

TESTIMONY FOR THE MENTAL HEALTH SERVICES WORKING GROUP

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By Jay E. Sicklick, Esq.
Deputy Director – Center for Children’s Advocacy, Inc.
Project Director, Medical-Legal Partnership Project

Thank you for providing the **Center for Children’s Advocacy** (CCA) with an opportunity to submit testimony to this committee. I submit this testimony as CCA’s Deputy Director and Director of the Center’s Medical-Legal Partnership Project. The Center for Children’s Advocacy (“CCA”) is the state’s largest non-profit legal advocacy organization that is exclusively dedicated to the representation of at-risk children. CCA’s mission is to fight for the rights of Connecticut’s most vulnerable children. CCA’s *Medical-Legal Partnership Project* (“MLPP”) is a collaborative endeavor that teams the legal advocacy expertise of the Center for Children’s Advocacy with the medical expertise of the pediatric and family medicine clinicians at numerous medical facilities throughout central Connecticut, including the Connecticut Children’s Medical Center and Saint Francis Hospital & Medical Center. The MLPP is a medical-legal collaborative program that was the second of its kind in the nation, and we have been working on behalf of Connecticut’s children in the clinical setting since April 2000.

Recent events in Newtown, Chicago and other communities throughout the country have brought the concept of risk to our children’s safety to the collective consciousness in all too tragic a fashion. As legal advocates, we recognize the need for drastic social change – not only to prevent similar carnage, but to address the more subtle risks that threaten the learning and the well-being of our most vulnerable children. While mental health has surfaced as a concern relative to high-profile tragedy, the framework in which this discussion has taken place has missed a critically important target. Screening for early warning signs with accessible mental health services and supports as early as possible has lifelong, multi-generational consequences for children and their families.

In any given year, about one out of every five Connecticut children (87,500 to 125,000) struggles with a mental health condition or substance abuse problem. More than half receive no treatment.¹ Today – the Center for Children’s Advocacy recommends three concrete proposals that are designed to address early screening and intervention on behalf of those children who are most vulnerable, including those who receive insurance through the state’s public insurance system (Medicaid/HUSKY A); those under three years of age who are abused or neglected and in the care of the state’s child welfare system; and students who are victims of traumatic stress.

Mandatory Behavioral Health Screenings in Primary Care

First– We propose that all children insured through the state’s public insurance system (Medicaid/HUSKY A) must receive a behavioral health screening at every well child visit starting at age one. The basis for these screenings is the federal statutory structure that comprises Medicaid’s child health component known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which has shaped the landscape of pediatric care to meet the special physical, emotional and developmental needs of low-income children. Since 1967, the purpose of EPSDT has been to “discover, as early as possible, the ills that handicap our children” and to provide continuing follow up

¹ *Building a Community Mental Health System*. Connecticut Voices for Children (2006)

and treatment so that handicaps do not go neglected.”² EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Screening services “to detect physical and mental conditions must be covered at established, periodic intervals (periodic screens) and whenever a problem is suspected (inter-periodic screens).”³ The source for these required screenings is rooted in federal Medicaid Law.⁴ Recent court decisions have consistently affirmed the broad EPSDT scope of benefits and the medical necessity definition which provides not only for the inclusion of physical intervention, *but also for mental health screening and services*. In the landmark case of *Rosie D. v. Romney*,⁵ a federal court in Massachusetts found that primary care providers (PCP) were woefully inadequate in screening children insured through the state’s Medicaid program – and ordered the PCP’s who performed EPSDT screenings to utilize a formal behavioral health screen.

CCA is presently working collaboratively with the Department of Social Services (DSS) and other key stakeholders to ensure that the federal EPSDT mandate for behavioral screenings is met.⁶ The goal is to provide a framework for pediatric and family medicine providers to engage in a *required* behavioral health screening at every well-child visit beginning at two years of age by

- providing the appropriate screening mechanism to PCP’s that is available in the public domain and user-friendly for both the provider and the patients’ families;
- revisiting the present Medicaid reimbursement scheme for behavioral health screens to expand provider knowledge about the reimbursement availability and collect data about reimbursements claimed; and
- forging a comprehensive link between primary care pediatric and family medicine providers and child and adolescent psychiatrists to strengthen available resources when screens indicate potential problems/warning signs.

Improving Access to Early Intervention Services Abused and Neglected Young Children.

The state Birth to Three program helps children with developmental delays, including social and emotional impairments and other infant mental health challenges, by working with children in the home and giving their caregivers strategies and supports that promote children’s cognitive, motor, emotional and language development. Abused and neglected babies are at significant risk of developmental delay and social-emotional impairment. Timely intervention is essential to prevent life-long impairment and dysfunction.

Data from the National Survey of Child and Adolescent Well-Being report that over 40% of three year olds involved with the child welfare system were affected by developmental delay or an established medical condition, yet a very small percentage of those children ever received early intervention

² Source: “EPSDT and Title V Collaboration to Improve Child Health”, United States Department of Health and Human Services, Maternal Child Health Bureau, available at <http://mchb.hrsa.gov/epsdt/epsdtbackground.pdf>.

³ *Id.*

⁴ 42 U.S.C. § 1396d(r)(1) *et seq.*

⁵ 410 F. Supp.2d 18 (2006)

⁶ The task force includes members from the Connecticut Chapter of the Academy of Pediatrics, the Academy of Child and Adolescent Psychiatrists, the Departments of Children and Families (DCF), Developmental Services (Birth to Three), Education, the state Office of Policy and Management, the Connecticut Behavioral Health Partnership, the Connecticut Association of School Based Health Centers, and the Community Health Network of Connecticut.

services.⁷ Other studies indicate that for children who are removed from their homes due to abuse or neglect, 50% have significant communication and cognitive delays.⁸

Due to the overwhelming data about the developmental needs of abused and neglected children, the federal Child Abuse Prevention and Treatment Act (P.L. 108-36) requires that states maintain effective mechanisms for referring abused and neglected children under age three to early intervention (IDEA Part C) services.

As of December 1, 2012, DCF was working with almost 3,000 children, age birth to three, in the child protection system. Some of these children remain with their parents, and over 700 are placed in foster care. All of these children have experienced neglect or abuse that has been substantiated by a DCF investigation. In 2012, DCF referred or assisted with the referral of 300 children, and roughly half of those children—**128**--were deemed eligible for services. This represents a yearly referral rate of **10 percent** and a yearly service rate of **4.2 percent**,⁹ dramatically below the percentages of children we aspire to reach.

Accordingly, CCA proposes a pilot to review the effectiveness of automatic evaluation of abused and neglected children for early intervention services. Given the current low rate of referral and service deliver, the research estimates regarding the high incidence of developmental impairment or delay among abused and neglected infants and toddlers, and the data regarding the long term effectiveness of such services, it is essential that we demonstrate our most at-risk children are receiving the critical services they require.

Addressing the Impact of Traumatic Stress on Learning

Research suggests that approximately 25% of American children will experience at least one traumatic event by the age of sixteen. A child's reactions to trauma can interfere considerably with learning and/or behavior at school. However, schools also serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the impact of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom setting, and referring children to outside professionals when necessary.¹⁰ Far too often, children who have experienced some form of trauma are taught by school professionals who either did not think of the problem and its impact on learning and/or were not aware of what services are available to support the student at school and in the community.

Schools can address the impact of trauma on learning and school success by requiring each school district to (1) designate a trauma liaison in charge of developing and maintaining a resource list of trauma informed community service delivery systems, and how students can access services; (2)

⁷ National Survey of Child and Adolescent Wellbeing Issue Brief, No. 8: Need for Early Intervention Services Among Infants and Toddlers in Child Welfare, Available at: National Data Archive on Child Abuse and Neglect (NDACAN) Cornell University, ndacan@cornell.edu Administration for Children and Families (ACF, OPRE) http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/; see also Taletha Mae Derrington and John A. Lippitt, "State-Level Impact of Mandated Referrals From Child Welfare to Part C Early Intervention." *Topics in Early Childhood Special Education* 28, no. 2 (2008): 90. <http://cmx.sagepub.com/cgi/content/abstract/13/3/245>.

⁸ Addressing the Needs of Young Children in Child Welfare: Part C -- Early Intervention Services. Series: Bulletins for Professionals, https://www.childwelfare.gov/pubs/partc/partc_a.cfm; Jaudes & Shapiro, 1999; Spiker & Silver, 1999; U.S. GAO, 1995; Blatt, Saletsky, & Meguid, 1997; Hochstadt, Jaudes, Zimo, & Schachter, 1987.

⁹ Over a three year time period, data suggests that 30% of children may be referred to an early intervention evaluation.

¹⁰ <http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit>

coordinate a minimum of three hours of training for all newly hired staff on the impact of traumatic stress on a child's brain development, behavior and ability to learn; and (3) offer three hours of in depth training on treatment modalities and community resources for school personnel who offer mental health services or are responsible for direct instruction of pupils.

Submitted by:

Jay E. Sicklick, Deputy Director
Center for Children's Advocacy
65 Elizabeth Street
Hartford, CT 06105
(860) 714-1412
jsicklick@kidscounsel.org