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**Testimony of Jamey Bell, Acting Child Advocate,**
**before the Mental Health Services Working Group**
**of the**
**Bipartisan Task Force on Gun Violence Prevention and Children's Safety**
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*The mandate of the Office of the Child Advocate (OCA) includes evaluating the delivery of state funded services to children and advocating for policies and practices that promote their well being and protect their special rights.* Over 50% of the work we do—including responding to individual calls for assistance or information, and individual and systemic advocacy-- seeks to improve access to mental health services for children and monitor the emotional and behavioral health system supports for children and their families, across the lifespan. We applaud the Task Force's focus on mental health services as an essential component of gun violence prevention and children's safety.

It is estimated that in any given year, up to 20% of children in Connecticut struggles with a mental health or substance abuse problem. One-half to 2/3 of them never receive treatment.[1]

Our recommendations below comprise both short-term and longer-term strategies. The OCA will continue to work on mental health system-building and improvement efforts, in collaboration with the Office of the Healthcare Advocate (OHA) and others, and offers its ongoing support and assistance to policymakers.

1. **Launch a public information campaign to de-stigmatize mental health challenges and to publicize available resources.**

Though progress has been made in "mainstreaming" the existence of mental health challenges and the need for mental health treatment in a wide swath of the population, a mental health diagnosis is still far from being as accepted or "stigma-free" as other health conditions. Calls to the OCA regarding children and families with significant mental health issues reveal that all too often, these conditions are poorly understood and misinterpreted, especially those with significant behavioral manifestations. Punitive interventions such as seclusions or arrests, even with our youngest children, reinforce the persistent negative stigma. Diligence and persistence is

[1] NAMI State Advocacy 2010, State Statistics: Connecticut; Center for Children's Advocacy: "Blind Spot: Unidentified Risks to Children's Mental Health", 2012.

needed to change this dynamic and encourage children, youth and families to seek assistance as early as possible for the most effective outcomes.

**2. Support and invest in enforcing existing laws, especially regarding private insurance coverage, and publicly funded health coverage for children (Medicaid and EPSDT).**

During previous legislative hearings numerous mental health experts testified that an estimated ½ to 2/3 of the children with mental health issues in Connecticut currently cannot access mental health services when they need them due to persistent problems with capacity, availability and cost. Unfortunately, even individuals who have the ostensible benefit of insurance coverage for mental health treatment often have difficulty accessing appropriate treatment services. This problem is particularly serious for people with private health insurance, and is well documented in the Office of the Healthcare Advocate's report, "Findings and Recommendations: Access to Mental Health and Substance Use Services January 2, 2013". At a recent OHA hearing, numerous individuals testified regarding persistent problems with private insurance coverage. Services are denied, not authorized at the needed level of care or not allocated in ineffective time increments. In addition to resulting in a lack of needed care for the individual, inappropriate insurance coverage denials of needed mental health treatment can lead to inappropriate care-shifting and cost-shifting from the private sector to the public sector, which intensifies the access-to-care and financial crunch on the publicly funded health care side. Enforcing existing health insurance laws is an essential first step.

Further, federal law (the Medicaid Act) mandates that children who are eligible for Medicaid (in Connecticut are in the HUSKY Part A program) receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services pursuant to a professionally-informed (e.g. by the AAP) periodicity schedule, starting at birth. EPSDT program requirements clearly require **mental health** *screening* for children starting in infancy and continuing periodically, *diagnosis* of any problems, and then *treatment* for problems identified during screens. Yet pediatricians and other medical treatment providers are not routinely educated, empowered, trained or paid to conduct these mental health/emotional development screens for children, and so a crucial opportunity to identify and treat mental health problems early and preventively is missed. Enforcing and strengthening implementation of this mandate, which is eligible for federal matching dollars under the Medicaid Act, would go far in beginning to meet the mental health screening and treatment needs of the over 270,000 children under age 19 in the HUSKY A program.

**3. Create a system to provide mental health assessment and treatment across the lifespan—from birth through adulthood.**

The OCA fully supports and endorses the recommendation in the OHA's January 2, 2013 report that "Connecticut should adopt an overall vision for health that integrates and coordinates access to effective, timely, high quality and affordable mental health and substance use prevention and treatment services into overall health care." The many laudable efforts currently underway, including the Bipartisan Task Force, the Governor's Sandy Hook Advisory Commission and the Connecticut Department of Public Health's "Connecticut Health Improvement Planning Coalition", should all be foundational for a *permanent* structure and process to create Connecticut's vision, and ultimately its system that seamlessly integrates mental and emotional health into overall health.

4. **Infuse mental health promotion and wellness into all educational settings— including infant care, family and center-based child care, pre-school, and K-12 (through school-based health clinics, special education services, school climate initiatives, school discipline approaches).**

Schools are a critical hub for children and are too often missed as a natural environment to educate children and families about promoting positive mental health, identifying early signs of mental/emotional distress, and providing prompt access to appropriate resources. National studies indicate that educational, behavioral and social outcomes for students with emotional disorders continues to be the worst of any disability group.[2] The OCA has significant experience investigating the circumstances of children in the "deepest end" of the service delivery system—in the residential facilities and hospitals which provide the most intensive, restrictive and expensive care-- whose life course may well have been changed if their special needs had been identified early and appropriate services provided within their home, community and school, which are the natural environments for all children and essential for their health and well being. School based health centers in Connecticut have demonstrated effective and timely access to mental health care for thousands of children and adolescents avoiding costly and ineffective emergency department services.[3] Of the children and adolescents who do receive mental health services, 70 - 80 % receives them in schools. Expanding access through this venue could potentially fill a tremendous void in our current service delivery system.

5. **Investigate altering and expanding the state's delivery of "early intervention services" under the federal Birth to Three program, to also serve very young children with developmental delays in social and emotional development, with accompanying federal matching dollars.**

"Early intervention services" in the Birth to Three program under Part C of the federal Individuals with Disabilities Act (IDEA) can include services to address the social and emotional developmental needs of an infant or toddler. Current public policy has significantly limited access to Birth to Three services in Connecticut to a more restricted profile of developmental delays. The state's Birth to Three program could potentially reach many more children and families at risk if eligibility criteria were broadened to capture these children, and the Birth to Three program became part of an overall mental health system focused on meeting the needs of young children.

6. **Ensure access to timely mental health assessment and services for underinsured or uninsured children and adults in a community health system that is not reliant on hospital emergency departments.**

Hospital providers are reporting significant increases in the number of individuals, children and adults, who present to the state's hospital emergency departments with acute and chronically unmet mental health issues. Emergency departments (EDs) are designed to address medical and trauma-related emergencies, and are significantly challenged to effectively manage acute psychiatric problems. ED staff do not have the training, skills or expert resources readily

[2] Center for Children's Advocacy: "Blind Spot: Unidentified Risks to Children's Mental Health", 2012.
[3] NAMI State Advocacy 2010, State Statistics: Connecticut; CT Association of School-Based Health Centers, Issue Brief, "Connecticut's School Based Health Centers Engage Adolescent African-American and Latino Males in Mental Health Services".

available to meet the needs of this population. Mental health patients often wait significant amounts of time to be seen by qualified mental health practitioners, and those in need of specific services, such as inpatient care, often wait days for services to become available. Patients with acute medical and trauma related problems are affected as well as ED staff cannot always attend to their needs in a timely manner.

**Thank you for the opportunity to provide testimony.**