

New Jersey and New Hampshire have specific access standards that health plans must meet, shown in the table below. New Jersey's standards apply to health maintenance organizations (HMOs). The regulating agency requires an annual supplement to be filed, giving updated information on the network parameters and activities done to ensure network listings are accurate. New Hampshire's standards apply to health insurance carriers (not only HMOs). The health carrier annually must report to the regulating agency, showing compliance with the standards and also addressing, for primary care, wait times for appointments and whether providers are accepting new patients.

| **Table C-4. Nearby States' Prescriptive Network Adequacy Standards** | | |
|---|---|---|
| | ***New Hampshire*** | ***New Jersey*** |
| Psychiatrist | 45 miles or one hours of driving time | lesser of 45 miles or one hour of driving time |
| Primary care | >= 2 providers within 15 miles or 40 minutes of driving time | >= 2 physicians within 10 miles or 30 minutes of travel time |
| Inpatient psychiatric care | 45 miles or 60 minutes | lesser of 45 miles or one hour of driving time |
| Medical hospital | | 20 miles or 30 minutes' driving time |
| Residential substance use Treatment | | lesser of 45 miles or one hour of driving time |
| Outpatient behavioral health | 25 miles or 45 minutes travel time | 20 miles or 30 minutes' driving time |
| Within | County or hospital service area | 90 percent of members within county or sub-county service area |
| Source: PRI staff review of New Jersey and New Hampshire insurance regulations as provided by regulating entities. | | |

Maine had access prescriptive standards similar to New Hampshire and New Jersey's, but those requirements were replaced a few years ago. The current standards require that insurers meet the NCQA adequacy provisions.[90]

New York does not have specific adequacy standards in law or regulation, but communication with regulating entities indicated that HMOs must meet certain requirements.

### Connecticut Health Carriers' Networks for Substance Use Treatment

The five major carriers of Connecticut fully-insured health plans provided program review committee staff with information, shown in Table C-5, on their provider networks related to substance use treatment. Although the plans varied in whether they included only substance

[90] According to a March 2013 conversation with staff from the Consumer Health Care Division, Bureau of Insurance, Maine Department of Professional and Financial Regulation.

use treatment providers, both substance use and mental health treatment providers, or did not specify which types of providers are included, it is clear there are some differences. The reasons for and implications of the differences are uncertain.

**Table C-5. Connecticut Major Health Carriers' Networks Related to Substance Use Treatment**

| | ***Plans A & D*** | ***Plan B*** | ***Plan C*** | ***Plan E*** |
|---|---|---|---|---|
| Inpatient detoxification | 43 | 40 | 29 | 24 |
| Inpatient residential | 16 | 10 | 24 | 31 |
| Residential | 12 | 12 | 7 | 12 |
| Partial hospitalization | 59 | 54 | 25 | 42 |
| Intensive outpatient | 71 | 88 | 66 | 69 |

Notes:
Plans A and D share a network.
Program review committee staff asked for the number of in-network providers (i.e., facilities), by level of care, giving substance use treatment.
Outpatient network information is omitted due to apparent differences among the plans (e.g., whether each in-network practitioner in a facility or practice is counted).
Source: CT Association of Health Plans.

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# Appendix D

## Treatment Locators

| Table D-1. Substance Use Treatment Locators or Search Tools | | | |
|---|---|---|---|
| ***Range*** | ***Locator / Tool Name*** | ***Operator*** | ***Web Address (if applicable)*** |
| Substance use and mental health | CT Clearinghouse *(DMHAS-operated or -funded services only)* | Wheeler Clinic's CT Clearinghouse (DMHAS funded) | https://www.ctclearinghouse.org/Directory/default.asp |
| | How to Find Services in Your Area *(DMHAS-operated or -funded services only)* | DMHAS | http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335206 |
| | 24-Hour Crisis Services | DMHAS | http://www.ct.gov/dmhas/cwp/view.asp?a=2902&Q=378578&dmhasNav=\|#M [to find the phone number for crisis services in a given town] |
| | Behavioral Health Treatment Services Locator | SAMHSA | http://findtreatment.samhsa.gov/ [or dial 1-800-662-HELP (4357)] |
| Behavioral health and social services | Infoline 2-1-1 | United Way of Connecticut (partly state-funded) | http://www.211ct.org [or dial 2-1-1 from a landline telephone] |
| | Network of Care: Embrace Hope, Expect Change | Trilogy Integrated Resources, LLC (funded by federal, state and private partners) | http://connecticut.networkofcare.org/mh/ |
| Source: PRI staff research. | | | |

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# Appendix E

## Licensed Substance Use Treatment Provider Survey

The program review committee staff surveyed substance use treatment providers licensed by the Department of Public Health to gather capacity, treatment, and insurance information. This appendix describes survey distribution, participation, and results (including a list, for respondents, of services offered and payment methods). It also contains, at the end, a copy of the survey (Figure E-1).

### Distribution

Program review committee staff primarily distributed the survey electronically, via the Connecticut Community Providers Association and e-mail addresses found online or obtained through telephone calls by committee staff. Electronic contact information for a few providers could not be located; these were sent hard copies of the survey.

The first round of survey distribution occurred in late September 2012. In mid-October, reminders were sent. Additional attempts to obtain responses were made in November 2012 and in January 2013. Roughly half of responses were provided upon the initial contact, with approximately one-quarter each given in the second and third rounds. The survey response dates therefore ranged across months. Consequently, the capacity and waitlist information should be interpreted with caution – as one source, among several, of information in this area.

### Participation

The precise participation rate is difficult to calculate because many providers have multiple sites and not all respondents answers for the entirety of their employer's services. Thirty-seven of the seventy-one providers who had DPH-licensed substance use treatment facilities or specialty psychiatric hospitals were included in the final survey data analysis. Two of those providers also accounted for three of the four children's residential treatment facilities, which are licensed by the Department of Children and Families. These responses represented 102 of 205 facilities and specialty hospitals. Two outpatient mental health clinics also participated. It was not determined whether any particular type of provider (in terms of level of care, geographic area, clients served, or other characteristic) was over- or under-represented. The survey respondents are listed – along with levels of care offered and payment methods accepted – at the end of this appendix.

### Data Entry and Analysis

The survey was administered via SurveyMonkey and manipulated using Excel and SPSS. Generally, multiple responses concerning a single organization were consolidated into one response, except when there were large variations in the population served or payment methods accepted. Program review committee staff attempted to contact respondents for clarifications and more complete information when necessary.

## Respondent Characteristics

**Levels of care offered**. The entire range of substance use treatment levels of care was offered by survey respondents. There were 39 providers or major subsets of providers represented. Table E-1 indicates regular, individual outpatient treatment was offered by the vast majority of providers (82 percent), and inpatient care was the rarest type (15 percent).

**Table E-1. Levels of Care Offered By Survey Respondents**

| | *# Respondents* | *% of All Respondents* | *Of Respondents Providing Certain Level of Care, Minimum Percent Offering Level to Different Populations* | | |
|---|---|---|---|---|---|
| | | | *Adults* | *Pregnant Women* | *Adolescents* |
| Inpatient | 6 | 15% | 83% | 17% | 17% |
| Detox. | | | | | |
| Inpatient | 6 | 15% | 83% | 17% | 17% |
| Outpt. | 7 | 18% | 100% | 14% | 14% |
| Resid. | 2 | 5% | Not applic. | Not applic. | Not applic. |
| Resid. | 16 | 41% | 69% | 50% | 13% |
| Comm. Liv. | 7 | 18% | 100% | 29% | 0% |
| Part. Hosp. | 7 | 18% | 100% | 57% | 29% |
| Day/Eve. | 18 | 46% | 72% | 56% | 44% |
| In-home | 8 | 21% | Not applic. | Not applic. | Not applic. |
| Intensive Outpt. | 20 | 51% | 85% | 75% | 25% |
| Outpt. – Indiv. | 32 | 82% | 78% | 66% | 63% |
| Outpt. – Group | 29 | 74% | 79% | 72% | 52% |
| Med.-assist. | 17 | 44% | * | * | * |

* Information on the specific types of patients to whom pharmacological therapies were offered frequently was not provided by survey respondents. Therefore, the percentages are omitted here.
Source: PRI staff survey.

**Clients served**. One-third of survey respondents served exclusively clients with a substance use or co-occurring disorder, as shown in the table below.

**Table E-2. Percent of Survey Respondents' Clients That Have A Substance Use or Co-Occurring Disorder**

| *Clients With a Substance Use or Co-Occurring Disorder* | *% Respondents* | *# Respondents* |
|---|---|---|
| 1 to 24 percent | 13% | 5 |
| 25 to 50 percent | 15% | 6 |
| 51 to 75 percent | 21% | 8 |
| 76 to 99 percent | 13% | 5 |
| 100 percent | 33% | 13 |

Note: There were 39 respondents to this question.
Source: PRI staff survey.

## Capacity Information

The survey gathered information on capacity and waits for services, for substance use treatment. The information is not age-specific. Committee staff considered but decided not to ask for capacity information separately for children, young adults, and other populations. This was one of several decisions made to make the survey manageable for respondents, in response to survey piloting feedback.

**Respondent capacity**. The client capacity (i.e., the number of people who can be served at each level) for thirty-six providers responding to the survey is presented in the table below. This is a minimum estimate of respondents' collective capacity because seven omitted capacity numbers for at least one level of care offered, and three respondents did not provide any. Based on these numbers, survey respondents can provide substance use treatment to more than 36,000 people.[91] No information on slots or wait-times specific to youth was gathered in an effort to make the survey manageable for respondents (in response to survey piloting feedback).

**Table E-3. Survey Respondents' Collective Substance Use Treatment Capacity, By Level of Care**

| | ***Number of Clients That Can Be Served at One Time*** |
|---|---|
| Inpatient | 175 |
| Residential | 864 |
| Comm. living arr. | 411 |
| Partial hospitalization | 151 |
| Day/evening treatment | 11,502 |
| In-home services | 421 |
| Intensive outpatient | 1,110 |
| Outpatient - Individual | 12,155 |
| Outpatient - Group | 9,061 |
| Med.-assisted treatment | 10,060 |

Source: PRI staff survey.

Twenty-three respondents offered services to adolescents. These services represented nearly the entire range of levels of care, except for community living arrangements.

**Wait for services**. The presence and length of a wait for services varied among the levels of care, and within levels, by survey respondents, as shown in the table below.

[91] When the capacity is summed for all levels of care except outpatient group sessions and medically-assisted treatment – because those clients often are engaged simultaneously in another level of care – the total is 26,789.

| Table E-4. Wait for Survey Respondents' Substance Use Treatment Services, by Level of Care | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | ***None*** | | ***1-2 Days*** | | ***3-6 Days*** | | ***7+ Days*** | |
| | ***%*** | ***n*** | ***%*** | ***n*** | ***%*** | ***n*** | ***%*** | ***n*** |
| Inpatient | 50% | 3 | 33% | 2 | 17% | 1 | 0% | 0 |
| Residential | 13% | 2 | 19% | 3 | 31% | 5 | 38% | 6 |
| Comm. living arr. | 43% | 3 | 0% | 0 | 0% | 0 | 57% | 4 |
| Partial hospitalization | 71% | 5 | 0% | 0 | 14% | 1 | 14% | 1 |
| Day/evening treatment | 58% | 11 | 16% | 3 | 11% | 2 | 11% | 2 |
| In-home services | 29% | 2 | 0% | 0 | 14% | 1 | 57% | 4 |
| Intensive outpatient | 72% | 13 | 0% | 0 | 22% | 4 | 6% | 1 |
| Outpatient - Individual | 48% | 15 | 10% | 3 | 13% | 4 | 29% | 9 |
| Outpatient - Group | 74% | 20 | 7% | 2 | 11% | 3 | 7% | 2 |
| Source: PRI staff survey. | | | | | | | | |

Partial hospitalization, day/evening treatment, and outpatient group sessions were the levels of care for which more than half of survey respondents reported no wait. However, within each of these levels, at least one provider indicated a wait of at least a week for these same services.

Residential treatment and in-home services were reported by less than one-third of respondents to have no wait for services. The length of wait for residential treatment was at least three days for more than two-thirds of respondents' services, and for in-home treatment, more than half reported a wait of at least one week.

Some respondents chose to comment on the types of programs and clients that experience the longest waits. Longer waits for Spanish-speaking clients and those with Court Support Services Division (CSSD) involvement were noted by one provider each.[92] A few wrote that family or personal scheduling limitations could lead to a wait, particularly for evening services. The area of most comment was in-home programs: three respondents explained that these have the longest wait, of the service array offered.

*Adolescents*. Both survey respondents offering residential treatment to adolescents indicated this level of care has a wait of three to six days, although one noted that the wait is sometimes due to family coordination needs. Four of the five respondents providing intensive outpatient said there usually is no wait for that level of services; the other indicated a wait of three to six days. As noted above, a few providers wrote that the wait for an in-home program can extend far beyond one week (the longest option provided in the multiple-choice question).

[92] The Court Support Services Division of the Judicial Branch provides probation, bail, and juvenile detention services.

## Payment Methods

Insurance acceptance, whether a provider is in the insurer's network, and the cost of private pay each could impact access to substance use care.

About 80 percent of respondents accepted private payment on a sliding scale.[93] This method, which takes into consideration a client or family's income and ability to pay, can make it easier for non-wealthy people to access care. Only six respondents had a fixed-fee policy.[94]

A similarly large share of respondents – 89 percent – accepted at least one type of private insurance, while 94 percent accepted Medicaid. Just under ten percent take only Medicaid insurance, while one respondent was purely private-pay (i.e., no insurance accepted).

A provider may accept a type of private insurance but not be part of the health plan's network. Out-of-network care could mean a higher rate of cost-sharing for the client and/or a lower reimbursement rate for the provider.

Among those responding providers accepting private insurance, about two-thirds were in-network providers for all six of the major private health plans.[95] Of the remaining one-third of responding providers, 13 percent were in-network providers for five major plans, while 21 percent were in-network for four or fewer of the plans. The survey asked these respondents to explain (using multiple options) why certain insurance is not accepted.

Overall, no pattern emerged from the survey data regarding particular health plan network admission decisions or factors that could lead a provider to decide not to pursue network admission. Five responding providers indicated they had applied for in-network status but been rejected, for between one and all private insurers - with no insurer named more than once, among providers not rejected from all networks. Between four and six respondents each (with some overlap) cited insurer requirements or decisions regarding level of care authorization and/or length of care authorization as a reason for their insurance status. Just two providers stated that the level of paperwork required to receive reimbursement was a factor in their insurance status.

## Experiences with Private and Public (BHP) Insurance

The survey asked respondents that accept both private and Medicaid (BHP) insurance to compare their experiences with each type in obtaining authorizations for treatment. The table below shows that a majority of respondents found it easier to receive the level and length of treatment requested from Medicaid, with about one-quarter to one-third reporting no difference between the two. Less than ten percent of respondents found private insurance easier to work with, in each respect.

[93] Twenty-nine of thirty-six respondents to the question.
[94] These six providers were: two outpatient clinics serving both children and adults; one adult outpatient clinic; one adult residential treatment center; one inpatient children and adult hospital; and one clinic providing outpatient and day/evening treatment to both children and adults.
[95] Twenty-four respondents gave insurance network information.

| Table E-5. Survey Respondents' Comparison of Ease in Obtaining Care Authorizations From Medicaid (BHP) and Private Insurance | | | |
|---|---|---|---|
| | ***No difference*** | ***Medicaid easier*** | ***Private insurance easier*** |
| Level of care requested | 23% | 73% | 3% |
| Length of care desired | 33% | 60% | 7% |
| Note: There were 30 respondents to this question.<br>Source: PRI staff survey. | | | |

**Changes over time**. The survey also asked respondents to identify whether the level of private insurer restrictions had changed over the last two years. About half (53 percent) said it had not. Just over one-third (37 percent) indicated private insurers had become more restrictive, while one-tenth stated that these insurers were less restrictive.[96]

The optional comments showed that a respondent's assessment generally depended largely on the specific type of care offered by that provider. For example, two of the three respondents who have found less restrictive coverage decisions noted that insurers are increasingly covering methadone maintenance, which they offer. Those who indicated more restrictive policies wrote about:

- more difficulties receiving authorization for intensive outpatient, residential and inpatient detoxification, and residential treatment;
- an increase in credentialing requirements; and
- a demand for more detailed authorization requests that must be supplied more frequently.

**General comments regarding payors**. Four respondents chose to offer further comments at the end of the survey. While two additionally addressed other issues, each noted that at least some private health plans are difficult to work with. Specific complaints were:

- conflicting and inappropriate reasons for denials of coverage, given "on a regular basis;"
- the variation in insurer requirements (not further specified), which are "labor intensive" for providers to track and comply with;
- inadequacy of reimbursement rates to cover the cost of evidence-based practices; and
- strict requirements restricting reimbursement to certain licensure statuses.

One respondent wrote about Medicaid. This person noted that, "Medicaid rates are generally insufficient on their own for the provision of high quality services and much of the service system relies on state grants to serve those without coverage or to provide services that are necessary but not covered by insurance or Medicaid."

[96] There were 30 respondents to this question.

## Therapies

The survey asked respondents a few questions regarding the therapeutic treatment offered to clients with substance use disorders. The first question asked whether co-occurring substance use and mental health disorders are treated in an integrated way; the vast majority (91 percent) of respondents indicated yes.

*Youth*. Additional questions attempted to understand treatment that is offered specifically to adolescents and young adults.

All respondents indicated that they employ at least one type of evidence-based therapeutic approach or model when working with this population. Cognitive behavioral therapy – either the traditional version or the approach incorporating family – was marked by every respondent. The use of these and other approaches is described by the table below.

**Table E-6. Approaches Used By Survey Respondents, When Working with Adolescents**

| | *%* | *n* |
|---|---|---|
| Cognitive behavioral therapy (CBT) | 78% | 18 |
| Cognitive behavioral therapy (CBT) with family involvement | 87% | 20 |
| Incentives | 13% | 3 |
| Motivational interviewing | 91% | 21 |
| Multidimensional family therapy (MDFT) | 26% | 6 |
| Multisystemic family therapy (MST) | 22% | 5 |
| Seven Challenges | 13% | 3 |
| 12-Step facilitation | 43% | 10 |

Note: There was an option to write in additional approaches. One respondent each added the following: Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC); Trauma-Based CBT; family counseling, family and parent support groups, intervention; and Functional Family Therapy (FFT).
Source: PRI staff survey.

One question attempted to determine whether adolescents and young adults were being treated with different approaches, compared to older adults. However, one respondent's write-in response led committee staff to doubt that all respondents were interpreting the question as intended - as a comparison of approaches, not merely the levels of care available. Despite this possible limitation, the data are presented below.

**Table E-7. Comparison of Survey Respondents' Services / Approaches for Youth**

| | *% Yes (different)* | *% No (same/ very similar)* | *n* |
|---|---|---|---|
| Is adolescents' treatment different from young adults'? | 30% | 70% | 20 |
| Is young adults' treatment different from older adults'? | 7% | 93% | 29 |

Source: PRI staff survey.

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| Alcohol & Drug Recovery Centers, Inc.* | Hartford | Inpatient Adult | Incl detox: Adult | Adult Preg. | Adult Preg. | Adult Preg. | --- | --- | Adult Preg. | Adult Preg. | Adult Preg. | State agency clients (no CLA)<br>Sliding scale<br>MCaid<br>All mj priv ins |
| APT Foundation* | N. Haven<br>Bridgeport | --- | --- | Methad.<br>Bupe. | Adult Preg. | --- | --- | --- | Adult Preg. | Adult Preg. | Adult Preg. | State agency clients<br>Sliding scale<br>MCaid<br>Most priv. ins. (except Anthem), in-network |
| BHcare (incl. Shoreline Clinic) | Ansonia<br>Branford | --- | --- | --- | Adult (mostly CO) | Adult | DE Adult | --- | Adult Preg. | Adult Preg. | Adult Preg. | State agency clients<br>Sliding scale<br>MCaid<br>All mj priv ins in-network |
| Catholic Charities – Archdiocese of Hartford | Hartford | --- | --- | --- | --- | --- | --- | --- | Adult Preg. | Child Adult Preg. | Child Adult Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Catholic Charities – Fairfield Cty. | Bridgeport<br>Danbury<br>Norwalk<br>Stamford | --- | --- | Bupe.<br>Other(s) | --- | --- | Child Adult Preg. | --- | --- | Child Adult Preg. | --- | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Center for Change (DBA) CT Clinical Services Inc.* | N. Haven | --- | --- | --- | --- | --- | --- | --- | Men | Men | Men | Fixed fee<br>All mj priv ins |
| Central Naugatuck Valley Help Inc.* | Danbury<br>Torrington<br>Waterbury | --- | --- | --- | Adult | --- | --- | --- | Adult Preg. | Child Adult Preg. | Adult Preg. | State agency clients<br>Sliding scale<br>Mcaid |
| Chem. Abuse Services | N. Haven | Outpt. Adult | --- | Methad.<br>Bupe. | --- | --- | Adult Preg. | --- | Adult Preg. | Adult Preg. | Adult Preg. | Sliding scale<br>Medicaid |

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| Agency: Multicultural Ambulatory | | | | | | | | | | | | |
| Child and Family Agency of SE CT, Inc.** | Essex<br>Groton<br>N. London | --- | --- | --- | --- | --- | --- | Child | --- | Child | --- | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Child and Family Guidance | Bridgeport | --- | --- | --- | --- | --- | --- | Child<br>Adult | --- | Child<br>Adult | Child | State agency clients<br>Sliding scale<br>Medicaid<br>All mj priv ins |
| Child Guidance Center of S. CT | Stamford | --- | --- | --- | --- | --- | --- | Child | --- | Child | --- | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Community Health Resources | Bloomfield<br>Danielson<br>Enfield<br>Manchstr.<br>Putnam<br>Willimntc. | --- | --- | Methad.<br>Adult<br>Preg. | Adult<br>Preg. | Adult | DE:<br>Child<br>Adult<br>Preg.<br>PHP:<br>Adult<br>Preg. | Child | Adult<br>Preg. | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Medicaid<br>Most priv. ins. (except Anthem), in-network |
| CT Counseling Centers, Inc.* | Danbury | Outpt.<br>Adult | --- | Methad.<br>Adult<br>Preg. | --- | --- | --- | --- | Adult<br>Preg. | Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Sliding scale<br>Medicaid |
| CT Junior Republic | Waterbury | --- | --- | --- | --- | --- | DE:<br>Child | Child | -- | Child | Child | State agency clients<br>Medicaid |
| CT Renaissance | Bridgeport<br>Norwalk<br>Stamford | --- | --- | Bupe.<br>Adult<br>Preg. | Men | --- | --- | Child | Adult<br>Preg. | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Cornell Scott Hill | N. Haven | --- | --- | --- | --- | --- | DE<br>Child | --- | --- | Child | Child | State agency clients<br>Sliding scale |

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| Health Center-Child & Family Guidance | | | | | | | Preg. | | | | | MCaid<br>All mj priv ins |
| Cornell Scott Hill Health Center-Grant St. Partnership | N. Haven | --- | --- | Bupe.<br>Other(s) | Men<br>Mil. | Adult<br>Preg.<br>Mil. | PHP, DE<br>Adults<br>Preg.<br>Mil. | --- | Adult<br>Preg. | Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Family Intervention Center | Waterbury | --- | --- | Other(s) | --- | --- | --- | --- | --- | Child<br>Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Fixed fee<br>All mj priv ins |
| Family Resource Associates | Stratford | --- | --- | --- | | | | | Child<br>Adults | Unclear | Girl<br>Men | State agency clients<br>(no OP-G)<br>Fixed fee<br>All mj priv ins in-network |
| Farrell Treatment Center* | N. Britain | --- | Men | --- | Men | --- | --- | --- | Men | Adult | Adult | State agency clients<br>Sliding fee |
| Hartford Dispensary* | Bristol<br>Hartford<br>Manchstr.<br>N. Britain<br>N. London<br>Norwich<br>Windham | Outpt.<br>Methad.<br>Adult<br>Preg. | --- | Methad.<br>Bupe.<br>Adult<br>Preg. | --- | --- | DE<br>Adult<br>Preg. | --- | --- | --- | --- | State agency clients<br>Sliding scale<br>Medicaid |
| High Watch Recovery Center* | Kent | --- | --- | --- | Adult<br>Preg. | --- | --- | --- | --- | --- | --- | Fixed fee |
| MCCA, Inc.* | Danbury<br>N. Milford<br>Waterbury | Inpt.:<br>Adult<br>Preg.<br>(Dby.)<br>Outpt.:<br>Child | | Bupe.<br>Adult | Adult<br>Preg.<br>(Dby.)<br>Incl.<br>Detox. | Adult | DE<br>Child<br>Adults | --- | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>(no CLA)<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| | | Adult | | | | | | | | | | |
| New Directions, Inc. | Enfield | --- | --- | --- | --- | --- | PHP:<br>YA<br>DE:<br>Women | --- | Adult | Child<br>Adult | Child<br>Adult | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| New Hope Community Counseling | Manchstr. | --- | --- | Other(s) | --- | --- | --- | --- | --- | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Medicaid<br>All mj priv ins acc; all but Cigna in-network |
| Newtown Youth & Family Services | Newtown | --- | --- | --- | --- | --- | --- | --- | --- | Child<br>Adult<br>Preg. | Adult<br>Preg. | State agency clients (OP-I)<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Optimus Health Center (CO) | Bridgeport | --- | --- | --- | --- | --- | PHP:<br>Child<br>Adult<br>Preg.<br>DE:<br>Child<br>Preg.<br>Adult26+ | --- | --- | Child<br>Adult | Adult | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Recovery Network | Bridgeport<br>Shelton | Outpt.:<br>Adult<br>Inpt.:<br>Men | Adult<br>Preg. | Methad.<br>Bupe.<br>Adult<br>Child | Adult | --- | --- | --- | Adult<br>Preg. | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>Mcaid<br>All mj priv ins; Aetna and Anthem in-network |
| Rushford Center, Inc. | Durham<br>Meriden<br>Middltwn.<br>Portland | Resid.<br>Adult<br>Preg. | --- | --- | Boys<br>Adult<br>Preg. | | PHP, DE<br>Child<br>Adult<br>Preg. | --- | Child<br>Adult<br>Preg.<br>Seniors | Child<br>Adult<br>Preg.<br>Seniors | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| South Central Rehab. Center (SCRC), Cornell Scott Hill Health | N. Haven | Inpt.<br>Outpt.<br>Adult | Adults | Methad.<br>Bupe.<br>Other(s)<br>Adult<br>Preg. | --- | --- | DE | --- | --- | Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| Silver Hill Hospital | New Canaan | Inpt.<br>Child<br>Adult | Child<br>Adult | Bupe.<br>Other(s) | --- | --- | --- | --- | Adult<br>Preg. | --- | --- | Fixed fee<br>All mj priv ins in-network |
| Stonington Institute* | Groton<br>N. Stngton. | Adult<br>Active Mil.<br>Inpt.<br>Resid.<br>Outpt. | Adult | --- | Adult | Adult | PHP, DE<br>Adult | --- | --- | --- | --- | Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| The Children's Center of Hamden | Hamden | --- | --- | --- | Child | --- | DE<br>Child (st. ag. clients only) | --- | Child | Child | Child | State agency clients<br>Medicaid<br>All mj priv in acc; only Aetna and Anthem in-network |
| The Connection Inc. – Counseling Centers | Groton<br>Meriden<br>Middltwn.<br>N. Haven<br>Old Sybrk. | --- | --- | --- | Preg. | --- | DE<br>Adult<br>Preg. | Preg. | --- | Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins acc; only Anthem in-network |
| The Connection, Inc. | Groton<br>Meriden<br>Middltwn.<br>N. Haven<br>Old Sybrk. | --- | --- | --- | Women<br>Preg. | --- | DE<br>Adult | --- | --- | Adult<br>Preg. | Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>Most mj priv ins acc in-network; CTCare and United/Oxford not accepted |

| Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Provider*** | ***Locations Included*** | ***Detox.*** | ***Inpatient*** | ***MAT*** | ***Resid.*** | ***CLA*** | ***PHP/ DE*** | ***In-home*** | ***IOP*** | ***OP-I*** | ***OP-G*** | ***Payment*** |
| | | | | | | | | | | | | |
| United Community & Family Services | Colchester<br>Jewett City<br>N. London<br>Norwich | --- | --- | Other(s)<br>Adult<br>Preg. | --- | --- | --- | Child<br>Adult<br>Preg. | --- | Child<br>Adult<br>Preg. | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |
| United Services, Inc. | Columbia<br>Dayville<br>Willimntc. | --- | --- | --- | --- | --- | DE<br>Child<br>Adult<br>Preg. | --- | --- | Child<br>Adult<br>Preg. | --- | State agency clients<br>Fixed fee<br>Medicaid<br>Anthem & CTCare in-network; Aetna, Cigna, United/Oxford acc. |
| Wellmore Behavioral Health* | Shelton<br>Waterbury | --- | --- | Other(s)<br>Child | Adult<br>Preg. | Men | PHP<br>Adult | Child | Child<br>Adult<br>Preg. | Child | Child<br>Adult<br>Preg. | State agency clients<br>Sliding scale<br>Mcaid<br>All mj priv ins in-network |

Levels of Care: Detox. is Detoxification. MAT is medically assisted treatment. Resid. is residential treatment. CLA is community living arrangement. PHP is partial hospitalization. DE is day/evening treatment. IOP is intensive outpatient. OP-I is regular outpatient individual counseling, while OP-G is group outpatient counseling.
* Exclusively treats clients with SU (no solo MH) in programs incl in inventory
**Refers out of SU complaint is primary. Is a CGC.
Mil. Noted they also serve veterans and active duty military. Active Mil. indicates active military.
YA = Young Adults (18-25)
CO = Co-occurring disorders (mental health and substance use)
acc = accepted
Source: PRI staff review of survey responses.

**Figure E-1. Survey**

## Introduction

Thank you for participating in this survey of the Legislative Program Review & Investigations Committee. You are helping us understand licensed providers' capacity and treatment, to what extent treatment is available to those with insurance, and provider experiences with insurance.

The survey will take 10 to 30 minutes to complete. Detailed information on capacity is requested.

General information about your facility or clinic - name, location, levels of care offered, whether different types of clients are served, and types of payment accepted - may be shared in a section of the study's report that aims to catalog treatment options available. No other information about your facility or clinic's policies or experiences will be shared with identifiable information; results from those aspects of the survey will only be presented aggregately.

If you need to close the survey before you have fully completed it, please **close your browser window** so you can later return where you left off. To return to where you left off, you will need to click on the link to the survey using the same computer and browser, and have cookies enabled. Alternately, you can re-start the survey, by clicking on the survey link using a different computer or browser (or one that does not accept cookies).

## Basic Information

**1. Facility / clinic name:**

**2. City / town: (please list all your organization's sites that are included in your response)**

**3. Please provide your contact information so we can follow up with you if any responses are unclear. Your name or contact information will not appear in any study reports or related documents.**

Name:

Work telephone number:

Work e-mail address:

**4. Approximately what percent of your facility or clinic's clients are dealing with a substance use or co-occurring disorder? (Please enter a whole number; do not use punctuation or a percentage sign.)**

## Detoxification Services

**5. Does your facility offer detoxification services (in any type of setting)?**

- Yes
- No

## Detoxification Services

**Figure E-1. Survey**

**6. In which setting(s) does your facility offer detoxification services? (Check all that apply.)**

- ☐ Inpatient
- ☐ Residential treatment
- ☐ Partial hospitalization
- ☐ Outpatient / Ambulatory

**7. How many people who are using detoxification services can your facility treat at a time? (Please enter a whole number, without punctuation.)**

**8. Which type(s) of people can receive detoxification services at your facility? Please mark in which settings detoxification services are available, for each type of client.**

| | Inpatient | Residential | Partial Hospitalization | Outpatient / Ambulatory | None of these settings |
|---|---|---|---|---|---|
| Girls (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Boys (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pregnant women | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women above 25 and not pregnant | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men above 25 | ☐ | ☐ | ☐ | ☐ | ☐ |
| State agency clients (DOC, DMHAS, CSSD, DCF) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Any other special group(s) | ☐ | ☐ | ☐ | ☐ | ☐ |

Please specify other special group(s):

**9. About what percent of the time are your detoxification services full (i.e., cannot take any more clients)? Please enter a whole number and do not use punctuation (e.g., no % sign).**

**10. If whether the services are full tends to vary by type of client (e.g., boys vs. men), please explain for which client types your facility tends to be full.**

## Medication-Assisted Treatment

**Figure E-1. Survey**

**11. Does your facility offer medication-assisted treatment?**

- ◯ Yes
- ◯ No

## Medication-Assisted Treatment

**12. Which types of medication-assisted treatment are offered? (Please check all that apply.)**

- ☐ Methadone maintenance
- ☐ Buprenorphine (Suboxone)
- ☐ Other(s)

## Levels of Care and Capacity: Partial Hospitalization and Higher Levels

**For the following questions, please respond *only* for your facility's services that are available to people with a substance use or co-occurring disorder.**

**13. What levels of care / types of services are offered at your facility? Please check what is offered for each type of client. If none of these levels / types of care is offered for a client type, please check "None of these."**

| | Inpatient | Residential Treatment | Community Living Arrangement | Partial Hospitalization | Day/evening Treatment | None of these |
|---|---|---|---|---|---|---|
| Girls (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Boys (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pregnant women | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women above 25 and not pregnant | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men above 25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| State agency clients (DOC, DMHAS, CSSD, DCF) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Any other special group(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Please specify other special group(s):

**Figure E-1. Survey**

**14. What is the total capacity for each level of care? (In other words, how many clients can be served at the same time?)**

| | |
|---|---|
| Inpatient | |
| Residential Treatment | |
| Community Living Arrangement | |
| Partial Hospitalization | |
| Day/evening Treatment | |

**15. What levels of care / types of services are usually at capacity or have a waitlist? If there is a waitlist, about how long is the wait? (If the wait varies by type of client / payment method, please respond for the *longest* wait, and describe how the wait varies, below.)**

| | There usually is space / no waitlist | Usually is waitlist: 1-2 days until served | Usually is waitlist: 3-6 days until served | Usually is waitlist: At least one week until served | This level/type of care is not offered |
|---|---|---|---|---|---|
| Inpatient | ○ | ○ | ○ | ○ | ○ |
| Residential Treatment | ○ | ○ | ○ | ○ | ○ |
| Community Living Arrangement | ○ | ○ | ○ | ○ | ○ |
| Partial Hospitalization | ○ | ○ | ○ | ○ | ○ |
| Day/evening Treatment | ○ | ○ | ○ | ○ | ○ |

If the wait varies by client type / payment method, please describe which have the longest and shortest waits:

## Levels of Care and Capacity: Intensive Outpatient and Lower

**Again, please respond *only* for those services that are available to people with substance use or co-occurring disorders.**

**Figure E-1. Survey**

**16. What levels of care / types of services are offered at your facility? Please check what is offered for each type of client. If no care is offered for a client type, please check "None."**

| | Intensive Outpatient | Regular Outpatient (Individual sessions) | Outpatient Group Sessions | In-home Services | Medically-assisted Treatment | None of these |
|---|---|---|---|---|---|---|
| Girls (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Boys (under 18) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men 18-25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pregnant women | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Women above 25 and not pregnant | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Men above 25 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| State agency clients (DOC, DMHAS, CSSD, DCF) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Any other special group(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Please specify other special group(s):

**17. What is the total capacity for each level of care? (In other words, how many clients can be served at the same time?)**

| | |
|---|---|
| Intensive Outpatient | |
| Regular Outpatient (Individual sessions) | |
| Outpatient Group Sessions | |
| In-home Services | |
| Medically-assisted Treatment | |

**Figure E-1. Survey**

**18. What levels of care / types of services are usually at capacity or have a waitlist? If there is a waitlist, about how long is the wait? (If the wait varies by type of client / payment method, please respond for the *longest* wait, and describe how to wait varies, below.)**

| | There usually is space / no waitlist | Usually is waitlist: 1-2 days until served | Usually is waitlist: 3-6 days until served | Usually is waitlist: At least one week until served | This level/type of care is not offered |
|---|---|---|---|---|---|
| Intensive Outpatient | ○ | ○ | ○ | ○ | ○ |
| Regular Outpatient (Individual) | ○ | ○ | ○ | ○ | ○ |
| Outpatient Group Sessions | ○ | ○ | ○ | ○ | ○ |
| In-home Services | ○ | ○ | ○ | ○ | ○ |
| Medically-assisted Treatment | ○ | ○ | ○ | ○ | ○ |

If the wait varies by client type / payment method, please describe which have the longest and shortest waits:

## Client Level of Care Decisions

**19. How do practitioners at your facility determine what level of substance use / co-occurring disorder care is necessary?**

- ☐ We have a unique facility- or company-specific protocol.
- ☐ We use an established protocol, used by others in the field.
- ☐ We allow our practitioners to use a variety of appropriate sources.

**20. Which sources are used by your facility / company / practitioners? Check all that apply.**

- ☐ General expertise / knowledge
- ☐ American Academy of Pediatrics guidelines
- ☐ American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC)
- ☐ Connecticut Client Placement Criteria
- ☐ American Psychiatric Association guidelines
- ☐ American Academy of Child and Adolescent Psychiatry guidelines
- ☐ Other

Other (please specify):

**Figure E-1. Survey**

## Care Offered for Youth

**21. Is counseling or other care offered for those under 18 with substance use or co-occurring disorders?**

- ◯ Yes
- ◯ No

## Care Offered for Youth

**22. What specific therapies does your facility / clinic employ with those under 18 who have a substance use disorder or problem? (Please check all that apply.)**

- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Cognitive Behavioral Therapy (CBT) with family involvement
- ☐ Multidimensional Family Therapy (MDFT)
- ☐ Multisystemic Therapy (MST)
- ☐ Motivational Interviewing
- ☐ Incentives
- ☐ Seven Challenges
- ☐ 12-Step Facilitation
- ☐ We do not employ specific therapies when working with adolescents.

Other (please specify)

**23. How does your facility's/clinic's substance use treatment for young adults (18-25) compare to its treatment for other age groups listed? (If there are any differences, please describe.)**

| | Same / very similar | Different | Not applicable: We do not care for clients in this age group |
|---|---|---|---|
| Ages 12-17 | ◯ | ◯ | ◯ |
| Age 26 and above | ◯ | ◯ | ◯ |

Please describe differences:

**Figure E-1. Survey**

**24. Are substance use and mental health disorders treated in an integrated way, when someone has a co-occurring disorder?**

- ◯ Yes
- ◯ No

## Payment Methods

**25. Does your facility accept private payment (e.g., cash, credit card, check), and if so, what type?**

- ◯ Yes: Fixed fee
- ◯ Yes: Sliding scale
- ◯ No

## Payment Methods: Insurance

**26. For each major insurance carrier listed below, please mark whether it is accepted by your facility/clinic and whether your facility is in-network.**

| | Accepted? | In-network? |
|---|---|---|
| Aetna | ☐ | ☐ |
| Anthem BC-BS | ☐ | ☐ |
| CIGNA | ☐ | ☐ |
| ConnectiCare | ☐ | ☐ |
| HealthNet | ☐ | ☐ |
| United/ Oxford | ☐ | ☐ |
| Medicaid (BHP) | ☐ | ☐ |

**27. If you accept Medicaid: About what percent of your facility's clients have Medicaid as their payment method? (Please enter a whole number, without a percentage sign.)**

☐

**Figure E-1. Survey**

**28. If your facility/clinic does not accept one or more of the major carriers: Why not? (Please check all reasons that apply, by insurer - or, "all of these".)**

| | Aetna | Anthem BC-BS | CIGNA | ConnectiCare | HealthNet | United/ Oxford | Medicaid (BHP) | All of these |
|---|---|---|---|---|---|---|---|---|
| Applied but was not accepted into network. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Company does not generally authorize the level of care we seek to provide. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Company does not generally authorize the length of care we seek to provide. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Level of effort required to persuade company of level of care needed. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Level of paperwork required to deal with insurance billing. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Reimbursement level. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Client no-show rate. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Other (please specify):

**29. Have you found any difference in the ease of getting requested substance use treatment care approved for coverage by insurers for whom your facility/clinic is on the panel, versus those for whom your facility/clinic is not on the panel?**

- ◯ Not applicable: We are not on any insurer panels or only take insurance when we are in-network.
- ◯ No
- ◯ Yes: Harder to get requested care approved, when we are "on" the insurer's panel
- ◯ Yes: Harder to get requested care approved, when we are "not" on the insurer's panel

**Figure E-1. Survey**

**30. In the last two years, across private insurers, have you seen any changes in insurer requirements or coverage concerning substance use or co-occurring treatment?**

- ◯ No
- ◯ Yes: Less restrictive
- ◯ Yes: More restrictive

Please explain what changes you've seen, if any:

## Payment Methods: Other Public Insurance

**31. Does your facility / clinic accept any of the following other types of public insurance? (Check all that apply; if none, please respond "No".)**

- ☐ Medicare
- ☐ TRICARE
- ☐ No

## Insurance: Experiences

**32. If you accept both private insurance (at least one type) and Medicaid (BHP), with which type of insurance is it easier to do each of the following:**

| | Private Insurance | Medicaid (BHP) | No difference between private insurance and Medicaid | No experience in trying to do this |
|---|---|---|---|---|
| Join the insurer panel | ◯ | ◯ | ◯ | ◯ |
| Get approval for the level of care your practitioners believe is necessary (without an appeal) | ◯ | ◯ | ◯ | ◯ |
| Get approval for the length of care your practitioners believe is necessary (without an appeal) | ◯ | ◯ | ◯ | ◯ |

## Appeals

**Figure E-1. Survey**

**33. Does your facility have a policy (either written or in practice) regarding pursuing appeals of insurer adverse determinations (i.e., full or partial denials of coverage)? (Please check all that apply.)**

- [ ] We do not appeal.
- [ ] We will pursue internal appeals for a client in our care.
- [ ] We will pursue external appeals for a client in our care.
- [ ] We will pursue internal appeals for a potential client.
- [ ] We will pursue external appeals for a potential client.

## Any Additional Comments

**34. Please share any other comments on matters addressed in this survey.**

## Thank you for completing this survey!

Thank you very much for your time, effort, and thoughts.

If you have any questions about the survey or study, or would like to be added to the study's e-mail list, please contact the study's staff at:

860-240-0300
or
janelle.stevens@cga.ct.gov

# Appendix F

## Available Treatment Services

Information on the substance use treatment services available to youth in Connecticut was gathered from a variety of sources, including:

- the Statewide Health Care Facilities and Services Plan issued in October 2012 by the Office of Health Care Access (OHCA) within the Department of Public Health (DPH);
- three treatment locators;
- program review committee staff surveys of both the state's DPH-licensed substance use treatment providers and Connecticut colleges and universities; and
- the National Survey of Substance Abuse Treatment Services (N-SSATS), a federal point-in-time survey.

**State agency sources**. The OHCA Facilities and Services Plan contains the most comprehensive information on the capacity of residential substance use treatment providers. The plan indicates there are 205 sites that offer adult and/or child substance use treatment.[97] Generally these are not state-operated programs (which are not required to hold licensure). The levels of care, locations, and, where available, capacity information are depicted in Table F-1.

*Contracted services*. The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) both fund, through contracts, many of the licensed private behavioral health care providers. These dollars are intended to help providers serve clients without ability to pay through insurance or income.[98]

[97] Table 20, in the plan's appendix, lists the 199 DPH-licensed providers of substance use treatment. In addition to these, there are two DPH-licensed specialty psychiatric hospitals that can provide treatment and four DCF-licensed facilities giving residential substance use treatment to adolescents.

[98] For example, DCF funds 12 outpatient substance use treatment clinics, as well as 34 enhanced care behavioral health clinics, which are to have demonstrated co-occurring treatment competency.

| Table F-1. Substance Use Treatment Offered by Facilities, Clinics, and Specialty Hospitals [a] Holding Specialty Licensure from the Department of Public Health or the Department of Children and Families | | | |
|---|---|---|---|
| ***Level / Type of Care*** | ***Min. Number of Slots (Point-in-time), unless otherwise noted*** | | ***Locations*** |
| | ***Adolescents (12-17)*** | ***Adults (18 and up)*** | |
| Specialty Hospital | 189 | | Mansfield and New Canaan |
| Residential: 3-6 month stay [b] | Not applic. | 972 | Bridgeport, Canaan, Glastonbury, Groton, Hartford, Lebanon, Middletown, New Haven, New London, Norwich, Plainfield, Portland, Putnam, Stamford, Torrington, Waterbury, Windham |
| Residential: 3-4 week stay [c] | Not applic. | 128 | Kent, Sharon |
| Residential: Short stay [d] | Not applic. | 265 | Bridgeport, Danbury, Hartford, Middletown, New Britain, N. Stonington, Putnam, Torrington, Waterbury |
| Residential: Detox. and Evaluation | Not applic. | 147 | Bridgeport, Danbury, Hartford, Middletown, New Haven, New London, North Stonington |
| Residential: Adolescents only | 58 [e] | Not applic. | Durham, Hamden, Manchester |
| Day / evening Treatment | 21 sites | | Bloomfield, Bridgeport, Danbury, Enfield, Groton, Hartford, Kent, Middletown, New Haven, N. Stonington, Waterbury |
| Outpatient | 153 sites | | Statewide |

[a] Excludes state-operated facilities (e.g., DMHAS-operated Connecticut Valley Hospital and Blue Hills Campus, which have 152 inpatient slots, according to the governor's February 2013 proposed budget), school clinics, and small outpatient clinics unlicensed by the Department of Public Health. Also excludes general hospitals, which are not required to obtain a separate license for substance use treatment services.
[b] DPH licensure: Intermediate and Long Term Treatment and Rehabilitation. Because of the duration, it is likely these facilities serve mostly/all DMHAS clients.
[c] DPH licensure: Care and Rehabilitation
[d] DPH licensure: Intensive Treatment
[e] Some slots are reserved for state clients (e.g., juvenile justice-involved). Licensed by DCF.
Source: PRI staff analysis of OHCA 2012 Facilities Plan.

**Treatment locators**. There are numerous treatment locators. Three tools – the United Way's 2-1-1, the Connecticut Clearinghouse's, and the Network of Care – were reviewed. Although capacity information is not given, the sites do show the number of programs offering various types of care (as well as program-specific information to help consumers determine whether the program is appropriate for them). There is some disagreement among the sites' listings. The numbers of programs from each locator is listed in the table below. It is clear there are many more outpatient providers than those for any other level of care.

| Table F-2. Number of Substance Use Treatment Providers by Level of Care, According to Three Treatment Locators | | | |
|---|---|---|---|
| ***Type of Treatment*** | ***2-1-1*** | ***CT Clearinghouse*** | ***Network of Care*** |
| Detoxification: Inpatient | 23 alcohol; 22 drug | 27 | 19 |
| Detoxification: Outpatient | 4 alcohol; 25 drug | 36 | 24 |
| Inpatient | 9 | 28 | 7 |
| Residential treatment | 51 | 55 | 49 |
| Community living arrangement | 23 | 23 | Not included |
| Partial hospitalization / day or evening treatment | 73 | 34 | 67 |
| Outpatient counseling | 140 | 132 | 151 |
| Care / case management | 62 | Not included | Not included |
| Source: PRI staff review of treatment programs listed at these treatment locators. | | | |

**Study survey: Providers**. Program review committee staff surveyed all DPH-licensed substance use treatment providers and received responses from thirty-seven of seventy-one provider organizations (including specialty psychiatric hospitals), as well as from two providers licensed as mental health outpatient clinics. These responses represented 99 of the 201 substance use treatment and specialty psychiatric hospital licensed sites.

Because the survey results do not encompass all providers, and it is unclear whether geographical, level of care, and other characteristics are properly represented, information on capacity from the survey is not included here. However, the survey results can help fill the knowledge gap for capacity of treatment levels below inpatient. These results, given in the following below, should be interpreted as potential capacity for substance use treatment because many of the respondents additionally provide services to those with mental health (not co-occurring) diagnoses.

| Table F-3. Survey Respondents' Collective Substance Use Treatment Capacity, By Level of Care | |
|---|---|
| | ***Number of Clients That Can Be Served at One Time*** |
| Inpatient | 175 |
| Residential | 864 |
| Comm. living arr. | 411 |
| Partial hospitalization | 151 |
| Day/evening treatment | 11,502 |
| In-home services | 421 |
| Intensive outpatient | 1,110 |
| Outpatient - Individual | 12,155 |
| Outpatient - Group | 9,061 |
| Med.-assisted treatment | 10,060 |
| Source: PRI staff survey. | |

**National survey (N-SSATS)**. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) annually conducts the National Survey of Substance Abuse Treatment Services (N-SSATS), resulting in a point-in-time view of treatment facilities and their clients, as noted in this study's June 2012 update.[99] The data discussed below are the most recently available - from March 31, 2011 - and pertain to Connecticut (except where otherwise noted).[100]

*Youth in care.* Just over two percent of those receiving treatment in Connecticut were under age 18 (adolescents);[101] data specific to other age groups, beyond "all adults," are not collected. The percentage of those in care who are adolescents has fluctuated over the past five years for which data are available, ranging from 3.5 percent in 2008 to 1.9 percent two years later. In Connecticut, adolescents have been a much smaller subset of those receiving treatment, than nationally (6.7 to 9.1 percent, in 2007 through 2011).

Nearly all (97.4 percent) of adolescents in the 2011 survey were receiving outpatient treatment, with the remainder in non-hospital residential care. This is an increase from 93.9 percent in 2010. Nationally in 2011, a higher percentage of adolescent clients was in residential care (11.8 percent in non-hospital care, and 1.3 percent in hospital inpatient care).

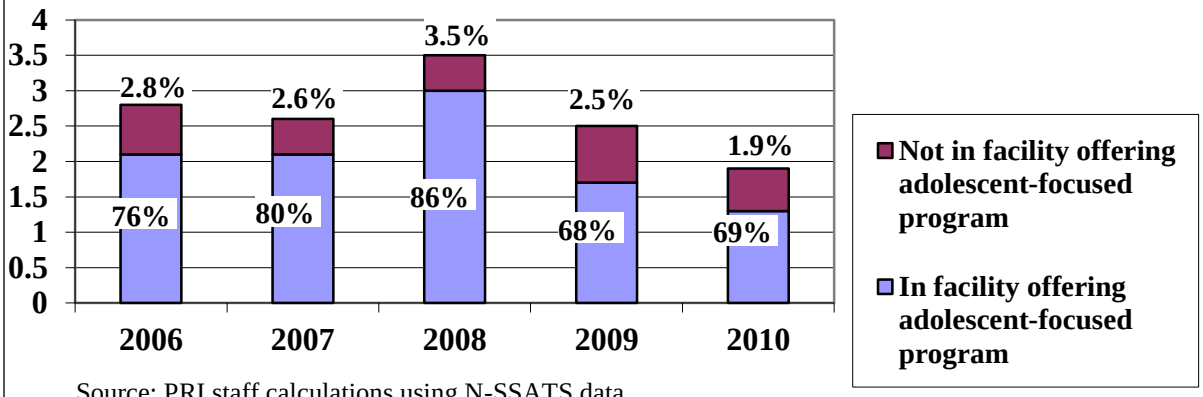
Data are not collected regarding if adolescents are in a program specific to their age; it is known only whether the facility at which they were receiving treatment offered such a program. There has been variation recently in the percentage of adolescents who are in facilities that offer special adolescent programs or groups, as shown in Figure F-1. In the past two years for which data are available (2009 and 2010), however, the percentage has been relatively stable, at 68 to 69 percent. This is well below the national averages of about 81 percent in both 2009 and 2010.

[99] N-SSATS, conducted by SAMHSA, includes all facilities that are either government-operated or state-licensed. Some providers that are neither (e.g., small group counseling practices, hospital-based programs) also participate, but the extent to which they do so is unknown. Solo practices might not be captured at all. Those providers who have requested inclusion in SAMHSA's online treatment locator are sent an N-SSATS survey, according to a June 15, 2012 committee staff conversation with DMHAS staff.

[100] The 2011 N-SSATS state-to-state comparison data have not yet been published; therefore, in some cases, 2010 data are the most recently available.

[101] The number of adolescents in treatment was 612.

**Figure F-1. Percent of Connecticut Clients Who Were Adolescents (Under Age 18), and Whether Those Clients Were Receiving Treatment in a Facility that Offered an Adolescent-Focused Program, 2006-2010**

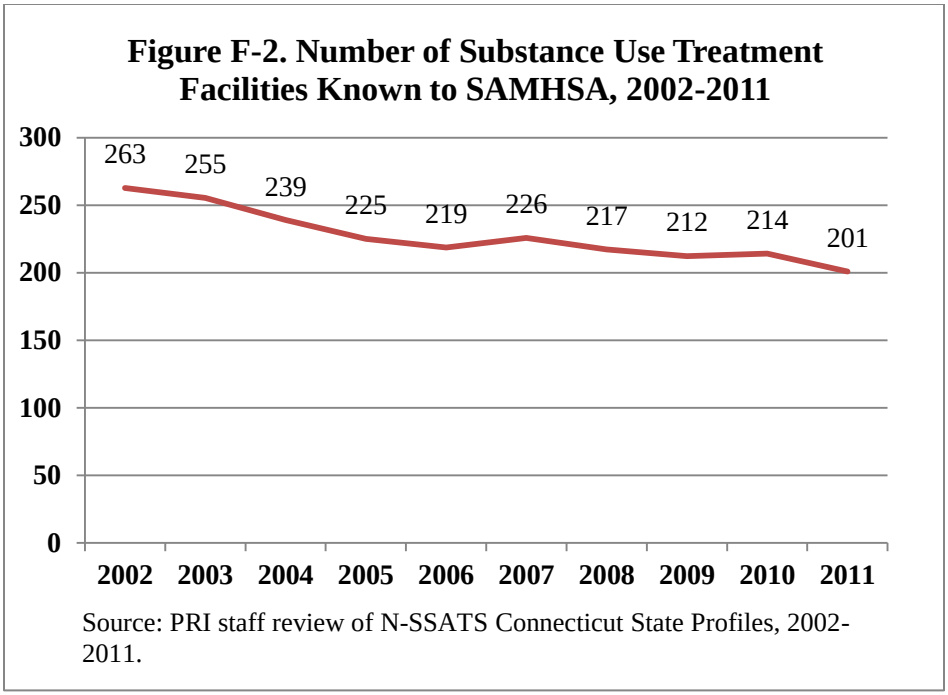



Source: PRI staff calculations using N-SSATS data.

In 2011, 16 percent of Connecticut facilities offered an adolescent-focused program or group, substantially lower than the rate nationally (28 percent). Connecticut was among the five states with the lowest percentage of facilities with these programs, in 2010. (State comparison data were not available for 2011.)

*Number of treatment facilities*. There were 188 Connecticut treatment facilities participating in the 2011 survey; 68 percent received public funds for substance use treatment. The total number of participating facilities has declined 13 percent from its recent-year peak of 216, in 2007 (and 10 percent when using the 2010 data). This contraction is more pronounced than the 3 percent national decline between 2006 and 2010.

The number of Connecticut treatment facilities known to SAMHSA (i.e., that received an N-SSATS survey) has declined substantially in recent years. The chart below shows these facilities have declined from 263 in 2002 (the earliest year for which data are available) to 201 in 2011, a drop of 24 percent.




*Levels of care offered.* Many facilities offer multiple levels of care, ranging from the most intensive (hospital inpatient) to different types of treatment provided on an outpatient basis. The overall percentages of Connecticut facilities offering the various levels in 2011 are shown in the table below.

**Table F-4. Levels of Care Offered by Connecticut Substance Use Treatment Facilities, 2011**

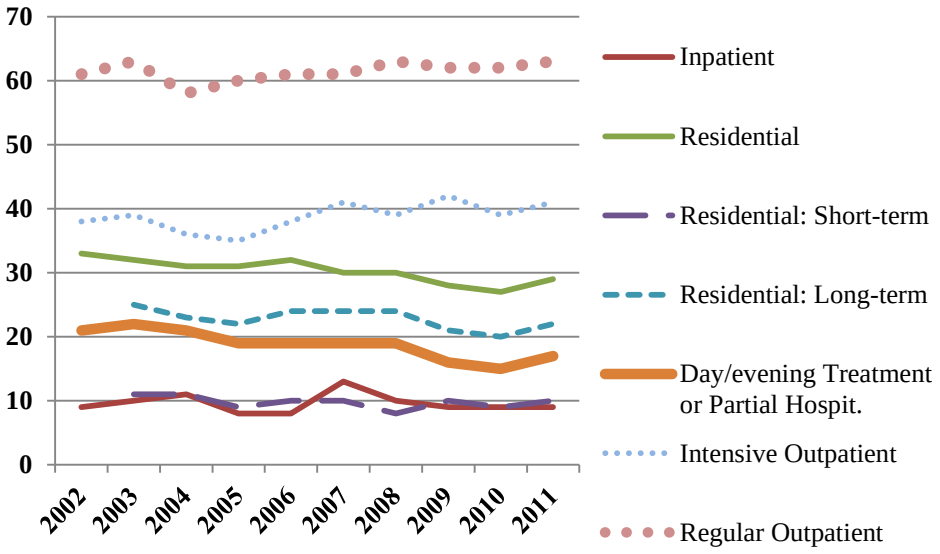
| ***Level of Care/Setting*** | ***Percent of Facilities Offering*** |
|---|---|
| Hospital Inpatient | 8.5 |
| Detoxification | 8.0 |
| Treatment | 6.4 |
| Residential (non-hospital) | 28.7 |
| Detoxification | 1.1 |
| Long-term | 22.3 |
| Short-term | 9.6 |
| Outpatient | 71.3 |
| Detoxification | 14.4 |
| Day/evening treatment or partial hospitalization | 17.0 |
| Intensive | 41.0 |
| Regular | 63.3 |
| Methadone maintenance | 16.0 |

Source: N-SSATS data. Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf

There have been only small changes in the levels of care offered by those facilities responding to N-SSATS over the last ten survey years. The chart below shows that there have been:

- slight increases in the percent of respondents offering intensive and regular outpatient;
- essentially no change regarding inpatient or short-term residential treatment; and
- slight declines for long-term residential treatment and day/evening treatment or partial hospitalization.

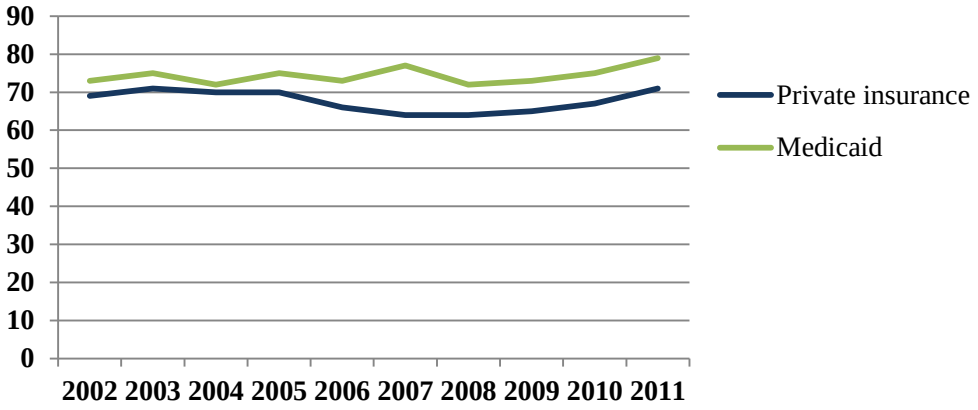
**Figure F-3. Levels of Care Offered by Facilities Participating in N-SSATS**




Source: PRI staff review of N-SSATS Connecticut State Profiles, 2002-2011.

*Insurance acceptance*. The chart below indicates that over the past ten years, the majority of facilities that participated in the N-SSATS survey have accepted Medicaid and/or private insurance. Medicaid acceptance has ranged from 72 (in 2004 and 2008) to 79 (in 2011) percent, with a recent upswing. Private insurance acceptance was about flat at 70 percent until declining in the mid-2000s, to a low of 64 percent in 2007 and 2008. Since then, there has been a gradual increase, resulting in a 2011 return to the previous high of 71 percent.

**Figure F-4. Percent of N-SSATS Responding Facilities Accepting Certain Types of Insurance, 2002-2011**




Source: PRI staff review of N-SSATS Connecticut State Profiles, 2002-2011.

**School-based services**. Adolescents and young adults may seek and receive substance use counseling at school.

***Public school system***. Many elementary and secondary public schools in Connecticut have at least one behavioral healthcare practitioner (e.g., school psychologist, social worker) who potentially could provide substance use-related counseling. The availability of these professionals and extent of counseling services they could provide on an ongoing basis is unknown.

Substance use counseling may be sought by adolescents at school-based health centers (SBHCs), which offer physical and behavioral health care (along with, in some, dental care). Twenty-two towns have among them 121 school-based health centers.

It does not appear, however, that SBHCs frequently provide substance use counseling. In FY10, six state-funded SBHCs – located in middle and high schools – provided substance use counseling, with an additional 13 (including a few elementary schools) providing "other counseling" that may have included care for substance use issues.[102]

Beyond personal counseling, few substance-use specific services within schools (e.g., recovery support groups) appear to exist in Connecticut. Neither are there such options as a school specifically for students in recovery, which are available in a few states. One Bridgeport public high school, however, appears to have been very successful at reducing substance use. The school continues to offer substance use groups at several times during the school day, as

[102] According to the Department of Public Health. In FY11, the state supported about two-thirds of all SBHCs (71 clinics). ("Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011," Legislative Program Review and Investigations Committee, March 2012 (p. 42). Accessed January 30, 2013 at: http://www.cga.ct.gov/pri/docs/2011/Adol_Health_Final_%20Report.PDF )

well as a substance use counselor who is available after school.[103] Providers and parents expressed to program review committee staff that some schools seem reluctant to offer substance use-related programs (other than strictly prevention), perhaps due to lack of support for such efforts among the schools' broader communities.

***Postsecondary institutions***. The majority of the Connecticut four-year colleges and universities responding to a program review committee survey offer behavioral health counseling, including for substance use. The state's community colleges have counseling centers but counseling is focused on academic coursework and addressing barriers to educational success.

*Respondents*. The survey, which was sent in October, requested information from all of Connecticut's public and private postsecondary institutions, except for the state community colleges (which generally lack personal counseling services). Eighteen campuses responded: three University of Connecticut sites (including the Storrs branch), all four of the Connecticut State Universities, and 11 private institutions.[104] The median estimated enrollment was 3,308, with an average enrollment of 5,880.

*Substance use counseling offered*. Nearly all (but one) respondents have a behavioral health counseling center; of those, about three-quarters (76 percent) of the centers offer counseling for substance use and/or co-occurring disorders, with an additional one providing only substance use assessment (not substance use counseling). For the most part, centers provide integrated treatment for co-occurring disorders.[105]

*Accessibility*. Although only one center had a waitlist for services, students at most of the responding colleges would not have immediate access to counseling. The following table indicates that students at more than two-thirds of responding colleges would have a wait of more than one day for counseling services; students at just over half would experience a delay of four or more days.

**Table F-5. Wait for Counseling Services Among College Counseling Center Survey Respondents**

| ***Wait*** | ***Percent of Respondents*** | ***Number of Respondents*** |
|---|---|---|
| One day | 31% | 4 |
| Two to three days | 15% | 2 |
| Four to five days | 23% | 3 |
| Seven days | 23% | 3 |
| 14 days | 7% | 1 |

Source: PRI staff analysis of survey data.

[103] "Peer to Peer Program," Bridgeport Central High School. Accessed January 30, 2013 at: http://bridgeport.ct.schoolwebpages.com/education/school/school.php?sectionid=351. http://bridgeport.ct.schoolwebpages.com/education/school/school.php?sectionid=351

[104] Four institutions that offer undergraduate degrees did not respond: Yale University, Quinnipiac University, Trinity College, and the University of Bridgeport. (Rensselaer Polytechnic Institute Hartford offers exclusively graduate-level degrees.)

[105] There were 14 respondents to this question; 12 (86 percent) indicated they treat co-occurring disorders in an integrated way.

*Types of counseling offered*. Regular (non-intensive) outpatient is the only level of treatment offered among responding schools. About forty percent of respondents (seven of 18) offer at least one outpatient group for students with substance use or co-occurring disorders. Some groups are open to any students (as at three colleges), while others are specific to:

- women or men (two colleges, each);
- student-athletes (one college)
- violators of the school's substance policies (three colleges);
- students with co-occurring disorders (three colleges); and
- students in long-term recovery (one college).

There appears to be sufficient group counseling capacity given demonstrated demand; no school reported a waitlist.

*Limitations on counseling*. Some counseling centers (42 percent of respondents) restrict the number of sessions available to any particular student.[106] The individual session limit ranged from six to 12 sessions per semester, and from 12 to 20 for an academic year.

*Payment*. Just one of the 18 respondents charges for counseling center services. This center's staff noted that all the college's students must have health insurance, and one popular student insurance option provides behavioral health coverage without any cost-sharing. If a student feels unable to bear a co-pay or deductible required under a policy, then the counseling center will assist the person in finding a low- or no-cost option. This particular center does have a session limit and a substantial wait for an individual counseling appointment.

*Other substance use services on campus*. Six of the 18 respondents have an office separate from the counseling center that provides substance use prevention and assessment services, with one additional school having an office providing only prevention. Among the six, two offer individual counseling for substance use. One of these limits counseling to a few sessions, while the other allows several.

The majority (61 percent) of respondents does not have mutual support groups on campus. Five campuses host Alcoholics Anonymous meetings, while two more offer similar mutual support group meetings.

One-third of respondents whose campuses include student housing indicated there are substance-free housing options available.[107] These four campuses have at least a substance-free floor in a residence hall, with two offering an entire substance-free residence hall and three offering a substance-free "house" option.

One campus reported a program specifically for students in recovery.[108] This program, which enrolls 12 people, includes individual and group counseling, Alcoholics/Narcotics Anonymous meetings, and a special recovery lounge. This particular school has DMHAS grants that are supporting this and other efforts to address substance use, such as offering multiple

[106] There were 12 respondents to this question; five indicated limitations on the number of counseling sessions.
[107] An additional campus reported that the whole location is substance-free.
[108] Fifteen campuses responded to the question of whether a recovery program is offered on-campus.

substance use-focused group counseling sessions. (Three other colleges – including some state universities – also receive these grants but do not have recovery programs.)

**Primary care**. The OHCA plan notes that providers typically associated with primary care also give substance use treatment. First, general or children's hospitals – which are required by law to screen trauma patients for substance abuse – may directly provide treatment at any level of care.[109] In recent years, all 29 of the state's general or children's hospitals have provided substance abuse treatment at some level of care. The table below lists the eleven hospitals that are listed in the Connecticut Clearinghouse treatment locator as having outpatient treatment programs, and displays the type of program at each.

**Table F-6. General Hospitals Providing Outpatient-Setting Substance Use Treatment**

| ***Hospital*** | ***Town of Treatment Services*** | ***Partial Hosp./ Day or Evening Treatment*** | ***Outpatient Counseling*** |
|---|---|---|---|
| Bristol Hospital | Bristol | ✓ | ✓ |
| Danbury Hospital | Danbury | ✓ | ✓ |
| Greenwich Hospital | Greenwich | No | ✓ |
| Griffin Hospital | Derby | ✓ | ✓ |
| Hospital of Central CT at New Britain General | New Britain | No | ✓ |
| Norwalk Hospital | Norwalk | No | ✓ |
| St. Francis Care | Manchester | ✓ | No |
| St. Mary's Hospital | Waterbury | ✓ | ✓ |
| UConn. Health Center | Farmington | No | ✓ |
| Waterbury Hospital | Waterbury | ✓ | ✓ |
| Yale-New Haven Hospital, St. Raphael Campus | New Haven | ✓ | ✓ |

Source: PRI staff review of the Connecticut Clearinghouse's treatment locator, "Behavioral Health Services in Connecticut."

Second, at least a few pediatric outpatient practices offer both physical and behavioral healthcare services.[110]

The integration of primary and behavioral health care recently has been gaining momentum. For example, the federal Patient Protection and Affordable Care Act (ACA) of 2010 gave states increased Medicaid reimbursement for using a medical home approach to manage patients' care. The medical home could be either a physical or behavioral health care provider.

Within Connecticut, there are a few efforts to improve access to behavioral health care through boosting screening and connection to treatment in medical settings.

[109] C.G.S. Sec. 19a-490h, enacted by P.A. 98-201.

[110] "Behavioral Health Services in Pediatric Primary Care: Meeting the Needs in Connecticut," Julian Ford, Anne Pidano, and Lisa Honigfeld, Child Health and Development Institute of Connecticut, September 2006.

*SBIRT*. DMHAS received a federal grant to offer Screening, Brief Intervention and Referral to Treatment (SBIRT) at eleven community health center sites.[111] Primary care providers screen for substance use. Those patients indicating troublesome use are asked to see a co-located behavioral health educator, who conducts further assessment and then gives either a brief intervention or appropriate referral to treatment. From February 2012, when SBIRT implementation began, through December 2012, more than 9,000 people were screened.

This grant also involves an SBIRT Training Institute at the UConn Health Center, which aims to assist general hospitals and DMHAS's Military Support Program for National Guard-affiliated people in adopting SBIRT.

*Alternative-to-Hospitalization*. This program, begun in 2005, attempts to divert substance use and co-occurring patients from acute inpatient mental health treatment. Emergency department staff in nine participating general hospitals assess patients. Those who are willing to contract for safety and to try care in a different setting are connected with a DMHAS / Advanced Behavioral Health, Inc. case manager who helps the hospital and patient locate and travel to a more appropriate treatment setting. Eighty percent of 313 emergency department presentations were successfully diverted through this program, in FY 2012. DMHAS selected participating hospitals when it was responsible for providing behavioral health services to General Assistance state clients, based on data showing which venues could improve substance use treatment diversion of those clients.

*Educating Practices in the Community*. The Child Health and Development Institute of Connecticut, Inc. – an independent research and technical assistance organization – offers healthcare providers in-office trainings on a range of topics. One training helps pediatricians and others learn how to integrate behavioral health screenings into routine visits, including familiarizing them with different screening tools.

[111] The grant, from SAMHSA, is for a collaborative partnership among DMHAS, the Community Health Center Association of Connecticut, and the University of Connecticut Health Center.

# Appendix G

## Examinations of the State's Substance Use Treatment Capacity Adequacy

### Office of Health Care Access (OHCA) Facilities Plan

The Department of Public Health's (DPH) OHCA 2012 Statewide Health Care Facilities and Services Plan catalogs DPH-licensed services but did not, in the behavioral health chapter, assess whether need exceeds capacity. However, emergency department staff focus groups conducted for the purposes of the plan's development discussed behavioral health capacity problems. The focus groups found shortages in:

- outpatient care, stating hospital-associated outpatient behavioral health services generally have a three-to-six week wait, with this care being difficult to locate for those patients without insurance but ineligible for any state assistance;
- adult inpatient care;
- child residential care; and
- community behavioral health care available for intakes in the evening and early morning hours.[112]

The focus groups also discussed issues that result in capacity problems. Provider policies can lead to higher than necessary volume for the emergency department. For example, some sober houses simply discharge people who have relapsed, instead of connecting them with alternative services, while some detoxification centers require, for intake, a referral from an emergency department. Other contributing factors are the absence of both community-based case management services - to help coordinate care across hospitals and community providers - and a "comprehensive resource directory and an up-to-date census report" focusing on treatment beds.

These shortages, policies (among others), and deficiencies "add days to untreated behavioral health needs, huge costs to hospitals and insurers, and disruption in patients' and family members' lives."[113]

To alleviate these problems, focus group participants discussed numerous possible approaches:

- expansion of diversion programs or initiatives, such as Emergency Mobile Psychiatric Services (a Department of Children and Families program) and the

[112] "Statewide Health Care Facilities and Services Plan," Department of Public Health Office of Health Care Access, October 2012. Appendix G.
[113] Ibid.

Department of Mental Health and Addiction Services's (DMHAS's) diversion program;

- hospital initiatives, such as engagement of community providers to educate them on appropriate emergency department use, admitting minors with behavioral health concerns into inpatient pediatric care for observation instead of holding them in the emergency department, and staffing emergency departments with more (unbillable) case managers;

- development of state-funded, self-contained psychiatric emergency facilities like California and New York;

- integration of care coordinated across systems;

- creation of a bridge care program, with observation / respite beds and a patient/peer navigator;

- urgent walk-in behavioral health care centers, perhaps co-located with existing primary care centers; and

- a comprehensive "On-line Capacity Management System," to assist in connecting patients with other levels of care.[114]

The plan's behavioral health recommendations largely center on creating a comprehensive inventory of services and an assessment of capacity adequacy.

**Practitioners**. The plan notes Connecticut has a mental health care practitioner shortage, equal to about half the shortage of primary care and dental professionals. It also states that roughly one-fifth (27 of 106 areas) of the state has a mental health care shortage.[115] Substance use specifically is not addressed.

**DMHAS Priorities Report**

Every two years, DMHAS develops a priority-setting report for its mental health and substance use services. Its 2012 report[116] relied on a survey of DMHAS-funded providers, as well as on regional focus groups, which included providers, clients, family members of clients, and referring organizations. In addition to the statewide report, each region has its own priority report.

[114] Ibid.
[115] "Statewide Health Care Facilities and Services Plan," Department of Public Health Office of Health Care Access, October 2012. Chapter 2.
[116] "2012 Report on Statewide Priority Services," Connecticut Department of Mental Health and Addiction Services, September 2012.

**Service availability**. The following services were indicated by the survey to have limited availability, with more than 50 percent of providers stating the service is "not available or sometimes available":[117]

- residential care, for everyone but especially pregnant women and people with co-occurring disorders; those in need of long-term residential care (including DMHAS clients) also were pointed out as a particular need, during the focus groups;

- detoxification in all settings: ambulatory (including buprenorphine), residential, and hospital-based, with an average wait time of one day – with shortness of stay described as problematic, in the focus groups;

- intensive outpatient, for pregnant women; and

- chemical maintenance.[118]

The report considers the other types and settings of services – standard and intensive outpatient, assessment, screening and brief intervention, methadone maintenance, and access lines – to generally be available. The data indicate, however, that a substantial percent of providers find even those sometimes or never available. For example, more than 20 percent indicated standard outpatient has limited availability – and nearly 40 percent did so, for intensive outpatient.

Survey respondents also rated several types of recovery support services (discussed more below) as limited availability: transportation, education, employment services, sober/recovery housing, and faith based services. (Case management services were found to be usually available by just over half of respondents.) In focus groups, housing was discussed as a particular shortage. Participants said the housing that exists can be difficult to locate and largely is in proximity to wide-scale drug availability, making it especially hard for residents to remain substance-free.

The focus group participants underscored the need for young adult-specific services, due to developmental stage and "difficulty connecting with older adults who make-up [sic] the majority of clients in substance abuse programs." Providers stated that a key factor in youth treatment drop-out is that age-specific services are not available.

**Availability specific to youth**. The focus groups also noted that capacity adequacy varies within and across regions, with shortages for young adults specifically in:

- inpatient treatment;
- residential treatment;
- outpatient treatment, in some regions (unspecified);
- age-appropriate mutual help groups, in rural areas;

[117] "Don't know" responses were excluded from DMHAS's analysis.
[118] Buprenorphine was included in two categories: ambulatory detoxification and chemical maintenance.

- specialized services for lesbian, gay, bisexual, and transgender youth.

The focus groups noted that as with mental health services and services for those of other ages, youth need but often lack transportation, as well as other treatment and recovery supports. (Areas of need for other special groups, such as the elderly, also were discussed by the groups and summarized in the report.)

**Focus group themes**. Several themes emerged from the focus groups:

- "…difficulties in navigating the substance abuse system";
- "…barriers to accessing care by private insurance";
- troublesome treatment facility placement and inadequacy of treatment capacity, particularly for medication-assisted treatment, due to zoning resistance; and
- lack of recovery supports, including no recovery centers in the Northwest (which covers the western portion of the state, excepting Fairfield County) and South Central regions.

**Recommendations**. In response to the survey data and focus group information, the priority setting report sets out numerous recommendations to improve timely access to substance use treatment services and support recovery (i.e., sustain the effectiveness of treatment). The recommendations particularly relevant to this study are:

- improve timely placement into appropriate settings by launching: 1) a "24-hour access line"; and 2) a website with treatment bed availability across the state (inclusive of all state and nonprofit providers);
- "Explore and address policies and practices that are barriers to coordinated and effective behavioral health care equity";
- further facilitate access by: 1) clarifying, simply and in plain language, how to enter and navigate the public treatment system; and 2) establishing priority access points in community-based settings for people presenting at hospital emergency rooms;
- evaluate residential treatment bed capacity; and
- expand recovery and prevention supports, including through increased training for recovery coaches; and
- integrate substance use care into physical health care through encouraging all primary care settings to use the SBIRT tool and supporting the co-location of physical and behavioral health services.

Specific to young adults, key recommendations were to:

- ensure treatment and recovery services are age-appropriate, increase capacity of those services that are also evidence based, and educate providers on young adults' "unique needs"; and

- "Create an interagency coalition that promotes collaboration and improved communication between providers and agencies that work with youth."

**Department of Children and Families Needs Assessment**

The Department of Children and Families is conducting a comprehensive needs assessment for all of its purchased services, including substance use and mental health treatment. The effort involves an inventory and assessment of capacity, identification of resource gaps and unmet needs, and community resource mapping. The project began in October 2012 and is expected to be complete by fall 2013.

**Office of the Healthcare Advocate Report**

In January 2013, the Office of the Healthcare Advocate (OHA) issued a report on access to behavioral health care. Its analysis was based on the testimony of providers, practitioners, patients, and family members of patients in an October public hearing held on the topic by OHA; the knowledge gained through its daily activities in assisting the public with accessing healthcare; and prior reports issued by OHA and other state offices.

The OHA report found problems in accessing both substance use and mental health care treatment, stemming from "lack of capacity in our current system, denials from insurers of coverage and lack of provider participation" in insurance networks. Access to inpatient and child psychiatric care was noted as a particular problem, citing in part a 2007 report of the Offices of the Attorney General and of the Child Advocate finding less than half of child and adolescent psychiatrists responding to a survey accepted private insurance.

The OHA report described particular insurance practices (beyond utilization review) that can impede access to care by restricting the number of practitioners willing to participate in the network. One practice is maintaining relatively low reimbursement rates for some behavioral health care providers. For example, some licensed psychologists part of private insurer networks receive an insurance reimbursement rate lower than that of traditional trades' hourly rates (e.g., electrician, plumber) and master's level practitioners in at least one plan have had no reimbursement increase in at least a decade. Another practice is BHP's policy of not allowing licensed clinical social workers to give reimbursed services to HUSKY C and D clients, although they can offer helpful case management - and do, for the HUSKY A and B programs.

The report's recommendations included assigning responsibility for the state's behavioral health delivery system to a single coordinating entity. It notes that OHA is seeking funding to evaluate the Behavioral Health Partnership's suitability for this task.

**Other Research**

The views of nonprofit providers were obtained for this study in two ways: via a survey, and through conversations and other communications facilitated by the Connecticut Community

Providers Association (CCPA).[119] Much of the survey information presented below is also found in Appendix D.

**Survey**. The study survey asked each respondent whether there is usually space in each level of care offered, and if not, about how long the wait for care tends to be. The presence and length of a wait for services varied among the levels of care, and within levels, by survey respondents, as shown in the table below.

**Table G-1. Wait for Survey Respondents' Substance Use Treatment Services, by Level of Care**

| | ***None*** | | ***1-2 Days*** | | ***3-6 Days*** | | ***7+ Days*** | |
|---|---|---|---|---|---|---|---|---|
| | ***%*** | ***n*** | ***%*** | ***n*** | ***%*** | ***n*** | ***%*** | ***n*** |
| Inpatient | 50% | 3 | 33% | 2 | 17% | 1 | 0% | 0 |
| Residential | 13% | 2 | 19% | 3 | 31% | 5 | 38% | 6 |
| Comm. living arr. | 43% | 3 | 0% | 0 | 0% | 0 | 57% | 4 |
| Partial hospitalization | 71% | 5 | 0% | 0 | 14% | 1 | 14% | 1 |
| Day/evening treatment | 58% | 11 | 16% | 3 | 11% | 2 | 11% | 2 |
| In-home services | 29% | 2 | 0% | 0 | 14% | 1 | 57% | 4 |
| Intensive outpatient | 72% | 13 | 0% | 0 | 22% | 4 | 6% | 1 |
| Outpatient - Individual | 48% | 15 | 10% | 3 | 13% | 4 | 29% | 9 |
| Outpatient - Group | 74% | 20 | 7% | 2 | 11% | 3 | 7% | 2 |

Source: PRI staff survey.

Partial hospitalization, day/evening treatment, intensive outpatient, and outpatient group sessions were the levels of care for which more than half of survey respondents reported no wait. However, within each of these levels, at least one provider indicated a wait of at least a week for these same services.

Residential treatment and in-home services were reported by less than one-third of respondents to have no wait for services. The length of wait for residential treatment was at least three days for more than two-thirds of respondents' services, and for in-home treatment, more than half reported a wait of at least one week.

Some respondents chose to comment on the types of programs and clients that experience the longest waits. One provider respondent each noted that Spanish-speaking clients and those with CSSD involvement face longer waits. A few wrote that family or personal scheduling limitations could lead to a wait, particularly for evening services. The area of most comment was in-home programs: Three respondents explained that these have the longest wait, of the service array offered.

*Adolescents*. Both of the survey respondents offering residential treatment indicated this level of care has a wait of three to six days, although one noted that the wait is sometimes due to

[119] The Connecticut Association of Nonprofits (i.e., CT Nonprofits) contacted and solicited views from members but received little response.

family coordination needs. Four of the five respondents providing intensive outpatient said there usually is no wait for that level of services; the other indicated a wait of three to six days. As noted above, a few providers wrote that the wait for an in-home program can extend far beyond one week (the longest option provided in the multiple-choice question).

**Association communications**. Connecticut Community Providers Association (CCPA) members in conversations identified inadequate service capacity for:

- individuals with private insurance, no insurance, or developmental disabilities, or who live in suburban areas (due to zoning restrictions);
- poor minority youth, who if caught with an illegal substance, appear to more often be sent to jail instead of treatment;
- children seeking outpatient or in-home treatment, with waits for the latter of five to seven weeks; and
- residential treatment.

CCPA members suggested that capacity could be improved by two state-level policy actions:

- requiring private insurers to reimburse providers for care given by someone in training; and
- returning DCF outpatient clinic funding to its prior level because demand exceeds capacity and the funding level is pressuring clinics to see fewer uninsured clients.

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# Appendix H

## Adolescent In-Home Treatment Models

The state's Department of Children and Families (DCF) developed three in-home treatment models to address adolescents' substance use treatment disorders:

- *Multidimensional Family Therapy (MDFT) for adolescents*: This therapy looks at adolescent use as a network of influences (individual, family, peer, community), and tries to increase positive behavior in multiple settings. The individual and family are counseled both separately and individually.

- *Multisystemic Therapy (MST)*: MST is family-based, involving joint counseling for the individual and family, with the intent of addressing a range of influences on the youth: individual (e.g., attitude toward use), family (e.g., discipline, conflict), peer, and community (e.g., school, neighborhood).

- *Functional Family Therapy (FFT)*: FFT's premise is that "behaviors influence and are influenced by multiple systems within the adolescent's life, including the family."[120]

DCF also established Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS). This program is geared toward children with mental health disorders but able to serve those with a secondary substance use diagnosis.

**Accessing the models**. Families with private insurance and no DCF involvement can attempt to access MDFT and MST by directly calling the department's contracted nonprofit providers. Utilization review is done only for Medicaid clients. For FFT, access is managed through utilization review by the BHP administrative services organization. Voluntary Services enrollment is not necessary to access these programs.

IICAPS is freely available to children with HUSKY. Those with commercial or no insurance must apply (to DCF, via the department or service providers) for a partial Medicaid benefit that covers only the program costs. This process allows IICAPS providers to bill the Behavioral Health Partnership for the IICAPS services provided to non-HUSKY children, and is unique to the IICAPS program. About 60 percent of IICAPS clients are not DCF-involved (for child welfare or juvenile justice reasons).

[120] "Addiction Medicine: Closing the Gap Between Practice and Science," The National Center on Addiction and Substance Use at Columbia University, June 2012. Accessed August 23, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf

| Table H-1. DCF In-Home Substance Use Treatment Programs | | | | | | |
|---|---|---|---|---|---|---|
| ***Program*** | ***Distinctive Characteristics*** | ***# Sessions Per Week (except where noted)*** | ***Duration (months)*** | ***Evidence-Based?*** | ***Area Offices With Access to Program*** | ***Number of Families Served in FY 2012*** |
| **FFT** | Youth often have other problematic behaviors. | 2 | 4 | Yes | All | 519 |
| **MDFT** | Focus on parent interventions; 1 clinician and case mgr./family. Structural and strategic family therapy. | 3: 1 each family, parent, and individual child | 4-6 | Yes | All | 713 |
| **MST** | Structural family therapy. 1 clinician per family. Are special programs for: juvenile offenders, problem sexual behavior, transition age youth involved with juvenile or criminal justice, parole youth; and families with maltreatment and substance use (Building Stronger Families). | 3 | 3-8 months, depending on program | Yes | Varies depending on program | 327, plus 24 DCF-involved families |
| ***IICAPS*** | *Primary purpose is to prevent psychiatric inpatient admission; can have substance use as secondary diagnosis.* | *4-6 hrs./wk.* | *6* | *Research to establish as evidence-based is being conducted* | *All* | *Approx. 2,000 families (will be 2,500 in 2013)* |
| Source: PRI staff analysis of DCF-provided information and Commissioner Joette Katz's testimony to the Bipartisan Task Force on Gun Violence Prevention and Children's Safety; Mental Health Services Working Group, January 29, 2013. Accessed March 1, 2013 at: http://www.cga.ct.gov/asaferconnecticut/tmy/0129/Joette%20Katz,%20Commissioner%20of%20DCF.pdf. | | | | | | |