Andrew S. Lustbader, MD, FAAP

Bullet points:

- Triple Board certified in Child and Adolescent Psychiatry, General Psychiatry, and Pediatrics
- Assistant Clinical Professor: Yale University School of Medicine (joint appointments at The Yale Child Study Center, the Department of Pediatrics, and the Department of Nursing)
- Medical Director: Child Guidance Center of Mid-Fairfield County
- Chairman: Joint Leadership Committee of the CT American Academy of Pediatrics and the CT American Academy of Child and Adolescent Psychiatry
- Director: The Therapeutic Center for Children and Families (a multidisciplinary private practice group in Westport, CT)

Description (of above):

Andrew S. Lustbader, MD, FAAP is a triple-board certified physician in Child and Adolescent Psychiatry, General Psychiatry, and Pediatrics and a Fellow of the American Academy of Pediatrics. Dr. Lustbader trained at the Yale University School of Medicine for all three disciplines after graduating from the Albert Einstein College of Medicine in New York. He has been a practicing physician in Connecticut since 1991. Dr. Lustbader is an Assistant Professor at the Yale University School of Medicine. He also serves on the clinical faculty in the Departments of Pediatrics and Nursing at Yale-New Haven Hospital. As one of the Directors of the Psychopharmacology Clinic at the Yale Child Study Center, he supervises a multidisciplinary team of child and adolescent psychiatrists, pediatricians and nurse practitioners in training, in the science and practice of comprehensive evaluation, and non-pharmacological and pharmacological forms of mental health treatment.

He is the Medical Director of the Mid-Fairfield Child Guidance Center in Norwalk, Connecticut. The Clinic assists children with mental health needs with prevention programs, emergency assessments, and pre/post hospital intensive programs, as well as many other forms of therapy – without regard for financial need.

Over the last decade, he has started a multidisciplinary, 10-member, private practice group in Westport Connecticut He supervises psychiatric nurse practitioners who are located within local pediatric practices. He has started two multidisciplinary COR groups (Collaborative Office Rounds with pediatricians and mental health providers) in lower Fairfield County. He has given many seminars to mental health, school-based, and primary care providers, as well as community-based organizations regarding: psychopharmacology, psychiatric evaluation and treatment, treatment of physical and psychiatric chronic illnesses (including anxiety and trauma, depression, bipolar disorder, ADHD), parenting and divorce issues, and suicide prevention. In addition, he provides executive coaching for the leaders of major corporations, and serves on the executive board of a local, value-based, private high school. He also serves on the board of the Austen Riggs Center in Stockbridge, Massachusetts.

He has received a national award from the American Academy of Pediatrics in honor of his collaborative efforts to increase children's access to quality mental health care. He is currently Chairman of the Joint Leadership Committee of the Connecticut American Academy of Pediatrics and the Connecticut American Academy of Child and Adolescent Psychiatry; a committee comprised of leaders from Connecticut of both pediatric and child and adolescent psychiatry groups. The committee is dedicated to improving the quality of health care for children in Connecticut – with a special emphasis on alleviating the crises in children's mental health care. At the request of the Office of the Child Advocate, in January of 2010, the committee released a Blueprint for a mental health system for children in CT that would provide quality mental health care for all children in need.

A Mental Health Blueprint for Connecticut's Children

Early Identification and Timely Access to Quality Mental Health Care for All Children

Private insurance coverage of behavioral health services for kids has failed

- Only one child in four who need mental health care receives it – *translating to over 120,000 children in CT are not receiving the mental health services that they need and deserve.*
- One in 14 Connecticut high school students have attempted suicide, and about one in four have experienced symptoms of depression.

When children and families with mental health needs are not effectively served through their private insurance they shift to state-funded services to get appropriate care, or rely on the state to cover the costs of expensive crisis services.

The Mental Health Blueprint Implements Two Critical Reforms: 1) It changes the system for managing, approving and paying for mental health and substance abuse services children and youth, and 2) It enhances the current service system by improving efficiency and ensuring increased identification and access to quality mental health care.

The Behavioral Health Partnership (BHP) is the state's model for managing and coordinating services (utilization management) for children and families that covers a comprehensive service continuum and reduces incentives for the denial of care.

The BHP has emerged as a critical success, helping to efficiently distribute scarce mental health dollars, while boosting key quality indicators. The Mental Health Blueprint expands this model to the private insurance industry eliminating the incentive to deny care and opening access to a continuum of evidence based and promising community based services.

Children will be more likely to remain in their homes and communities, families will have alternatives to the most costly mental health services. Evidenced based practices have demonstrated long lasting effects. Early intervention and appropriate treatment can prevent the development of more serious, costly disorders across the lifespan. By **improving access**, the current disparities in access to mental health care will be diminished.

At a minimum, private insurance companies should be required to cover medically necessary and appropriate mental health services and treatments for children.

The money saved through increased efficiency and reduced reliance of acute and costly crisis services will be reinvested to support five critical service system enhancements:

- Consolidate Children's Mental Health Under One Autonomous Oversight Body
- Establish Regionalized Systems of Coordination: Prevention Programs, Child Guidance Centers (CGCs) as Hubs and Partnering with Schools and Primary Care, Improve Care of Sickest (and Costliest) Kids, Systems of Care, Intensive In-Home, EDTs, PHPs, Acute Stabilization
- Collaboration with Primary Care: develop Massachusetts model of primary care consultation, expand Collaborative Office Grounds (COR) to promote better education and collaboration between primary care and

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behavioral health specialists, better integrate primary care and behavioral health through expansion of models of co-location

- Enhance and expand School Based Mental Health Initiatives
- When Comprehensive Community Services System Exists (and above implemented) → Recalibrate Longer Term In-Patient Facilities, Residential Facilities, and Therapeutic Schools

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ADDRESSING THE CHILDREN'S MENTAL HEALTH CRISIS IN CONNECTICUT: A PRACTICAL, AFFORDABLE PROPOSAL TO RAPIDLY IMPROVE ACCESS TO HIGH QUALITY PROFESSIONAL MENTAL HEALTH CARE FOR ALL CHILDREN IN CONNECTICUT

Mental Health Care 'Blueprint' for Children in Connecticut

Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry

THERE IS A MENTAL HEALTH CRISIS OF EPIDEMIC PROPORTIONS FOR THE CHILDREN OF CONNECTICUT. THIS PROPOSAL BY THE JOINT PEDIATRIC – CHILD PSYCHIATRIC CHILD MENTAL HEALTH TASK FORCE WILL IMPROVE ACCESS AND QUALITY OF MENTAL HEALTH CARE FOR CHILDREN. THE PROPOSAL RELIES ONLY ON EXISTING LEVELS OF PROFESSIONAL MANPOWER AND RESOURCES WHICH ARE CURRENTLY BEING PAID FOR BY THE STATE, AS WELL AS ON CURRENT RESOURCE LEVELS FROM COMMERCIAL INSURANCE COMPANIES AND PRIVATE CHARITABLE SOURCES.

January 2010 (first draft)

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EXECUTIVE SUMMARY

Children and families in Connecticut face a mental health crisis of epidemic proportions. Improving children's mental health has been a central focus of a decade-long collaboration between pediatricians and child psychiatrists in Connecticut. Building on a century-long tradition of collaboration, the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of Child and Adolescent Psychiatrists united to create the Joint Child Mental Health Task Force (CMHTF) that has become a national model in the medical profession. At the request of Jeanne Milstein, the State's Child Advocate, the CMHTF has generated a practical, affordable proposal to address this dire mental health care crisis. The proposal offers a framework for ongoing evaluation and re-direction. The goal of the proposal is to rapidly improve access and quality, eliminate waste, and control overall cost of mental health care for children without violating the Hippocratic standards of good clinical care or compromising the dignity-based primary goals of care. The proposal will save the state money by targeting the many children who desperately require mental health services, thus avoiding the immediate and long term consequences of leaving so many children untreated.

PROPOSAL BRIEF

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. [1] Poor mental health treatment is a major component in the decline of Americans' health.[2] 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. [3] 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.[4] 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.[5] 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.

The CMHTF 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. [6]

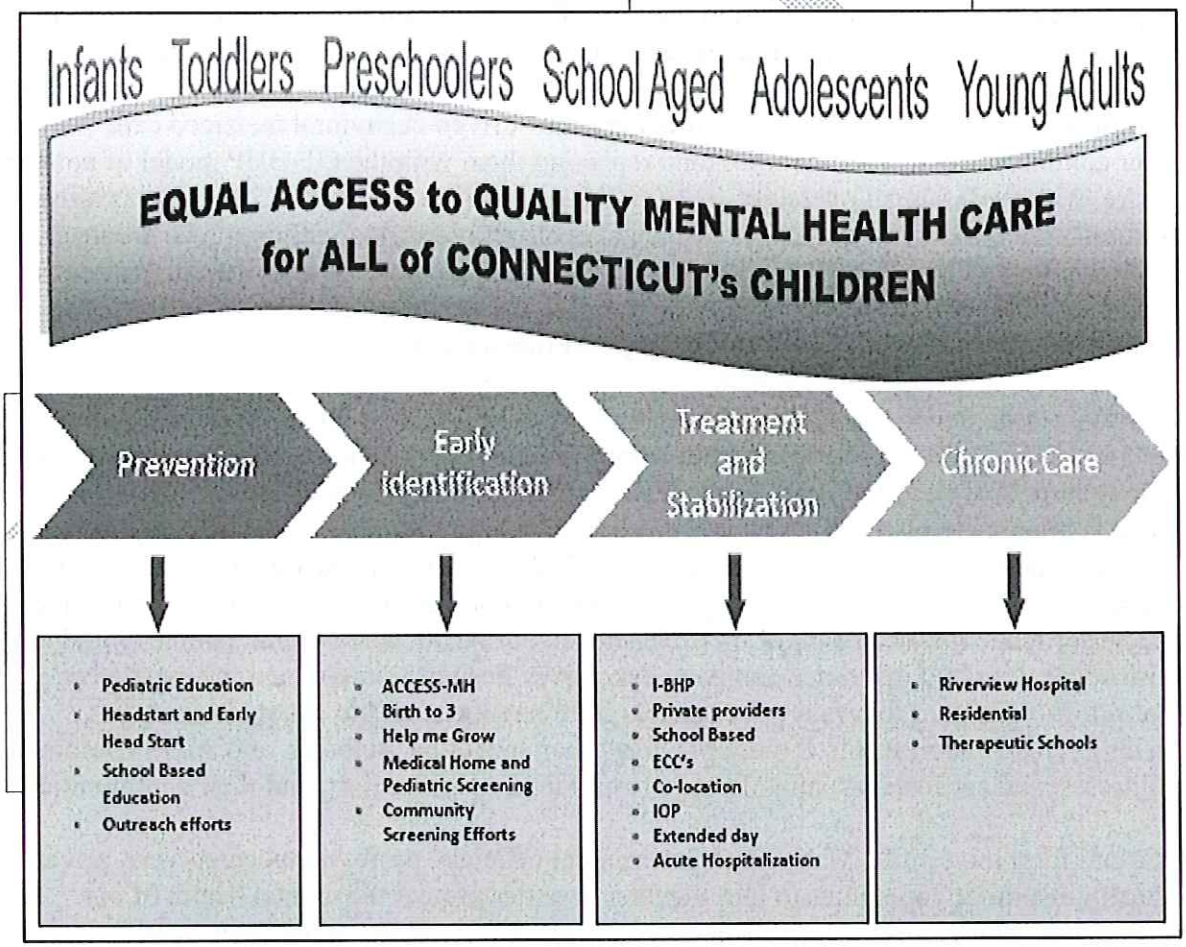
The following efficiency measures are being proposed to address these five critical barriers to care:
1. **The creation of a regionalized integrated system of care**, based on home address, in which outpatient mental health and primary care providers, child guidance centers including ECCs, school-based 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 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.

This proposal is a call for a joint initiative by State government officials, professional caregivers, private businesses and health insurance companies to join together to better protect the mental health of our children, in a fashion that also serves our private economic interests and those of our State government. It is morally imperative that doctors and other care-giving professionals work to achieve these reforms; it is a duty for the citizens and leaders of our rights-based democracy, and it is a requirement for all civilized men and women who want to live in country that does not violate the basic values that give meaning to our lives.

Graphic: Summary of Potential Future Integrated CT Children's Mental Health System

As illustrated in the graphic below, the Blueprint outlines four areas in Connecticut's mental health care system: Prevention, Early Identification, Treatment and Stabilization, and Care for the Chronically Ill. Prevention programs center around early childhood programming, pediatrician's office and school settings, as well as outreach programs that are unique to Connecticut, such as the Nurturing Families Network and the "Minding the Baby" program at Yale. Early Identification efforts are highly dependent on the work of pediatricians and school-based health centers, but are often limited by a lack of training, communication between providers, and funding mechanisms. Families' access to Treatment and Stabilization services is often limited by "donut-hole" insurance coverage, limited availability of community guidance clinics due to DCF restrictions, an insufficient number of providers, and poor reimbursement policies for mental health services. Care for the chronically ill in Connecticut rests mostly with Riverview Hospital and residential treatment facilities. These facilities often have long waiting lists and some do not accept adolescents, leaving families with no options for their chronically ill children. The private insurers restrict access to such facilities.



Glossary of Terms:

ACCESS-MH: Access for Connecticut's Children of Every Socio-economic Status – for Mental Health
A proposed program – based on a successful Massachusetts model – to increase identification and treatment of children with mental health needs, by providing primary care physicians immediate access to triage and urgent care through regionalized networks of child psychiatrists and related mental health providers.

CMHTF / CTAAP / CCCAP: Joint Child Mental Health Task Force
A 10-year collaboration of leaders from the Connecticut Chapter of the American Academy of Pediatrics (CTAAP) and the Connecticut Chapter of Child and Adolescent Psychiatrists (CCCAP) united to create this Task Force to address the crises in mental health issues in children in CT.

COR: Collaborative Office Rounds
Regular cross-disciplinary meetings of pediatric health care providers and child psychiatrists to discuss cases and clinical issues. These rounds allow primary care physicians to become more comfortable and proficient in the early identification and management of children with mental illness.

CGC / ECC: Child Guidance Clinic / Enhanced Care Clinic
CGC's are existing child guidance clinics and community outpatient clinical programs geographically covering the entire state. The enhanced ECC designation identifies CGC's that agree to a set of conditions facilitating a more rapid access to emergent, urgent and routine care for children and families who are insured through Medicaid or HUSKY insurance.

CT-BHP: Connecticut Behavioral Health Partnership
A Medicaid-based not-for-profit mental health system designed to effectively deliver mental health care to children and families on Medicaid. Managed by ValueOptions, a behavioral health insurance subcontractor, CT-BHP incentivizes appropriate uses of less intensive levels of care.

I-BHP: Insurance company based-Behavioral Health Partnership
A proposed commercial insurance-based mental health care payment system for commercial insurance-dependent families, modeled on CT-BHP and other successful state initiatives. See section V. for further explanation.

IBF: Insurance Based Fund
The fund commercial insurers will pay into under the proposed I-BHP to subsidize CT children's mental health care. The cost to commercial insurers will be less than they currently pay for mental health care while providing better coverage.

IICAPS: Intensive In-home Child and Adolescent Psychiatric Services
A 14-site statewide in-home program designed to stabilize children while keeping them in their home community and out of acute or chronic inpatient care.

IOP: Intensive Outpatient Program
An intensive program that provides high levels of care for patients who do not require hospitalization.

RTC: Residential Treatment Center
Mental health treatment involving a long-term stay at a residential facility.

Other Abbreviations:

APRN Advanced Practice Registered Nurse
BOE Board of Education
DCF Department of Children and Families
DPH Department of Public Health
DSS Department of Social Services
FTE Full-Time Equivalent
PCP Primary Care Provider
SBHC School Based Health Center
SDE State Department of Education
SED Seriously Emotionally Disturbed

EQUAL ACCESS TO QUALITY MENTAL HEALTH CARE FOR ALL OF CONNECTICUT'S CHILDREN
January, 2010

Mental Health Care 'Blueprint' for Children in Connecticut
Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry*

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•Child guidance centers lead local independent agencies to create Intra-District Teams (IDTs) of mental health providers to perform treatment and prevention in schools
•Expand School Based Health Centers
•Systems of Care to include school-based programs
•Financing to be partly insurance based (future I-BHP/BHP), and local BOE

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•Create a regionalized integrated system, based on home address, in which outpatient – mental health and primary care providers, child guidance centers including ECCs,

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school-based programs, in-home programs such as IICAPS, mobile crisis teams, partial hospitalization programs, and inpatient programs are all linked geographically in one system of care.
•Use I-BHP to fund evaluation and treatment for insurance-dependent children and families
•Expanding statewide child guidance centers licenses and other programming
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Names and Affiliations of Task Force Members

*The Joint Child Mental Health Task Force (CMHTF), of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry, has been an ongoing central priority for the both professional organizations for almost a decade. The Task Force rests on a foundation of a full century of collaboration between pediatricians and child psychiatrists in Connecticut that has become a national model in the medical profession. The CMHTF is composed of senior clinicians, clinical administrators and clinical teachers, from both the public sector and private sector medicine. These are the front line medical professionals who have pinpointed the most serious barriers to effectiveness through their years of experience providing care in an inefficient system. The member physicians include both private and academic practitioners who are experts not only in child development and public/community health, but also in the physical and emotional needs of children they work with in daily clinical practice. The members sustain a network of consultation and collaboration with many other clinical experts in mental health, pediatrics, education, day care, and other medical specialties.

It should be noted that these physicians are only concerned with the physical and mental welfare of the children of Connecticut, with no other agenda. **The members of the group are independent of any outside financial interests when it comes to children's welfare**. Members of the task force receive no financial or other incentives to participate, and this paper represents their opinions as doctors concerned with the welfare of children, rather than any interest group. This unique group of Connecticut physicians combines intensive clinical experience in children's physical and mental health with an understanding of the systems issues that drive the success or failure of health care programs for children.

Members of the Joint Task Force
The Connecticut Chapter of the American Academy of Pediatrics (CTAAP)
And The Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry (CCCAP)

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I. Introduction: The Need for Change: Mental Health Care Delivery for Children in Connecticut – Summary of Blueprint Recommendations

Childhood mental health is an area of urgent and unmet need in the United States. According to the Surgeon General's report, nearly 1 in 5 American children suffers from a diagnosable mental disorder. Yet only 20-25% of these children receive the treatment they require.[3] 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 15-44, according to the World Health Organization.[5] Untreated mental illness also tends to worsen over time, such that increasingly intensive – and expensive – treatments are needed. Effective treatments are available for childhood mental illness – treatments that can prevent loss of productivity and expensive hospital stays. However, the Surgeon General's report points to a fragmented mental health system with significant barriers for children and families trying to access this care.

The State of Connecticut is paying a price for unmet mental health needs. 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. Undetected and untreated mental disorders cause children unbearable suffering, poor academic performance, occupational underachievement, social failure, and 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.

According to the 2000 report, *Delivering and Financing Behavioral Health Services for Children in Connecticut*, 70% of state spending on behavioral services was spent on just 19% of all Connecticut's children who require mental health services. These very ill children require the most acute and most expensive services – inpatient and residential programs. In 2007, over $80 million were spent on residential placements alone for 810 children, at a cost of $100,000 per child. The remaining 81% of Connecticut children requiring mental health services were assigned just 30% of state funds.[7] Thus, community-based programs that serve the majority of children in the state were disproportionately drained by a small group of very acute, very expensive services. Prevention and early intervention stem the need for such expensive services and prevent children from placing such heavy burdens on the mental health system. With a burden of child mental illness that is similar to the national average,[8] the State of Connecticut faces additional challenges of access as long-term care facilities face possible closure

In response to the urgent need for a more integrated mental health system in Connecticut, the Joint Task Force (CMHTF) of Connecticut Chapters of the American Academy of Pediatrics (CTAAP) and the American Academy of Child and Adolescent Psychiatry (CCCAP) has created this proposal. Our goal is to help create a plan that will provide "**Equal Access to Quality Mental Health Care for All of Connecticut's Children**." This proposal presents an overview of existing systems and services in Connecticut, designed to provide policymakers with a basis for action to improve the mental health care system in Connecticut. Effective preventive measures and treatments are available for childhood mental illness. Early detection and treatments can save state money immediately by shifting resources to less expensive ambulatory prevention and treatment programs, reducing the utilization of expensive

emergency interventions and hospital stays. With early detection and quality treatment, few children go on to become burdens (and potentially dangers) to society, and much of the short term and long term collateral costs to the families and the State can also be significantly reduced. However, the Surgeon General's report on the nations mental health system and extensive first hand experience in our own state point to a fragmented mental health system with major barriers preventing children and families from obtaining access to adequate care.

The CMHTF 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, 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 private insurers are able to save by preventing mental health treatment in a child, the state pays many more dollars as the child's illness unfolds in later childhood and adulthood. [6]

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, takes care of the children and their families, and utilizes interdisciplinary professional care teams that make optimal use of their unique expertise. These collaborative relationships are central to ensuring quality and continuity of care for the children of Connecticut and their families; especially the most ill children – many of whom get lost only to return to the mental health system when they are in crises.

2. **Increased allocation of resources to pediatric, day care and school settings for the prevention and early detection** of mental health problems in children. Pediatricians and other primary care providers, as well as school mental health providers and day care workers, have the best chance of identifying, referring, and often treating children with mental health needs. However, they lack the tools and funding to provide diagnoses and treatments in both medical and school settings. ACCESS-MH (Section III) is a proposed program that integrates mental health services into the primary care setting to provide more children with services and link them to treatment; and expanding school based mental health services (Section IV) will also provide a different effective avenue for both identification and treatment.

3. **Improved timely access to high quality appropriate intervention**. The proposal improves access to treatment by expansion and improvement of the statewide network of child guidance clinics. Currently, Child Guidance and other community-based mental health clinics for children and families around the state are being overwhelmed by patient demand without having the resources to build capacity to meet that demand. One result of that increased demand is that many clinics – especially those that are Enhanced Care Clinics (ECC's) – are limited in their ability to accept non-HUSKY patients (Section V.B). Increased insurance-based funding through I-BHP and decreased DCF restrictions would allow for equal access to care and greater ability to serve children who are enrolled. In addition, the child guidance clinics could use their licenses to operate within schools and other local places where the threshold to access to care may be lower. Better access to care expands the competency of teachers, pediatricians, nurses and social workers; provides better consultative support; provides readily available emergency psychiatric consultation or evaluation; and improves practice conditions, including adequate reimbursement.

4. **Preservation of a centralized, high quality, long term, inpatient treatment center for the entire state at Riverview state hospital**, and improvements in utilization patterns to reduce length of stay and the number of required admissions to eliminate the need to send patients out of state for very expensive care. Although budgetary concerns have led lawmakers to consider closing long-term care institutions like residential and sub-acute facilities, as well as Riverview Hospital (Section VI), these institutions provide a crucial stabilization role for children whose needs are too great to be met in a community setting. There is an economy of scale to have one centralized facility – Riverview Hospital – provide the extensive evaluation and treatment necessary to understand and treat these very ill children. Local area hospitals that provide acute stabilization cannot be retrofitted to provide all that is required to fully evaluate and stabilize this chronic and severely ill population. Also, CT must bring back the many children who are placed out of state because in-state treatment facilities are not available. The cost of out-of-state residential treatment far exceeds what in-state residential treatment programs cost. This would provide additional cost savings to the state and to taxpayers. Out-of-state care is divorced from patients' families, communities and the network of health care clinicians that need to follow them after discharge.

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 the profit-driven subcontractors of the commercial managed care companies for commercially insured families, and replacing them with the CT-BHP model of not-for-profit managed care, with guidance from and accountability to a professional oversight council. The Connecticut-Behavioral Health Partnership (CT-BHP) is successfully improving the quality and efficiency of mental health care for poor children in the Husky program. CT-BHP only meets the needs of children on Medicaid, but mental illness does not discriminate by income. Thousands of children who are covered by insurance have no way of accessing mental health services: insurance does not cover such services, and the costs can easily create significant financial hardship and even bankrupt affluent families. A not-for-profit Insurance company based-Behavioral Health Partnership (I-BHP),

based on the CT-BHP model described below, would be formed through new legislation requiring all Connecticut commercial insurance companies to place funds for mental health reimbursement into one state-mandated fund (the IBF or Insurance Based Fund). As is the case with the current Husky-based CT-BHP, the behavioral health subcontractors of the commercial insurance companies would then be invited to bid for management of these IBF mental health funds with similar statewide oversight. I-BHP would incentivize increased service provision and decreased waste. Under the I-BHP, the cost to commercial insurers will be less than they currently pay for mental health care while providing better coverage; and there would be cost savings to the state, as well.

A primary goal of CT-BHP is to correct inefficient service utilization by decreasing the use of expensive residential, inpatient, and emergency room stays. This is accomplished by increasing the availability and appropriate utilization of less expensive outpatient services earlier in the course of illness, before mental health issues become more severe and require more intensive treatment. In its first year, CT-BHP saw a 5.5% increase in the number of children receiving outpatient services, and concurrent decreases of almost 10% in days of residential treatment per 1000 members and of 5.9% in the number of children admitted to inpatient care.[9] This change in patterns of utilization suggests that CT-BHP provides a useful model for adjusting services to meet patient needs in ways that are more appropriate and less expensive. This effective use of services is put into operation by utilizing a commercial behavioral management company, functioning as an Administrative Service Organization (ASO), on a fee for service basis, without taking on any insurance risk, and without any perverse financial incentives to covertly ration care to increase profit. It is guided by and accountable to a state oversight body that represents not only the relevant economic stakeholders, but more importantly, the wide array of professional caregivers and clinical administrators who have the expertise and motivation to improve the mental health and development of children.

Interweaving enhanced current systems with new programming will make payment more readily available for identification and treatment. In order to achieve universal and "Equal Access" to mental health services, children must be identified and treated where there are the greatest number of children and the greatest percent likelihood of their being seen as having a problem, if they have one. In order to maintain higher quality services, we must enhance already existing programs (such as the Child Guidance Center network) to provide the mental health care delivery in schools and primary care practices. As the data above indicates, redistribution of resources to outpatient services will save money in the present, as well as in the future. A payment system needs to be created (I-BHP described above) that is less expensive to consumers and parent insurance companies, and which utilizes successful models that already exist. Also, we must regionalize each of these steps so that treatment can be efficient and the most ill children will not just reemerge at the moment of crises requiring the most costly, and often least effective, treatments that the system has to offer.

There is a fragmented array of private and public agencies, foundations and individual providers who are trying to negotiate a solution for a system burdened by a lack of communication, focus and a unified voice for children. The Connecticut Council of Child and Adolescent Psychiatry and the Connecticut Chapter of the American Academy of Pediatrics have created this draft of a cohesive and affordable mental health plan for the State of Connecticut focusing on issues of access, quality, and collaboration. There should be a "unified voice" for all health care providers delivering care to children. As physicians, we believe we should be advocates in presenting the health and development needs for the children of Connecticut, whose voices are hard to hear in the policy and legislative arena. Within our associations we are more able to be independent from the agencies for which we work, and better able to speak openly about the best health practices and important issues for those in our care. The bioethics principles of 'beneficence,' 'non-malfeasance,' 'jurisprudence' and 'distributive justice' in medical ethics guide this motivation. We

are aware that other stakeholders in children's mental health are important participants in the process and need to be brought to the table.

Prevalence of Mental Health Problems in Children

Across the nation, approximately 12-27% of children and adolescents suffer from some form of mental health problem.[10-14] These numbers change based on where a child lives and what kinds of resources they have available: higher rates of behavioral health disorders are found in areas of social and economic hardship. A recent report by Costello et al.[15,16] revealed that by age 16, 36.7% of children in the study had met diagnostic criteria for one or more psychiatric disorders, with the highest prevalence taking place in 9-10 year old children. Boys had a greater likelihood of having a disorder, which was primarily attributed to a higher prevalence of both conduct disorders and attention-deficit/hyperactivity disorder (ADHD). Girls had significantly higher rates of depression and anxiety disorders. Overall, the prevalence rates for childhood-onset behavioral health disorders have been estimated to be as follows, with some variation depending on the criteria and population that is studies: ADHD at 9% for boys, 3% for girls; anxiety disorders at 9%; depression at 2% for school-aged children, 5% for young adolescents and 8% for older adolescents; and conduct disorder at 6–16% for boys and 2–9% for girls.[10-15, 17.]

Comorbidity, or the occurrence of more than one disorder simultaneously, is also an important issue to consider when examining the prevalence of behavioral health disorders. Approximately 25.5% of children diagnosed with a psychiatric disorder have at least one other diagnosis.[15-16] Preschoolers represent another important group where there is growing awareness of significant behavioral health issues. Prevalence rates of behavioral health problems in preschoolers have been estimated to range from 7 to 24%.[18] Preschoolers and young children in the poverty range also continue to suffer with high rates of behavioral problems.[19]

These statistics demonstrate that across the continuum of childhood, from infancy to adulthood, children experience a significant rate of mental health disturbances. **Left untreated, these disorders result in high legal, medical, and social costs for the state of Connecticut.**

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II. Prevention Efforts

Problems
Lack of secure funding for prevention programs
Sparse information on quality of current prevention programs
Recommendations
Establish ongoing, secure funding for prevention efforts
Establish regional oversight to monitor the effectiveness of prevention programs

Preventing mental illness in children requires intervention on multiple levels. Most preventative care currently takes place in Head Start Classrooms, pediatric practices, and schools. For young children, particularly those children who are growing up in poverty, early enrollment in Head Start and Early Head Start provides increased cognitive and language stimulation, opportunities for pro-social experiences, and greater social support and case management for families. School-based health centers, as well as school psychologists and social workers, offer options for identification and treatment. Within pediatric settings, clinicians are increasingly focusing their anticipatory guidance on the importance of early childhood experience and child behavior. Novel interventions, such as group well child care, are being implemented to promote more in-depth discussions of children's development and behavioral health. Primary care practices stand at the front line of prevention and intervention efforts, and should be encouraged to include mental health resources in their practices.

Additionally, programs throughout Connecticut work with high-risk families to provide crucial services and reduce the cumulative risks that can increase the likelihood of mental illness in children. These programs include the Nurturing Families Network Home Visiting Program, designed to support young mothers in their efforts to raise healthy children. Other preventive programs work with older children and teens who already have mental health needs to protect them against further adversity. Youth Service Bureaus also provide essential preventative services to small towns across Connecticut. **However, funding for many of these programs is dependent on yearly grants with limited security and little centralized quality control regarding mental health issues. Of present concern is the Governor's Budget Mitigation Plan that jeopardizes funding for a number of prevention and early identification programs. It is essential to establish regionalized oversight of prevention efforts, especially in the preschool population, in order to establish level of needs and interventions required.**

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III. Early Identification: Primary Care

Problems
Fragmented access to mental health care
Lack of mental health professionals to identify and treat children
Problems with identifying children in need of services, including poor reimbursement for time required for assessments in primary care settings
Difficulty in making referrals to mental health providers
Recommendations
Create a regionalized system of integrated mental health services
ACCESS-MH program to provide primary care clinicians with mental health capacity
Expand and standardize the "medical home" model
Formalize and support the use of CORs

ACCESS-MH is a proposed program to provide timely, effective, and integrated mental health services through primary care centers in Connecticut. Based on a successful Massachusetts program, ACCESS-MH uses a collaborative method between mental health and primary care providers to screen, treat, and refer children for mental health services.

It is well known that there are not enough pediatric mental health providers to address the needs of children with mental health issues. Recent estimates suggest that, nationwide, there are 1.6 child and adolescent psychiatrists for every 1000 children with a DSM-IV diagnoses of a severe mental illness. Even when children are referred to specialty mental health providers, a large percentage of these children will experience lengthy wait times for an initial visit, will have only one visit, or will miss their appointment and be lost to the system.

As a consequence, pediatricians are increasingly called upon to identify and manage children with complex behavioral health problems, although such disorders are not emphasized in pediatric training. Often pediatricians may have questions about whether to refer, or what kind of treatment would be most appropriate for a child. Pediatricians are well-positioned to increase the engagement of the family in the treatment process, helping them overcome the stigma, and providing motivation for them to change. It is therefore crucial to build capacity for mental health treatment within the primary care system. In our experience as pediatricians and mental health providers, this can take place through collaborative relationships in which education and consultation can act as key tools in improving the delivery of care to children and adolescents with mental illness.

Current practices of managing mental health in conjunction with primary care, such as COR groups, using pediatricians as the case manager(as in the Primary Care Case Management model), and the Memorandum of Understanding between pediatricians and Enhanced Care Clinics (ECC's)have not produced nearly the level of success necessary to overcome the difficulties associated with identification and treatment of mental health problems in children.

Our proposal for building mental health care capacity in the primary care system would include providing primary care providers with the knowledge and clinical tools to: 1) independently manage children with less complex behavioral health conditions, 2) diagnose behavioral health problems with greater accuracy, 3) become more adept at knowing which children need referral and assisting them in the referral process,

4) develop skills in educating families and enhancing their motivation around the very delicate issue of accessing mental health care for their children.

We expect that as pediatricians become more fluent in recognizing and treating behavioral health problems of children and adolescents, they will have a decreased need to refer patients for subspecialty evaluation. This will effectively improve a child's ability to obtain services within the primary care setting, and will create more openings in specialty mental health practices for children who do require specialty care. Organized connections between primary care and mental health will create local, sustainable, professional relationships that will improve access, streamline communication, and improve overall patient care. Establishing a uniform language for children's health care providers across the state, and perhaps nationally, will facilitate more coordinated and fluid efforts to create services that better meet the needs of patients and providers. This is especially true for areas of the system that are underdeveloped, such as the lack of triage centers for all children and the lack of assessment centers for infants and young children.

There are several initiatives aimed at addressing the difficulties pediatricians face in managing the behavioral health needs of their patients. The Commonwealth of Massachusetts has successfully piloted and implemented the Massachusetts Child Psychiatry Access Project (MCPAP), a program to effectively make child psychiatry services more accessible to primary care providers (PCP's) throughout the Commonwealth. We propose a Connecticut version of the MCPAP, based extensively on the original program, with budget numbers based on that program's real-time experience. Our program is called Access to Connecticut's Children of Every Socio-economic status for Mental Health (ACCESS-MH).

The goal of ACCESS-MH is to make child psychiatry services more accessible to PCP's throughout the state of Connecticut. ACCESS-MH would provide PCP's with timely and region-specific access to child psychiatry consultation and, when indicated, transitional services into ongoing behavioral health care.

ACCESS-MH would be available to all children and families, regardless of insurance status, as long as the point of entry is through their PCP. Through ACCESS-MH, teams of child psychiatrists, social workers, and care coordinators would provide assistance to PCP's in accessing psychiatric services. ACCESS-MH would be regionalized to facilitate ongoing relationships between mental health providers on the ACCESS-MH teams and the PCP's. ACCESS-MH would operate from 9 a.m. to 5 p.m., Monday through Friday, and is not designed to replace necessary emergency coverage.

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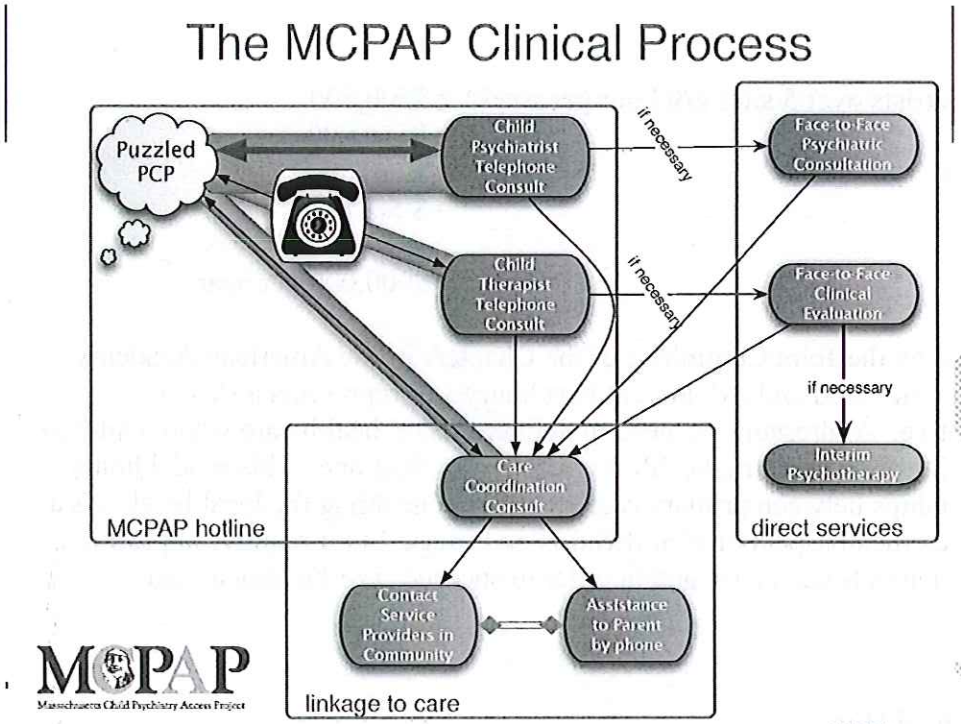

Based on the MCPAP model, services for the state would be divided between 5 regional teams. A regional team consists of 1 FTE of child psychiatrist, 1.5 FTE of a licensed social worker, 1 FTE of a care coordinator, and appropriate administrative support. Each team builds relationships with the PCPs in their region to provide psychiatric telephone consultation, often immediately, but at most within 30 minutes of the PCP's call. In this way, consultation can take place while the patient is still available to the PCP. The consultation will result in one of the following outcomes depending upon the needs of the patient and family

1. An answer to the PCP's specific mental health question by the appropriate member of the regional ACCESS-MH team, with no further action or referral necessary;
2. Referral to the team care coordinator to assist the family in accessing routine, local behavioral health services, with the understanding that there may be a 4-6 week wait;
3. Referral to the team social worker to provide transitional face-to-face care or telephonic support to the patient and family until the family can access routine, local behavioral health services;
4. Referral to team child psychiatrist for an acute psychopharmacologic or diagnostic consultation.
5. Possible referral to emergency services including emergency mobile psychiatric teams and hospitals.

The regional ACCESS-MH team would also provide PCP's with training and behavioral health continuing education -- an essential component of the program. Much of this education would occur during telephone consultations around specific patients, creation of local COR (Collaborative Office Rounds -- see below) groups with regular meetings between pediatricians and child psychiatrists and/or "brown bag," lunch and learn, or other types of learning sessions at the PCP office.

Conceptually, the regional ACCESS-MH teams would be **financed by and integrated with the I-BHP** initiative proposed in section V below, and overseen by the I-BHP/CT-BHP Joint Oversight Council. However, this ACCESS-MH program **can also stand alone**. The budget for it would likely be:

ACCESS-MH Annual Budget:

2 FTE Child and Adolescent Psychiatrists over 5 sites (70 hour per week)	= $500,000
3 FTE MSW over 5 sites	= $150,000
5 FTE care coordinators over 5 sites	= $200,000
1 administrator FTE over 5 sites	= $ 50,000
Total	$900,000 per year

This project has been conceptualized by the Joint Committee of the Chapters of the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry and represents a strong interdisciplinary collaborative initiative. Addressing the need to deliver mental health care where children and adolescents are currently receiving their pediatric health services is a critical one. This model holds the potential to create lasting partnerships between primary care and mental health at the local level. As a reminder, this program addresses the crucial aspect of identification and triage, but it requires appropriate and available practitioners to whom patients can be triaged in order to succeed (see Treatment and Stabilization sections below).

The Patient-Centered Medical Home:
Pediatricians and Other Primary Care Clinicians Providing Therapeutic Interventions

Problem
Medical home model is effective but is not used consistently across the state
Recommendation
Develop more medical homes across Connecticut

The Medical Home System of Care uses primary care clinicians to identify children in need of mental health services. In March of 2007, The AAP, AAFP, ACP, and AOA agreed on Joint Principles of the Patient-Centered Medical Home. This is an approach to providing comprehensive primary care.

A medical home includes:

- A partnership between the child, family, and the primary care physician (PCP)
- A relationship based on mutual trust and respect
- Respect for cultural and religious beliefs
- After-hours and weekend access to medical consultation
- Coordinated care across all elements of the complex health care system and the community
- A PCP who takes responsibility for providing for the child's health care needs or arranging care with other qualified professionals.

The PCP needs to be involved with the care of their patients' behavioral health needs through therapeutic intervention, if appropriate, or through a robust working relationship with behavioral health professionals. Any system for quality pediatric care must include institutional support for these relationships. The PCP is the child's lead practitioner and takes responsibility for accessing appropriate levels of care for that child.

Currently, the Medical Home System of Care for Children and Youth with Special Health Care Needs in CT divides the state into 5 regions. Each region has a Medical Home Team. The composition of the members of the teams varies by region. Each region has selected a model of care that they have deemed appropriate. For example, the Northwest Region Team is comprised of a Program Coordinator, four pediatric RN Care Coordinators, one social worker Care Coordinator, parent partners, and a physician champion. Four of the Care Coordinators are imbedded in practices and the other works with families of non-medical home practices. Referrals come from several sources. After a referral is made, a needs assessment and complexity index is completed to determine the level of care coordination needed for the child and family.

Children with behavioral health needs are, by definition, children with special health care needs. To serve the largest number of children and avoid unnecessary work and duplication of services, the ACCESS-MH and Medical Home systems should work together. Based on the MCPAP diagram above, the most likely point of overlap would be at the care coordination/consult level, which interfaces between the hotline and linkage to care. This would facilitate access to care as well as communication with the PCP.

Collaborative Office Rounds (COR)

Problem
CORs are important for regional collaboration and patient care, but are poorly attended
Recommendation
Increase COR funding through I-BHP to make COR attendance reimbursable and required for primary care clinicians

Collaborative Office Rounds (COR's) are a nearly 50-year-old solution to the scarcity of care for seriously mentally ill children. COR's are made up of a group of primary care physicians who care for children (pediatricians and family practitioners) and a child psychiatrist who can help them enhance their knowledge of mental health issues. Through these rounds, primary care physicians become more comfortable and proficient in the early identification and management of children with mental illness.

There is no formal methodology by which the COR operates. One established model invites Child and Adolescent Psychiatrists (CAP's) to present cases in a non-judgmental atmosphere. While all participants are encouraged to participate as equals and colleagues, CAP's provide useful teaching and best practices, screening tools, validation and clarification of diagnostic, management, and systems issues. The atmosphere of comfortable collegiality minimizes anxiety and maximizes collaborative learning, and pediatricians' skills in diagnosis and management improve.

The greatest benefit of this program is in the professional relationships that are built over time, allowing for better communication and understanding between the disciplines. One major benefit of the enhanced pediatric-psychiatrist relationship is that pediatricians have more confidence and are therefore more inclined to manage cases themselves when they know they can reach a child and adolescent psychiatrist easily to help coach them through cases, or to help triage cases

CORs are meant to help the primary care physician, but they also helps the CAP's by facilitating management of child psychiatric issues by primary care physicians. By delegating more stable cases to primary care physicians, CAP's are able to open their case loads to more complicated cases that are difficult to manage in a primary care setting.

Over the last 50 years, the COR experience has taught providers that care for children improves through shared motivations. Moreover, obstacles to care are more manageable when they are faced by a group of thoughtful problem-solvers. Unfortunately, as there has been no reimbursement for these COR groups, and only a small percentage of physicians attend on a regular basis. We hope to make these COR groups an important aspect of ACCESS-MH (see part 1 above), in order to help increase preventive efforts, improve access to quality care, provide standards of care, and help remove obstacles to mental health care for children. One of the goals is to create COR groups in every section of the state -- including the more rural areas where none currently exist.

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IV. Early Identification:
School Based Mental Health Centers and other Connecticut Initiatives

Problems
Fragmented and poor access to mental health care
Problems with identifying children in need of services
Difficulties with in-school treatment
Mental health stigma difficult to overcome in order to help children obtain treatment
Difficulty in making referrals to mental health providers
Recommendations
Create School-based Mental Health Services (School-MHS) to become a collaborative project of state agencies DPH, DMHAS, DCF, and SDE; with oversight by the BHP now, and later by the I-BHP/BHP Joint Oversight Council -- when implemented
Child guidance centers lead local independent agencies to create Intra-District Teams (IDTs) of mental health providers to perform treatment and prevention in schools
Expand School Based Health Centers
Local Systems of Care to include school-based programs
Financing to be partly insurance based (future I-BHP/BHP), and local BOE

Current State of Mental Health Services in Schools: It is estimated that only one fourth of children who need mental health care receive it. Of those children who do receive any mental health services 70-80% receive that care in a school setting[20, 21]. Expansion of school based mental health services has been consistently recommended as a strategy to remove barriers to care[22-24]. Despite these recommendations, since 2001 funding to support school based programs has been decreasing[25].

There is ample evidence that school based mental health services are an essential component of a comprehensive community based continuum of mental health services for children and families. Schools provide a logical "portal of entry" to services that allows for 'early identification'. Early identification is essential both in ensuring effective treatment and remediation of symptoms as well as reducing overall cost. Early identification and treatment will reduces the likelihood of a youth developing multiple disorders.[26] Effective treatment of behavioral disorders contributes to positive educational outcomes for youth. Much as employers have discovered the cost effectiveness and benefits of EAP (Employee Assistance Programs), students' educational functioning will be sustained/enhanced, and their schooling will be more cost effective, with early treatment of problems interfering with school performance.

School based mental health services supported by the local education authority primarily target youth designated as seriously emotionally disturbed (SED) due to the requirements of IDEA. Similarly, the network of community services developed through DCF/DSS KidCare is driven by the very specialized needs of the children and families involved in the child welfare system.[27] Youth who are experiencing mild-to-moderate disorders and who are not involved in the child welfare system are experiencing increasing difficulties in accessing appropriate care. In an unpublished report in 2002, SDE found that the "only" school based health care system devoted to the mental health needs of "regular education" students is the School Based Health Center program in Connecticut.

The University of Florida Center for Mental Health Research identified three conceptual models of school based mental health services. These include: Mental Health Spectrum referring to the implementation of "traditional interventions" applied to a school setting; Interconnected Systems: an integrated system of

prevention, early identification and care coordination; and Positive Behavior Supports (PBS), a school based utilization of applied behavior analysis.[28]

Of these three models Connecticut educators are most familiar with PBS which has been adopted with varying degrees of fidelity by many districts. The State Department of Education and its State Education Resource Center (pbs.ctserc.com) provides ongoing training opportunities to local schools and districts. The recent relocation of Dr. George Sugai, a PBS champion, to the UCONN School of Education department has spread this movement to Connecticut schools. PBS has helped create a climate in schools that supports collaboration with mental health practitioners and the adoption of clinically informed ways of thinking about children's behavior.

Connecticut's local school districts have "experimented" with a number of school based mental health initiatives over the decade. Since 1999 SAMHSA has funded several school based mental health projects in the State (Waterbury, New Haven, Hartford, Bridgeport). In 2001 six district elementary schools were funded by the K-3 Early Intervention Project a project jointly administered by SDE and DCF which supported the implementation of several evidence based prevention interventions; PMHP; PATHS; Second Step; as well as bringing community mental health providers into the schools. In 2007, at the request of Senator Ted Kennedy, then chairman of the Committee on Health, Education, Labor and Pensions of the US Senate the Government accounting Office conducted an investigation of school based mental health. Two Connecticut communities, Hartford and Bridgeport (of seven communities nationally) were selected as "experts" in this area of mental health services to children.[29]

The School Based Health Center programs, a program of the Maternal and Child health division of CT Department of Public Health has successfully operated comprehensive School Based Health Centers for over 27 years. Currently there are 75 Centers in 20 diverse communities. Their level V clinics provide comprehensive physical mental and dental health services utilizing a public health approach to service design and delivery. Connecticut has been a pioneer in the School Based Health Center movement of the early 80s in that our State early on recognized the importance of integrating physical care and mental health care on site. Youth who attend a school where there is a school based health center are ten times more likely to receive mental health services![30]

The public health approach to the development of services identifies three types of services: universal, selective, targeted. Universal services are those from which all youth would benefit. Selective interventions are directed toward youth who are at "risk" for the development of a behavioral health problem. Targeted services are those that are directed toward youth who present with symptoms of a diagnosable condition.

Proposal for Increased School Based Mental Health Care

We propose to build the mental health care capacity of the schools by utilizing a public health approach to service delivery that draws on the success of the School Based Health Center experience across the State. The cornerstone of this model is **collaboration** of an interdisciplinary team. Our School based mental health teams will be comprised of a master's prepared clinician, a case manager and a consulting psychiatrist. The team will work closely with the pediatric provider (school based or community based), the family, and the school mental health, administrative, and teaching staff. Our teams will follow the recommendations of the local districts' mental health providers within each school. Depending upon need and existing resources, these teams will be assigned to schools to ensure "integration." School based mental health services are particularly appropriate for youth who have limited parental support; for youth

who lack motivation to engage in community based treatment; and youth experienced social/peer difficulties.

The number of **newly-formed, Intra-District Teams (IDTs) required per district** would be based on demographics and on need, as assessed jointly by local and state agencies under I-BHP/BHP oversight. Integration with BHP, I-BHP, ACCESS-MH, as well as some of the structures already in place (e.g. school-based health centers, Local Systems of Care, child guidance centers), will be essential, but the lead agency in most cases would be the child guidance centers. The child guidance centers are present and serve every town in the state. Using expanded licenses, they would be approved for every school district. The local mental health professionals in each school would identify students in need of enhanced mental health care. The identified students would then be referred to the IDTs for treatment. Optimally, treatment would occur on site at the schools. However, as these IDTs would be open to the general population because they are part of the child guidance centers' licenses, the triage function within the school conducted by the child guidance centers might send some of the patients back to an off-site central location of the child guidance centers. Another function of the IDTs would be to help teach the local staff at the schools how to employ preventive techniques, as well as to help them identify students who have mental health problems.

Our proposal will result in the following positive outcomes:

1) By **improving access**, the current disparities in access to mental health care would be diminished.
2) **By increasing the collaboration between mental health workers and school staff**, educators will develop enhanced ability to identify, and respond to youth's behavioral health issues, allowing for a substantial **decreased demand of current school resources** for this at-risk population.
3) By integrating mental health services into the school, the stigma attached to mental health services will be **reduced.** Students who are reluctant/ambivalent about change can benefit from psychoeducation and motivation enhancement strategies.
4) **By improving collaborations the quality of care is improved** and youth are less likely to "fall through the cracks".

We **recommend** the following steps

1) Development of a **State level infrastructure**:
   We propose **that School-based Mental Health Services (School-MHS) become a collaborative project of DPH, DMHAS and DCF and SDE**. Each of these agencies devotes significant funds to the provision of services to youth. These services should be 'coordinated' and resources reallocated so that dollars are maximally allocated to benefit our youth utilizing the schools as their "portal" of entry into the mental health system.

   The Behavioral Health Partnership Oversight Council represents all stakeholders in children's' mental health except the school based providers and consumers. We propose that the BHP (and later **the I-BHP/BHP joint venture** described in section V below) should be expanded to include these stakeholders. A subcommittee should be formed to address issues that are particular to the school based mental health community.

2) **Creation of Intra-District Teams (IDTs)** as noted above.

3) The **child guidance centers would be granted licenses for entire school districts** not just for each school separately, as is the current practice. The criteria for licensure would be similar to the criteria currently used.

4) A task force established by of the collaboration group School-MHS, including DPH, SBHC administrators; DCF behavioral health administrators and key SDE administrators and a legislative "champion" be formed to review the successes and failures of previous and ongoing School Based Mental Health interventions so that **a "bank" of effective interventions** can be available to practitioners.

5) **Financing -- Short term**, before I-BHP is created: This cross agency collaborative group, School-MHS, should pursue all potential funding possibilities, including the reallocation of existing resources as well as:
   - Full implementation of the Medicaid Rehabilitation Option with children to make it more possible to locate community providers in the schools and access Medicaid funding for services.
   - School Based Health Centers that are a satellite of Community Health Centers are accepted as a "best practice". This model in needs to be expanded Connecticut.
   - Advocate with private health insurers to reimburse for services provided in the school by licensed mental health providers.

6) Local school districts will work with their respective Community Collaboratives to **expand the Local System of Care to include school based programs.**

7) **Local Boards of Education should conduct a needs assessment** of their schools to determine what mental health resources are needed by their student population.

Other existing Early Identification Initiatives in CT

The following programs are but a few of the many programs currently providing or facilitating early identification services for children with mental health needs. These include national initiatives to assess very young children as well as collaborative relationships between mental health providers that facilitate improved identification and treatment:

-Birth to Three
-Help Me Grow
-Community Screening Efforts

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V. Treatment and Acute Stabilization

Problems
Fragmented access to mental health care
Unequal or no access to quality mental health care, depending on family's resources
Recommendations
Create a regionalized integrated system, based on home address, in which outpatient mental health and primary care providers, child guidance centers including ECCs, in-home programs (such as IICAPS), school-based programs, mobile crisis teams, partial hospitalization programs, and inpatient programs are all linked geographically in one system of care
Use I-BHP to fund evaluation and treatment for insurance-dependent children and families
Expand statewide child guidance centers licenses and other programming
Creation of I-BHP/BHP oversight Council
Reimbursement for collaboration between providers
Expansion of co-location models

Once a child is identified as needing services, he or she is referred for treatment. In the management of childhood psychiatric disorders, providers of mental health care develop a treatment plan in the context of what is referred to as "levels of care". This framework presents a set of generally well-recognized criteria for illness severity, determined by the illness' impact on the safety of self, the safety of others, and the patient's daily functioning. According to this metric, mild illness can be managed with an outpatient level of care; moderate illness can be managed in an intensive outpatient program or partial hospitalization program; severe illness is best managed on an inpatient unit, especially when safety is an acute concern; and severe but persistent, or chronic, illness is best managed in a longer-term inpatient facility or a residential program.

Equal Access to Mental Health Care, Regardless of Resources

Our health care system is not a system of equal access. Depending on a family's resources, employment status, and other factors, they will possess different degrees of access to the mental health care services they require. These degrees of access are typically described by a three-tiered system for the provision of mental health care and special educational services, which consolidated in CT in the 1980's.

Tier I. For the very wealthiest, a variety of "boutique" arrangements have sprung up outside of the traditional state and private insurance arrangements that, when cobbled together, produce a facsimile of the continuum of care alluded to above. Private residential schools offer programs, often of uneven quality, designed to provide intermediate length extended and intensive mental health and special educational services once available in inpatient settings. Even for the wealthiest, skill is needed to negotiate this fabulously expensive and piecemeal system. Thus the suggestions for equal access proposed in this Blueprint also hold true for this population.

Tier II a. For the families who depend on their public schools and employer-based Commercial health insurance to meet the special educational and mental health needs of their children, a managed care

system that profits from withholding care has reduced the range of available mental health treatments and fragmented the continuum of care. Low rates and unreasonable service restrictions imposed on child and adolescent mental healthcare providers through the raw power of the for-profit healthcare insurance monopoly have led to the exodus of many skilled outpatient providers from this system. Longer term inpatient programs have been driven out of the market by managed care pressures, as a more profit-friendly, acute care model has come to dominate. Other elements on the continuum of care, such as partial hospital and intensive outpatient programs, are under steady pressure to reduce length of stays. Home-based services are widely unavailable, as well. Many families with very sick children turn to State "voluntary programs" or to the schools under the special educational laws to supplement the limited array of services covered by the private sector. These transfers of services costs have produced increasing stresses for the chronically underfunded public school and State mental healthcare provision systems.

Tier II b. For many of the working poor in CT, health care insurance is unavailable. Employment based insurance is unavailable or beyond the means of the employee. Individual plans, far more expensive, are out of reach as well. With an income too high to qualify for Medicaid or other state programs, these families have very limited access to mental health services.

Tier III. Families with the *least resources,* whose incomes meet the eligibility criteria for Medicaid, ironically have at least theoretical access to a broad array of mental health services. Accessing these services, when they are, *in fact,* available, may be difficult for a variety of reasons. These may include the difficulties the families have with advocacy to meet their needs, the various structural barriers to service access, and the scarcity of services arising from chronic underfunding. In addition, these families often have very complex mental health needs that the public system would be hard put to meet under the best of circumstances. Moreover, the requisite special educational services that would complement a comprehensive package of mental health services may be unavailable, given the financial distress typical of the inner city school districts to which these children are often attached and the increasing financial constraints for many of CT's cities and towns in these recent economic times. For all these reasons, children from Tier III are like the Tier II children, are too often abandoned by the system.

Given these tiers, each facing its own set of difficulties in accessing needed care, the Blueprint suggests the following programs as sources of coverage that can increase access across all the tier categories:

A: Programs for Tiers I and II:
"I-BHP" (Insurance companies' based- Behavioral Health Partnership)

I-BHP is a proposed insurance-based payment system for commercial insurance-dependent families. I-BHP is modeled on two successful public dissemination and coverage programs: the State of Connecticut's vaccination program for children, and the existing HUSKY mental health payment system, the Connecticut Behavioral Health Partnership (CT-BHP).

For the past eight years or so, commercial health and life insurance companies have been required to pay a certain amount of money per enrollee to the State of Connecticut to fund childhood vaccinations. These funds are deposited into the budget of the Department of Public Health and used by the DPH's Vaccination Department to purchase childhood vaccines for the coming year. The Immunization Department has a Vaccine Purchase Committee that recommends which vaccines will be paid for by the fund, since there is not enough money to buy all the recommended vaccinations. The Department of Public Health purchases the recommended vaccines through a government contract with the Centers for Disease Control. Because government contract rates are comparatively low, this arrangement allows the

state to purchase more vaccines for the dollar. The vaccines are then shipped directly to primary care providers at no cost. The provider can bill the patient's insurance company for the service of vaccine administration, but the vaccine itself is not charged. In this system, the Department of Public Health collects money from insurance companies and manages this money to maximize access to vaccines and minimize cost and third-party involvement.

This management model, in which funds and resources are distributed through an overseeing management organization, is also successfully implemented in Connecticut's mental health system. In the Connecticut Behavioral Health Partnership (CT-BHP), a not-for-profit insurance program for Medicaid patients, the state invited different insurance companies to bid on the opportunity to administer state funds for children's mental health services. ValueOptions won the bid; in exchange for managing mental health funds for children on HUSKY A, the state's Medicaid program, ValueOptions garners a fee of up to 7.5% fee on all money they distribute. This system creates an incentive for ValueOptions to provide funds for mental health services — in contrast to the current system, which rewards service refusal by allowing the behavioral health subcontractors of the commercial insurance companies to pocket any money they don't spend on services.

Drawing from these two examples, the Blueprint offers a proposal for the coverage of Connecticut children who are covered by private commercial insurance companies rather than by Medicaid. As stated above, these children fall above the cutoff point for state services but face significant difficulties in accessing the mental health services they desperately need.

I-BHP PROPOSAL for treatment of non-Medicaid children who are dependent on insurance

To create a mental health coverage system for those children who are dependent on private insurance, health and life insurance companies shall pay a set amount of money per enrollee into a statewide Insurance-Based Fund (IBF). The State of Connecticut deposits the IBF into the Department of Social Services (DSS) budget. As opposed to the current CT-BHP for the Husky Program, **the State does not have any financial responsibility for this program**, since the money comes from commercial insurance companies. DSS pays the provider – e.g., the general clinics (CGC's) covering every geographical (catchment) area of CT – from the newly created IBF. The provider will provide mental health services to all patients who are insurance-dependent. Under this model, the provider will be paid by DSS from the IBF specifically to hire clinicians to treat patients who are insurance dependent. The provider is paid on patient demand, which will drive the number of clinicians required.

Similar to the current HUSKY environment, the behavioral health subcontractors of the commercial insurance companies can bid for the role of administrator of the program. The program can be run in the same way as the current CT-BHP, with its multiple levels of State oversight. Moreover, the cost of the I-BHP program can be informed, in large part, by the current BHP. Minimum and maximum lengths of stay for specific required services will be established between the oversight boards and the insurance companies, but should be no less than:

General Clinic: 14 weeks
Psychiatric: as needed
Group therapy: 10 weeks
Intensive Out-Patient (IOP): 12 weeks
Extended Day Treatment (EDT): 16 weeks

Partial Hospital (PHP): 6 weeks
Acute In-Patient: 7 days
Sub-acute hospital: 3 weeks
Intensive In-Home: 12 weeks
Bilingual treatment: 14 weeks
Emergency services: as needed
Substance abuse disorders: 9 months
Eating disorders: 9 months
Juvenile justice: 9 months

Clinicians can utilize less time than is allocated in the above guidelines; however, if more time is required for treatment, clinicians must contact the Program Administrator.

Similar to the current HUSKY or insurance-based environment, other services will be included in the coverage of these insurance-dependent patients, such as: Psychiatric, Intensive Outpatient (IOP), Extended Day Treatment (EDT), Partial Hospital Programs(PHP), Acute Inpatient, Sub-acute Inpatient, Intensive In-Home, Bilingual treatment, and emergency services. Other services will include treatment for substance abuse disorders, eating disorders, and juvenile justice programs.

As stated in the ACCESS-MH proposal, we strongly endorse the creation of a regionalized system, 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 geographically in one system of care The I-BHP process should also be regionalized, such that coverage for programs reflects the organization of state services. When providers are linked geographically (e.g., Systems of Care, ACCESS-MH, COR groups) they get to know one another and are more likely to communicate with one another, with the area primary care providers, and with schools. In addition, employing mental health case managers (as proposed in ACCESS-MH and/or expanding the current Systems of Care) to help coordinate care for children who need more intensive levels of care would greatly and significantly help in delivering care. Concurrent care models such as the CT-BHP supported, in-home model practiced by IICAPS, are especially skilled at care coordination and establishing more appropriate after-care services for children and families. In short, such a system would help to promote care that is both efficient and effective, resulting in stabilization of illness and ultimately reducing costs and service needs.

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Expansion of Co-Location Models

Problems
Primary Care Providers benefit from the presence of mental health providers but rarely have access to them
The stigma of asking for help for mental health often presents too high a threshold for seeking the proper care for many parents
Recommendations
Expand grant- and insurance-based co-location models that place mental health providers in a primary care setting
Expand Collaborative Office Rounds (COR) groups (See section III above)

In the field of mental health, a co-location model is understood to be a system in which mental health services are available through primary care clinics or other broader health-care locations. Two current co-location models are being successfully implemented throughout Connecticut.
One is a grant-driven model that allows any children's mental health clinician to provide mental health treatment in a primary care setting and receive reimbursement through the grant. If the mental health clinician in the primary care setting does not have prescribing privileges, the supervising child and adolescent psychiatric physician provides medication evaluation and treatment, if necessary. The other co-location model currently used in Connecticut is an insurance-based model that inserts a nurse practitioner specialist in child mental health into the primary care environment. Under this model, a nurse practitioner provides both therapy and medication -- if needed—to primary care patients.
Reimbursement flows from the insurance company through the primary care practice, just as it would for any other clinical service in a primary care setting. Because of the high patient volume in primary care clinics, the embedded nurse practitioner tries to provide care only if a patient has no outside mental health providers, and only if the patient's problem is judged to be amenable to short-term treatment. If longer-term or more intensive treatment is necessary, the patient is referred to a specialty clinic for care, if available In both models, the child and adolescent psychiatrist serves a dual role in that he or she provides direct weekly supervision to the co-located mental health clinician, and also provides didactics and case supervision to the primary care providers who are delivering direct mental health care to their patients.

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B. Programs for Tier III: Child Guidance Clinics/ Community Outpatient Clinics (CGC's)

Problems
Current funding of CGC's restricts access to HUSKY population only
CGC's serve a large population but often lack close collaboration with other providers
CGC's have high clinician dropout rates due to higher burnout from working with disadvantaged population
Recommendations
Expand access to Child Guidance Centers (CGC) for all CT residents by increasing CGC funding
Use CGC's as the major hub of the regionalized service system within the I-BHP/BHP model
Increased funding to CGC's to attract and retain a sufficient number of clinicians to meet demands of this work
Other detailed recommendations

The title of Enhanced Care Clinic is a designation given to various existing child guidance clinics and community outpatient clinical programs throughout the state. The designation identifies clinics that agree to a set of conditions facilitating a more rapid access to emergent, urgent and routine care for children and families who are insured through Medicaid or HUSKY insurance.

We acknowledge the strong collaboration of the Connecticut Behavioral Health Partnership (CT BHP), Department of Social Services (DSS) and Department of Children and Families in trying to increase access for emotionally and behaviorally disordered and psychiatrically ill children from low income families via the Enhanced Care Clinic process. Although this process presents its own set of challenges, it serves as model for other commercial payers.

Suffice it to say, our current mental health care system is difficult to access for both physicians and families, especially in emergency situations. Addressing this barrier to access became the impetus for ECC providers and for ACCESS-MH. Providers stress the importance of equal access for all children to the health care providers who might be able to facilitate access of mental health services.

Some problematic issues related to ECC's, which may extend to other providers and payers, include the following problems or concerns related to the mission statement of the Blueprint, "Equal Access to Quality Mental Health Care for All of Connecticut's Children":

Equal:

1. In the present configuration, not all clinics have equal access to the desired close collaboration between the PCP and the mental health team. Currently, such collaboration is only available for two primary care practice affiliations per local ECC as part of their funding criteria. All regional primary care practices should have equal access.

2. To date, rapid access to care is an unfortunately rare occurrence in the high demand, low supply world of child psychiatry. Long wait lists for both public and private sector resources are commonplace. Presently, many community programs that once serviced a broader array of clients (commercially insured, fee for service and Medicaid) have had to shift their focus to lower income families due to Medicaid funding constraints and contractual obligations for ECC's with the state. This creates longer wait times for all other patients, with a resulting loss of commercial revenue.

3. While community clinics tend to attract clinicians who are interested in public health and providing for community benefit , a more disadvantaged clientele tend to have associated complexities such as substance abuse, single parent families, limited education, abuse/neglect of children and foster care, all of which increase the associated case management, work, and stress loads for clinicians and institutions. The equal weight of such loads is borne by fewer than needed staff and is of particular concern in this time of high unemployment, shrinking resources, and federal, state, and municipal budget cuts.

Access:
The Department of Social Services clearly has the data to indicate that access to care is quicker for patients of Enhanced Care Clinics (ECC's). More patients are assessed and admitted to the mental health system. However, certain problems exist in an accelerated care environment:

1. Both self-referred and physician-referred patients are not always coming in for their appointments. This is of particular concern for issues of prevention and early identification and treatment of treatable conditions as well as serious mental illness, abuse and neglect

2. Rapid access but delayed egress (i.e. successful treatment and end of care episodes) leaves the ECC's overburdened with too many patients. This "funnel effect" ultimately decreases patient's access to mental health services. Presently, there is not a good working mechanism for these clinics to open up assessment and treatment slots without risking quality of care.

3. Access is adversely affected when clinician turnover is high. Position vacancy in low pay, high workload community agencies is a common problem.

Quality:
There is a need for continuing quality improvement initiatives and enhanced provider network communications to enhance quality across all ECC"s. Collaboration and work towards best practices is not yet a priority in a program focused more on accelerated access for disadvantaged populations. In creating a shift towards admitting patients as quickly as possible, there is a risk that clinical staff will choose other positions outside ECC's, have less time for continuing education and risk offering lower quality care and efficacious treatment modalities:

1. High demand, stress, clinician turnover or burnout, and less continuing education will adversely affect quality care for this already disadvantaged patient population.

2. Agencies may begin isolated shifts in provision of services towards modalities that may not be evidence-based or efficacious as a means of serving higher numbers of patients.

3. Clinician turnover will not be good for the agency and the community as key relationships with schools and local authorities (area providers, schools, police, courts, DCF) take time to develop.

4. Clinician turnover is also not good for the patient, who has to endure a change in provider relationship. The transfer of care may lengthen treatment, lead to premature ending and may lead to diminished quality.

Suggestions: From ECC to Equal Access for ALL

Purpose:

A. To build upon the core principles of 'Collaboration' and 'Timely Access to Care' that DSS, DCF and CT BHP set out for their HUSKY patients. Specifically building on a model such as COR and ACCESS-MH to enhance behavioral health services for all children, regardless of payer.

B. To increase communication amongst various ECC providers and the state agencies and CT BHP in working towards shared goals and solving problems.

C. ECC programs should in no way detract from service availability for other children in the state. Again, "Equal Access to Quality Care for All" should be the theme.

Detailed Recommendations:

1. Create an **I-BHP/BHP joint venture oversight council** to ensure that the needs of all patient populations are being met. If the safety net for both programs – i.e., the child guidance centers – do not have sufficient manpower to meet local mental health service needs (as is currently the case), the joint-venture Oversight Council will work to make resources available for areas of unmet demand, as set forth in the ECC guidelines and in Section 7A above.

2. **Incentivize increased clinician interest** across the state to draw skilled child behavioral health practitioners (including those from the private sector) through:
   Loan forgiveness programs for all disciplines
   Waive or subsidize license fees (MD's and mental health clinicians)
   Consider other financial incentives:
   i. tax credits
   ii. bonuses for equal access and quality
   iii. malpractice coverage
   iv. free training on best practices, evidence based practices, brief treatments
   v. Wellness Programs for clinicians and staff

3. Identify **communities that lack care options** as high demand areas and provide corresponding higher incentives for clinicians to work in those areas.

4. **Standardize practice and level of care** guidelines across the state so that providers, government agencies, and insurance companies are all speaking the same language.

5. Include a 3-6 month 'No Harm or No Risk' clause for **agencies that uncover and report problems in providing care** that might otherwise affect their clinic status designation. This clause will encourage self-oversight and reward organizations for correcting and reporting errors, with a goal of continuous quality improvement for mental health clinics..

6. Hire care managers with the goal of **educating primary care clinicians and the public** to make timely mental health referrals. A broader system that involves all of CT's primary care providers for children is needed.

7. Include **best practice guidelines and training for clinicians in statewide initiatives** in order to meet the demands of our population.

8. **Review acuity and level of care criteria with outpatient providers** prior to discharge from higher levels of care.

9. Engage state attorney's office to develop **malpractice awareness** seminars and services for providers.

10. **Standardize procedures** for discharge or referral of problem clients and clients who fail to show.

11. Address concerns about **burnout for clinicians in high-volume programs** such as child guidance centers. Loss of good clinicians to other jobs, such as to the state, is a well known phenomenon. Develop a time-service expectation (or payback period) for clinicians who fare offered financial incentives to go elsewhere.

12. **Case management codes** should be included for all insurers and reflect **parity**.

13. The ability to **code for multiple services in one day is a more efficient**, family-friendly practice that offers more opportunity to achieve all the goals in a given patient visit.

Additionally, the following actions steps are recommended to improve communication and initiate research into treatment outcomes in order to promote best practice:

14. **Reimbursement for collaboration between providers.** Currently, primary care and mental health providers confer on cases sporadically and often do not get reimbursed for their collaborative work, leading to decreased communication and lack of continuity of care.

15. Begin an initiative of **statewide communication**, possibly through I-BHP/BHP and ACCESS-MH, to weave together the fragmented array of private and public agencies, foundations and providers that care for and advocate for children.

16. The CT I-BHP/BHP Behavioral Health Oversight Council, as the Administrative Service Organization, and its varied sub-committees will communicate regularly—at least quarterly—with all child mental health providers in order to **create common practice goals**.

17. Provide important **public service announcements** about social services, funding and revenue cuts affecting children's health care.

18. **Prioritize the publication and updating** of information regarding services and providers in regional catchment areas for use by local area collaboratives.

19. Add **more clinical training links** and other material to the current CT BHP website (see MCPAP website for comparison.)

20. **Enhance Local Systems of Care** and invite community members to the table to offer resources for children.

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21. All agencies **will keep track of the length of waitlists** or waiting times for the commercially insured and for those who are not insured.

22. Implement a statewide tracking process to **track down no-shows**. These are potentially people who fall through the cracks and suffer most.

Intensive Outpatient Mental Health including Pre/Post Hospital

Problems
Intensive programs exist but have limited capacity
Very few intensive programs exist for adolescents
Recommendations
Expand intensive services as part of I-BHP regional services
Design and fund new intensive programs for adolescent population

Earlier in this section, we discussed the different levels of care that psychiatric providers use to design treatment plans for children with mental illness. In this section we discuss intensive outpatient care, which applies to moderate levels of illness severity.

Pre-hospital programs are programs designed to help keep hospitalizable children in their home community for as long as possible while still providing the necessary level of structure and safety. Examples include Partial Hospital Programs (PHP's), Intensive Outpatient Programs (IOP's),and juvenile offender mental health programs. There is a need for greater local capacity in each of these programs statewide.

An Intensive Outpatient Program (IOP) provides weekly, multiple-service menus of individual treatment, family psychiatric consultation, outreach, and in-home contacts designed to prevent out-of-home placement and/or inpatient psychiatric care.

One form of intensive outpatient treatment designed to keep behaviorally challenged children from being removed from their homes and communities is an Extended Day Treatment program (EDT). This intensive form of program can be offered as both an after-school and a summer program. The after-school program is usually an extended day program in a therapeutic setting for behaviorally challenged children from ages 6 to 12. It includes group and individual therapy, recreational activities, art and drama, psychological testing and monitoring, parent education, guidance and support, school consultation, family counseling and crisis intervention. It is generally held for 3-4 hours every day during the school year. Their goal is to serve seriously emotionally disturbed children who are having difficulty with peer and adult relationships.

The summer program is usually a six-week group experience similar to the after school program, but with additional recreational activities to create a more camp-like environment. Currently, we have approximately 8-10 such EDT programs that, depending upon the time of year, may or may not have immediate availability and have difficult-to-meet inclusion criteria for acceptance.

Intensive In-Home Services (e.g. IICAPS)

Problem
IICAPS is a very successful intensive, family-based, in-home program that is not widely available to CT communities
Recommendation
IICAPS should become a staple of the regional BHP/I-BHP programs

Intensive in-home services programs target children who are at high risk of hospitalization or high-service utilization. These programs provide wraparound services to children and families in an effort to stabilize the children while keeping them in their home community and out of acute or chronic inpatient care. Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) is one such program. From a single site at Yale University, IICAPS has developed into a 14-site statewide program with data showing significant improvement in the severity of clients' behaviors.[31] Clinicians work intensively with families and children using a family-based approach, assist with accessing resources and coordinating services, and otherwise provide support. Families are often referred through DCF or through their primary clinicians when outpatient services are not sufficient to address a family's complex mental health needs.

Acute Inpatient Stabilization:
Local Area Hospitals -- Inpatient and Partial Hospital Programs

Problems
Extremely difficult to find local acute care beds
Little help reintegrating children after a hospital stay
Recommendations
Institute regional acute beds to maintain patients in their home community
Use the regionalized network to provide continuity of care upon reintegration

When a child's psychiatric illness requires an intensity of services or a level of safety that is impossible to achieve in a community setting, hospitalization becomes necessary. In general, the decision to refer a child to either an inpatient or partial hospital program is precipitated by significant risk or disability that requires immediate access to high levels of care. When the needed services are available, the intake process is smooth. When there is a waitlist, however, the child's condition will go untreated and may worsen, requiring even higher levels of care than were initially sought. The system depends on local hospitals to meet community needs, not just in terms of the number of inpatient beds or length of stay that is available, but also in terms of collaboration with outpatient providers to figure out the most effective and personalized treatment plan for the child.

In both inpatient and partial or intensive outpatient programs, there is a lack of regionalization of mental health care. From the perspective of overcrowded Emergency Departments, where many children with urgent mental health needs will begin their journey to hospital-level care, any bed in the state is as good as any other. If a child has outpatient providers in the Hartford area, and the Hartford intensive programs or hospitals have no openings, then the patient is sent to wherever there is availability. While this approach addresses the immediate problem of crowded emergency departments and waiting rooms, it often results in poor coordination and fragmentation of care. Additionally, when the child is discharged to a slightly lower level of care, such as partial hospital programs, the programs may be too far away for families to transport their children on a daily basis.

VI. Chronic Care

Although budgetary concerns have led lawmakers to consider closing long-term care institutions like residential and sub-acute facilities and Riverview Hospital, these institutions provide a crucial stabilization role for children whose needs are too great to be met in a community setting. Local area hospitals that provide acute stabilization cannot be retrofitted to provide the tremendous amount of resources required to stabilize this chronic and severely ill population. Therefore, the most efficient means to provide the extensive evaluation and treatment necessary to understand and treat these very ill children is to have one centralized excellent facility -- Riverview Hospital.

Residential Treatment:

Problem
Long-term facilities are at risk of decreased funding in spite of continued need
Recommendation
Maintain long-term beds at facilities capable of delivering this high level of care

Despite a variety of community-based services, some children and adolescents require treatment in facilities where they can participate in multiple treatment modalities which may include individual, family, group, recreational and other therapies as well as psychiatric evaluation and treatment and in which staff are on hand and awake 24 hours per day to help support them and monitor for safety. The problems of these youth may include recurrent suicidal ideation and suicide attempts, deliberately self-destructive behavior, repeated aggressive actions toward others, impulsive behavior of a dangerous nature, psychosis, serious problems with substances and others which cannot be safely managed and treated in a home-based setting. Particular children need concurrent, ongoing intensive treatment of serious medical illnesses as well during this time. The course of residential treatment typically lasts from 6 to 24 months and possibly longer depending on the individual needs of the children and their families. Every attempt is made to support and encourage the children in their therapeutic work so they can transition as soon as possible to a less restrictive level of care and if possible return to the care of their families. However, some children may require an intermediate level of care such as treatment in a group home setting before they are stable enough to reside with either their own or another family. Usually the children and adolescents attend a therapeutic school setting within the residential treatment complex as the vast majority has significant mental health and behavioral problems and/or learning disabilities that prevent them from making adequate academic progress in a regular educational setting.

Therapeutic Group Homes:

Children and adolescents whose psychiatric and/or behavioral problems are so severe that they need trained personnel on hand and awake 24 hours per day for support and safety but who are stable enough to not require an institutional setting may live in and receive therapy and psychiatric care in a therapeutic group home. The children's psychiatric and behavioral problems are similar to those of children in residential treatment but are not as frequent and intense. This type of placement allows them to be part of their community while still receiving therapeutic services and support within their living environment. Nursing care is available to them within the group home. If they do not require a therapeutic school environment, they are educated in their local public schools. For some youth this is a transitional environment with the goal of additional treatment and stabilization and future placement within a family,

their own if possible. For others the group home is a longer-term living environment with some adolescents remaining until completion of high school.

Chronic Inpatient Treatment for Severe Mental Illness: Riverview Hospital

Problem
Chronic inpatient facilities like Riverview Hospital are in danger of closing
Recommendation
The most efficient means to provide the extensive evaluation and treatment necessary to understand and treat the most severely ill children is to have one centralized excellent facility -- Riverview Hospital

Despite quality outpatient or residential treatment, there will continue to be a need for chronic long term hospitalization for a small percentage of children with severe chronic psychiatric illnesses. The State of Connecticut has provided this level of care through the Department of Children and Families at Riverview Hospital. The current facility, located in Middletown, Connecticut, is the result of a merger in the early 1990's of three child and adolescent state hospitals that were located throughout the state. Riverview provides long-term psychiatric hospitalization for children between 5 and17 years of age.

Criteria for admission may include some or all of the following:

- The child/adolescent poses a risk of harm to him/herself or others.
- The child/adolescent has failed a course of treatment in a less restrictive or less acute hospital setting.
- The family/guardians are incapable of caring for the child and/or are incapable or unwilling to comply with treatment recommendations.
- The child/adolescent possesses developmental or other impairments to normal functioning.

In addition, Riverview also provides psychiatric (forensic) evaluations as ordered by the courts. Because of court involvement and based on the degree of risk, these youngsters often need to be evaluated in a locked setting.

The purpose of a long-term hospitalization for this subset of seriously ill patients is, first and foremost, the stabilization of chronic dangerous behaviors. Long-term hospitalization can also be used to stabilize children who have severe chronic psychiatric illnesses, which substantially improves their chances of leading productive lives in the community, rather than spending years moving from institution to institution. Stabilization requires intensive treatment by teams of highly trained professionals from the areas of psychiatry, psychology, pediatrics, nursing, social work, education and rehabilitation. Successful treatment of these patients requires a careful and often extensive evaluation process, including a clinical psychiatric evaluation, psychological and educational testing, medical examination, and laboratory testing.

Medication management, individual counseling, group and family therapy, substance abuse counseling and intensive individual coaching are all used collaboratively in the management of these extremely difficult and complicated patients. Ultimately, the goal for all patients would be to discharge to the least

restrictive setting (i.e. lowest level of care) possible, with services in place that would ensure successful transition back to the child's home community.

The recent economic crisis has led to the consideration by lawmakers to close Riverview Hospital and other important residential programs for children and youth. Although this is an appealing option for short term budget stabilization, the long-term costs to the State of Connecticut would be devastating. The needs of these very sick children would threaten to overwhelm a less intensive and comprehensive system of care.

Riverview Hospital's economy of scale - its ability to provide the galvanizing comprehensive services that build on one another as noted above - will be lost if Riverview is closed. If spread across multiple locations, these same services would not be adequate enough to meet the programming, oversight, and therapeutic needs of children with such intensive treatment requirements. Such inadequacies open the door for legal liabilities and increased costs, as the care would become fragmented

However, the implementation of a far-reaching, more outpatient-focused, mental health care delivery system for Connecticut's children may have an impact on the actual of number of chronic mental health beds that are currently required. The vision of early treatment and easy access to community mental health providers will help prevent a sizable number of children from requiring higher levels of care including more chronic, long-term psychiatric care at facilities and Riverview Hospital. In addition, the current physical plant of Riverview may be modified to accommodate other treatment programs described earlier in this statement, if the need for fewer long term hospital beds is realized.

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