



State of Connecticut
GENERAL ASSEMBLY



Commission on Children

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Children Committee
Connecticut General Assembly
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Senator Bartolomeo, Representative Urban and Members of the Children Committee:

My name is Elaine Zimmerman. I am the Executive Director of the Connecticut Commission on Children and am here today in **support** of:

- SB 972 - An Act Concerning Children and Behavioral Health;
- HB 6525 - An Act Establishing a Childhood Obesity Task Force;
- HB 6497 - An Act Concerning the Marketing of Firearms to Young Children; and
- HB 6501 - An Act Concerning Parent Engagement.

I spent the weeks after the Newtown shootings in Newtown, co-directing the play space and art stations for children and youth at John Reed Middle School while their parents sought advice and counseling for their families. One first grader said to me, quite seriously, "We are moving my school to another school. My school has a mental illness. They want to be sure we do not catch it. So they are closing it down and moving us away."

On the one hand, someone must have told her that the children were killed by someone with an illness. But now she worries that it is contagious. In fact, she worries that she will catch it. So how do we help children not "catch" mental illness? Prevention, early intervention, assessment and a coordinated system of mental health care.

Connecticut's children and adolescents are experiencing a mental health crisis. There is a critical shortage of mental health and substance abuse prevention and treatment services. Twenty percent of all children and adolescents in Connecticut struggle with a diagnosable and treatable mental health problem. Only twenty-five

percent of all children and adolescents with emotional-behavioral problems currently access adequate mental health treatment services. Connecticut's suspension rate for black students with learning disabilities is the third highest among all 50 states. One in fifteen Connecticut high school students attempted suicide in the last year.

Focus on Prevention, Proven Practice and Start Early

If we start at the beginning, we have the best outcomes and the best return on investment. Our state needs an interconnected framework of supports in which schools, mental health, child and family services, and early childhood programs are organized in a continuum of intervention services to ensure that children with emotional-behavioral problems have access to good mental health services. Some of this is no cost or low cost and more about systems building than about new services.

Home visitation

For example, our state has been the recipient of over 27 million dollars in home visitation from the federal government, working with our most vulnerable families to ensure strength, minimize trauma and to buffer stressors.

In 2010, the Department of Public Health conducted a statewide needs assessment for Maternal, Infant and Early Childhood Home Visitation programs, referred to as the MIECHV Needs Assessment. Seventeen towns were identified as in 'very high need' of maternal and infant home visiting services and were targeted for the statewide MIECHV plan. They include New Haven, Hartford, Meriden, Bridgeport, New Britain, East Hartford, Waterbury, Windham, Bristol, Norwich, Bloomfield, Torrington, Winchester, Ansonia, Derby, New London, and Putnam.

There are approximately 40,000 births in CT each year. Roughly 10,000 births are to families with at least one significant risk factor. Of these births, 2400 babies are born to mothers, age 19 and younger. We have programs in towns and cities reaching out to pregnant moms and vulnerable parents helping the family with mental health issues, substance abuse challenges, trauma and other high level constraints on family functioning.

But we do not have a system of home visitation. It is program by program, town by town. Home visitation needs to be integrated with early care and education. It needs to be integrated across program model. It needs to be linked to mental health and our outreach workers who should all be trained in trauma-informed practice.

Home visitation is not the primary staircase to a mental health system. But it is a preventive strategy that could buttress numerous early and weak links from breaking apart and harming children. This includes attending to maternal depression, neglect, abuse and violence.

Home visitation is the earliest preventive strategy where mental health occurs in the home with new and particularly vulnerable parents. Better woven and coordinated with our early care and mental health systems, our Birth to Three system which works with infants and toddlers facing specified neurological and developmental challenges, this model could be a system of family strengthening, parent support and early infant toddler assessment.

Early Care and Education

We were, not long ago, expelling children in child care for behavior problems. The numbers made a mockery of us. Instead of tending to, we were throwing out, before children were four years old.

This challenge was addressed through mental health consultation with the early childhood field. Helping early care providers know how to deal with behavior challenges assisted the children in developmentally appropriate ways, helped parents know what they might do at home and assisted in early detection of delays, learning challenges and social emotional issues. We need to take this early childhood consultation model to scale and bring it also to the elementary schools.

Similarly, Enhanced Care Clinics, under the Behavioral Health Partnership, should have at least one clinician endorsed in infant mental health. Birth to Three, an excellent system of intervention and assessment of children with particular neurological difficulties and developmental delays, could be enhanced to better assess and address mental health needs in very young children.

Pediatricians similarly benefit from training. They may be skilled in stages of development, but this does not mean they are trained to pick up social emotional challenges. Of equal import, pediatricians are not trained in the nexus between learning disability and mental health. Learning disability, with emotional challenges, is often an explosion ready to happen. But this is rarely studied, shared with parents or prevented through intentional diagnostic care or planning. Some parents are not able to access professionals. Others do, but do not get the assessment or interventions necessary or accurately targeted to impede escalation

of symptoms, psychological distress and severe crisis. Often health care plans do not cover what is necessary and urgent.

There is no single problem facing the vulnerable families in our state. Rather there are a multitude of challenges which negatively affect parenting, maternal and child health, and social emotional development. Massachusetts supports universal screening for mental health concerns at all well-child pediatric visits. Our state should adapt this model. We would prevent and intervene earlier, with greater success and stability for the child and family. Similarly we need to ensure that all mental health and developmental screening is reimbursable for pediatric providers.

A Fragmented System

Our mental health programs are not coordinated or linked to systems, such as schools, in ways that would maximize referrals and alignment. More children see counselors in school than in most systems. 70 to 80 % of children who receive mental health services are seen by guidance counselors, school psychologists and psychiatric nurses in our educational system. We need to promote school-based early identification and screening efforts due to the access, use and normative context.

We need to ensure that these counselors are in our schools, with proper resources and parent information on how to access quality services. We also need a coordinated system of care with more attention to trauma- informed practice. Bringing research- based practice, prevention and families as partners into our medical home system will bolster our early interventions. This has truly not yet been done. Our neighbor, Vermont, is a strong model of this structure and its improved outcomes.

Community Mental Health

Only 36% of those with mental disorders receive treatment in a given year, according to the NIMH. There is a shortage of mental health specialists and child psychiatrists treating children and teens. There is a shortage of hospital beds for acute mental health and substance abuse treatment. We need to expand and ensure supply, quality and access for youth and young adults.

Timing and intervention are critical to mental illness. When a problem is not addressed, it grows and coils. There are often permeable lines between kinds of emotional disorders and mental illness. Crossing more and more streets with no intervention can lead to a growing emotional disorder with more challenges and

deeper obstacles to recovery. It is as if the expanse of time expands wounds to the core.

Children with mothers who are depressed face extreme challenges. Depression leads to isolation, lack of connection and, at its extreme, and an absence of nurturance. For a child, this lacuna is harmful to the heart of childhood growth, play and attachment. The core connection is clipped and the child can become troubled. Targeted programs that address maternal depression can help children avoid a stigmatized and lonely existence with outcomes that predict social emotional difficulties.

In early intervention, the right diagnosis and practice matters as in any science. But in this science we have a shortage of practitioners, a shortage of locations for healing, and a culture that says that emotional challenges are not to be discussed. The community needs to be supported in creating mental health programs that are as normal to the neighborhood as stop and go signs.

Substance Abuse

We need to enforce the health parity law which prohibits health plans from placing limits or costs on treatment for mental health and substance abuse that are more restrictive than those imposed on medical and surgical services. Too many youth and young adults suffer for lack of treatment options due to health plans that have stopped covering residential treatment and/or addiction services. Confounded requirements for a patient's stay let suicidal patients loose when they should be better stabilized and cocooned in care. Intermediate levels of care, such as intensive outpatient services are not included in some health plans.

Summary

One first grade Newtown student said to me, "There is nothing you can say or do that will convince me that this will not happen again." Let's prove him wrong.

I offer some language to the chairs that would create a home visitation system. I also offer language that would create a comprehensive mental health system over the next decade, phased in and attentive to our fiscal crisis.

The Commission also supports the bills before you today on firearms (HB 6497) on obesity (HB 6525) and on parental engagement (HB 6501).

Thank you for your time and consideration.