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*Hearing, Helping & Healing*

**Testimony before the Appropriations Committee  
12/10/09**

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Good afternoon, my name is Sherry Perlstein. I am here as Executive Director of the Child Guidance Center of Southern Connecticut (CGC), and as a representative of the Children’s Mental Health and Substance Abuse Division of the Connecticut Community Provider’s Association (CCPA) to ask for your continued support of grants through DCF that subsidize vital behavioral health services, and for the BHP budget that funds fees for service for HUSKY children.

The CCPA division’s members provide a continuum of community based children’s behavioral health services across the state. We have partnered with DCF and DSS to achieve the goals of KidCare and the Behavioral Health Partnership and are proud of the progress we’ve made together implementing programs and services that meet the mental health needs of children, adolescents and families locally, while reducing reliance on the more costly and disruptive alternatives of hospitalizations and out-of-home placements.

With the advent of Enhanced Care Clinics we eliminated waiting lists for outpatient services, and are successfully meet access goals based on the degree of urgency of each referral. Though specific targets were established for HUSKY patients, at CGC we committed to not discriminating based on payer source, providing the same access to all families, including 22% of families we served last year who were uninsured.

We are mindful of the challenge you face in balancing the budget in the midst of an economic crisis. As you make decisions about ways to maximize revenues and reduce expenses, I respectfully request that you consider the relative value and long term consequences of every line item, rather than considering across the board cuts. When you look at the state’s relatively small investment in community based mental health services for children and families, please consider the immediate and long term consequences of reducing access to these critically needed, highly effective programs.

Our programs are targeted to children, who experience mental health problems that interfere with daily functioning and threaten long term development. Priority access is provided to youngsters with serious symptoms (i.e. suicidal ideation, violent or self destructive behavior,

psychotic symptoms, including gross impairments in judgment and reality testing) and those children experiencing trauma or crisis (child abuse, neglect and sexual abuse, children suffering from serious physical illness or impacted by the illness or death of a parent or significant other). Though services are available for families from all economic and ethnic backgrounds, we are committed to assuring access to lower income, uninsured and underinsured families, and to providing services that are culturally and linguistically appropriate for our multi-ethnic community.

The unstable economic environment has dramatically increased need for our services, with new referrals at my agency up by almost 20% last year, and the trend continuing this year. Feared or actual job loss, home foreclosures and evictions, the need to make lifestyle changes and even cutback on necessities, takes a toll on the stability of the family. Parental anxiety, depression, substance abuse, domestic violence all increase and children lose the sense of security they require for healthy development.

At CGC of Southern Connecticut, our services have traditionally been funded by a combination of state grants; Husky, private insurance and sliding scale fees for services; and over \$1.5 in corporate, United Way, and foundation grants, and individual contributions. The economy has reduced philanthropy and we have had to cut expenses. Any reduction in state support will result in reduced access and a loss of services.

Untreated, mental health problems have immediate and lifelong consequences, resulting in behavior that can create dangers for the child, family, and community; seriously impair normal functioning; threaten long term development and increase the risk that as adults, the untreated youngster will experience unemployment, poverty, antisocial behavior and difficulties in creating stable marriages and providing responsible parenting.

Outcome data from national studies and local CGCs documents that timely access to effective mental health services stabilizes crisis, reduces emotional suffering and dysfunctional behavior, strengthens families and helps children achieve their optimal potential. I ask you to understand this in very human terms by listening to typical examples of children referred to CGCs. As I describe these real situations (with names changed to protect confidentiality), ask yourselves, which of these children you would turn away or place on a waiting list – because that is the question we must face as we try to manage increasing referrals and declining revenues.

At 8 “Vanessa” is suffering from insomnia and can barely stay awake during the day. She is a ragged looking child with dark rings under her eyes. She is listless and depressed, and tells the therapist that she thinks about poking her eyes out with a fork, and stabbing herself. Her mother was recently reported to DCF after she pushed her child’s face through a pane of glass. Mother’s boyfriend was recently convicted of multiple incidents of sexually abusing this child several years ago

“Carlos,” age 4, was adopted from another country when he was 2. He was abandoned by his parents at 1&1/2 and spent many months in an orphanage. Though initially making a good adjustment to his new home, his mother is concerned that the birth of her new son has affected him badly. He constantly needs her attention and has increasingly angry and violent outbursts.

She says he is too disruptive to be left with a sitter, and his behavior too threatening for him to be alone in a room with his baby brother

“Jeannette” is 13. Following a recent test at school she began to talk about hating herself and wishing that she were dead. Until this year, she has been an A student. Her mother feels that the relationship between the 2 of them has gone from exemplary to horrible, and she insists it is people at school that are responsible for all of this.

At 10, the rituals that have increasingly controlled “Christopher’s” young life have become unbearable. Each day he insists that he has to count the money in his mother’s purse and dad’s wallet three times before going to sleep and when he awakes in the morning. At night he patrols the house, checking every window and door three times before he can go to bed. The list of food he will eat is narrowing, and he will eat nothing on his plate if the foods are touching each other. Described as an otherwise pleasant child, the rituals are consuming him and his family.

“Tyler” is 8 and recently moved into the home of his new adoptive parents after living in several different foster homes over the last 4 years. His mother a drug addict, finally relinquished custody after repeated reports of physical abuse and neglect. Tyler is an anxious boy who wanders the house when he cannot sleep at night, hoards food, rejects hugs and is frightened of showering. His new parents want to help him make a positive adjustment to their home and are concerned about the effect of his strange behavior on their 7 yo daughter.

The psychiatrist at a nearby hospital has called wanting to discharge a 14 year old girl to our care. The girl has been hospitalized 3 times in the past year and a half, having made multiple suicide attempts and threats. The most recent incident involving swallowing 70 Aleve capsules. She has experienced visual hallucinations, engaged in self cutting and forced vomiting. The child is not stabilized, but the hospital staff implores us to accept the referral, as the insurance company will not authorize continued hospital care.

When police arrive at the scene of a stabbing, they found 9 yo John, cowering in the corner of his mother’s bedroom. The police knew the family well. Mom had finally worked up the courage to separate from her abusive husband over a year ago. While overseeing the removal of the victim, (mom’s boyfriend), by ambulance and obtaining information from her about the possible whereabouts of her the offender, John’s father, the police called our crisis program for assistance with John.

Failure to continue support for these children will re-establish long waiting lists for community based services. This will reverse a decade of progress we have made, overtaxing hospitals and residential facilities. The state’s investment in community based mental health services has reduced expenditures for hospital stays and out-of-home placements, and will pay dividends in the lives of families and the community for generations to come

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