Joint Committee
Connecticut Chapter of the American Academy of Pediatrics
And
Connecticut Council of Child and Adolescent Psychiatry

I am Dr. Ken Spiegelman and am a practicing pediatrician in Manchester. I am here today representing the CT Chapter of the American Academy of Pediatrics. My colleague is Dr Mirela Loftus, a Child and Adolescent Psychiatrist who practices at the Institute of Living here in Hartford, and she is representing the members of the CT Council of Child and Adolescent Psychiatry.

From generation to generation, Americans have fulfilled the promise to make life better for our children than it was for us. But today, because of the state of health and medical care in this country, our children's generation is predicted to have a shorter life expectancy than our own. Poor mental health treatment is a major component in the decline of Americans' health. According to the Surgeon General's report nearly 1 in 5 American children suffers from a diagnosable mental disorder. Seventy-five to 80% of these children do not receive any treatment at all. For those who do receive some care, it is often inadequate, sometimes abysmally so. This unmet need for services translates into high levels of cost, both socially and economically, and is a leading cause of death in older children. Untreated mental illness often persists into adulthood, where it constitutes the leading cause of disability in the United States and Canada for ages 15 to 44, according to the World Health Organization. Untreated mental illness also tends to worsen over time, such that increasingly intensive – and expensive – treatments are needed.

Undetected and untreated mental disorders cause children unbearable suffering, poor academic performance, occupational underachievement, social failure, and can lead to social deviance. They impose huge intangible and tangible costs on the society, costs that are reflected in enormous demands on the State budget. Untreated and inadequately treated mental illness in children can impose very large burdens on State-supported schools, police departments, courts, prisons, foster care and halfway houses. Parents and other family members are themselves driven to seek state services because their physical health, mental health, social adjustment and financial stability are undermined by trying unsuccessfully to care for a sick child who is not receiving the professional treatment. Families come apart, small businesses fail, wage earners become unproductive or unemployed, all costing the State money and reducing overall economic activity and tax income. As mentally ill children grow into handicapped adults, the State pays again directly and indirectly for deferred mental health and drug addiction costs.

Yes, we all know we need to do something. It is not about any provider not being willing to do the work. It is about having enough providers in the right places, and

allowing them to do the work. This means support for the providers in terms of other team members, payment, and insurers paying for the treatment that they are obligated to pay for.

The CT Chapter of the American Academy of Pediatrics and the CT Council of Child and Adolescent Psychiatry have been collaborating for a number of years on co-educating our colleagues on clinical topics and ways to enhance the mental health services that we can provide at the primary care level. Primary care Pediatricians have been doing more and more mental health work in our daily routine of caring for children. We have been working with other organizations on co-location models which will bring mental health provides into the primary care offices.

Our organizations created a task force and created **The Mental Health Blue Print for Children in CT**. The proposal is designed to contain mental health costs for the State government, commercial insurers and businesses that insure their employees. It relies almost entirely on professional manpower and financial resources already in place. It achieves improved access and improved quality of mental health services solely by markedly increasing the efficiency of care and the efficiency of insurance. In an effort to improve access to quality mental health care for all of Connecticut's children, the task force proposes solutions to the five most critical barriers to care listed below:

1. Poorly coordinated, fragmented and discontinuous care.

2. Impediments to creating and sustaining programs for prevention and early identification of mental health problems.

3. Impediments to early access to high quality mental health treatment.

4. Failure to provide an adequate number of high-quality inpatient long-term beds, and to sustain care for the most critically ill children consistently throughout the course of illness.

5. Failure of the managed behavioral health care programs to provide sufficient resources to deliver the necessary quality of care for children with commercial health care coverage.

These behavioral health subcontractors waste a huge proportion of the mental health insurance dollar on excessive administration, marketing, executive pay and large shareholder profits; while they undermine the quality of care by refusing to insure many patients in need, inadequately reimbursing clinicians, harassing clinicians and patients, and refusing payment for necessary treatment, collaboration, consultation and clinical case management. For every single dollar that <u>private</u> insurers are able to save by preventing mental health treatment in a child, the <u>state</u> pays many more dollars as the child's illness unfolds in later childhood and adulthood

The following efficiency measures are being proposed to address these five critical barriers to care:

1. **The creation of a regionalized integrated system of care**, based on home address, in which outpatient mental health and primary care providers, child guidance centers including ECCs, school-based programs, in-home programs such as IICAPS, mobile crisis teams, partial hospitalization programs, and inpatient programs are all linked in one system of care. This creates a system of care that supports the central role of the primary medical home, pediatric clinician, and school health service, integrates physical and mental health care, integrates care of the children and that of their families, and utilizes interdisciplinary teams that make optimal use of the unique expertise of each profession. The integrated system of care creates a community of caregivers and culture of respect.

2. **Increased allocation of resources to pediatric, day care and school settings for the prevention and early detection** of mental health problems in children.

3. **Improved timely access to high quality appropriate intervention.** The competency of teachers, pediatricians, nurses and social workers is improved by better access to consultation and support from experienced mental health providers. Respectful supervision and adequate reimbursement for case consultation, collaboration and management increases efficiency by eliminating demoralization of caregivers, and by reducing redundancy and discontinuity of care. The proposal also improves access to treatment by expansion and improvement of the statewide network of child guidance clinics.

4. **Preservation of a centralized, high quality, long term, inpatient treatment center for the entire state at Solnit Hospital (Riverview State Hospital)**, and improvements in utilization patterns to reduce length of stay and the number of required admissions. Such changes will reduce the need for out-of-state long-term care, which is very expensive and divorces patients from their families, communities and ongoing caregivers.

5. **The CMHTF proposal helps commercial insurance companies and self-insured businesses, because it provides much more efficient and complete care for their beneficiaries, without spending any additional money.** The proposal calls for eliminating profit-driven behavioral managed care subcontractors, for commercially insured families, and replacing them with the CT-BHP model of not-for-profit managed care, with professional oversight. The CT-BHP model was created in 2006, and is already

successfully improving the quality and efficiency of mental health care for poor children who are insured by Medicaid. Implementing a CT-BHP type model for those children covered by commercial insurers and self-insured employers will increase the money available for mental health care and provide care that is more efficient and more effective, while not spending any additional money.

We believe that with a strong legislative and administrative initiative, and no increase in State funding, we can rapidly build a much more effective and efficient mental health system. This system would save a lot of money in the long term as well as the short term. We are spending the money already, but inefficiently. There is long-standing, destructive and unwarranted stigma against mental illness that continues to perpetuate the failure of our society to ensure affordable access to adequate prevention and treatment for children with mental disorders. If large numbers of children were not getting effective and affordable treatment for leukemia as a result of inefficiencies in our health care system, people would join together with business leaders and insurance company executives to swiftly implement the legislative, fiscal and clinical reforms required to remove the barriers from having access to adequate care. Yet, mental illness in children and adolescents is more prevalent than leukemia, diabetes, and AIDS combined, and, like these illnesses, can cause devastating damage to children, their families, and their communities.

Our organizations and the over 1200 members are all ready and willing to help provide the best healthcare for the children in this state. Thank you very much for your time and interest.

NNCPAP homepage

Home

Welcome to the National Network of Child Psychiatry Access Programs (NNCPAP) website. Our mission is to promote the development, sustainability, and quality of child mental health and psychiatry access programs designed to address the mental health needs of children and adolescents within the primary care setting.

Please use the links above to learn more about the network, its members, and resources for child psychiatry consultation programs.

We gratefully acknowledge the support of TeenScreen, which provided a grant to make this website possible, and the ongoing support of the Massachusetts Child Psychiatry Access Project and The Center for Mental Health Services in Pediatric Primary Care. For more information on how to support NNCPAP, click here.

nncpap

NNCPAP homepage

Existing programs

Member organizations by home state

- **ALASKA** – Alaska Partnership Assistance Line
- **ARKANSAS** – Psych TLC
- **CALIFORNIA** – The San Diego Psychiatric Consultation Program, Contact Bella Montgomery, NP, for more information
- **COLORADO** – Colorado Child Psychiatry Consultation Service (CPCS), contact Debbie Keairnes, LPC, for more information
- **DELAWARE** – Primary Care Consultation using the Creatri(cs Pro-Pack Toolkit ™, contact Mark Borer, MD, for more information
- **FLORIDA** – Florida Pediatric Psychiatry Hotline
- **ILLINOIS** – Illinois DocAssist
- **IOWA** – Child and Youth Psychiatric Consult Project of Iowa (CYC-I)
- **LOUISIANA** – Gulf Coast Consultation in Child and Adolescent Psychiatry Program (GCAP)
- **MAINE** – Child Psychiatry Access Program (CPAP)
- **MASSACHUSETTS** – Massachusetts Child Psychiatry Access Program (MCPAP)
- **MICHIGAN** – University of Michigan Child Collaborative Consultation Program (MC3), Contact Sheila Marcus, MD, for more information
- **MISSOURI** – Collaborative Care at Washington University School of Medicine, Division of Child and Adolescent Psychiatry, Contact Ginger Nicol, MD for more information
- **NEW HAMPSHIRE** – Teen Mental Health Project, Dartmouth Medical School, Dartmouth Co-op
- **NEW JERSEY** – New Jersey Primary Care Child Psychiatry Collaborative Program, Contact Gary Rosenberg, MD, for more information
- **NEW YORK**– Project TEACH
    - Child and Adolescent Psychiatry Education and Support (CAPES) Program for Primary Care Physicians

    - Child and Adolescent Psychiatry in Primary Care (CAP-PC)
- **NORTH CAROLINA**– Mental Health Consultation Clinic of the School Health Alliance for Forsyth County
- **OHIO** – Ohio Pediatric Psychiatry Network (PPN)
- **PENNSYLVANIA** – Children's Community Pediatrics Behavioral Health & Developmental Services, Contact Abigail Schlesinger, MD, for more information
- **TEXAS** – Texas Pediatric Access to Subspecialists (TexasPASS)
- **VERMONT** – Teen Mental Health Project, Dartmouth Medical School, Dartmouth Co-op
- **WASHINGTON** – Partnership Access Line
- **WYOMING** – Partnership Access Line
- **WISCONSIN** – ChildPsych911 Collaborative Consultative Service, Ministry Medical Group, Contact Gabriella Hangiandreou, MD, for more information

National member organizations

- The Center for Mental Health Services in Pediatric Primary Care
- The REACH Institute
- TeenScreen

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