The Connecticut General Assembly

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

Co-Chairs:

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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

October 8, 2013

Members present: Daniel Connor, M.D.; Sheryl Ryan, M.D.; Anne Melissa Dowling; Marcy Kane, Ph.D.; Judge Robert Killian, Jr.; Katherine Kranz Lewis, Ph.D.; Scott Newgass, LCSW; Kelly Phenix; Patricia Rehmer, MSN; Ashley Saunders; Cara Lynn Wescott; Andrew Martorana, M.D.; Victoria Veltri, JD, LLM

Absent members: Stacey Adams; Anton Alerte, M.D.; Aura Ardon, M.D.; Sarah Eagan; Tim Marshall; Ted Pappas, M.A.; Laura Tordenti, Ed.D;

Others present: Rep. Susan Johnson; Mickey Kramer representing Sarah Eagan; Robert McKeagney representing Tim Marshall

At the October 8, 2013 meeting, the Task Force discussed Barriers to Care Issues for young adults ages 16-25 years old living in Connecticut. Barriers to Care Issues discussed include:

1. Barriers to access BH information for parents when urgent youth BH intervention is required. Parents and young adults are too often not aware how to access BH referral information when such information is needed. Even for parents and youths who have knowledge about how to access help the referral system is often too difficult to navigate for parents in need. Parents often feel isolated, alone, and overwhelmed while attempting to access help.

    a. Should a 2-1-1 type of emergency system be created for the BH population 16-25 years-old?

b. Should the TF recommend creation of system navigators and support for this job description (care coordinators) to help parents and youths in need?

2. System fragmentation is strongly identified as a major Barrier to Care. Contributors to fragmentation include:

a. Payment for BH care in CT. Multiple differences between services available under commercial mental health insurance plans vs. public funding exist contributing to mental health service treatment inequities for youths with BH issues.

i. For publically insured youths more services appear available and readily accessible than for commercially insured youths.

ii. Communication across PCP and BH providers is not adequately reimbursed contributing to system fragmentation.

iii. Insurance reimbursement rates for BH providers are not high enough to incentivize providers to take insurance and practice within a system-of-care. Thus, many qualified BH providers provide a "boutique" cash-only service, limiting accessibility to treatment based on parental socioeconomic status and ability to pay. Primary care clinicians are not adequately reimbursed when spending the extra time necessary to evaluate and treat youths with BH issues limiting their availability to youths with such issues.

iv. One size does not fit all: Payment models for persistent and chronic mental illness need to be distinguished and modeled separately from payment models for more transient BH issues.

1. In addition to DMHAS (young adult services) and DCF (transition services for those adolescents in need), is the Federally Qualified Health Care Clinic (FQHC) system a place to think about care for the persistently mentally ill young adult?

v. Are the CT laws governing the operation of behavioral health care for commercial insurers somewhat different than the laws governing the operation of public systems of payment for BH disorders? If so, does this difference contribute to system fragmentation?

b. School Mental Health Clinics: many demonstration models in Connecticut. Instead of asking children/families to go to clinics, should the clinic be where the adolescents are (in school)? Would high school MH clinics decrease barriers-to-care in CT?

i. This does not address young adults 18-25 years-old who are out of school and can make their own decisions as adults.

3. Other Identified Barriers-to-Care:

   a. Homelessness

   b. Need for a more robust culturally-competent and multilingual BH workforce in CT.

   c. Geographic distribution of BH Workforce. Some areas have more providers than do other areas in CT (north west and north east regions of CT)

   d. High rates of BH Workforce turnover

   e. Capacity: not enough providers resulting in long wait times for referral.

   f. Discrimination/Stigma: How best to address across CT as a whole and within population subgroups?

Next Meeting of the Task Force: Tuesday October 22, 2013, 2:30 to 4:00 PM.