

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

American Academy of Child and Adolescent Psychiatry
Statement for the
Senate Health, Education, Labor and Pensions Committee Substance
Abuse and Mental Health Services Subcommittee Hearing on
Mental Health in Children and Youth: Issues Throughout the
Developmental Process
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American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
202. 966.7300
202. 966.1944
www.aacap.org

Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 6,900 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7 – 12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are the only medical specialty fully trained in the treatment of mental illness in children and adolescence.

The AACAP thanks Substance and Mental Health Services Subcommittee chairman, Sen. Mike DeWine (R-OH) for holding this important hearing, and we applaud his continued commitment to increasing access to treatment for children and adolescents with mental illnesses.

The Surgeon General's 2000 report on children's mental health estimated that 20% of American children and adolescents have a diagnosable mental or emotional illness. Of this number, fewer than one in five receive treatment. Barriers to treatment include a lack of affordability, lack of availability of specialists, including child and adolescent psychiatrists, and stigma. Anxiety disorders, ADHD, and depression are the most common mental illnesses occurring in children and adolescents.

Early Intervention

The barriers to early identification and treatment are the critical areas of focus for children and adolescents with mental illnesses. Five studies funded by NIMH have consistently identified under-recognition of mental illnesses as a major problem. Missed opportunities, because of under-identification or no opportunity for identification, translates into losing the option of early intervention. For children and adolescents, an early diagnosis and adequate treatment may limit the severity of a life-time disorder or minimize a less severe disorder. After the option of early intervention is lost, the chain of life-time devastation from mental illness looms ahead: school failure, family crises, substance abuse, entrance into the juvenile justice system, more and more costly interventions, and on into adulthood. The President's New Freedom Commission on Mental Health listed the expansion of early intervention services for children and adolescents with mental illnesses as one of its main recommendations in its final report, *Achieving the Promise: Transforming Mental Health Care in America*. In the report, the Commission states, "If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other illnesses damage so many children so seriously." The increased availability and affordability of treatment will enable earlier identification and interventions for children and adolescents with mental illnesses.

Coverage

Today, approximately 85% of all privately insured families, and a growing number of those covered by Medicaid, are in a managed health care plan. Children are being enrolled in managed care plans at a higher rate than adults and represent a disproportionately larger number of managed care members. The current efforts to contain costs increase the risk of compromises in the quality of care for a population that is still growing.

One of the key barriers to treatment for children and adolescents with mental illness is a lack of parity in insurance coverage for mental illness. Discriminatory coverage, including limiting the number of inpatient and outpatient visits, and higher copays and deductibles for children and adolescents, is uniquely counterproductive. Reducing treatment options contributes to missed school days, involvement with the juvenile justice system or even suicide attempts. Too often, a misperception of the cost of mental health coverage prevents access to care, but the Congressional Budget Office (CBO) estimates that managed nondiscriminatory mental health benefits will increase average premiums by less than 1% the cost of the average benefit. The cost offset of not treating a child with a mental illness will prove to be much more expensive in the future.

Due to the risk-adjustment strategies to protect the financial interests of managed care organizations, there is little incentive in a managed care system to offer parity for services for children with the most serious disorders. These children tend to be high service utilizers and are often involved in multiple agencies. They pose a challenge to managed care systems because they require services at various levels of intensity for extended periods of time. These children are then left underserved, resulting in shifting the responsibilities for care to other systems such as special education, child welfare or juvenile justice. Co-pays for children and adolescents should not only reflect parity but should be set so moderately that families seek early intervention, evaluation and treatment for mental and physical illnesses without the fear of financial disaster. With early intervention and treatment, children will live healthier, productive lives into adulthood. When managed care systems deny coverage to children and adolescents, an expedited appeals process should be in place to resolve denials.

Coverage that Meets Developmental Needs

Children and adolescents are too often treated according to adult standards. They are not little adults and need age-appropriate treatment coverage that respects developmental needs. Accurate comprehensive evaluations are more time consuming for children and adolescents. This is recognized in the *CPT* manuals for interactive psychotherapy. Health care plans should not limit the assessment of all levels of neurological and behavioral development. There are current pressures for child and adolescent psychiatrists to prescribe medication without a full evaluation, which is not good medicine or an efficient use of resources.

Most managed care systems for behavioral health have been designed without input from a child and adolescent psychiatrist or family members of children with serious emotional disorders. Most do not understand the importance of strong links among the treatment, home, and community environment. Services that support a system of care for a child's treatment plan should not be denied automatically if they fall outside the inpatient or

outpatient benefit or be discriminated against because the benefit is for a mental illness. Children and adolescents with serious emotional disorders and their families need many kinds of services from a variety of sources, such as schools, community mental health centers, and social service organizations. Many managed care systems are not yet coordinating these services that children with serious emotional disorders and their families need, and, too often, when the services are implemented, the coverage for their use is denied and only partially covered.

Coverage, with parity, should include a full continuum of treatment -- including, but not limited to, preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Treatment for children and adolescents requires that services involve the child or adolescent and family as well as appropriate collaboration with other significant caregivers, teachers, physicians or providers of other needed services.

Access

The health system's denial of access to specialists, such as child and adolescent psychiatrists for mental illnesses is a major concern. Children and adolescents should have access to all providers in the plan, with direct access to specialists with training in treating the disorders of childhood and adolescence. Child and adolescent psychiatrists are physicians specifically trained to treat children and adolescents with mental illnesses. The denial of access to such specialists can result in inadequate diagnosis and treatment of the illness and delayed treatment.

Often children and adolescents are faced with discriminatory coverage combined with their physicians being eliminated from the provider networks. Continuity of care between a child and adolescent psychiatrist and his/her patient is crucial to the well being of the child. Trust between a doctor and patient is critical, and the relationship between a child or adolescent and his/her psychiatrist must not be compromised. When a child or adolescent is suddenly required to change therapists, the trust and confidence that child depends on is undermined, damaging the outcome of the treatment and of future treatments.

Systems of Care

Currently, most state mental health, education, juvenile justice, social service and child welfare agencies do not provide coordinated treatment for children and adolescents with mental illnesses; although, a number of federal laws and programs, including Medicaid and the Individuals with Disabilities Education Act (IDEA) mandate comprehensive coverage for low -income children, children in the child welfare system and children with disabilities, including children with serious emotional disorders. Differing eligibility criteria for services and a lack of state mandates or funding streams contribute to fragmentation of state service systems. This lack of coordination across state service systems, coupled with the lack of parity in the insurance system, has forced many families to consider the unthinkable - giving up custody of their children to state child welfare or juvenile justice agencies in order to access treatment for their children.

No services should be denied that support a system of care for a child's treatment plan. Children and adolescents should have direct access to the services that support them and their families. A serious emotional disturbance touches every part of a child's life. Therefore, children and adolescents with serious emotional disturbances and their families need many kinds of services from a variety of sources, such as schools, community mental health centers, and social service organizations.

Studies suggest that effective systems of care:

- reduce the need for hospital and out-of-home residential treatment placements;
- improve how children behave and function emotionally;
- improve school performance;
- reduce juvenile involvement with the justice system; and
- provide services to more children and families who need them.

Model Systems of Care Program

The Substance Abuse and Mental Health Administration's (SAMHSA) Comprehensive Community Mental Health Services for Children and Their Families program is a model systems of care program for states. The program is a discretionary grant and contract program that supports the development of intensive community-based services for children and their families based on a multi-agency, multi-disciplinary approach involving the public and private sectors. Recent evaluation data found notable improvements for children after one year of services in the following areas: reduced law enforcement contact, improved school attendance and academic performance, and improved emotional and behavioral problems. The program currently funds 67 programs in 43 states and services a total of 46, 633 children and adolescents with serious emotional disorders. The AACAP recommends an increased appropriation for the SAMHSA's Children's Mental Health Services Program so that it may be expanded to serve all states.

Medicaid Access

The Medicaid program provides low-income families with comprehensive health care. Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program mandates that all children eligible for Medicaid receive comprehensive mental health treatment. Despite this mandate, full implementation in all states has not occurred, leaving many eligible children without access to the comprehensive care they are entitled to by law. This is due to a lack of parity for mental illnesses in state Medicaid systems, differing state eligibility criteria and regulations, and a lack of coordination between service systems. Allowing middle-income families of children with mental illnesses to buy-in to the Medicaid program, for example through the home and community-based waiver currently available in the states of Kansas, New York, Vermont and Indiana, provides access to intensive treatment services such as residential treatment centers for these families that they would otherwise not be able to afford. Increased access to Medicaid coverage for middle-income families and low-income families who are ineligible for Medicaid because of family assets such as ownership of a home, would remove one of the barriers to treatment for these children and their families. The AACAP recommends passage of the Dylan Lee James Act, S. 622 and H.R. 1822, to allow families of children with serious emotional disorders to buy into the Medicaid program.

Shortage of Children's Mental Health Professionals

A final barrier to treatment for children and adolescents with mental illnesses is the lack of available specialists trained in the diagnosis and treatment of these disorders. In particular, there is a critical national shortage of child and adolescent psychiatrists. There are about 7,000 child and adolescent psychiatrists nationwide while the prevalence rate for children and adolescents with mental illnesses is between 10 and 15 million. Data on this professional shortage comes from several sources including the Surgeon General, the President's New Freedom Commission on Mental Health, the Council on Graduate Medical Education (COGME), a committee of the Department of Health and Human Services and the Bureau of Health Professions. The Abt Associates report for COGME concluded that by 1990, the nation should have over 33,000 child and adolescent psychiatrists. The Bureau of Health Professions projected that between 1995 and 2020, the use of child and adolescent psychiatrists will increase by 100%, with general psychiatry's increase at 19%. An increase in the numbers of all children's mental health professionals can help reduce one of the barriers to treatment for the families of children with mental illnesses. The AACAP recommends congressional action in this effort, including passage of the Child Healthcare Crisis Relief Act, S. 1223 and H.R. 1359, which would encourage individuals to enter all children's mental health professions through the creation of education incentives.

Conclusion

Children and adolescents in America, regardless of their family income level, should have access to psychiatric treatment, which should be provided on a nondiscriminatory basis integrated with other necessary medical services. Services should include a full continuum of treatment – including, but not limited to, preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Treatment for children requires that services involve both the child or adolescent, and family as well as appropriate collaboration with other significant caregivers, teachers, physicians or providers of other needed services.

Summary of Legislative Recommendations:

- Enactment of the Paul Wellstone Mental Health Parity Act, S. 486 and H.R. 953, sponsored by Sen. Domenici (R-NM) and Kennedy (D-MA), and Reps. Kennedy (D-RI) and Ramstad (R-MN).
- An appropriation of \$140 million for SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families program.
- Enactment of the Keeping Families Together Act, H.R. 3309 and S. 1704.
- Enactment of the Dylan Lee James Act, S. 622 and H.R. 1822, sponsored by Sens. Grassley (R-IA) and Kennedy (D-MA), and Reps. Sessions (R-TX) and Waxman (D-CA).
- Enactment of the Child Healthcare Crisis Relief Act, S. 1223 and H.R. 1359, sponsored by Sens. Bingaman (D-NM) and Collins (R-ME) and Reps. Kennedy (D-RI) and Ros-Lehtinen (R-FL).

The AACAP appreciates this opportunity to submit a statement for the record on issues throughout the developmental process for children and adolescents with mental illnesses.

Attachment: Health Care System Leaves Mentally Ill Children Behind. Boston Globe, March 26, 2004.

http://www.boston.com/news/globe/health_science/articles/2004/04/27/health_care_system_leaves_mentally_ill_children_behind/

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