Connecticut State Medical Society
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Written testimony submitted to the Mental Health Services Working Group
Public Hearing
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Child psychiatrist and Committee on Disaster Preparedness

Senator Harp, Representative Wood and distinguished members of the Mental Health Services Working Group: on behalf of the more than 6,500 physicians and physicians in training of the Connecticut State Medical Society (CSMS), thank you for the opportunity to testify before you and file these written comments today..

My name is Dr. Ted Zanker. I am a child psychiatrist practicing in New Haven, and a past president of the Connecticut Psychiatric Society as well as a past president of CSMS and chairman of its Committee on Disaster Preparedness. In that role, I was personally involved in helping to coordinate the mental health care provided in the immediate aftermath of Newtown, visiting the Counseling Center and also personally serving as a volunteer child psychiatrist on Christmas Day.

Addressing the tattered mental health service system in Connecticut today is like peeling the layers of an onion. Every layer reveals another with deficiencies and inadequate coordination that need to be remedied. No one could successfully outline them in the few minutes afforded before the subcommittee. Several of my colleagues are testifying before you about outpatient services in both the private practice and community clinic settings. There are only few of us who are trained further in the subspecialty of child and adolescent psychiatry who have chosen to work on acute inpatient services. In my 46 years in practice, I have devoted half my time to office practice of child, adolescent, adult and geriatric psychiatry and the other half to community service in acute inpatient child psychiatry treatment. As a result, in the limited time I have today I'll choose to focus on the inpatient treatment programs.

A good way to think about the child's inpatient experience might be – input, throughput and output – or rather, admission, their inpatient stay, and their discharge arrangements.

"Child psychiatry" is really a misnomer- it's really family psychiatry with the child as the identified patient. And if you were to leave this hearing with one clear message from me, it would be that **we could avoid a significant number of psychiatric admissions and readmissions to Connecticut hospitals if our system let us provide adequate treatment for families both in and outside our hospitals.** This would involve intensive resources, but I am confident it would be far less expensive than the patchwork in-patient care we deliver today in Connecticut.

For example, in-home support services like Voluntary Services provided through the Connecticut Department of Children and Families were showing good results. Many of the children receiving these services have private insurance, but the only way they could get what they needed was under

the auspices of the DCF program – paid for by state funds. As such, private insurance companies have been subsidized by the state to the tune of millions of dollars while our state has been fighting a budget crisis. It would seem that resolving the way these services are coordinated and paid for would allow necessary outpatient care to continue without inappropriately using taxpayer dollars. I urge this committee to re-examine the funding stream for the DCF Voluntary Services program to correct this funding flaw.

Inpatient Care

In my experience, as soon as a child is admitted to a hospital for a psychiatric problem, their private insurance company begins trying to push that child back out. Though their websites describe so-called "reasonable medically necessary standards" for maintaining inpatient treatment, reality is very different in Connecticut hospitals. Health insurers review every single case, often every day, often expecting us to change a child's medication every day when the human brain does not respond that quickly to the kind of medication involved. The review system for inpatient pediatric psychiatric care is almost always adversarial rather than collegial to say the least, and we are expected to justify why the child should be in the hospital. The unwritten rule seems to be "Doctor, if the noose is off the neck, why is the child still in the hospital?" This might be a standard for commitment based on imminent danger or severe disability rather than intensive daily inpatient treatment being recommended as necessary to move outpatient treatment forward. Ironically, the patients who get the most thorough inpatient treatment now are the kids on HUSKY as they have the most enlightened and integration-oriented review process.

Discharge

Furthermore, the faster we discharge children, the more likely that we will see them readmitted within 30 days. There are some patients we could discharge sooner, but when they leave the hospital, there are often inadequate community resources available to support them and insurance often does not pay for these community services (but will pay for repeat emergency room visits and hospitalizations).

Some children are so severely damaged that they need long-term resources if they are to survive, much less live anything like normal lives.

But if this subcommittee were able to recommend and fund a mechanism to develop and oversee a real network of integrated community resources for families and children to receive the care they needed after a hospitalization, then all of you would be able to say that you really accomplished something in terms of prevention – in terms of making our homes and schools and communities safer for everyone.

Disaster Preparedness

One important lesson we have all learned not only from Newtown, but also from Storm Sandy and other recent events is that the state's disaster preparedness plans need to include protocols for community emergency mental health assessment and provision of care in the aftermath of disasters. The aforementioned organizations worked together well, and CSMS pledges to continue its role helping coordinate care as a resource for the state and any community that needs it. We need to plan, but we must include in those plans mental and behavioral, as well as substance abuse services.

Summary

In summary, I would be remiss if I did not highlight the importance of providing adequate funding to the mental health support programs in western Connecticut for the foreseeable future. They have

performed amazingly in response to the aftermath of the Sandy Hook shooting. The invisible trauma there will take a long time to heal. Even in New Haven, we are seeing a great deal of anxiety and reactivation of post-traumatic stress disorder (PTSD) symptoms among children who are afraid there will be sudden violence in their schools. None of us is immune to psychological pain. It is how we deal with it that determines whether we are well or need medical care – and as a state and a community we will be evaluated in the same way.

I will be happy to be available to members of the subcommittee or the full bipartisan committee to assist in any part of your work where I can be helpful.