State of Connecticut
GENERAL ASSEMBLY

COMMISSION ON CHILDREN

Children's Mental Health Testimony

January 29, 2013

Senator Harp and Representative Wood,

My name is Elaine Zimmerman. I am the Executive Director of the Connecticut Commission on Children and am here today to speak on children's mental health.

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 care that is not thin or spindly.

Start Early

If we start at the beginning, we have the best outcomes and the best return on investment.

Home visitation -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 assure strength, minimize trauma and to buffer

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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 all need to 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 Ed

We were not long ago, expelling children in child care for behavior problems. The numbers made a mockery of our prevention focus. 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.

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.

A similar and equally laudable initiative has emerged through a partnership between DCF and Early Head Start. Prevention, early professional training, supports and intensive linkages bolster children, families and assert successful pathways for young children. Such collaborations, co-mingling resources and shared staff training, help the family, block inappropriate development and assist in much more sophisticated professional development.

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.

EPIC trains pediatric providers to screen children for a variety of health and mental health issues an behavior problems, trauma and autism at well child visits and connects them to further evaluation and intervention services, when needed. This, or other similar models of training for pediatric primary care providers, needs to be expanded.

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 assure 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 assure 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 helps children not face a stigmatized and lonely existence with outcomes that predict social emotional difficulties. One shadow creates many for the infant, toddler and preschooler.

Child First is a model in our state that reaches parents early who are facing depression and mental health challenges. Developed in Bridgeport in 2001, it is one of twelve nationally recognized evidence based home visitation models by HRSA. It is the only national model with a research based mental health component. The model addresses emotional challenges, behavioral problems, improved child competencies and social skills, language development, maternal depression and access to community based services and supports. 78% of the children and families served showed

significant improvement in at least one of these risk areas. This program, a pride of our state and now recognized by the federal government as a research based best practice, should be brought to scale.

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.

Youth Assets

Children and youth are increasingly isolated. Parents are juggling two and three part time jobs to make it in this troubled economy. A growing body of work around positive youth development illustrates that resiliency can be nurtured and strengthened through positive relationships and activities. It is known that children and youth do better when they have committed, stable and meaningful relationships with adults and peers. These positive relationships include those a young person has with family, peers and teachers.

Children and youth facing difficulty are more likely to get help, referral and intervention if they are part of a community and youth network. A youth friendly local system needs to include staff competency and cultural

competency. When youth feel isolated, they further isolate or join groups of others who feel similarly isolated, often in actions that spur intentional or unintentional crisis personally, or within the law. We need to assure community programs such as afterschool, occupational training, and family resource centers to assure activities with caring adults who can support children and youth.

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.