



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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Governor

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**Testimony by Miriam Delphin-Rittmon, Ph.D.,
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Before the Public Health Committee
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Good Morning Senator Gerratana, Representative Ritter, and distinguished members of the Public Health Committee. I am Acting Commissioner Miriam Delphin-Rittmon of the Department of Mental Health and Addiction Services (DMHAS), and I am here today to speak to SB 1089 AN ACT CONCERNING MENTAL HEALTH SERVICES. I appreciate the opportunity to testify before you on this very comprehensive piece of legislation. I will keep my remarks limited to the sections of the bill that impact DMHAS.

Sections 1, 2, and 3 would mandate Mental Health First Aid (MHFA) Training for teachers, peace officers (which include state police and DOC employees), EMTs, and municipal police departments. While DMHAS supports all efforts to educate the public about mental illness we currently have a number of programs in place that already reach some of these professions.

We coordinate the **LAW ENFORCEMENT & CITIZENS WITH SPECIAL NEEDS** class at the Meriden Police Academy for both State and Municipal Police Recruit Officers. DMHAS is contacted by the municipality when a class is needed and we use forensic clinical staff to conduct the training. The course is four hours and the course objectives are driven by the academy requirements. This course focuses on recognizing and dealing with persons who have special needs, persons in crisis, and persons demonstrating social/emotional deviance such as neurotic or psychotic behaviors. Other forms of behavior stemming from emotional problems are explained as well.

So far in FY15, we have conducted three Municipal Recruit classes and one State Recruit class for a total of 206 recruit officers. We are scheduled for another Municipal Recruit class the end of March and expect another 50 officers.

In addition, we teach the **Responding to Citizens with Special Needs** class for State and Municipal certified Officers once a month from September to June at the Meriden Police Academy. So far this year, we have taught 112 officers from police departments around the state. This seven and a half hour class is similar to the Citizens course but includes the Hearing Voices class where participants use headphones for listening to a specially designed recording. During this simulated experience of

hearing voices, participants undertake a series of tasks including social interaction in the community, a psychiatric interview, cognitive testing, and an activities group in a mock day treatment program. The simulation experience is followed by a debriefing and discussion period..

This course teaches state and municipal certified police officers how to recognize the causes, signs and symptoms of behavioral disturbances; how to assess the risk of danger to self or others; how to use verbal interventions to de-escalate individuals in distress; and how to assess DMHAS Crisis Resources. Participants also participate in a simulated Hearing Voices learning activity that is designed to increase their understanding of auditory hallucinations.

The DMHAS Crisis Intervention Training (CIT) program provides a 5-day, 40-hour training on dealing with citizens with mental health issues to 135-230 police officers annually. The program also provides specialized CIT clinicians to work with police departments in 15 towns and cities to serve citizens with mental health issues who come in contact with the police. CIT is a national model that has been shown to reduce shooting of people with mental illness, reduce arrest and incarceration, reduce injuries to police and citizens and subsequent litigation, reduce worker compensation claims, and improve police-community relations.

In the absence of other training, Mental Health First Aid (MHFA) training may be a useful resource for police officers. However, police officers in Connecticut who have attended MHFA training and the companion MHFA for Law Enforcement report that it does not sufficiently prepare them like CIT training for the situations that they encounter in the community. The Crisis Intervention Team model that has been implemented in the United States and internationally recommends that even if every police officer in a department has mental health training there should also be a cohort of CIT trained police officers as first responders to incidents involving a person with a mental health crisis.

Statewide Model:

- Two components (1) Training for police (2) CIT-designated DMHAS clinicians to assist police
- DMHAS funds 5-day, 40-hour trainings for 135-230 officers and others annually
- The CT Alliance to Benefit Law Enforcement (CABLE, Inc.) provides the training
- All CIT clinicians are sited in LMHA Mobile Crisis programs
- Mobile Crisis staff are also being trained in CIT
- CIT Clinician contact with clients may be at the time of police contact or as a follow-up after police contact (no arrest) to ensure safety and connection to Treatment.

Police Departments served by CIT clinicians:

- Norwich, New London, Waterford, and Groton City, Waterbury, Hartford, Norwalk, Bridgeport, Fairfield, Stamford, Greenwich, West Haven, and New Haven are served regularly. Danbury and Newtown are starting to be served in February 2015.

- Clinicians occasionally respond to other nearby departments.

Local Mental Health Authorities (LMHAs) with CIT clinicians: WCMHN-Waterbury, WCMHN-Danbury (started December 2014), CMHC, GBMHC, SMHA, FSDC

As of December 31, 2014, over 1,750 police officers in 96 municipal, state, federal, and other public safety agencies in Connecticut have attended CIT training as well as several hundred others that include mental health staff, probation officers, parole officers, correctional officers, EMS staff, and others. Nearly 50 police departments have an official CIT policy. Of the 1,750 trained police officers about 1,500 were trained with DMHAS funds (including federal grant funds 2004-2007).

Currently, DMHAS has eight staff trained as Youth Mental Health First Aid YMHFA instructors. We have been working with SDE to train the district school climate safety officers. We have provided the YMHFA training to school district when requested. DMHAS also has a contract with Wheeler Clinic to facilitate MHFA Training. Wheeler Clinic currently has capacity to train approximately 150 individuals a year. In addition to Wheeler Clinic there are other private non-profit agencies that employ individuals that are certified to provide the MHFA Training. Connecticut currently has 56 individuals "certified" as MHFA instructors.

It may make more sense to ask school districts to have designated certified instructors of YMHFA in order to have greater flexibility in scheduling the classes for the entire school district. The instructor class is a 5-day training that costs \$2,000/person. But, once again, there are costs associated with this plan as well. Let's say there are 165 school districts, that's \$320,000 – this is the cost without a venue to host National Council (NC) or travel expenses for all these people to attend trainings set up by NC and then there's the cost of books, at \$15/person, for all the teachers who will get the training from their district's trainer as well as the professional day or days that a teacher will need to take the training itself.

For others mentioned in the bill, MHFA trainings are scheduled frequently throughout the year and trainers are also available to teach this course as requested. While trainings offered by Wheeler Clinic are offered free of charge to participants utilizing DMHAS funding there are some costs associated MHFA training. These costs can vary depending on a number of conditions, including trainer fees, space fees and materials. When the training is offered entities must often pass the associated costs of the training on to participants.

DMHAS would be willing to work with Wheeler clinic and others to help facilitate the trainings, but wanted to bring to your attention the costs associated with widespread implementation of this endeavor well as the issues raised by police departments regarding this training.

Section 7 requires our Mobile Crisis line be managed through 211. Currently it costs the Department of Children and Families (DCF) \$500,000 a year to pay United Way to do this for them. We have so many different options for folks depending on where they live, we believe it would be best for 211 to continue referring individuals to our crisis number, which would not obligate DMHAS to pay additional fees. In this very tight budget year, we cannot support this proposal.

Section 8 would expand the regional behavioral health consultation and care coordination program for primary care providers who serve children to young adults up to age 25. It is our understanding that this proposal is inherently included in the State Innovation Model plan to be piloted later this year and to go into effect 1/1/16. As a result, the language in this section would not be necessary.

Section 9 asks DMHAS, in consultation with DCF, to annually publish and distribute information regarding the sharing of information regarding behavioral health care. We are more than happy to comply with this language as we believe misinformation regarding HIPAA and other privacy laws can be a barrier to providing the treatment.

Section 14 is unnecessary as it repeats the mandate which already exists for the Behavioral Health Partnership Council. The Council has the legislative mandate to assess the development and ongoing implementation of the Behavioral Health Partnership, and make recommendations to the State agencies and the Connecticut General Assembly. The oversight areas include, but are not limited to:

- Review/comment on the contract between DSS, DMHAS, and DCF and the administrative service organization (ASO), Value Options, to ensure ASO decisions are based on clinical management criteria developed by the clinical management committee that includes two members of the BHP Oversight Council.
- Review the delivery of behavioral health services to ensure maximum federal revenue.
- Review and make recommendations to the State agencies and the legislature based on the BHP program reports on services, finances and outcomes and the achievement of the program goals. The BHP Oversight Council may initiate and/or conduct an *external independent evaluation of the BHP program*.
- Review and make recommendations to the State agencies and the Administrative Service Organization on policies and evaluation of evidence of the equitable statewide delivery of individualized, family-driven, community-based and culturally competent services in the Behavioral Health Partnership Program.
- Consumer grievance procedures, developed by the BHP agencies, shall be submitted to the BHP Oversight Council for review and comment.
- Review all proposals for initial service rates, reductions to existing rates and rate methodology changes. The Council may recommend acceptance of the rates or forward Council rate-specific recommendations to the General Assembly committees of cognizance (Human Services, Public Health and Appropriations).
- Review and comment on policies related to the coordinated delivery of both physical and behavioral health services for the covered populations.

The Behavioral Health Partnership shall seek to increase access to quality behavioral health services through:

- 1) Expansion of individualized, family-centered, community-based services;
- 2) Maximization of federal revenue to fund behavioral health services;
- 3) Reduction in the unnecessary use of institutional and residential services for children;
- 4) Capture and investment of enhanced federal revenue and savings derived from reduced residential services and increased community-based services;
- 5) Improved administrative oversight and efficiencies; and
- 6) Monitoring of individual outcomes, provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

Section 16 would expand our behavioral health home model to hospitals and federally qualified health centers. DMHAS, working with our LMHAs has established seven, soon to be fifteen, Health Homes to coordinate behavioral health and primary care. We have invested 10 million dollars in this initiative. Behavioral Health Homes are positioned in LMHAs because they already specialize in care coordination and are built into the fabric of the service community as they have multiple community connections via their everyday work.

Our LMHA system was also able to use in kind services which enabled our dollars to go a lot further. Creating additional behavioral health homes as stated in section 16, would result in additional costs which were not funded this biennium.

Section 17 proposes that DMHAS collect and report annually on a number of performance indicators for each agency it funds. The proposed legislation includes language requesting information such as unduplicated clients, admissions and discharges, client demographics, service hours and bed days provided, client satisfaction, discharge outcomes, and undefined "recovery measures". DMHAS already compiles all of this information in Quarterly Dashboard Quality Reports which are distributed to all funded providers and posted each quarter on the DMHAS website. These dashboard reports are part of a comprehensive performance measurement system that was initiated in 2009 and continues to evolve.

Several aspects of this section are unfeasible and would be very difficult to implement. The bill would require that DMHAS report on the admission and discharge criteria for all agencies. These criteria differ, depending on the types of services offered by an agency. Some agencies could provide over 10 service types. The collection of admission and discharge criteria would be labor intensive and could not be done within existing resources. Similarly, this section asks DMHAS and DCF to report on average waiting time for services. Nationally, wait lists are viewed as unreliable as clients may appear on multiple agency wait lists. These additional data elements are not collected centrally by DMHAS and would incur significant costs to compile and report the information, while adding little value.

Section 18 establishes a grant program within DMHAS to provide funds to organizations that provide acute care and emergency behavioral health services. The Community Care Team (CCT) model was developed to provide patient-centered care and improve outcomes by developing wraparound services through multi-agency partnership and care planning. These teams are usually comprised of local community providers and agencies that deliver authorized and non-authorized services. One of the most important components of the CCT process is communication—between providers, within the hospital departments (medical and behavioral health), between the CCT and the emergency departments (EDs) and with the members.

The theory behind the CCT is that if a person's immediate needs, which cause them to frequently return to the ED, can be met in more appropriate venues outside of the ED; there will be greater opportunities for recovery and stability. The desired outcome is that the pattern of high utilization of the ED and other services at higher levels of care will be interrupted by the customized care efforts of the local CCT. Through the Behavioral Health Partnership, DMHAS and its state partner agencies, have tasked Value Options (VO) to work with the five hospitals with the highest volume of frequent ED visitors to develop CCTs or enhance existing meetings to encompass the functions of a CCT. VO does this as a part of their base contract with the BHP and receives no grant funding and no procurement has taken place.

Establishing a CCT requires coordination and the establishment of buy-in across large and multifaceted hospital systems and diverse community providers and support agencies. Such a complex endeavor seldom happens quickly or without encountering barriers and obstacles.

Keys to success include addressing the barriers identified above and getting buy-in from Behavioral Health, ED, and other leadership within the hospital. It is critically important to have an influential champion who understands and embraces the CCT philosophy and can explain it to others. Identifying the right people to bring to the table (those who can make decisions/commitments) and securing their commitment to the team is also vital to success.

Value Options staff have worked diligently to “develop or enhance” CCTs at the hospitals participating in the ED PT. The strategies, challenges and timeframes have been different at each hospital, and, the CCTs are at different stages of development.

The model at Middlesex Hospital has been very successful as has the model in the Hartford area which looks a little different and does not require the same amount of fiscal resources. However, there are no dollars associated with this expansion in the budget, and, therefore, we cannot support this section.

Section 20 requires DMHAS to look at our inpatient beds and what the needs are in Connecticut. We would welcome the opportunity to study the current utilization of, and the need for, hospital beds for acute psychiatric care in the state. Section 21 would expand intermediate care beds to three geographic regions; this expansion is not funded in the Governor's budget, so we do not support this section of the bill. We currently have two contracts for these beds with 3-4 beds at Natchaug on a grant and around eight at Hallbrook (which is part of St. Vincent's Hospital in Bridgeport) also on a grant. The grant with Hallbrook has been difficult to administer and as a result has created frustration within the hospital community. When we originally set up the intermediate care bed program at

Hallbrook, it was funded through a state plan amendment and as a result we have to follow Medicaid rules when allowing someone into the beds. If the Committee was going proceed with the study as outlined in section 20, perhaps it may consider incorporating this issue into the study as well.

We appreciate the time and effort that went into this proposal. We believe it's important to bring to your attention the existing programs which have been working very well, in order to decrease the cost to the state. We understand there are sections of this proposal that would enhance the current system; however, the funding is unavailable to implement them at this time, so our agency cannot support these proposed provisions of the bill.

Thank you for your time and attention, I would be happy to answer any questions you might have at this time.