

**Connecticut Council
Child and Adolescent Psychiatry
104 Hungerford Street
Hartford, CT**

I am Dr. Mirela Loftus, a Child and Adolescent Psychiatrist. I practice at the Institute of Living here in Hartford and I am representing the members of the CT Council of Child and Adolescent Psychiatry. I am here to add to the discussion of SB 169 ***AN ACT CONCERNING THE ASSESSMENT AND DELIVERY OF MENTAL HEALTH SERVICES AND INTERVENTIONS FOR CHILDREN.***

CT Council of Child and Adolescent Psychiatry and the CT Chapter of the American Academy of Pediatrics and the have been collaborating for a number of years on co-educating our colleagues on clinical topics and ways to enhance the mental health services that we can provide at the primary care level. Primary care Pediatricians have been doing more and more mental health work in our daily routine of caring for children. We have been working with other organizations on co-location models which bring mental health providers into the primary care offices. Together we created a ***Blue Print for Mental Health for Children in CT.*** I have attached the executive summary of that document to my testimony, and I have forwarded the entire Blue Print for your attention.

We propose the following efficiency measures are being proposed to address areas that we see as critical barriers to care:

1. **The creation of a regionalized integrated system of care**, based on home address, in which outpatient mental health and primary care providers, child guidance centers including ECCs, school-based programs, in-home programs such as IICAPS, mobile crisis teams, partial hospitalization programs, and inpatient programs are all linked in one system of care. The integrated system of care creates a community of caregivers and culture of respect.
2. **Increased allocation of resources to pediatric, day care and school settings for the prevention and early detection** of mental health problems in children.
3. **Improved timely access to high quality appropriate intervention.** The competency of teachers, pediatricians, nurses and social workers is improved by better access to consultation and support from experienced mental health providers.
4. **Preservation of a centralized, high quality, long term, inpatient treatment center for the entire state at Solnit Hospital (Riverview State Hospital)**, and improvements in utilization patterns to reduce length of stay and the number of required admissions. Such changes will reduce the need for out-of-state long-term care, which is very expensive and divorces patients from their families, communities and ongoing caregivers.

5. **Create a primary care collaboration system of regional sites** where child psychiatrists are available in real time to consult with primary care providers, and help access services and/or direct care to pediatric practices to help extend child psych services. This model has been effective in 26 states including our neighbors in Mass. Senator Gerratana has asked the created of this model, Dr Barry Sarvet from MA, to come present this model to whomever is interested in knowing more. That presentation is currently scheduled for March 4. (10-11:30AM)

Thank you very much for your time, energy and interest in this very important topic.

**ADDRESSING THE CHILDREN'S MENTAL HEALTH CRISIS IN CONNECTICUT:
A PRACTICAL, AFFORDABLE PROPOSAL TO RAPIDLY IMPROVE ACCESS
TO HIGH QUALITY PROFESSIONAL MENTAL HEALTH CARE
FOR ALL CHILDREN IN CONNECTICUT**

Mental Health Care 'Blueprint' for Children in Connecticut

Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and
the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry

THERE IS A MENTAL HEALTH CRISIS OF EPIDEMIC PROPORTIONS FOR THE CHILDREN OF CONNECTICUT. THIS PROPOSAL BY THE JOINT PEDIATRIC – CHILD PSYCHIATRY CHILD MENTAL HEALTH TASK FORCE WILL IMPROVE ACCESS AND QUALITY OF MENTAL HEALTH CARE FOR CHILDREN. THE PROPOSAL RELIES ONLY ON EXISTING LEVELS OF PROFESSIONAL MANPOWER AND RESOURCES WHICH ARE CURRENTLY BEING PAID FOR BY THE STATE, AS WELL AS ON CURRENT RESOURCE LEVELS FROM COMMERCIAL INSURANCE COMPANIES AND PRIVATE CHARITABLE SOURCES.

January 2010

EXECUTIVE SUMMARY

Children and families in Connecticut face a mental health crisis of epidemic proportions. Improving children's mental health has been a central focus of a decade-long collaboration between pediatricians and child psychiatrists in Connecticut. Building on a century-long tradition of collaboration, the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of Child and Adolescent Psychiatrists united to create the Joint Child Mental Health Task Force (CMHTF) that has become a national model in the medical profession. At the request of Jeanne Milstein, the State's Child Advocate, the CMHTF has generated a practical, affordable proposal to address this dire mental health care crisis. The proposal offers a framework for ongoing evaluation and re-direction. The goal of the proposal is to rapidly improve access and quality, eliminate waste, and control overall cost of mental health care for children without violating the Hippocratic standards of good clinical care or compromising the dignity-based primary goals of care. The proposal will save the state money by targeting the many children who desperately require mental health services, thus avoiding the immediate and long term consequences of leaving so many children untreated.

PROPOSAL BRIEF

From generation to generation, Americans have fulfilled the promise to make life better for our children than it was for us. But today, because of the state of health and medical care in this country, our children's generation is predicted to have a shorter life expectancy than our own.¹ Poor mental health treatment is a major component in the decline of Americans' health.² According to the Surgeon General's report nearly 1 in 5 American children suffers from a diagnosable mental disorder. Seventy-five to 80% of these children do not receive any treatment at all.³ For those who do receive some care, it is often inadequate, sometimes abysmally so. This unmet need for services translates into high levels of cost, both socially and economically, and is a leading cause of death in older children.⁴ Untreated mental illness often persists into adulthood, where it constitutes the leading cause of disability in the United States and Canada for ages 15 to 44, according to the World Health Organization.⁵ Untreated mental illness also tends to worsen over time, such that increasingly intensive – and expensive – treatments are needed.

Undetected and untreated mental disorders cause children unbearable suffering, poor academic performance, occupational underachievement, social failure, and can lead to social deviance. They impose huge intangible and tangible costs on the society, costs that are reflected in enormous demands on the State budget. Untreated and inadequately treated mental illness in children can impose very large burdens on State-supported schools, police departments, courts, prisons, foster care and halfway houses. Parents and other family members are themselves driven to seek state services because their physical health, mental health, social adjustment and financial stability are undermined by trying unsuccessfully to care for a sick child who is not receiving the professional treatment. Families come apart, small businesses fail, wage earners become unproductive or unemployed, all costing the State money and reducing overall economic activity and tax income. As mentally ill children grow into handicapped adults, the State pays again directly and indirectly for deferred mental health and drug addiction costs.

The CMHTF proposal is designed to contain mental health costs for the State government, commercial insurers and businesses that insure their employees. It relies almost entirely on professional manpower and financial resources already in place. It achieves improved access and improved quality of mental health services solely by markedly increasing the efficiency of care and the efficiency of insurance. In an effort to improve access to quality mental health care for all of Connecticut's children, the task force proposes solutions to the five most critical barriers to care listed below:

1. Poorly coordinated, fragmented and discontinuous care.
2. Impediments to creating and sustaining programs for prevention and early identification of mental health problems.
3. Impediments to early access to high quality mental health treatment.
4. Failure to provide an adequate number of high-quality inpatient long-term beds, and to sustain care for the most critically ill children consistently throughout the course of illness.
5. Failure of the managed behavioral health care programs to provide sufficient resources to deliver the necessary quality of care for children with commercial health care coverage. These behavioral health subcontractors waste a huge proportion of the

mental health insurance dollar on excessive administration, marketing, executive pay and large shareholder profits; while they undermine the quality of care by refusing to insure many patients in need, inadequately reimbursing clinicians, harassing clinicians and patients, and refusing payment for necessary treatment, collaboration, consultation and clinical case management. For every single dollar that private insurers are able to save by preventing mental health treatment in a child, the state pays many more dollars as the child's illness unfolds in later childhood and adulthood.⁶

The following efficiency measures are being proposed to address these five critical barriers to care:

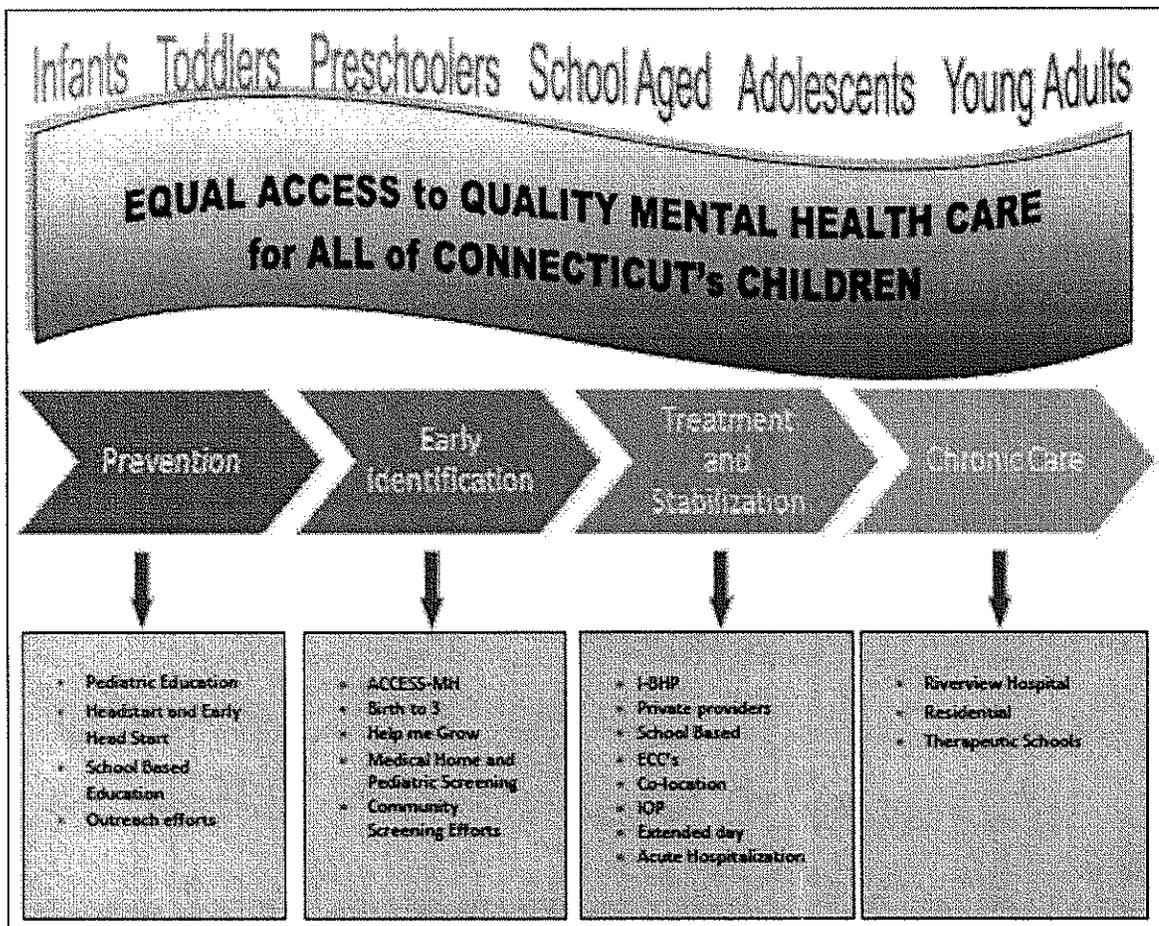
- 1. The creation of a regionalized integrated system of care**, based on home address, in which outpatient mental health and primary care providers, child guidance centers including ECCs, school-based programs, in-home programs such as IICAPS, mobile crisis teams, partial hospitalization programs, and inpatient programs are all linked in one system of care. This creates a system of care that supports the central role of the primary medical home, pediatric clinician, and school health service, integrates physical and mental health care, integrates care of the children and that of their families, and utilizes interdisciplinary teams that make optimal use of the unique expertise of each profession. The integrated system of care creates a community of caregivers and culture of respect.
- 2. Increased allocation of resources to pediatric, day care and school settings for the prevention and early detection** of mental health problems in children.
- 3. Improved timely access to high quality appropriate intervention.** The competency of teachers, pediatricians, nurses and social workers is improved by better access to consultation and support from experienced mental health providers. Respectful supervision and adequate reimbursement for case consultation, collaboration and management increases efficiency by eliminating demoralization of caregivers, and by reducing redundancy and discontinuity of care. The proposal also improves access to treatment by expansion and improvement of the statewide network of child guidance clinics.
- 4. Preservation of a centralized, high quality, long term, inpatient treatment center for the entire state at Riverview State Hospital**, and improvements in utilization patterns to reduce length of stay and the number of required admissions. Such changes will reduce the need for out-of-state long-term care, which is very expensive and divorces patients from their families, communities and ongoing caregivers.
- 5. The CMHTF proposal helps commercial insurance companies and self-insured businesses, because it provides much more efficient and complete care for their beneficiaries, without spending any additional money.** The proposal calls for eliminating profit-driven behavioral managed care subcontractors, for commercially insured families, and replacing them with the CT-BHP model of not-for-profit managed care, with professional oversight. The CT-BHP model was created in 2006, and is already successfully improving the quality and efficiency of mental health care for poor children who are insured by Medicaid. Implementing a CT-BHP type model for those children covered by commercial insurers and self-insured employers will increase the money available for mental health care and provide care that is more efficient and more effective, while not spending any additional money.

We believe that with a strong legislative and administrative initiative, and no increase in State funding, we can rapidly build a much more effective and efficient mental health system. This system would save a lot of money in the long term as well as the short term. We are spending the money already, but inefficiently. There is long-standing, destructive and unwarranted stigma against mental illness that continues to perpetuate the failure of our society to ensure affordable access to adequate prevention and treatment for children with mental disorders. If large numbers of children were not getting effective and affordable treatment for leukemia as a result of inefficiencies in our health care system, people would join together with business leaders and insurance company executives to swiftly implement the legislative, fiscal and clinical reforms required to remove the barriers from having access to adequate care. Yet, mental illness in children and adolescents is more prevalent than leukemia, diabetes, and AIDS combined, and, like these illnesses, can cause devastating damage to children, their families, and their communities.

This proposal is a call for a joint initiative by State government officials, professional caregivers, private businesses and health insurance companies to join together to better protect the mental health of our children, in a fashion that also serves our private economic interests and those of our State government. It is morally imperative that doctors and other care-giving professionals work to achieve these reforms; it is a duty for the citizens and leaders of our rights-based democracy, and it is a requirement for all civilized men and women who want to live in country that does not violate the basic values that give meaning to our lives.

Graphic: Summary of Potential Future Integrated CT Children's Mental Health System

As illustrated in the graphic below, the Blueprint outlines four areas in Connecticut's mental health care system: Prevention, Early Identification, Treatment and Stabilization, and Care for the Chronically Ill. Prevention programs center around early childhood programming, pediatrician's office and school settings, as well as outreach programs that are unique to Connecticut, such as the Nurturing Families Network and the "Minding the Baby" program at Yale. Early Identification efforts are highly dependent on the work of pediatricians and school-based health centers, but are often limited by a lack of training, communication between providers, and funding mechanisms. Families' access to Treatment and Stabilization services is often limited by "donut-hole" insurance coverage, limited availability of community guidance clinics due to DCF restrictions, an insufficient number of providers, and poor reimbursement policies for mental health services. Care for the chronically ill in Connecticut rests mostly with Riverview Hospital and residential treatment facilities. These facilities often have long waiting lists and some do not accept adolescents, leaving families with no options for their chronically ill children. The private insurers restrict access to such facilities.



Glossary of Terms:

ACCESS-MH: Access for Connecticut's Children of Every Socio-economic Status – for Mental Health A proposed program – based on a successful Massachusetts model – to increase identification and treatment of children with mental health needs, by providing primary care physicians immediate access to triage and urgent care through regionalized networks of child psychiatrists and related mental health providers.

CMHTF / CTAAP / CCCAP: Joint Child Mental Health Task Force

A 10-year collaboration of leaders from the Connecticut Chapter of the American Academy of Pediatrics (CTAAP) and the Connecticut Chapter of Child and Adolescent Psychiatrists (CCCAP) united to create this Task Force to address the crises in mental health issues in children in CT.

COR: Collaborative Office Rounds

Regular cross-disciplinary meetings of pediatric health care providers and child psychiatrists to discuss cases and clinical issues. These rounds allow primary care physicians to become more comfortable and proficient in the early identification and management of children with mental illness.

CGC / ECC: Child Guidance Clinic / Enhanced Care Clinic

CGC's are existing child guidance clinics and community outpatient clinical programs geographically covering the entire state. The enhanced ECC designation identifies CGC's that agree to a set of conditions facilitating a more rapid access to emergent, urgent and routine care for children and families who are insured through Medicaid or HUSKY insurance.

CT-BHP: Connecticut Behavioral Health Partnership

A Medicaid-based not-for-profit mental health system designed to effectively deliver mental health care to children and families on Medicaid. Managed by ValueOptions, a behavioral health insurance subcontractor, CT-BHP incentivizes appropriate uses of less intensive levels of care.

I-BHP: Insurance company based-Behavioral Health Partnership

A proposed commercial insurance-based mental health care payment system for commercial insurance-dependent families, modeled on CT-BHP and other successful state initiatives. See section V. for further explanation.

IBF: Insurance Based Fund

The fund commercial insurers will pay into under the proposed I-BHP to subsidize CT children's mental health care. The cost to commercial insurers will be less than they currently pay for mental health care while providing better coverage.

IICAPS: Intensive In-home Child and Adolescent Psychiatric Services

A 14-site statewide in-home program designed to stabilize children while keeping them in their home community and out of acute or chronic inpatient care.

IOP: Intensive Outpatient Program

An intensive program that provides high levels of care for patients who do not require hospitalization.

RTC: Residential Treatment Center

Mental health treatment involving a long-term stay at a residential facility.

Other Abbreviations:

APRN Advanced Practice Registered Nurse

PCP Primary Care Provider

BOE Board of Education

SBHC School Based Health Center

DCF Department of Children and Families
Education

SDE State Department of

DPH Department of Public Health

SED Seriously

Emotionally Disturbed

DSS Department of Social Services

FTE Full-Time Equivalent