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**TESTIMONY OF JAN VANTASSEL, ESQ.  
PUBLIC HEALTH COMMITTEE  
MARCH 18, 2015**

**RE: SB-1089 AN ACT CONCERNING MENTAL HEALTH SERVICES  
OPPOSITION TO SECTIONS 14 & 20 AS DRAFTED**

My name is Jan VanTassel, and I am the Executive Director of the Connecticut Legal Rights Project (CLRP) a statewide non-profit legal services program that represents low income adults with serious mental health conditions on matters related to their treatment and civil rights. Because of the breadth of the recommendations in SB 1089, my colleague, Kathy Flaherty, is also testifying on sections of this bill.

My comments are limited to Sections 14 and sections 20 of SB 1089, which both mandate interagency actions regarding specific elements of the state's behavioral health services. Section 14 requires DMHAS, DSS and DCF, in consultation with providers, to develop and implement a program to improve services for Medicaid beneficiaries, improve the coordination of services and reduce state costs. Section 20 mandates that DMHAS, in consultation with DSS, DCF and providers, study the utilization and need of hospital beds for acute psychiatric care.

While both of these sections address important issues related to the state's behavioral health system, their limited scope and failure to include all groups involved in the behavioral health system, particularly families and persons with lived experience, would undermine their credibility and usefulness.

In addition to the exclusion of persons with lived experience, the narrow focus of these sections directly conflicts with the emphasis that recent state reports on mental health have placed on the importance of "a more comprehensive approach that prioritizes the promotion of mental health as well as the treatment of mental disorder." Actions that will address only one element of services, such as hospitals or Medicaid beneficiaries, promotes the kind of fragmentation that has been criticized in every report.

Section 20, for example, fails to address the closure of psychiatric inpatient beds by general hospitals in the last decade or look at the relative number of state operated beds in surrounding states as a point of comparison for the need for beds. Excluding a review of community services and housing, which are barriers to discharge, and the need to expand access to a peer supports and recovery-oriented services dictates a narrow focus on funding more inpatient beds. Similarly, while the bill mandates an increase in Medicaid

rates for behavioral health services, it does not speak to the underfunding of private non-profit providers that are critical partners in the behavioral health system.

I would also be remiss if I did not advise this committee that increased funding for the expansion of inpatient beds could well place the state at risk of violating the community integration mandate of the Americans with Disabilities Act (ADA). That mandate specifically requires states to provide services to persons with disabilities in the setting which will maximize their opportunity to interact with persons who do not have disabilities. In other words, persons with disabilities have an explicit legal right to live with everyone else. Over the past several years, federal courts have repeatedly ordered that states implement specific steps to develop supportive housing for persons with disabilities to live in the community and close state operated inpatient beds. (*Williams v Quinn*, Illinois; *Disability Rights v Velez*, New Jersey; *United States v Georgia*; *Disability Advocates Inc. v Paterson*; New York; *U.S. v New Hampshire*; *U.S. v North Carolina*; *U.S. v Delaware*).

In fact, Connecticut Valley Hospital has been monitored by the Department of Justice for the past five and one-half years. While the initial four years of oversight covered a range of treatment-related matters, the DOJ extended its work for two years specifically because the state was not in substantial compliance with the provisions related to timely discharge planning and community integration. Expanding state-funded beds at a time when there is ongoing unmet demand for community services would invite litigation.

I must also address the failure of this legislation to fund the expansion of peer supports and recovery-oriented services. For example, while there is a mandate to fund additional intermediate care hospital beds, there is no provision for funding a residential recovery and respite centers, such as Soteria House, which have been shown to have positive long term outcomes. Despite the advances that Connecticut has made in peer run and peer-oriented programs, proposals such as these focus exclusively on costly medical and clinical interventions.

Behavioral health services must be integrated into over all health care and Connecticut currently has demonstration projects in place and in development to promote that goal. It is also in the process of implementing a model for shared savings which will establish quality measures and standards designed to promote integration. We need to be sure that health care investments are consistent with our overall planning.

The Sandy Hook Commission challenged the State to establish an effective health care system that promotes “social, emotional and psychological wellness throughout the lifespan.” This requires “comprehensive and coordinated systems of care in which behavioral health and physical health are understood as highly interrelated, are given equal priority, and are part of a holistic approach to wellness that sees the individual in the context of the family and broader community.

As someone who served on the Governor’s Blue Ribbon Commission on Mental Health, which issued its report fifteen years ago this July, I urge this committee to review the recommendations in that document. Many have not yet been addressed. I also urge the members of this committee to consider establishing an accountability mechanism to

monitor the various reports that have been issued and over see the actions taken to comply with them.

In closing, I would like to quote the words of former DMHAS Commissioner, Patricia Rehmer, who noted that “everyone recovers in a different way.” We need to consider the breadth of options, and not continue to focus on business as usual. Connecticut has an opportunity at this moment in time to be a model for the nation in embracing a holistic approach to its behavioral health services. I hope this committee will provide the leadership necessary to make that a reality.

## *Peer-run Crisis Respite Services and the Soteria Project: Examples of Viable Alternatives*

Peer-run crisis respite services (PRCR's) have been in existence in many states for quite some time, and there is evidence that they represent a viable, effective, and cost-effective alternative to forced treatment, in the form of either inpatient or outpatient commitment. PRCRs have been described by The National Coalition for Mental Health Recovery (NCMHR) as "a place for people in crisis to process stress, explore new options for short-term solutions, increase living and coping skills, and reduce susceptibilities to crisis in an environment that provides support and social connectedness" (Mead, Hilton, & Curtis, 2001; NCMHCSO, 2008). They are usually operated in accordance with principles such as the following: "Safety and acceptance through connection: Hold[ing] hope for others when they cannot hold it for themselves; Us[ing] everyday language to describe one's experiences; Self care and personal responsibility; [and] Encourag[ing] mastery and power over one's own life" (Ostrow & Fisher, 2011).

There is now much evidence for the effectiveness of PRCRs. In one randomized controlled trial (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008), it was found that "the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction" (Ostrow & Fisher, 2011). Additionally, the cost of running a PRCR was found to be significantly less, approximately \$211 per day versus \$665 per day for hospitalization, in this same study. The authors concluded that the PRCR alternative was "at least as effective as standard care" and a "promising and viable alternative" (Greenfield, Stoneking, Humphreys, et al., 2008).

There is also evidence that PRCRs can increase self-direction, one of the measures correlated with successful recovery identified in the SAMHSA National Consensus Statement on Mental Health Recovery (SAMHSA, 2004). As a one-year qualitative evaluation of the Sweetser program in Maine showed, a PRCR can help people change how they think about themselves, their illnesses, and their recovery (Macneil, 2002). There is evidence also of higher guest satisfaction with the PRCR than traditional inpatient services, as was the case in a study conducted of the Rose House in New York (Legere, 2009). And perhaps most strikingly, this same study found that 7 out of 10 users had not utilized psychiatric inpatient hospitals since their experience at the respite. This result points to a potential dramatic decrease in chronicity of service utilization.

Another example of viable, evidence-based alternatives to inpatient or outpatient commitment is the Soteria Research Project, which was conducted between 1969 and 1983. This project compared the Soteria method of treatment, which "can be characterized as the 24 hour a day application of interpersonal phenomenologic interventions by a nonprofessional staff, usually without neuroleptic drug treatment, in the context of a small, homelike, quiet, supportive, protective, and tolerant social environment" ( Mosher, 1999), with inpatient hospital psychiatric interventions for people diagnosed as having schizophrenia. Dr. Loren Mosher, the psychiatrist who conducted the study, describes the outcomes of the research project in the following ways. The first thing he points out is that "in terms of psychopathology, subjects in both groups improved significantly and comparably, despite Soteria subjects not having received neuroleptic drugs" (Mosher, 1999). He goes on to say that "at 2 years

postadmission, Soteria-treated subjects... were working at significantly higher occupational levels, were significantly more often living independently or with peers, and had fewer readmissions” (Mosher, 1999). Dr. Mosher also reports that although the average length of stay in the hospitalized control group was one month, and the average length of stay at the Soteria House was five months, the cost of the first 6 months of care for both groups was equal (approximately \$4000 in 1976 dollars), making per diem cost of treatment of the Soteria control group subjects five times less expensive (Matthews et al., 1979; Mosher et al., 1978).

The research on projects such as Soteria House and many peer-run crisis respites points to their proven viability as treatment options. They are viable because their demonstrated track record includes higher reported wellness outcomes, substantially decreased lifetime service utilization, and they can typically operated at less than 33% of the cost of traditional services involving forced treatment. Most importantly, their operation does not hinge upon the violation of human rights in any way. For all these reasons, PRCRs can be seen as a substantially more desirable alternative to forced treatment.

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