The Connecticut General Assembly

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

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MEETING SUMMARY AND NOTES

TASK FORCE TO STUDY THE PROVISION OF

BEHAVIORAL HEALTH SERVICES FOR YOUNG ADULTS (16-25 YEARS OLD)

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

September 24, 2013

Members present: Daniel Connor, M.D.; Sheryl Ryan, M.D.; Anton Alerte, M.D.; Anne Melissa Dowling; Marcy Kane, Ph.D.; Judge Robert Killian, Jr.; Katherine Kranz Lewis, Ph.D.; Tim Marshall; Scott Newgass, LCSW; Ted Pappas, M.A.; Kelly Phenix; Patricia Rehmer, MSN; Laura Tordenti, Ed.D; Cara Lynn Wescott; Andrew Martorana, M.D.

Absent members: Stacey Adams; Aura Ardon, M.D.; Sarah Eagan; Ashley Saunders; Victoria Veltri, JD, LLM

Others present: Mickey Kramer representing Sarah Eagan; Jill Hall representing Victoria Veltri;

The 13 legislative charges to the Task Force To Study The Provision Of Behavioral Health Services For Young Adults (16-25 Years Old) could be organized into three broad domains for discussion: Capacity,Access, and Other (clearinghouse for MH information, outpatient legal commitment law, and accountability/program outcome methodology). Today's discussion focused on *Capacity*:

Capacity:

1. Behavioral Health Services System for 16-25 year-olds:
    a. Improving MH screening, early intervention, and treatment
        i. Should behavioral health capacity in the 16-25 year-old population be increased by more involvement of schools (high schools) in the MH system? Should schools under their Local Educational Authority (LEA) be empowered and

resourced to develop MH screening in high schools? Should an intermediate-level mobile behavioral health team staffed by social work/psychology be created for each LEA to evaluate youths who screen positive in the schools for MH problems and be responsible for intermediate-level mental health evaluation including risk assessment, and outcomes (either calling 2-1-1 for MH crisis, police, or contacting parents, etc.)?

1. Connecticut already is in possession of data from parents stating parents *do not want schools involved in MH screening.* What about that?

2. How to change an adolescent culture of stigma around mental health issues?

3. What about 16-25 year-olds who have MH problems and are not in school?

    a. Adolescents' ≥ 16 years-old can sign-out of MH interventions against advice. How to think about this?

ii. Should behavioral health capacity in the 16-25 year-old population be increased by supporting the medical health system to become more involved in MH screening, evaluation, treatment, and referral of 16-25 year-olds?

1. Should ACCESS MH Connecticut be expanded and funded to include psychiatry telephone consultation to young adult primary care providers for patients up to age 25 years? How much additional would this cost the State?

2. Should the State fund contracts to fund increased MH training to pediatric, adolescent, and young adult primary care clinicians to enhance PCP skill in screening, evaluation, and treatment of MH problems in the 1-25 year old population?

3. Should the commercial insurance MH industry be required to reimburse primary care clinicians at a higher rate and give more reimbursable office time per visit when PCPs are evaluating or treating a youngster with a behavioral health billing code?

4. Should the commercial insurance MH industry be required to reimburse PCPs for their time and effort spent communicating with psychiatrists and allied mental health professionals when engaged in MH treatment of a youngster in the PCP practice in order to facilitate communication and coordination of care under the Medical Home model?

5. Should the commercial insurance MH industry be required to reimburse for in-home MH care for youths 16-25 years old?

iii. Could the behavioral health capacity in the 16-25 year-old population be increased by supporting alternative interventions for youths with MH problems including:

1. Reimbursement for mentoring programs

2. Reimbursement for respite programs

3. Support for peer-to-peer interventions for at-risk youth

2. The Connecticut Behavioral Health Workforce:

Is there a capacity issue in the behavioral health work force in Connecticut? In other words, (1) does CT require more social workers, psychologists, and psychiatrists who are professionally educated and skilled in providing MH treatment to the child, adolescent, and young adult population? AND/OR; (2) Does Connecticut have enough professionals in the MH workforce but needs to reimburse them better or more effectively so that they elect to devote a higher percentage of their work week to evaluation and treatment in this population? AND/OR; (3) Does Connecticut need to utilize the existing MH workforce for children, adolescents, and young adults in more creative and effective models of care? For example, creating public-private insurance industry grouped and shared collaborations and funding models to decrease discrepancies in reimbursable services across multiple insurance systems (public and multiple private commercial insurances), facilitate co-location of mid-level MH providers into PCP offices, reimburse for care coordination and communication across disciplines in the care of youth with MH issues, creation of in-home models of treatment, create models of reimbursement so that the MH clinician is reimbursed for evaluating and treating the parents of a child, about the child, and not the child directly, models of insurance reimbursement to support child psychiatry and psychology consultation to school systems, AND/OR; (4) Does Connecticut need to educate its existing MH workforce more comprehensively? In other words, progress in the mental health scientific data base supporting new evidence based psychotherapy and psychopharmacological treatments for early-onset and young adult mental health disorder is rapid, and may be too rapid for working professionals to learn and become readily expert and experienced in. This may run the risk of a too generalized clinical approach to child, adolescent, and young adult MH problems, when what is needed is a highly specialized, disorder-specific (externalizing behavior disorder, internalizing behavior problems, posttraumatic stress disorder, eating disorder, developmental delay, autism, substance abuse, psychosis, bipolar, stress-related disorders, psychosomatic disorders, etc.), and evidence-based trained MH workforce. Thus, should Connecticut invest in additional training for its MH work force (including PCPs) emphasizing the extant scientific evidence?

a. How does Connecticut distinguish between what social work, psychology, and psychiatry provide and offer to this age group? Are the professions distinguishable only by economic factors such as salary? Are all the professions clinically interchangeable from a state workforce perspective, or does specific professional training and credentialing infer certain areas of clinical expertise that are important for the state to identify and utilize?

b. How much is enough? In order to meet clinical demands are there enough social workers and psychologists who spend ≥ 50% of their work week in the clinical evaluation and treatment of children, adolescents, and young adults with behavioral health needs?

    a. Is there data on the number of licensed CT social workers and/or psychologists who spend ≥ 50% of their work week in the clinical evaluation and treatment of children, adolescents, and young adults with behavioral health needs?

        i. This data is needed to have a data-informed opinion on whether there are workforce shortages in this area.

    b. According to the CT Council of the American Academy of Pediatrics and CT Chapter of the AACAP there are about 225 child and adolescent psychiatrists in the State of CT. They are preferentially distributed on the coast of CT towards NYC and in the central CT corridor stretching from New Haven to Hartford, up to Springfield, MA. Western CT and NE CT have few child and adolescent psychiatrists.

        i. Does CT have enough child & adolescent psychiatrists to meet the demand?

        ii. Should general adult psychiatrists without specialized training in child and adolescent psychiatry be encouraged to evaluate and treat adolescents 16 and 17 years-old as a way of expanding the psychiatric workforce for young adults 16-25 years old?

Next Task Force Meeting: **Tuesday October 8, 2013 2:30 PM to 4 PM** at the Legislative Office Building. The agenda will include a presentation by the private commercial insurance industry on mental health reimbursement.