STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

M. Jodi Rell
Governor

Patricia A. Rehmer, MSN
Commissioner

Testimony by Patricia Rehmer, MSN, Commissioner Department of Mental Health and Addiction Services Before the Public Health Committee March 1, 2010

Good morning Chairpersons Harris and Ritter, Ranking Members Debicella and Geigler, and other distinguished members of the Public Health Committee. I am Commissioner Patricia Rehmer of the Department of Mental Health and Addiction Services, and I am here this morning to speak in favor of three bills before you: **HB 5291 An Act Concerning The Sharing of Information Between the Department of Mental Health and Addiction Services and the Department of Social Services as Relates to Medicaid Funded Services, SB 246 An Act Concerning Issuance of Emergency Certificates and the Safety of Patients and Staff at facilities Operated by the Department of Mental Health and Addiction Services and SB 247 An Act Concerning Technical Changes to the Statutes Pertaining to the Department of Mental Health and Addiction.** I want to thank the Committee for your assistance in raising these bills.

The first of the bills **HB 5291 An Act Concerning The Sharing of Information Between the Department of Mental Health and Addiction Services and the Department of Social Services as Relates to Medicaid Funded Services** — is our priority legislation for the 2010 legislative session. It would allow us to have access to critical information about the people we serve in the community. Currently, when individuals who have been in one of our hospitals for a prolonged period of time are discharged into the community, they are served by one of our local mental health centers which provide a myriad of services that allow them to remain in the community while continuing to work on their recovery. These services are funded through our grant system and Medicaid. We have fourteen such local mental health centers located throughout Connecticut, some of which are state-operated and some state-funded. They are a critical part of a person's success when he/she moves into the community.

Many of the individuals we serve are insured through Medicaid. If one of these individuals needs to go into a general hospital for psychiatric care, we would not necessarily know about that admission. There is no formal way for us to keep track of how the individual is doing, why he/she was hospitalized and what action, if any, we could have taken to either prevent the hospitalization (like offering crisis, respite or peer services) or manage the individual's hospital stay and discharge. The ability for us to share such information with DSS would allow us to better evaluate the services provided by our local mental health centers and see who is succeeding in the community, and who may need additional services or supports. DMHAS has been exploring language to accomplish this task for many years, while at the same time ensure compliance with Medicaid confidentiality requirements. We have narrowed the language to

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individuals receiving targeted case management, because that is our connection to Medicaid and DSS in the community and that gives us the ability to have access to this information.

In **SB 246 An Act Concerning Issuance of Emergency Certificates and the Safety of Patients and Staff at facilities Operated by the Department of Mental Health and Addiction Services,** we ask for expansion of a current statute (§17a-503) that allows us to use our clinicians to place someone in an ambulance who needs to go to the hospital for a psychiatric evaluation and possible treatment. We currently allow our licensed clinical social workers and our advanced practice registered nurses to write these papers in certain identified programs in the statute. This practice has prevented unnecessary police involvement and fewer arrests of individuals in our system who need to go to the hospital. We do have police as backup in these situations, but we have found that such clinical intervention results in better outcomes. We are moving from an Assertive Community Team (ACT) model where we use this intervention currently, to a model called Community Support Programs (CSP), which will allow us to use the same practice in this community model of care. We would ask that the committee consider an amendment to this proposal. We made a mistake when we drafted this proposal before you. It is DMHAS that certifies these programs not CMS. We would ask that the language reflects that requirement. We have attached the requested change to the back of our testimony.

Lastly, in **SB 247 An Act Concerning Technical Changes to the Statutes Pertaining to the Department of Mental Health and Addiction,** we seek to change the words "place" and "placement" to "discharge" in §17a-471 where individuals are actually discharged from a state hospital setting into the community for continued recovery services. Our advocacy community approached us on this language change, and we are fully in accord with this change. We also requested that our communications statute (§17a-546) regarding individuals served in our hospitals be made consistent. In one section we use the words "threatening" and "harassing," while in another section we use the works "obscene" and "threatening." We suggest that we use all three words — i.e., obscene, threatening and harassing — when referring to mail and phone calls. This request was omitted from the technical change proposal and we ask that it be included should you decide to move forward on this bill. Please remember that we are not trying to paint all individuals under our care with one brush, but we do serve individuals with a wide range of issues, and these measures are necessary in our day to day work. Once again, we attached the language we would like to add to the back of our testimony.

Thank you for the opportunity to address the Committee on these three bills. I would be happy to answer any questions or concerns you may have at this time.

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Attachment:

SB 246 AN ACT CONCERNING ISSUANCE OF EMERGENCY CERTIFICATES AND THE SAFETY OF PATIENTS AND STAFF AT FACILITIES OPERATED BY THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2010*):

(a) Any police officer who has reasonable cause to believe that a person has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, and in need of immediate care and treatment, may take such person into custody and take or cause such person to be taken to a general hospital for emergency examination under this section. The officer shall execute a written request for emergency examination detailing the circumstances under which the person was taken into custody, and such request shall be left with the facility. The person shall be examined within twenty-four hours and shall not be held for more than seventy-two hours unless committed under section 17a-502.

(b) Upon application by any person to the court of probate having jurisdiction in accordance with section 17a-497, alleging that any respondent has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, and in need of immediate care and treatment in a hospital for psychiatric disabilities, such court may issue a warrant for the apprehension and bringing before it of such respondent and examine such respondent. If the court determines that there is probable cause to believe that such person has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, the court shall order that such respondent be taken to a general hospital for examination. The person shall be examined within twenty-four hours and shall not be held for more than seventy-two hours unless committed under section 17a-502.

(c) Any psychologist licensed under chapter 383 who has reasonable cause to believe that a person has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, and in need of immediate care and treatment, may issue an emergency certificate in writing that authorizes and directs that such person be taken to a general hospital for purposes of a medical examination. The person shall be examined within twenty-four hours and shall not be held for more than seventy-two hours unless committed under section 17a-502.

(d) Any clinical social worker licensed under chapter 383b or advanced practice registered nurse licensed under chapter 378 who (1) has received a minimum of eight hours of specialized training in the conduct of direct evaluations as a member of any mobile crisis team, jail diversion program, crisis intervention team, advanced supervision and intervention support team, [or] assertive case management program <u>or community support program certified [by the Centers for Medicare and Medicaid Services]</u> <u>and</u> operated by or under contract with the Department of Mental Health and Addiction Services, and (2) based upon the direct evaluation of a person, has reasonable cause to believe that such person has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, and in need of immediate care and treatment, may issue an emergency certificate in writing that authorizes and directs that such person be taken to a general hospital for purposes of a medical examination. The person

shall be examined within twenty-four hours and shall not be held for more than seventy-two hours unless committed under section 17a-502. The Commissioner of Mental Health and Addiction Services shall collect and maintain statistical and demographic information pertaining to emergency certificates issued under this subsection.

SB 247 AN ACT CONCERNING TECHNICAL CHANGES TO STATUTES PERTAINING TO THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-471a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2010*):

(a) The Commissioner of Mental Health and Addiction Services, in consultation and coordination with the advisory council established under subsection (b) of this section, shall develop policies and set standards related to clients residing on the Connecticut Valley Hospital campus and to the [placement of clients discharged] discharge of such clients from the hospital into the adjacent community. Any such policies and standards shall assure that no discharge of any client admitted to Whiting Forensic Division under commitment by the Superior Court or transfer from the Department of Correction shall take place without full compliance with sections 17a-511 to 17a-524, inclusive, 17a-566 to 17a-575, inclusive, 17a-580 to 17a-603, inclusive, and 54-56d.

(b) There is established a Connecticut Valley Hospital Advisory Council [to] that shall advise the Commissioner of Mental Health and Addiction Services on policies concerning, but not limited to, building use, security, clients residing on the campus and the [placement of clients discharged] discharge of clients from the campuses into the adjacent community. [The] In addition, the advisory council shall periodically review the implementation of the policies and standards established by the commissioner in consultation with the advisory council. The council shall be composed of six members appointed by the mayor of Middletown, six members appointed by the Commissioner of Mental Health and Addiction Services and one member who shall serve as chairperson appointed by the Governor.

Sec. 17a-546. (Formerly Sec. 17-206g). Communication by mail and telephone.

(a) Every patient shall be permitted to communicate by sealed mail with any individual, group or agency, except as herein provided.

(b) Every hospital for treatment of persons with psychiatric disabilities shall furnish writing materials and postage to any patient desiring them.

(c) If the head of the hospital or his authorized representative receives a complaint from a person demonstrating that such person is receiving **obscene,** threatening or harassing mail from a patient, the head of the hospital or his authorized representative may, after providing a reasonable opportunity for the patient to respond to the complaint, restrict such patient's mail to the complainant. The head of the hospital or his authorized representative shall notify the patient of the availability of advocacy services if such patient's mailing rights are restricted. Any such restriction shall be noted in writing, signed by the head of the hospital, and made a part of the patient's permanent clinical record.

(d) If the head of the hospital or his authorized representative determines that it is medically harmful to a patient to receive mail, all such correspondence shall be returned unopened to the sender, with an

explanation, signed by the head of the hospital, for its return. A copy of this explanation shall be made a part of the patient's permanent clinical record.

(e) Every patient shall be permitted to make and receive telephone calls, except as herein provided. Public telephones shall be made available in appropriate locations.

(f) If the head of the hospital or his authorized representative determines that a patient has made obscene, [or] threatening **or harassing** telephone calls, he may restrict such patient's right to make telephone calls. Any such restriction shall be noted in writing, signed by the head of the hospital, and made a part of the patient's permanent clinical record.

(g) If the head of the hospital or his authorized representative determines that it is medically harmful to a patient to make or receive telephone calls, this fact shall be explained, in writing, signed by the head of the hospital, to the patient's family and any persons who regularly make calls to, or receive calls from, the patient. A copy of the explanation shall be signed by the head of the hospital and placed in the patient's permanent clinical record.