Testimony before the Committee on Children on Proposed S.B. No. 841, S.B. 925 and S.B. 843
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Senator Bartolomeo, Representative Urban, and Members of the Children's Committee:

My name is Elaine Zimmerman. I am the Executive Director of the CT Commission on Children and I am here today to speak on behalf of Senate Bill 841, An Act Concerning the Implementation of a Comprehensive Children's Mental, Emotional and Behavioral Health Plan, Senate Bill 925, An Act Establishing a Home Visitation Program Consortium and Senate Bill 843, An Act Concerning Trauma-Informed Practice Training for Teachers, Administrators and Pupil Personnel.

There is a critical shortage of mental health and substance abuse prevention and treatment services in our state. Approximately 20% of all children and adolescents in Connecticut struggle with a diagnosable and treatable mental health problem. Only 25% of all children and adolescents with emotional-behavioral problems currently access adequate mental health treatment services.

Connecticut launched a prevention based mental health bill, a landmark in fact, to systemically address our child mental health challenges. Public Act 13-178 stressed the design and implementation of a comprehensive mental health plan to assure that all children with emotional-behavioral problems have access to mental health services, with improvements in quality and access.

This Children's Committee, under the leadership of the Co-Chairs, Senator Bartolomeo and Representative Urban, propelled this launch. It was extraordinary to move as quickly and deeply while we were all still spinning from the Newtown massacre. The prevailing questions were, how do we prevent this tragedy from happening again? What can we embed in our mental health system for families and children to buffer personal and community crisis resulting from emotional illness? How do we reach the Adam Lanza's early and deeply, as there are children suffering in every town?

The focus was on: a) improved coordination between school, community and family in mental health services and communications; b) family strengthening through home visitation and a system of home visitation programs, c) professional development of early childhood providers, pediatricians in the prevention and early identification of mental health problems and in Infant

Attached to my testimony is a chart which compares the recommendations under Public Act 13-178 and those of the Sandy Hook Commission. The chart is organized by issue area and highlights where recommendations resonate in both proposals.

Because these excellent responses came out at different times in the aftermath of 12/14, we should ensure that we view them as building upon each other, rather than creating discrete responses that further fragment our incomplete system. These recommendations go hand in hand.

The combination of PA 13-178, written immediately following the Newtown massacre, and the latest recommendations from the Newtown Mental Health Committee, will place both arms carefully around the emotional needs of children in our state.

Thank you for your time.

DCF/CHDI Recommendations (PA 13-178)	ISSUES	*Sandy Hook Recommendations*
	Principles of plan	
Plan calls for 3 tier "system of care" • Tier 1 **Universal** (75%-80% of children): High quality supportive environments; nurturing & responsive relationships' preventative interventions. • Tier 2 **selective** (12-15%): targeted social emotional supports & services. • Tier 3 **indicated** (5-7%): intensive intervention		
		Mental health as more than mental illness --> must go beyond treatment to fostering of healthy individuals, families and communities. Redefining "care" - engaging whole person. Diagnosis should not be needed for access to care
	Financing	
Redesign publicly financed system to direct allocation of existing and new resources		
Identify existing spending on children's behavioral health across all state agencies -- looking for efficiency changes, pooling funding, etc.		
		Providers should be INCENTIVIZED through reimbursement mechanisms to integrate both physical and mental health services
		Inadequate reimbursement rates combined with high utilization rates have rendered many behavioral health clinics financially unsustainable (overall Medicaid rates for inpatient care have not increased in at least 8 years) -- recommends higher reimbursement rates which better reflect costs of care

DCF/CHDI Recommendations (PA 13-178)	ISSUES	*Sandy Hook Recommendations*
		Recommends continuing efforts to expand coverage to broad range of evidence supported services for those with private insurance
		Health plans should be required to keep up to date and accurate provider panel lists and make easily accessible for all members --> should create mechanism for fining insurers who publish inaccurate lists
		Despite changes in law, behavioral health providers continue to report repeated and inappropriate denials of care -- recommends all denials be processed through independent entity (e.g. Office of the Health Care Advocate) - independent clinicians should be available around clock for reviews. Burden of proof should fall to insurer to prove particular treatment is not necessary (rather than to provider to prove necessity)
	Access to comprehensive services & supports	
Build & resource array of services that can meet needs, is accessible to all and distributed across state		
Expand crisis behavioral services to address high ED rates		
Integrate and coordinate suicide prevention activities		
		Importance of continuity of care -- thinking about pediatric care through adulthood (so do not slip through cracks at 18)
	Data	
Convene a statewide Data-Driven Accountability committee grounded in new legislative authority to design a process to oversee all efforts focused on data driven accountability for access, quality and outcomes		
Develop integrated behavioral health data collection, analysis, reporting, etc. across integrated system		

DCF/CHDI Recommendations (PA 13-178)	**ISSUES**	*Sandy Hook Recommendations*
Strength connections between pediatric primary care & behavioral health services e.g. ensure public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis; require Continuing Medical Education credit each year in a behavioral health topic		
Screen for maternal depression, trauma, etc. for early appropriate intervention		
State should ensure increased capacity of early childhood interventions, home visitation services with trauma-informed models, early-care interventions, etc.		
Non-traditional and non-clinical services (e.g. community based, faith based, after school, grassroots, etc.) should be encouraged. They should also be considered with a plan for certification/licensing, support for fidelity and outcomes, and a path for insurance reimbursement		
		Should cover full range of services available through public behavioral health system e.g. programs that provide housing, vocational and occupational support, drop-in services, home visitation etc. as part of preventative model -- should be required as well for private insurers
		More on reinforcing protective factors
		Peer & professional support also stressed
		Recommends expansion and increased availability of early intervention programs for young adults early in course of developing mental illness to reduce likelihood of that a person facing psychotic illness might resort to violence or self-harm

DCF/CHDI Recommendations (PA 13-178)	**ISSUES**	*Sandy Hook Recommendations*
		children with disabilities (accordance with IDEA Act)
		Home-schooled children with disability - must have IEP and access to special ed services. Must have periodic reports filed (at least annually) to local superintendent, prepared by individualized education program team selected by parent. "The state should consider requiring that a parent's obligations under state law encompass approval of the individualized education plan and adequate process as documented in these reports"
		When disabilities necessitate "homebound" - the IEP must address the stated social, emotional and behavioral difficulties as well as academics
		Every school - to have school security and safety committee (under local & regional school boards) - include police officer, teacher, admin, custodian, school facilities manager, mental health professional, and a parent
		State should have a Commission-level indiv to whom local committee would be required to submit an annual written report to about school safety/security
		State and federal depts of education should establish lead sections or programs on school mental health to supplement (NOT replace) the work of CT DCF --> conducting and coordinating broad-based school prevention and intervention efforts

DCF/CHDI Recommendations (PA 13-178)	ISSUES	*Sandy Hook Recommendations*
		More emphasis on need to look at mental health strengths & challenges within social and relational environments
	Stigma	
		Need for anti-stigma campaigns around humanity of those with mental illness and recovery-oriented messages
		Provide psych ed for indiv and families about mental illness, treatment and strategies
		Programs should focus on wellness rather than illness, and promote role of ppl with lived experience as role models or successful recovery
	Privacy & Confidentiality	
		Cautions against measures that would curtail privacy for those with mental illness
		Efforts to clarify and education providers and public on issues of disclosure in context of concerns about safety need to go further
		For children --> info sharing should take place to full extent permitted by law so needs can be recognized and addressed across schools, health care, guidance, etc.
	Response to Disasters or Crises	
		Ct should develop comprehensive statewide plan for responding to large-scale school crisis events, other disasters, etc. - should specify interventions, needs of