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

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

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

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

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

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

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