American Academy of Child and Adolescent Psychiatry

Statement for the

Senate Health Education, Labor and Pensions Committee Hearing on

Parity In Mental Health Treatment

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Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1954. Now over 6,700 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 would like to thank the sponsors of the "Mental Health Equitable Treatment Act," S. 543, Senator Pete Domenici (R-NM) and Senator Paul Wellstone (R-OH). We applaud their continued commitment to improving access to treatment for mental illnesses. Passage of S. 543 will help eliminate a key barrier to treatment for children and adolescents with mental illnesses, lack of affordability.

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 and depression are the most common mental illnesses occurring in children and adolescents. Over the last several decades, the suicide rate in young people has increased dramatically, according to the Surgeon General's *Call to Action to Prevent Suicide*. From 1980-1996, the rate of suicide among persons aged 15-19 years increased by 14% and among persons aged 10-14 years by 100%. For African-American males aged 15-19, the rate increased by a shocking 105%.

Discriminatory coverage, including limiting the number of inpatient and outpatient visits, and higher copays and deductibles for children and adolescents, is uniquely counterproductive. Reducing the 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 two independent actuarial firms (Milliman & Robertson and Coopers & Lybrand) estimated that managed nondiscriminatory mental health benefits will increase average premiums by only 1.8% - 2.1% adding somewhere between $2.32 and $2.71 per child/per year to 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.

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.

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 increased availability and affordability of treatment will enable earlier identification and interventions for children and adolescents suffering from mental illnesses.

Coverage

Children and adolescents are too often treated according to adult standards. They are not little adults and need age-appropriate treatment coverage that respect 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 children s psychiatric experts 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 automatically denied 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.

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, 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. There should be no limit on inpatient or residential days or outpatient visits. Children and adolescents seldom need hospitalization, but when they do, it is extremely serious and should not be limited to the danger to self or others standard that is set for adults.

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 and 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

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 number of costly hospital and out-of-home residential treatment placements;
- improve how children behave and function emotionally;
- improve school performance;
- reduce violations of the law; and
- provide services to more children and families who need them.

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, preventative 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 care givers, teachers, physicians or providers of other needed services.

The AACAP appreciates this opportunity to submit a statement for the record on its support for parity for mental illnesses.

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