



Advocacy and Action
for Connecticut's
Mental Health

**Testimony of the Children's Committee of the Keep the Promise Coalition Before
the Public Health Committee
March 18, 2015**

Regarding

Raised Bill 1089, An ACT CONCERNING MENTAL HEALTH SERVICES

Good afternoon Senator Gerratana and Representative Ritter, and members of the Public Health Committee, my name is Susan Kelley and I am the Child and Adolescent Public Policy Manager for the National Alliance on Mental Health of Connecticut (NAMI Connecticut), and staff to the Children's Committee of the Keep the Promise Coalition (KTP). KTP is the largest group of stakeholders with a united voice advocating for smart mental health policies in Connecticut. The KTP Children's Committee advocates for increased access to a continuum of quality, community based mental health services and supports for all children and their families in Connecticut. I am testifying on behalf of KTP in support of Raised Bill 1085.

Of the many sections of RB 1089, our testimony is directed only to those sections we are taking a stand on. We have categorized our testimony according to the sections we support, generally support but need more information, or oppose sections.

While we appreciate that many important aspects of our mental health system are being addressed through this bill, we are concerned that sections either do not have adequate information supporting their creation, and/or have not been adequately connected, if at all, to important state planning efforts concerning children's mental health, including the 13-178 Children's Behavioral Health Plan and its Implementation Advisory Board which is just getting underway.

We support sections 1, 4-5, 6, 7, 11-13, and 17.

Section 1 adds mental health first aid training as a requirement for in-service training for teachers. We support mental health training for teachers as a means to bring awareness of children's mental health issues into schools. However, mental health first aid is crisis-oriented training. School personnel and teachers also need prevention training to understand children's mental health and identify concerns before problems reach a crisis point. This kind of prevention training emphasizes mental health as part of overall well-being and utilizes the perspectives of individuals with lived experience and families who have children with mental health conditions.

One such training program is NAMI Connecticut's "Parents and Teachers as Allies" which is conducted by a trained panel comprised of a family member, a person with lived experience, and an educator.

Sections 4-5 establish a behavioral health incentive program through Department of Public Health grants. We support this mechanism for increasing the number of behavioral health professionals in or state. We do have several practical concerns for how this section would operate, including the need for an eligibility requirement based on length of practice in state, and whether funds would be reimbursed over time as a means to keeping professionals.

Section 6 establishes a behavioral grant program through DPH for assisting boards of education with employing or contracting for services of LSCWs, MSWs, and psychologists. We support this program's focus on local and regional boards of educations in areas designated as health shortage areas. We have concerns though on whether there will be DPH funds available for these grants. In addition, rather than isolated two-year grants, the grants should be connected to long-term school/workforce planning that the state has already undertaken, such as implementation of the comprehensive Children's Behavioral Health Plan under 13-178 and its recommendations for increasing the role of schools to improve access to mental health services for children.

We support *section 7* (making DHMAS emergency mobile crisis services available through 2-1-1) and *sections 11-13* (telemedicine) as appropriate methods for increasing access to mental health services.

We approve of *section 17* and its requirement for data collection and annual reporting of data by DCF and DMHAS. This requirement should be coordinated with existing data collection/reporting efforts so as not to duplicate efforts or unduly burden agencies, and could possibly serve as a single report across agencies, as recommended by the 13-178 Children's Behavioral Health Plan.

We generally support the concepts of *Sections 8, 9, and 14* but need more information. *Section 8*, which adds DMHAS as partner with DCF in implementing behavioral health consultation between primary care providers and child psychiatrists, appears to add young adults up to age 25 to the Access MH program that was created by 2013 legislation based on the Massachusetts Child Psychiatry Access Project model. This may be a good thing but more information is needed on the needs of young adults in this area and whether there may be duplication of efforts under DHMAS's current Young Adult Services model.

We support the concept of agencies providing information under *Section 9* (requiring DMHAS, DCF, and DPH to publish an information notice for providers of behavioral health services), but we don't understand the description of the information to be published.

Section 14 requires DSS, DCF, and DMHAS, in consultation with behavioral health providers, to develop a program to improve behavioral health services to Medicaid recipients and improve care coordination among health care providers. This section sounds like the creation of a Care Management Organization/Entity for Medicaid and has crossovers to the Statewide Innovation

Model (SIM) and behavioral health homes. We support the concept of care coordination, but why is this program contemplated for Medicaid only? Focusing on care coordination only in the public context will further widen the disparity between the public and private sectors regarding insurance coverage for and access to quality mental health services. It is also unclear how this program would relate to DCF's creation of a CME to coordinate care for DCF involved children, SIM, and behavioral health homes. The contemplated care coordination should be vetted by the Implementation Advisory Board to the 13-178 Children's Behavioral Health Plan, which is convening for the first time later this month, to ensure consistency with existing state planning on this issue.

We oppose section 20. Section 20 requires DMHAS, in consultation with DCF, DSS, and providers to study current utilization of hospital beds for acute psychiatric care. We oppose the narrowness of the study compared to other elements in the overall mental health system and need more study details, including whether utilization covers all patients or just certain (Medicaid and/or DCF involved) and why this study would be undertaken without also looking at community based services that address psychiatric care.

Thank you very much for considering our testimony on Raised Bill 1089.

Respectfully submitted, KTP's Children's Committee,

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