CHAIRMEN: Senator Harp
Representative Wood

MEMBERS PRESENT:
SENATORS: Crisco, Gerratana, Kane, Kelly, Markley, Slossberg, Welch

REPRESENTATIVES: Abercrombie, Hovey, Johnson, Menga, Ritter, Sampson, Srinivasan

SENATOR HARP: Good morning everyone.

We're going to begin our public hearing. This is the Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety, and I want to welcome you here this morning.

My name is Toni Harp, and I represent the 10th Senatorial District, and I thought the committee members, who are here, could introduce themselves.

To my left is my co-chair.

REP. WOOD: Thank you, Senator.

My name is Representative Terri Wood. I represent Norwalk and Darien, the 141st District, and I very much welcome the dialogue, the information, we'll be getting today and think this is a very important piece of this task force.

Thank you.

I guess we'll go down to the rest of the committee now.

REP. JOHNSON: I'm Representative Susan Johnson. I represent the district -- the 49th District, which is Windham, and I look forward to hearing all the information today.

Thank you.

SENATOR GERRATANA: I'm Senator Terry Gerratana, 6th District, New Britain, Berlin and Farmington. I'm also the Senate co-chair of the Public Health Committee.

REP. SRINIVASAN: I'm Prasad Srinivasan. I come from the 31st District, which is Glastonbury, and I'm eagerly looking forward to today's testimony so that we move forward on this very important and daunting task that we have for a safer Connecticut.

SENATOR WELCH: Sure. State Senator Jason Welch from the 31st District and ranking member on Public Health.

SENATOR KANE: Good morning. State Senator Rob Kane from ten towns of the 32nd District.

REP. MEGNA: State Representative Robert Megna from New Haven and co-chair of Insurance and Real Estate.

REP. HOVEY: State Representative DebraLee Hovey, representing the 122th, Monroe and New Town.

REP. RITTER: State Representative Betsy Ritter from the 38th District, the towns of Waterford and Montville.

SENATOR CRISCO: Senator Crisco from the 17th: Hamden, Bethany, Woodbridge, Derby, Ansonia, Beacon Falls and Naugatuck; chairman -- Senate chair of the Insurance and Real Estate Committee.

SENATOR HARP: Good morning. I just wanted to make a few remarks before we start. I had hoped to -- actually, inform the public that I think that one of the things that I'm going to ask the working group to be very careful of and that is to assure that whatever it is that we decide to do doesn't add to further stigma of -- of this very vulnerable population. And so, at least, I would like to assure everyone that we will be taking that into consideration as we make proposals.

I learned yesterday from a doctor from Harvard that, of all of the gun violence, over half of the gun violence that leads to death is through suicide. Only -- so there's about -- they're about 20,000 suicides that come as a result of gun violence and the lethality of guns is really a concern.

The other thing that I learned as I sat on the Raise the Age Panel is that impulse control doesn't stabilize in an adults until 25. And if you think about guns and how lethal they are and impulse of young people between 15 and 25 -- which is where we see the largest suicides -- it is a dangerous combination.

The other thing that I learned yesterday was that people who are dealing with mental illness are most likely to be the victims as opposed to the perpetrators.

I think we should keep these things in mind as we move forward through this hearing.

I'm going to turn the meeting over to my co-chair, Representative Wood.

REP. WOOD: Okay. I've been asked by Capitol police to read this notice.

In the interest of safety, we would ask that you to note the location of and access to the exits in this hearing room -- it sounds like an airplane -- the two doors through which you entered the room are the emergency exits and marked with exit signs.

In the event of an emergency, please walk quickly to the nearest exit. After exiting the room, proceed to the main stairs or follow the exit signs to one of the fire stairs. Please quickly exit the building and follow any instructions from the Capitol police. Do not delay and do not return unless and until you are advised that it is safe to do so.

In the event of a lockdown announcement, please remain in the hearing room and stay away from the exit doors until an all clear announcement is heard.

Thank you.

Our working on this decided to break this into a couple parts: One, the informational hearing and panel; and then, the public hearing which will start at 1400 and was a sign-up by lottery.

There are three sections on the informational hearing, and we're very appreciative and grateful to all of the speakers who are able to come. They are experts in their field, and we anticipate there will be a lot of good information coming from them.

The three sections of the informational panel are mental health services, the public delivery System; the second part is mental health services, the private delivery system; and then the third part will be mental health services with regards to the court system.

So the first section we have four speakers and they will come up and speak in order -- in the order we've listed, but then pending what their schedule is some -- there may be some variation in this.

Commissioner Pat Rehmer is Department of Mental Health and Addiction Services, otherwise known as DMHAS.

The next speaker will be Vicki Veltri, the Office of the Healthcare Advocate. Then next Commissioner Joette Katz, the Department of Children and Families; and last will be Jesse White-Frese, the executive director the Connecticut Association of School-Based Health Centers.

So we welcome very much Commissioner Rehmer. Thank you for coming.

COMMISSIONER PATRICIA REHMER: Good morning, Senator Harp, Representative Wood and distinguish members of the task force. I am Commissioner

Pat Rehmer, and I -- I'm here and before you to talk a little bit about our mental health system and I want to thank the committee for asking me to speak before you today.

I've been asked to address three major issues for you: gaps in the mental health system, alternatives to outpatient treatment, and mental health first aid.

In order for me to address the gaps in the system, I first would like to talk about who we serve and the services we provide.

We serve individuals between the ages of 18 and the rest of the span of life -- I'm not sure how to say that -- so older adults as well, who are under insured, uninsured, and essentially this is a population that in laymen's terms is usually, poor so we do not serve individuals with private insurance or who have the means to pay for services by themselves. And I think that as this day goes on and we continue to talk about the issues, it's a very important delineation because the services that we are able to provide to the population that we serve are different from the services that people can avail themselves of when they have private insurance.

We serve approximately 60,000 individuals with mental health disorder, approximately 100,000 individuals total with mental health and substance abuse disorders annually. Many of these people do receive social security disability due to the severity of their illness. So some of the individuals, again, may be, especially, young adults who were on their parents insurance and because of their illness

are no longer able to have private insurance and so they become eligible for Medicaid and/or Medicare.

The only exception to that is if an individual does have private insurance, we do provide mobile crisis services to those individuals. Obviously, we are not asking somebody what their insurance is if they're calling us in a crisis so that is one important variation.

For the individuals served by DMHAS, we can provide within available appropriations in-patient and out-patient mental health and substance abuse services, case management, medication management, residential care, supported and supportive apartments, psychiatric rehabilitation services, employment services, peer-oriented services and peer-operated services, education and advocacy services, and social integration opportunities to a network of public and private nonprofit agencies.

We are one of the few states -- I think Hawaii is the only other state that has a combination of private-nonprofit providers and state providers so we are both a provider of service and the agency that oversees services.

We assist people in learning to manage their conditions and live more independently in the community. Warm lines, wellness programs help to become involved in satisfying and meaningful roles in the communities also contribute to recovery and self-sufficiency.

We do assist individuals involved with the criminal justice system and operate and fund programs for young adults with mental illness

who are aging out of DCF but I'd like to get back to the young adult system later in my testimony.

The people that DMHAS serves who demonstrate higher risks also have increased outreach supervision and monitoring. So we have homeless outreach teams that go out to shelters, under bridges, into the -- a lot into the urban areas trying to seek out individuals who may have mental illness or substance abuse disorders and engage them in the system. Engagement is key to recovery.

We have, approximately, 558 state-operated inpatient beds and we do contract for additional beds with general hospitals. We have a strong system, and we've been recognized nationally for many of our programs, as well as our commitment to a recovery system of care.

And I've attached a more comprehensive list of services to my testimony for your review.

Of course, there is always more we could do. We currently have three ACT or assertive community treatment teams across the state. Historically, we had ACT teams statewide, and over the years that they were in -- inactive, we began to sort of eat away at the edges of them and, ultimately, they really weren't ACT teams. So we made a decision, several years ago to really focus on ACT teams with a recovery orientation.

Part of the ACT model, historically, is that if you become a part of an ACT team, you are told and the expectation is you will be a part of that team for the rest of your life. We didn't see that as a particularly recovery oriented.

so we brought up three additional teams -- three teams really focused on fidelity to the model, which is a model that started in the late eighties, early nineties. These teams have a variety of clinical staff and case managers. They have smaller caseloads, and they work very hard to engage individuals in treatment, assist them with taking their medication, reach out to them and see them in the community not in an office. And it's a very, very intensive service.

They also have peer supports, again, an increasingly important part of our system as we work with individuals in recovery to assist us in engaging people who are experiencing a mental health issue -- issues.

We have supportive housing, which we know is a cornerstone of recovery. People who have safe, affordable housing, first of all, are easier to engage in the system but more importantly, feel safer and are more able to engage in activities that will help them with their recovery.

The bigger gaps, frankly, and I know that Vicki Veltri is going to talk about this but I just want to touch on it are for individuals with private insurance.

As you -- I'm not an expert on health insurance, but I do know that individuals with private insurance have a much more limited access to services. Essentially, they can get inpatient treatment, acute inpatient treatment, usually five- to seven-day average length of stay; they can get outpatient services, again, there are some limitation on how many services annually;

they can get intensive outpatient; and they can avail themselves to partial hospital programs.

I say this because I'm often called, again, especially, by parents of young adults who now are keeping their -- their children, young adults, on their insurance until they're 26, who need the services that we provide. They need case management, they need supportive housing, they need interactions with their peers. Those are things that the private insurance companies do not pay for. And if those services are not available, you're -- it's going to be much more difficult to assist people -- especially, with serious mental illness -- reach recovery.

The shortage of psychiatrists is another issue both in the public and private sector. While in Connecticut, we do have more psychiatrists than many other states, child and adolescent psychiatrists, in particular -- and again, I'm speaking from the adult world but I know this from the conversations I have with people -- are in very short supply. And often parents are forced to pay out of pocket because psychiatrists do not want to have to deal with the paperwork that comes with private insurance.

I also want to mention, Senator Harp, what you mentioned earlier, the stigma and the discrimination that goes along with mental illnesses. We've heard a lot of that over the last several days as we've heard people testify in front of various committees. It is another reason that families choose to pay out of pocket for treatment. They don't want their family members, their young adults, their mothers, their wives, their husbands to have a diagnosis in their medical record because of the

discrimination that people experience when they have a diagnosis.

So one of the problems, again, is that if we don't change the stigma and discrimination that is experienced by individuals who suffer from these illnesses, we will have a very hard time increasing their access to services or, at least, increasing their ability to utilize whatever means they have to pay for those services.

There are currently four -- I'm going to speak now to the issue of outpatient commitment, also referred to as assisted outpatient treatment. There are currently 44 states that have some form of involuntary outpatient commitment statute on the books. The laws are meant to compel individuals with mental illness into community treatment. We have been doing a state-by-state analysis of the statutes and how these statutes are implemented. And one of the things that we are finding -- well, a couple of things we are finding.

One is that no state that we have found so far, is forcibly medicating anybody in the community. Now, we think that's a good thing, but I think that there is a belief in the system, especially, among parents of young adults who are very desperate for their children to be in treatment that that will occur if we pass an outpatient commitment law. It is highly unlikely in this state if they're not doing it in any other state that that's going to happen.

I really do appreciate the opportunity to participate in this conversation. It's an important conversation to have so that people

understand what outpatient commitment can do and what it probably won't do. It is not without a price tag.

We've seen everything from New Jersey, who has had the statute on the books for the last several years who just appropriated about $2 million to begin the enforcement of that statute. They were unable to do so before this because there were no dollars appropriated and we've seen that price tag go all the way up to $30 million to enforce outpatient commitment.

I think it would be useful for us to think about that in the context of our treatment system and how we want to allocate dollars and what we want to do in terms of treatment.

It's important, also, to note that in Connecticut if you are a danger to yourself or others or you're gravely disabled, you are eligible for inpatient commitment where you can -- and any psychiatrist or psychologist can write an emergency certificate so that you are evaluated and placed in the hospital. In addition, we have some clinicians who are social workers and APRNs with special training who can also issue certificates.

The police, also, upon entering someone in the community who is in distress or creating an unsafe disturbance, can do the same; but, again, in the State of Connecticut, we have what we call, CIT teams, clinicians that ride with many police departments so when they walk into these situations, they can think about -- first, they can think about assisting and de-escalating the situation, and then is there an alternative to

placing somebody into an involuntary commitment situation.

Mental health first aid. Something that there's been a lot of talk about from the President and from other people in this state. It's really a training that helps teachers, other staffs, people in the community to try and recognize the signs of mental health disorders both in young adults and in other adults working in the community.

The Mental Health First Aid Act of 2013 in Congress calls for resources to train teachers, school administrators, students, emergency service personnel, police officers, faith community leaders, and primary care professionals. And let me just say, that some of the people that, also, will be trained are people like postmen, who are often people that go every day to somebody's house and may know when something is looking a little bit different.

Serendipitously, I received e-mail correspondence from SAMSA yesterday and through the evening -- last evening. They are more than willing to come in an assist with mental health first aid treatment based on this act in Congress, and we are already in active conversation with them about how many people need to be trained and when we can arrange for that training. So there are people, obviously, that are paying attention to Connecticut and resources that I believe we can avail ourselves of.

Youth mental health first aid is primarily designed for adults, family members, caregivers,

school staff, and human service workers, et cetera, who work with individuals between the ages of 12 to 25 and is appropriate for older adolescents.

I think, as you also said, Senator Harp, what we do recognize is with brain development, adolescent's goes on long beyond the age of 18 and that many individuals between the ages of 18 and 26 and sometimes a little bit older, their brain development is such that they are still, perhaps, behaving and acting in a way that we associate with adolescent behavior.

Thank you for your time and attention, and I would be glad to answer any questions that you have. I realize that I've jumped all over a little bit, but I'm here to answer any questions that any of you have about our service system. And I -- we forgot to attach the list of our services to the testimony and so we will get that to you.

If I could just -- I'm sorry. Can I just mention one additional program that I think is critical to mention.

We have a young adult service program that's very well funded. It's about $40 million in our budget line and that's -- that's a very generous amount of funding. That young adult program focuses on individuals who have come up through the DCF System and usually have very strong histories of trauma, have often been in multiple foster homes, really have very limited ability to live on their own and so our program focuses primarily on that population.

One of the things that I think we need to have a conversation about is another young adult population. And that is the population of young adults who may be experiencing their first psychotic episode.

We know that schizophrenia, for example, usually impacts individuals during a stressful, often transition time. It's not unusual for individuals to experience their first psychotic episode as their transitioning to college. Many of those individuals now, especially, are on their parents private insurance.

We know, now, that we can provide programming and treatment that can assist with decreasing the cognitive impairment that occurs over a longer period of time if we don't intervene at an earlier age. That is not a population that we are getting to as much as we could. Some of that is because they are privately insured and some of it is because, really, it's a population who also has a high degree of denial and is very reluctant to become involved in our system.

So the need, again, to use people who are in recovery that are young adults and use outreach and engagement and use ACT teams specific for that population I think is an area that we have not paid enough attention to and that we should, as we talk about the issues of mental health and substance abuse during this time period. And I'll stop with that.

REP. WOOD: Thank you, Commissioner, very much appreciated.

First to speak, will be Representative Hovey from New Town, and I think you'll also share

some information you know about the -- well, no you had mentioned it earlier to me, on -- on the police report --

A VOICE: (Inaudible.)

REP. WOOD: No. Just that we won't know the full report until June, I believe, so part of this will be flying by --

A VOICE: (Inaudible.)

REP. WOOD: (Inaudible.)

REP. HOVEY: You're supposed to ask permission before you out me that I'm sharing something. Sorry folks.

Yes, we -- you know, at this point in time, specifically with regards to Newtown, they -- we do not have in-depth information about the actual situation. So for those of us who represent Newtown and Sandy Hook, most specifically, you know we're nervous about different conversations occurring without all of the information. And again, whether or not all of that information will ever be public is part of the dialogue right now.

That having been said, I don't think that, especially, in the area of mental health, that it's ever to soon to start analyzing what our system is. What -- those of us are involved in the system.

I am in and out of schools in a different type of activity. In talking with teachers and talking with families, there are some things that have bubbled up that tend to be kind of

themes, in general, around our -- our mental health response, at least, as a state in general.

So I wanted to ask you a question with regards to your role as kind of the oversight of all the different entities and this idea of public versus private because I represent towns that probably as in Newtown and Sandy Hook, the majority of those individuals are privately, probably insured.

COMMISSIONER PATRICIA REHMER: Uh-huh.

REP. HOVEY: And so the disparity, sort of speak, between public access and quality of services versus private seems to be counterintuitive to me. You'd think if you're paying for something, you know, as a private individual, it would be, you know, kind of the best, so to speak, or better or whatever.

So that's an interesting thing, and I will ponder that and have a conversation with you. I think, kind of, off the grid about that further to understand it, but one of the things that I want to explore is this idea that we know that schools are our first line of defense around a lot of behavioral and mental health issues.

You know, our teachers are individuals in our school environment, bus drivers, all of them see children very early on that, you know, they're -- they're not walking and quacking like ducks. They're -- they're something that's just maybe, you know, a little different or whatever. And what I'm hearing from schools is that when they do need to make the referral out that the services are not there for them; that when the

IEP teams reach the point where those teachers and, you know, all of the individuals in the team have -- have done everything they believe they possibly can in the least restrictive environment. When it moves to the next level of possibly needing day treatment, more wraparound services, and -- and, say, more, you know, more restrictive environment for that child, they are very few options for them.

So the question I have is when it comes to looking at the licensing of day treatment facilities here in the state of Connecticut, are we licensing facilities to provide these services? And you're the clearinghouse for that? No?

Okay. So that's what I need someone to help me understand that system because what I'm hearing is we need access to more day treatment services. We need -- we need to eliminate or reduce the out-of-pocket costs for the privately insured because if they do have children who need or anyone actually, not just children --

COMMISSIONER PATRICIA REHMER: Uh-huh.

REP. HOVEY: -- anyone who needs therapeutic intervention, if they're going to see a therapist once a week that becomes very costly very quickly just with their co-pays --

COMMISSIONER PATRICIA REHMER: Uh-huh.

REP. HOVEY: -- and that that's prohibitive for families getting the kinds of services that they need.

So help explain that system to me --

COMMISSIONER PATRICIA REHMER: Sure.

REP. HOVEY: -- so that we can make some good decisions here. Thank you.

COMMISSIONER PATRICIA REHMER: And, Representative Hovey, I just want to emphasize something you said, which is we do not have any information about the mental health or any mental health issues that the shooter in the Newtown tragedy may have had. We know nothing about that.

And I think it's really important to say that repeatedly because I do think that people, perhaps, make assumptions about these kind of events and the mental health or mental illness associated with it.

But in terms of the question about treatment, we are one of five states that has a -- what I call a bifurcated system. So we do behavioral health for individuals over the age of 18. We do prevention in the schools, but we don't provide treatment for children and adolescents. DCF provides the behavioral health for and oversees behavioral health for child and adolescents, children and adolescents. And also, we're not the licensing agency for adults. The Department of Public Health is, but the Department of Children and Families, does license service levels of care for children and adolescents.

It's a little confusing but the system -- the systems are different, but I would echo your concern. As I said earlier, that if you private insurance what they pay for is limited and the co-pays can be prohibitive, especially, if

you're going to an IOP or partial hospital program where you may be paying a co-pay four times a week or every day and so that can be, certainly, one of the issues that keeps people out of treatment.

REP. WOOD: We have three more people that are going to speak and then any questions after that if you hand them to the clerk because we do have a schedule we want to keep on.

I, also, quickly want to mention they're a couple more representatives and senators that have come into the room and would like them to quickly introduce themselves.

Senator McKinney.

SENATOR MCKINNEY: Oh, thank you, Madam Chair.

John McKinney, state senator from the 28th District, senate minority leader representing the towns of Fairfield East and West and Westport and Newtown.

SENATOR SLOSSBERG: I'm Senator Slossberg. I represent Milford, Orange, West Haven and part of Woodbridge. I am the chair of the Human Services Committee, and that's it.

SENATOR MARKLEY: I'm Joe Markley from the 16th Senatorial District, ranking member of the Human Services Committee, representing Southington, Wolcott, Waterbury, Prospect and Cheshire.

REP. SAMSON: Good morning everyone. Rob Samson representing Wolcott and Southington. I'm the ranking member of the Insurance and Real Estate Committee.

REP. WOOD: Thank you.

Representative --

Oh, sorry -- Representative Abercrombie.

REP. ABERCROMBIE: Good morning everyone. Representative Cathy Abercrombie, the 83rd District, and I am co-chair of the Human Services Committee.

REP. WOOD: Thank you all.

Representative Ritter followed by Senator Kane, followed by Representative Johnson, and then any questions after that, please submit them to the Clerk.

Thank you.

REP. RITTER: Thank you very much, Representative Wood.

Good morning.

REP. WOOD: Good morning.

REP. RITTER: Thank you very much, Commissioner, for your very informative testimony and to get down to it quickly, I have two, I think, pretty direct questions.

The first I want to know was I correct in hearing your statement regarding outpatient commitment and state's that may or may not today force medication on people through outpatient programs. I believe you said there are none.

COMMISSIONER PATRICIA REHMER: There are none that force it in a community, and it's really unclear about whether people, for example, have somebody taken to a hospital and medicated. We think that may occur in Pennsylvania but, again, the enforcement of these laws is very, very difficult to do.

Almost all of the states who do have outpatient commitment start with a 72-hour hold and evaluation in the hospital and then step people down to outpatient commitment. And one of the things some of the states do, actually, is give you a voucher. So now you're outpatient committed, which gives you a voucher that allows you access to care but that voucher may not give you immediate access to care because the demand is so great.

REP. RITTER: Thank you.

And the reason I asked that is I think that's an important part of the conversation. I know that I have been the recipient of a lot of questions to that point and many, I think, feel that Connecticut is extraordinary in not requiring that when in -- in fact, I was not aware of any places where this occurred either so I appreciate that.

And my second question, you talked about mental health first aid and -- and also talked very well to Senator Harp's points about stigma. I'm interested in information in areas where mental health first aid is fairly commonly seen if it has an impact, a positive impact, on stigmatization. Because often we have found in areas regarding -- in policy areas when conversations are started, sometimes opinions

and things can change along the way. And if you have the ability to maybe later to point any of us towards that I think it would very helpful in the conversation.

COMMISSIONER PATRICIA REHMER: I -- I don't have any of that at my fingertips, but I'm sure we can find it.

What I can say is that what we do know from the research is that while we're doing a photo spread in the LOB in the beginning of February, which I hope people will look at about discrimination, and I think it's very important -- what the research actually shows that the best way to decrease discrimination and stigma is to have people who do have mental health issues or substance abuse issues be involved in the community and have people who don't have those issues interact with them on a regular basis because it sort of de -- I don't know what that word is that I'm looking for but it makes -- it normalizes it.

Thank you, thank you.

So -- but I will look at the -- because a lot of countries do mental health first aid and a lot of other states do it so I can -- and SAMSA, obviously, probably has information about that so I'll get that to you.

REP. RITTER: Thank you very much.

Thank you.

REP. WOOD: Senator Kane.

SENATOR KANE: Thank you, Madam Chair.

I'll be quick, just -- but to tag along with Representative Hovey's question in regards to public and private insurance, if you will, for a lack of a better word. There's a great issue here about mental health parity and -- and we know it doesn't take place in the private side. So does it take place on the -- the public side, meaning, individuals who are on Medicaid or Medicare, is it unlimited access or is -- is there co-pay?

I mean just explain that between the difference between private and public.

Thank you.

COMMISSIONER PATRICIA REHMER: There are some co-pays in terms of medication with Medicaid, I'm just double-checking myself on that. But in terms of treatment, there are not co-pays and, essentially, it is -- there are no limitations, for example, on outpatient visits or case management services or ACT team services so it is significantly different in terms of the amount of service that you can get when you need it.

REP. WOOD: Thank you.

Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair.

And thank you, Commissioner, for your testimony today.

Just quickly, one of the -- one of the things that I keep hearing is that people who are

diagnosed with mental illness have -- actually, are set upon more by people who are violent than they actually are committing acts of violence.

So I think that some of the conversation I wanted to hear about has to do with how do we make a determination as to who is violent and who isn't? And is -- is there a way to -- to do that and address those issues? Is there a way to understand what's going on with someone who has violence issues, and are these part of the -- the things that we were able to find when we -- when we have someone referred for services? Is that something that we're missing in terms of people falling through the cracks, as it were?

COMMISSIONER PATRICIA REHMER: We certainly do risk assessments, both in the inpatient setting and in the outpatient setting. Almost every time you see somebody, you're sort of inherently doing a risk assessment.

That being said, the ability to predict violence or risk is very, very limited. I think if you spoke with our forensic psychiatrists who are probably doing this the most, they will tell you that you can do a very lengthy risk assessment and still not be able to, in any hundred-percent way, predict risk.

But it is important to note that, really, most of the individuals with serious and persistent mental illness are victims. They are not perpetrators. And actually, I was just looking at some research last night, I think people, in general, think individuals with schizophrenia are the individuals who are the most violent, if you will, part of our population and that, in fact, is not true.

It's about -- the people who interestingly enough -- I was shocked -- that perpetrate the most violence are individuals who suffer from depression, which is very interesting.

Now, that may be concomitant with a substance use disorder which raises your risk. But I don't believe that it was given what I was looking at last night. So it really was surprising to me, but prediction of risk is very, very difficult to do.

REP. JOHNSON: Thank you.

Thank you, Madam Chair.

REP. WOOD: Thank you very much.

And thank you again, Commissioner.

Next to speak will be Vicki Veltri of the Office of the Healthcare Advocate.

VICKI VELTRI: Good morning. Good morning, Senator Harp, Representative Wood, members of the Mental Health Services Working Group.

For the record, I am Vicki Veltri, and I'm the state healthcare advocate.

OHA is an independent state agency. We're a watchdog entity. We have a threefold mission and that is to ensure consumers have access to medically necessary healthcare. We educate consumers about their rights and responsibilities under their health plans and we come to you when we see problems in the system.

I want to thank you all for your leadership on this issue and for inviting me here to speak today about mental health in Connecticut. You know, although the -- the tragic events at Sandy Hook have brought the deficiencies in our system really into sharp focus, it's important really to remember that a lot of the problems that we're seeing are systemic and have been around for quite a while.

On October 17th, our office held a hearing on barriers to access for preventative and treatment services for people with behavioral health issues. We really did that based on our long experience in seeing complaints from people with mostly private insurance and accessing mental health services coverage through their plans.

We wanted to really reset and level set the current delivery system in mental health and substance use in Connecticut. We do have convening authority in our statute to bring all stakeholders together on mental health issues. And we also have authority, obviously, to facilitate public comment on federal and state laws, monitor implementation of the laws but, quite frankly, it really wasn't necessary to even do that for us to understand the barriers Connecticut residents are facing in accessing mental health and substance use services.

Really, behavioral health complaints are the number one clinical complaint that come to OHA. It has been that way as long I've been there, which is almost seven years, and every year it increases.

OHA's hearing really made it clear to me, and I think everyone who attended, that we have a tremendous amount of work to do to address the problems in our system.

I attached to our testimony our -- our summary of our findings and recommendations, which are based on, again, our years of work and our witness to the really profound struggles of children, adults and families to access needed services.

To just go over a little bit what we've found -- what our office found in our report and by way of a little bit of background. You know mental illness is really common, very common in the United States. More common than I think people think it is. One in five people have symptoms of a mental illness and the estimated cost, really 20 -- one in 20 suffer from severe mental illness and really the estimated cost to our pocket every year -- pocket books every year is about $500 billion.

And really a lot of the situations with mental health go hand in hand with substance abuse often. There's a lot of co-morbidity: 11 percent of our youngsters or adolescence have used illegal substances and 20 percent of them used alcohol. That trend is increasing about only 10 to 15 percent of those with -- with substance use issues have received early and appropriate treatment and really early and appropriate treatment has proven to reduce symptoms and increase effective outcomes.

You know, the barriers for mental health and substance use treatment in Connecticut, you know, they've been well documented for a number

of years -- I probably restate all of them. I will say our delivery system -- and it's interesting that, actually, the agenda is set up in a way that reflects the current system we have in Connecticut, which is really tiered. It's a public system, a private system, and then a system for people who are uninsured.

I think -- or we think that is a major -- that's a major problem. We really have to look at delivering a comprehensive system with a comprehensive vision of integrating mental health and substance use treatment into overall healthcare.

You know, those -- those people with private insurances -- you heard from Commissioner Rehmer and you've asked her those same questions -- you know, it's a system that's really fragmented. If you have private insurance, you're not going to get many of the community-based programs that are offered through DHMAS and DCF that are evidence based and have been shown to overt hospitalizations and prevent the need for crisis care, like IICAPS, for instance, Intensive In Home Child and Adolescent Psychiatric Services, extended day treatment.

We have a service called Emergency Mobile Psychiatric Services, which I think, probably -- I don't know if Commissioner Katz will testify to or not -- but it's funded by DCF. Thirty-three percent of the people who access that service are insured, 33 percent, but it is not funded through insurance plans.

So we have -- we do have a really fragmented system of care. You know, full -- in Connecticut, our fully insured plans -- so the

plans that are regulated by the State of Connecticut, which I think it's important to note, are only a fraction of the insurance plans offered in the state. Many people in Connecticut are covered by plans that our state just does not regulate. The federal government regulates them. So even if we wanted to have some kind of control over those plans, we can't. And that's about a little more than half of the people covered by private plans are covered by self-insured plans.

Having said that, our insurance statutes are very comprehensive in terms of the range of licensed providers whose services must be reimbursed and the range of coverage that must be reimbursed so, for instance, our state law essentially says if you have a diagnosis that's recognized in this manual called the DSM manual, your service, essentially, must be covered as long as it's provided by one of the licensed providers -- a whole range of licensed providers covered.

Well, it's an example of the law that is very good on paper but isn't exactly working as well as it should in practice. So, for instance, our experience is and this was really highlighted to a large degree also in the Program Review and Investigations Committee Report -- which we have a link to in our report.

So -- so several issues for one -- for instance, criteria. So when plans decide what's going to be covered and what isn't going to be covered, they have to decide whether it's medically necessary so they use criteria to decide that. That criteria is to be based on up-to-date evidence-based guidelines from relevant practice

associations, such as the American Academy of Pediatrics, American Psychiatric Association, American Society for Addiction Medicine but when you look at the criteria that the plans use in the State of Connecticut and this actually, cuts to -- cuts across to people in self-insured plans because the criteria used in the state plans is also often used in self-insured plans because we have a lot of carriers in Connecticut who administer self-insured plans and use the same criteria.

The criteria don't really match across plans. So PRI's findings, similar to what we see, are that not every plan's criteria even though it says that it's based on ASAM or the American Academy of Pediatrics, you can't match it up, it doesn't really match up with that criteria. So it's really hard to evaluate whether there's something's medically necessary if the criterias not matching up right. So it's one issue we've seen.

Another issue that I think comes up a lot, at least in our view, is in the grievance process or in the adverse -- in the determination process when you're deciding what's medically necessary or not. Connecticut is -- is really out of -- is not really consistent with our surrounding states. So right now we say, in our law, any licensed clinical practitioner can make a decision at the -- in the internal process that a carrier uses to review whether something's medically necessary.

So, in practice, that means, so let's say, you're a neurologist but an endocrinologist can make the decision about whether neurological test is ordered or you're behavioral health

provider, well, somebody else who's not a behavioral health provider can make that decision.

Most -- our surrounding states have an elevated standard of that determination. They -- they use what we call a similar provider, someone who's got similar training, similar expertise, and -- and in our view is the right way to go, you know, for a couple reasons. One, you know you're -- you're paying a premium every month, you should really get access to a service based on whether your provider's recommendations are reviewed by someone with the same level of skill.

There's other reasons for it, too. Often we find that you know some of the providers that are used internally by the carriers haven't practiced in years. So, you know, you're not -- you're not quite up to the same level of speed that someone who practices is.

So that -- that's an issue so -- and that happens at every level of the process.

There are other issues -- in terms of cost shifting. I would say the lack of coverage for some of these services in the private side does make the State responsible for a lot of the cost of care.

So, for instance, we have seen -- we are doing a project right now with DCF, with the DCF Voluntary Services Program, where children who -- either whose insurance is not covering it or don't have insurance can go to DCF and ask for some help to get those services.

We have started a project that's working really well with DCF where if someone has an insurance policy, they're now going to come back to OHA and we're going to argue with the insurance company make -- to try to make them cover it rather than the State picking up the cost. But because the insurance companies don't cover some of these services, we're all -- the State is picking up some of these really evidence-based services.

So I would say just a couple points about that are: number one, I do think, you know, we have a model on the public side called the behavioral health partnership and that is a partnership that involves, actually, DMHAS, DCF, DSFs, that is an integrated type of model that integrates mental healthcare with primary care that offers community-based programming. And in the PRI study when they did a review of that they -- they saw that there were more approvals, there were more peer-to-peer discussions, there were more engagement with the providers and the consumers. So OHA has decided that you know what? we really need an independent study of the BHP to see whether we got another model so --

Okay. So we're -- we're exploring that as a potential option but just wanted to throw out that maybe we could consider, for this group, as a core recommendation to maybe -- as Senator Crisco knows we've talked about it and Representative Megna many time -- to take those PRI recommendations that's something, I think, pretty concrete that this committee or the work group could take on and maybe adopt or recommend be adopted.

So I want to thank you.

REP. WOOD: Right. No, thank you. This has been very interesting.

I think what a couple of us have been talking about this is something that we will definitely want to explore further with you. Would you mind -- but I'm just keeping an eye on the clock --

VICKI VELTRI: Yes, that's fine.

REP. WOOD: -- and the other speakers that it has been very informative.

Would you mind just wrapping up, covering the recommendations just for the record?

VICKI VELTRI: Oh, so our recommendations?

REP. WOOD: Yes, please, thank you.

VICKI VELTRI: Okay. So our recommendations -- well, number one, we would like to see -- I think that's the concrete proposal coming out of here today is we would really like to see the PRI recommendations codified. We think that would go a long way to helping those who are insured.

We do think that mental health and substance use delivery really needs to be coordinated, as you just heard from Commissioner Rehmer. It is -- cuts across many state agencies, and we do think it needs to be coordinated.

We would like to see prevention and awareness increase. We'd like to see access to community-based services for those who are privately insured. And we would like to see the Mental

Health Parity and Addiction Equity Act enforced in the State of Connecticut.

Those are the biggies, I think, for today.

So thank you.

REP. WOOD: Again, no, thank you very much.

Any questions, and keep in mind we are trying to keep a -- keep a lid -- not a lid but --

VICKI VELTRI: I know what you meant, don't worry about it --

REP. WOOD: Just keep on track. This is --

VICKI VELTRI: I know what you meant.

REP. WOOD: Hey, you know, I say it like it is.

And this is -- too, just for the record, this is the beginning, I think, of a long-term dialogue that we will be having so there will be lots of time over the next years, months and years to -- to explore this further.

Any questions from the committee?

Representative Srinivasan.

REP. SRINIVASAN: Thank you very much, Madam Chair.

Thank you very much for the presentation.

Knowing well of this bifurcation that exists between private insurers and what we provide of the state, do you feel that -- that we should have some form of reporting by people who render

services, knowing very well, we will run the risk of people not seeking help because now it is necessary for them to be -- to be in some form of registry?

Would that help when -- because we are not certain with that -- as you said, we can never predict risk, but we know people have these, you know, forms of depression, schizophrenia and Connecticut is one of the states where it is not mandated that these people have to be -- have to go into some form of a list or the other.

In your opinion, when you weigh the pros and cons, would it help us to have a general list of these people whom we can seek out and give them extra attention so that we are trying to reduce some of the risk factors.

Thank you.

VICKI VELTRI: Well, thank you for your questions. Good to see you.

I will say, I -- I do want to be very clear. I am not a clinician so I don't -- I don't even pretend to be one on television because it's -- it does require a lot of education and expertise. So I really don't feel qualified to necessarily render that opinion, except to say, that I think there's a reactionary component to -- to discussion about involuntary outpatient commitment.

And -- and some of us are of the belief that we really need to get to the forward or the beginning side of the equation rather than necessarily reacting in a way that -- that we don't have all of the information on yet.

So, frankly, I -- I don't feel qualified as to really render an opinion on that to be quite honest, but in terms of the fragmentation, I do think it's important. And when it comes to insurance, you know, the carriers will do -- they will cover what we tell them to cover. Frankly, they -- so we need to have those discussions. We need to have them at the table. I think we all need to be around the same table because that's the only way, I think, we're going to address the long-term systemic issues that we're facing.

You're welcome.

REP. WOOD: Thank you again very, very good testimony, very important. Thank you.

The next speaker is Commissioner Katz from DCF. Is Commissioner here?

Great. Thank you. Good eyes.

COMMISSIONER JOETTE KATZ: Just checking, should I begin?

Thank you.

Good morning, Senator Harp, Representative Wood and members of the Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety.

With me here today is Bob McKeagney of DCF, and Bob is in charge of clinical and community support. He's one of our chief administrators.

The unspeakable horror that took 20 young children and six brave adults from their families has naturally spawned a search for answers. And while no satisfactory response may immerge, one important part of the discussion has focused on children's mental health needs.

The Department has Children's Mental Health Initiative as one of our mandates and, as commissioner, I welcome the attention to this complicated subject, particularly, in light of this incomprehensible tragedy.

As Governor Malloy pointed out last month, the children's mental health System needs continued improvements, and I am committed to implanting reforms. While progress has been made under the current administration -- and many of you are familiar with it -- notably the share of children receiving treatment in congregate settings has declined by 26 percent and the number of children sent out of state to receive treatment has declined by 81 percent, much improvement has remains necessary. And that's -- we at DCF, that's why we are initiating a number of further reforms.

In the next month, the Department of Children and Families expects to launch a new RFP entitled the Community Bridge. Bob McKeagney with me here today is its chief architect.

It is intended to provide intensive community-based treatment for youth who are experiencing mental health or behavioral challenges that are of sufficient severity that a residential placement would historically have been the treatment of choice. The bridge is envisioned as a flexible array of family-based, community

residential and after-care programs that are closely linked and integrated. Most services will be oriented to an in-home venue and will be routed in evidence-based practice.

Youth referred to community-based services will be 11 to 18 years of age and have complex behavioral, emotional and physical needs that would necessitate out-of-home care if a successful intervention were not implemented.

In certain circumstances, however, a youth may require more intensive individual care to address a particularly difficult pattern of behavior. In such a case, inpatient stabilization may be needed to restore the youth to behavior that is acceptable and manageable within the family setting. The therapeutic focus of such treatment will be on decreasing, unsafe and high risk behaviors and on increasing pro-social skills, emotional competency and self-control.

This short-term stabilization will provide a therapeutic 24-hour living situation with supervision, structure, and multidisciplinary, multimodal therapies. Youth, at this level of care, will have access to consultation from a psychiatrist to monitor the effectiveness of medication. Treatment is less intensive than hospitals and residential levels of care and can be a diversion from initial hospitalization for those clients needing less intensive treatment in a structured residential setting.

In the community bridge system, intermediate short-term stabilization is part of a treatment continuum not a treatment destination.

For those youth who require an even longer term of inpatient treatment, the Albert J. Solnit Children's Psychiatric Center remains available. Based on a recent data review, the Solnit Center -- Children's Center is in a process of change and reorganization to better meet the needs of Connecticut's youth and their families. Upon completion of this conversion, the Solnit Center will be a 118-bed facility treating youth ages 13 through 17.

On its north campus, located in East Windsor, current residential beds will be converted to psychiatric residential treatment facility beds, otherwise known as PRTF beds, allocated to adolescent boys ages 13 to 17, with complex behavioral health needs that include but are not limited to, aggression, self-harm, substance abuse and low risk problem sexual behavior.

There will be a total of 38 treatment beds on this campus along with two emergency beds that social workers can access through the Department's care line, particularly, over the weekend.

The conversion on the East Windsor campus will be complete by September 2013. Fifty-two inpatient psychiatric beds will remain at the Solnit Center South campus located in Middletown, Connecticut. These beds will be for both genders, ages 13 to 17. The 16 PRTF beds for adolescent girls, 13 through 17, will also remain in operation.

And finally, the facility will close two inpatient psychiatric units currently serving very young children and open them as PRTFs. One unit will be to provide care for adolescent

girls, 13 to 17, while the other will serve both genders, ages 13 to 15, with complex behavioral health needs that include but are not limited to aggression, self-harm, substance abuse and low risk problem sexual behavior.

Notably, the Department is also making strides and expanding the array of in-state resources for youth on the autism spectrum. The services will include evidence-informed community-based programming, as well as closely linked residential services and family supports. Services will be available for both male and females, nine to 18 years of age.

And additionally, next month, we hope to open six intensive treatment slots for adolescent girls with trauma histories. These girls have traditionally been served out of state.

Attached to my testimony is a brief description of existing behavioral health programs, currently offered through the Department of Children and Families. We've been working diligently with many community providers, physicians, and psychiatrist, who've identified service gaps and who have helped design -- to design creative solutions.

Children's mental health will need more improvements still, but if there's any good that could possibly come from such extreme horror as we saw in Newtown, it may be a very serious and this committee is certainly the first step in it, a very serious and complete discussion of how to improve services for troubled children, and I welcome that development.

Thank you for the opportunity to appear before you today. I would just highlight, again, turning to the last few pages that you have before you an overview of the current behavioral health services that we employ.

At -- up to date, psychiatric outpatient clinics for children, we have engaged in 22,000 episodes; EMPS, 13,000 and IICAPS, 2,000. We've also received numerous federal grants and research partnerships, specifically, a $3.2 million trauma services grant in child welfare; two NIDA-funded research projects on effectiveness of adaptations of evidence-based models, MST and MDFT; two federal SAMSA service grants, service to science awards with Yale and CHDI; and a 5 million/five year ACF-funded supportive housing grant, and we were one of five recipients in the United States.

We engage in voluntary services. We engage in-home community-based behavioral health services. And you can see the laundry list of various types of services in which we engage: Outpatient psychiatric clinics for children.

And I'm happy to say, in the year of 2012 -- and what I mean by "happy," I'm happy that we were able to accommodate 22,402 children and their caregivers. EMPS intervention service is our crisis intervention service for children and their families. More than 90 percent of the children seen are seen in their home, at school or in the community and 85 percent remain within 45 minutes of receiving the crisis call.

More than 13,814 calls to EMPS system were -- occurred in 2012 and that developed into over 10,000 episodes of care. We have intensive in-

home child and adolescent psychiatric services, IICAPS. It is a six-month home-based intervention, addressing psychiatric disorders of the child, problematic parenting, and other family challenges that affect the child and family's ability to function.

Teams of professionals average four to six hours a week of intervention with the child and caregivers to prevent hospitalization or to return the child to the community based outpatient. And we currently serve 2,000 families annually.

Care coordination uses an evidence-based child and family wraparound team process to develop a plan of care that uses both formal and informal network of care to meet the identified needs of the child and family and services under care coordination have occurred for two -- for 1,200 families annually.

Family advocacy programs. Family advocates provide support and assistance to the parent, caregiver of a child with serious mental or behavioral health needs. The advocate works with the care coordinator in the family and engages in wraparound -- as part of a wraparound team focusing on providing care to both the child and the parent caregiver. And we have served more than 400 families annually.

The extended day treatment is a multidisciplinary team of psychiatrist or PRNs, clinicians and direct care staff at 19 program sites, delivering an array of integrated behavioral health treatment through individual family group therapies, therapeutic recreation and rehabilitative support services for a

minimum of three hours per day, five days per week through a milieu-based model of care. And this program has served over 1,100 children and their caregivers in the year 2012.

The Community Bridge. Youth and family receive intensive in-home therapeutic support on a 24/7 basis from a clinical team of licensed clinicians and paraprofessional mental health support workers. The team engages with family members and provides necessary support to the youth in all aspects of community functioning up to two years. Youth without adequate family resources are served in foster homes. This community-based service is supplemented by the availability of brief residential placement for purposes of assessment and behavioral stabilization.

This prototype is run by the Village for Children and Families in Hartford and has provided clinical interventions to 20 youth and families in its first five months of operation. And this Community Bridge Program is the model for the bridges that I identified earlier in my description of the RFP.

Respite care. Respite care is a nonclinical intervention, which provides stress relief to parents of children and youth of serious mental or behavioral health needs. Community or home-based respite is provided for up to four hours a week for 12 weeks and the annual capacity there is for 250 children.

Functional family therapy. It's an empirically grounded family-based intervention to improve family communication and supportiveness while decreasing negativity delivered within the

family setting by four providers, five teams, grant funded; and 519 youth and caregivers received services in the year 2012.

MDFT, otherwise known as multidimensional family therapy, including special population. This is a family-based intensive in-home treatment for adolescence with significant behavioral health needs or alcohol or drug related problems or who at risk of substance abuse. It provides individual care and family therapy in case management and, to date, 713 families receive services in the year 2012. I'm sorry.

MST, intensive family and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders, their homes and families, schools and teachers, neighborhood and friends, and 215 families receive services in the year 2012.

I thank you for the opportunity for indulging me and providing this opportunity to identify some of these programs. And I have a few more I'd like to highlight, and the reason I think it's so important is it gives me an opportunity to talk about what the agency does and not everyone knows what the agency does.

And I think, historically, a lot of families were afraid to come to the agency even under the auspices of voluntary services because of a stigma. And if we've learned nothing, we've learned that we need to deal with that stigma and so giving me the opportunity to talk about what we do in a positive light is, I think, informative and, hopefully, will -- will encourage other families to step forward.

Multisystemic therapy for special populations. This is a -- this is a treatment for population that includes problem sexual behavior, transition-aged youth and parole youth who are re-entering the community.

We have multisystemic therapy, otherwise known as MST, building stronger families. And this is an intensive in home treatment for families with maltreatment and substance abuse issues.

Re-entry and family treatment, MDFT for parole youth with substance abuse treatment.

Recovery based management for families with substance abuse and that's intensive recovery support services for families and children at risk for removal or at the point of removal.

Family-based recovery, which is an intensive in-home family treatment combining evidence-based substance abuse treatment with a preferred practice to enhance parenting and parent-child attachment.

JOTLAB, that is the Juvenile Opting to Learn Appropriate Behaviors Laboratory. It's a rehabilitative treatment for youth with problem sexual behavior that provides comprehensive clinical evaluation, individual psychotherapy, family counseling, psycho-educational therapy groups and social skills building problems.

Integrated family violence program, which is an in-home and clinical-based services for families where domestic violence has been identified.

And adolescent substance abuse outpatient treatment. It's a substance abuse screening

evaluation that provides thereafter individual, group and family therapeutic interventions in a clinic-based setting.

And I think as you've heard, at least, the first two thirds of the programs I identified are not just about the individual children but they're about their families and trying to provide services to those families as they struggle with the problems that their children experience.

Thank you again so much for the opportunity to talk about this, but we've talked about -- talk about what we're doing at the agency, and I welcome your questions, and Bob McKeagney, is probably going to be the one answering most of them.

Thank you, Bob.

REP. WOOD: Thank you very much, Commissioner, much appreciated and -- and a great recap of what you're doing.

I just want to mention for everyone, anyone who's watching, that all this testimony is available at the CGA web site so.

Representative Hovey.

REP. HOVEY: Thank you, Madam Chairwoman.

Good morning, Commissioner.

COMMISSIONER JOETTE KATZ: Good morning.

REP. HOVEY: It's still morning.

I don't think that they're any of us, as legislators who don't realize what a significant job DCF has. I've been here for ten years, and I've seen the highs and the lows of DCF.

So for this incident to, you know, have occurred in a community that I represent and for this task force to be organized to address it, I want to get to some of the things that the community is telling me.

And I don't know if you were here previously when I asked the question but I'm trying to get to this -- to this concept -- or reality that our schools are our first line of defense around identifying children who may be atypical of the and aren't going to move through the educational process in the typical manner, be it either because of learning issues or behavioral or emotional issues.

And what I'm clearly hearing from them is that when it comes time to make a referral for more restrictive supportive services, especially around the behavioral health areas, there is little resource in the State of Connecticut, and it's very frustrating for our educators and, also, in turn, for our families.

So with regards to licensing of day treatment facilities for children, say, five through 20 because under PL 94-142, they're entitled to a free and appropriate education until 20. So I'm not sure where the 18, seems like an arbitrary age because that's no longer considered adult in, I think, in anybody's mindset anymore. And under the special education laws, it is until 20.

We, as a legislative body, have legislated that young adults can stay on their parental insurance up to the age of 26 because of all the issues with, you know, brain development and all of that. So 18 seems way too young to be having as the cutoff for the services.

But with regards to that, under the day treatment, you are -- DCF is in charge of licensing those facilities?

COMMISSIONER JOETTE KATZ: Yes.

REP. HOVEY: And how many -- I think they're called, RFPs are in -- in the pipeline now to address the issues of the State of Connecticut for a day treatment for these children who have behavioral and mental health issues that our schools are just crying for help with?

COMMISSIONER JOETTE KATZ: Besides the RFP --

REP. HOVEY: Right.

COMMISSIONER JOETTE KATZ: About the bridge that I just identified for you?

REP. HOVEY: Right.

COMMISSIONER JOETTE KATZ: There are currently -- do you want to --

BOB MCKEAGNEY: The only current RFP for extended day treatment services is actually a re-procurement of services in the New Haven/Milford area. A provider who had been providing that service decided that it wanted to move on to other services so we're finding a substitute provider.

Other than that, we're not in the process of expanding those services.

REP. HOVEY: So since the Sandy Hook crisis, have DCF been contacted with different groups that are interested in starting new day treatment facilities? Have you've been contacted? Do you have any ideas about that?

BOB MCKEAGNEY: I am not aware of any specific requests from any of our providers to expand extended day treatment services.

I will say that most services, extended day treatment being one of them, clearly is not offered at the -- the size, scope, so that it's available equally to everybody everywhere. You know, that's -- that's characteristic of -- of most of the system.

REP. HOVEY: But it is a truism that there can be mental health issues in all stratas of our society here within the State of Connecticut so it's not a regional issue. It's a statewide issue; am I correct?

BOB MCKEAGNEY: That's absolutely correct.

REP. HOVEY: Thank you.

You know, I'm hear -- you hear a little of the tone in my voice, but I just look at the numbers and I'm -- I understand that you're working hard at it, but when I hear numbers of 215 youth being served, 713 youth being served in a state that's 3 point -- 3.4 million people, I'm underwhelmed. I'm completely underwhelmed by that and as a community that has been harmed, significantly, by a youth that probably needed

to have some alternatives, his family definitely needed some alternatives, I think we need to step it up.

COMMISSIONER JOETTE KATZ: I don't think we would disagree with you.

Currently, the extended day treatment is at -- we have 19 program sites currently, and in the year 2012, we served 1,134 children, not enough, no question, not enough.

The provider that Bob referenced who did provide this particular treatment in the Milford/New Haven areas is a wonderful provider was the Boys and Girls Village, but they, at my behest, asked to form -- to provide services for the most troubling problem sexual behavior children. And so they've converted their -- that space to be able take those children and so we longer had to send them out of state.

I personally review all applicants for the RFPs and the -- there were two applications that were presented to me last week. And it's always a challenge because this is what we call Region 2. So we have New Haven and then we have Milford. One provider that is in New Haven, one provider is situated closer to the valley. And then you get into all of these transportation issues, as well and that -- and that always remains a debate because you look at certain communities and they're rich with services, others are not and sometimes -- not sometimes, geography always has to play a role because if we make it too difficult, people won't go.

REP. WOOD: Representative Abercrombie.

REP. ABERCROMBIE: Thank you, Madam Chair.

Good morning, Commissioner.

COMMISSIONER JOETTE KATZ: Good morning.

REP. ABERCROMBIE: Thank you for being here.

COMMISSIONER JOETTE KATZ: Thank you.

REP. ABERCROMBIE: You know, as we've been talking about this issue and I've been talking to advocates and families around the state, you know, the one area that I would love to give some thought to -- and I'm going to apologize ahead of time to the commissioner of DHMAS about this because she'll give me the look after I say it -- but has the time come for us to go back to the old system of doing all the mental health under DHMAS, whether it's children or adult.

You know, we talk about systems of care. We talk about a child as a whole. You know, if you get them at the early ages, you continue. You don't have to go through the transition, which we know is a challenge between DCF and DHMAS.

You're probably not prepared at this point to comment on it or maybe you are, but, you know, I think it's something that we need to look at, as a state, and if you want to follow up with maybe some comments on it, I would really appreciate it but, you know, from what I hear, it was a good system back in the seventies. Why we changed it, I'm not really familiar with but, you know, I think it's an area we need to look at.

So I'd appreciate it if you have any thoughts on it or if you'd like to follow up with sending something out, that would be great.

And again, I apologize to the Commissioner in the back but, you know, we know that DMHAS does a great job. We hear it all the time and that's their specialty so I think it's something we need to think about.

BOB MCKEAGNEY: The Commissioner neither has asked me or allowed me to comment on this. I'm not sure which but --

COMMISSIONER JOETTE KATZ: Depends what you say.

BOB MCKEAGNEY: Well, I will watch myself so.

I've had the opportunity over the last -- quite a few decades to work with state systems in literally every single of the 50 United States, as well a number Canadian provinces, and I'm broadly familiar with how systems have been organized throughout North America.

The classic issue that we face with combined children and adult mental health systems has been that it's been very difficult to develop specialized services for children and children in families. The trend to pull children services out of comprehensive mental health systems has been driven exactly by that issue, by the intention to develop more targeted specialized services.

Clearly, there's a downside to it. One of our chronic challenges in managing this state's system is to help kids who are outgrowing the children system move comfortably and effectively

into the adult system. And it's a daily challenge to deal with questions of parental mental health when we're dealing with -- questions of the well-being of younger children. So there's some significant coordination challenges. This is a question that's well worth looking at in-depth.

My own opinion after rustling with this for many, many years, is that there's no best answer to this. The challenge really lies in state departments, divisions, bureaus, however it's structured, developing close working relationships and truly working as teams and how you slice that up and how you define it, resolves some problems, it creates different ones.

COMMISSIONER JOETTE KATZ: The only thing I would want to add is, I think -- and again, if -- if one -- one of the very, very little good, obviously, that other than this kind of a -- an opportunity to explore and hopefully make improvements in mental health, but one of the other good things that came out of Newtown was a real partnership among the state agencies. I mean we always liked one and other. We always collaborated, but I can tell you that this has brought us so -- so much closer together. And the focus on this issue and our children really out growing our services, going into DMHAS, going into DDS has -- has risen to the top.

REP. ABERCROMBIE: Thank you.

Thank you, Madam Chair.

REP. WOOD: Thank you.

Thank you, Commissioner.

And thank you, Mr. McKeagney very much.

COMMISSIONER JOETTE KATZ: Thank you very much.

REP. WOOD: Next speaker is Jesse White-Frese, the executive director of the Connecticut Association of School-Based Health Centers.

JESSE WHITE-FRESE: Good morning Senator Harp, Representative Wood and members of the mental health services subcommittee.

Thank you very much for the invitation to speak to you today about school-based health centers. My name is Jesse White-Frese, executive director of the Connecticut Association of School-Based Health Centers. And I have with me, Joann Eaccarino, who is the director of the School-Based Health Centers for Child and Family Agency of Southeastern Connecticut and is also the president of our board of directors.

School-based health centers are a model that works. The provision of primary care, medical, behavioral health and dental services in a school meets youth in their own environment and brings critical health issues within their -- health services, rather, within their reach.

For many children and adolescence, the ability to receive healthcare when they need it and where they need it is essential.

The Connecticut Association of School-Based Health Centers strongly supports the comprehensive model of school-based healthcare. This model posits that the co-location of

medical care and behavioral healthcare provides a unique opportunity to address and manage the needs of children and adolescents. For so many families, the school-based health center is a safety net that allows parents to stay at work with the assurance that their son or daughter will receive the healthcare they need in a safe and supportive environment.

Parents provide written permission for their children to use the services; they're enrolled in, other words.

School-based health centers provide students with immediate access to care for many serious health issue that impacts school performance and academic success.

As we turn our attention to the mental health needs of young people, it is important to note that an established infrastructure is already in place in 20 Connecticut communities that have Department of Public Health funded school-based health centers. The major source of operational funding is from the state allocation, along with insurance reimbursements and other small grants that allow these 80 centers to provide comprehensive healthcare to the school population.

Each year, more than 35,000 students receive care in their school-based health center in 131,000-plus visits. Of those total visits, 41,000 visits are from mental health concerns that impact the child's ability to focus on learning.

Many mental health issues are discovered during a student's medical visit to the school-based

health center, hence, the comprehensive model. Through the use of standardized screening tools, medical providers are often the ones who case find those students with severe behavioral health issues. As an example, in one community, which is Norwich in this case, 22 percent of those middle school students that were screened by the nurse practitioner had positive scores on that screening test, which were then followed up and managed by the school-based mental health clinician or referred to a child psychiatrist or, in some cases, emergency mobile psychiatric services for additional evaluation.

In addition to screenings initiated by medical providers in the centers, students are referred to the school-based healthcare for mental health treatment by school personnel, parents, or by self-referral. Treatment is provided by licensed mental health clinicians -- and I just want to emphasize there. The clinicians in the school-based health centers are the kind of therapists that you would receive treatment from in a community setting. They are placed in a school. So I want to emphasize their level of training and expertise.

The wide range of issues that we see in school-based health centers include peer conflict, suicidal ideation and attempts, self-injury, victimization, trauma, substance abuse, anxiety disorders, domestic violence, bipolar disorder, learning disorders, major depression, eating disorders, attention deficit disorders and more.

Many principals in the schools that have school-based health centers report that students' mental health issues are increasing in intensity

and are emerging at much younger ages, elementary school, in particular.

School-based health center providers offer more than individual clinical services. They provide group counseling to students with similar issues, such as, grief and loss or anger management. They offer classroom presentations on critical issues that are often suggested and requested by school staff.

They provide consultation to teachers regarding their concerns about specific students that are enrolled in the school-based health center. And the mental health clinicians in the school-based health centers participate in school crisis teams.

Families are in engaged in the therapy, when appropriate and whenever possible to address issues that impact the health of the student.

School-based health centers reduce the barriers experienced in traditional mental health settings, including stigma, difficulty accessing care, transportation difficulties, and potentially long wait times for appointments.

And in addition by keeping students in school, opportunities are -- for learning are maximized because time away from school is reduced. The treatment is provided within the school setting, within the school day.

Students that receive mental health services in their school-based health center report that they do not feel stigmatized because they see the clinicians in their school every day. They've often said I see them in the hall; I see

them in the cafeteria; they're all -- they're there. And they're able to build those ongoing relationships with the clinicians.

In a recent study conducted by our association, which you have in your packet, adolescent African American and Latino males that receive mental health services in their school-based health center reported that the centers provided an atmosphere of safety, confidentiality and trust. Characteristics that were of paramount importance to them. They described the importance of having someone in the school-based health center that they could talk to who is open and nonjudgmental. Students repeatedly emphasized that the staff were consistently available when they needed support.

We cannot underestimate the importance of this connection between students in need of mental health support and their school-based health center clinician. These clinicians intervene in many serious crises in their schools and have helped avert what may have been devastating outcomes.

For many young people, the school-based health center may be their only access to mental health care. Many more schools and communities could benefit from these services that engage schools, family, and the community in the care of children and adolescence.

While we are fortunate to have school-based health centers in 80 Connecticut schools, the terrible events in Newtown have been a reminder that the problems of troubled youth are not confined to our major cities. The earlier we can identify and serve youth with mental health

needs the greater our opportunity to avoid the often devastating consequences of delayed treatment.

I thank you, and I'm happy to answer any questions you may have.

REP. WOOD: Thank you very much.

I will say I'm an unabashed fan of the school-based health centers. We've got some in Norwalk, and I've visited them and tremendous, and I think you articulate it very well.

Thank you.

I think we do have a question from Representative Ritter.

REP. RITTER: Thank you very much, Representative Wood.

I will share that sentiment. I've had the opportunity work with you ladies quite a bit.

But I have a question, not only for you, from your perspective with the school-based health centers but, perhaps, for the prior two commissioners as we seek to gain more information. And often we try to -- we evaluate the effectiveness of programs and the capacity that we have, but the question that is still, sort of, at least out there in my mind is what aren't we doing?

And I hope that I would hear from the school-based health centers, as well as Commissioner Katz and Commissioner Rehmer, as to how you feel

and my best want to help me explore that question?

You've all given us a very good summary of all of your programs and the wonderful work that you're able to do, but it really leaves me with big questions about what portion of the population is not served, what that need is and how we might measure that against what we're doing?

And I'll be honest, I mean, I don't think of us -- my expectation is I'm not going to be happy with that answer. And I think a lot of us perhaps aren't, but if we're seriously taking on a discussion of what we're doing now and how where we think we want to go, it seems to me only responsible that we have a discussion, also, along the lines of what we think we're going to have to do to do the job. And so I'll leave that out there, but I really hope that that information gets back to -- to this group sadly, fairly soon.

Thank you.

REP. WOOD: So did you -- did you have a question?

A VOICE: Oh, all right, I guess it was --

A VOICE: Okay.

REP. WOOD: I was curious, too, but also aware of the time here.

So how many -- what percentage of the schools are you in? I mean 80 out of 169 towns but --

JESSE WHITE-FRESE: We're in 20 communities right -- in 80 schools.

REP. RITTER: Okay. I'll be a little bit more specific. I'm sorry. You're going to hate me.

I want to know. Can you see all the kids in your schools that need you or do kids have to wait?

We talked a lot about inpatient psychiatric beds that we have around the state. We heard from Commissioner Katz how many for children, we know what we have for adults, but we don't know how long it takes to get into one of those beds? How many people really need those services that aren't getting them now?

If there's, say, a lengthy list, I can presume that we're at a 100 percent capacity. I get that, but I want to know what we need and -- and I just -- I think that would very helpful to us in these discussions.

JESSE WHITE-FRESE: Well --

REP. RITTER: Does that help you a little bit?

JESSE WHITE-FRESE: Certainly.

REP. RITTER: Thanks.

JESSE WHITE-FRESE: So to -- to answer your question, could -- could we see every single person in the school, I mean, knowing that there might be -- I mean, schools range in -- tremendously in size from, you know, 300 students to 3200 in some high schools. Do every one of those children need mental health services? Certain --

probably not, but there may be a large percentage that needed at some point.

And I recall there was a -- there was a report done in the late nineties called "the Voice of Connecticut Youth Survey." And in this case, in particular, the survey was looking at -- asked principals in schools in this case that had school-based health centers, how many of the students in your school do you think could need mental health treatment at some point? And they said 75 percent. So -- so whatever that number is depending on the size of the school, you know, you have an issue of capacity.

In a school-based health center, typically, you have one mental health clinician, you know, who might be working there full time but their capacity is -- is somewhat limited, of course.

The way that -- having been a former director of school-based health centers to say the way that I saw it work and I think the way it works in lots of locations, is that you have some students that need a short amount of treatment to become stabilized; you have some students that may be stabilized but need to come back as various events are occurring in their life; and you have some other students that really need consistent support most of the time -- in consistent treatment most of the time.

And so the way you can make that work to expand your capacity, even though you still only have one mental health clinician, is to be able to see some of those students for a limited period of time that can function with sort of just touching base and getting stabilized and then

going on and that allows you to, sort of, fill more people into that slot.

But I think the reality that we've seen over the last ten years, in particular, in school-based health centers as I intimated in my testimony, is that there are a greater number of children that need mental health services. The intensity -- the issues that they are bringing to bear are greater and, as I've heard myself from principals, we're talking about children in kindergarten that are really presenting with some very intense symptoms.

So could we -- could we -- could it -- would -- would school-based health centers benefit from additional mental health clinicians -- spaced limited but yes, yes, I think the answer is yes in many situations we could use more mental health clinicians and that would allow us to also be able -- as we are screening more children, either through the medical provider or the behavioral provider, there would be greater capacity to be able to meet those needs, and I think Joanne wants to talk --

JOANN EACCARINO: I just had a couple other comments. One of the --

REP. WOOD: Can you mention your name for the record.

Thank you.

JOANN EACCARINO: Joann Eaccarino.

One of the other abilities of a school-based health center is to see groups of students together so that's rather difficult to do in a community setting, but in a school where you

have children with similar issues, you can sometimes bring them together and that actually is a -- a proven good model of therapy, as well.

We, also, I believe pride ourselves on the relationships that we've established with other providers in the community. So it's not just one person, but we do have the relationships with other programs, many of the programs that Commissioner Katz mentioned where there's wraparound services. Sometimes families will be in several of these programs.

And then finally about, you know, how far can we go? One of the things that -- that maybe it's time to look at is for those communities that would never qualify for a school-based health center by reason of need. We've just been proven wrong about who needs what, and I think Representative Hovey, you've talked about that, so is there an opportunity, perhaps for cost-sharing arrangement with some state funding and some funding from a community that would not otherwise qualify to be able to place school-based health centers in their schools, as well.

REP. RITTER: Thank you.

REP. WOOD: Thank you, Representative.

Senator Harp.

SENATOR HARP: Thank you.

I guess I wanted to follow as well, on the whole issue of billing. I know that we've worked for years to assure that you can bill Medicaid, but is it any easier to bill for your services through commercial insurance?

JESSE WHITE-FRESE: And I'm sorry. You said was it any easier to bill through commercial insurance?

Well, I think that there -- we experience some of the same issues that Vicki Veltri talked about, in terms of the private insurance, and there are different kinds of limitations. There are also -- there can also be issues around confidentiality that are somewhat different than children who are a part of our HUSKY system, and I -- I think that there are limitations and caps on the amount of service that can also be provided that could sometimes be prohibitive.

Did you want to add some more to that, Joann?

JOANN EACCARINO: I was just going to say thanks to the Senate Bill 400 from a couple of years ago, which became a public act. Commercial insurance companies were urged to contract with school-based health centers, and I think most of us have established those contracts that can't speak for everyone, but I know in my -- in my particular ones, we have them with all the commercial insurers so --

SENATOR HARP: Okay. Well, that's really good to hear because it sounds like it's different for the adult system.

So thank you.

REP. WOOD: Representative Johnson, and then I think we will go to written questions of the Clerk.

Thank you.

REP. JOHNSON: Thank you, Madam Chair.

And thank you for your testimony today.

Just quickly I was wondering, in terms of the schools that you're in, you probably have school resource officers in some of them. And I wondered how in circumstances where there maybe students who have behavioral issues that may utilize, also, the services of the resource officer, how you coordinate with them?

JESSE WHITE-FRESE: Thank you. That's a very good question and that -- that I probably did not address thoroughly is that one of the hallmarks, I think, of the school-based health center is that is -- is developing relationships with all of the other services that are already in the school. And so that being the school social workers, the guidance counselors, the school nurses, if there's a family resource center, other kinds of community programs that might be in the school, as well school resource officers.

So that the school-based health center staff very often participate in a -- if there's a crisis management team in the school, they will be a member of that team. They will respond in the event of -- of a mental health or other kinds of emergencies, as well, but participating is part of those teams and working with those other school personnel so that everyone is sort of the eyes and ears, particularly, to be able to identify children that are not getting service that might need them.

One of -- one of the things that I've been thinking about as I've been listening to the testimony this morning is that sometimes there are children that appear to be doing fine, their

grades are fine, they're quiet, they're not getting referred to the principal's office for, you know, for fighting or any other kinds of issues, so but -- but their flying under the radar because they are actually harboring, you know, issues that need to be dealt with.

One of the benefits, for instance, of the program that Joann mentioned where the mental health -- the medical clinician in the school-based health center is screening all the children, is that this is a way to be able to identify children that maybe seem fine superficially to all that would look but that there's really some issues going on.

And I thought it was very interesting that depression was actually a characteristic that was seen because this is one of the issues we pick up frequently when screenings are done in children that appear to be fine. So there is -- there is a teamwork approach and not only within the school but also with community services that are available, as well.

REP. JOHNSON: Thank you so much.

Thank you, Madam Chair.

REP. WOOD: Great. And thank you to you both for your work and for coming here today. Thanks much.

JESSE WHITE-FRESE: Thank you very much.

JOANN EACCARINO: Thank you.

REP. WOOD: Next we are going to go to the mental services, the private delivery system. And the

first speaker is Daniela Giordano, who is the public policy director for National Alliance on Mental Health in Connecticut, otherwise known as NAMI.

DANIELA GIORDANO: Good afternoon, Senator Harp, Representative Wood and members of the Task Force Mental Health Services Working Group.

My name is Daniela Giordano, and I am the public policy director for adults, state and national matters for the National Alliance on Mental Health -- Mental Illness here in Connecticut.

NAMI-CT is a state affiliate of NAMI, which is the nation's largest grassroots mental health organization dedicated to building better lives for all those affected by mental illness. NAMI-CT offers support groups across the state, educational programs, and advocacy for improved services, more humane treatment and an end to stigma and economic and social discrimination. We represent individuals who live with mental illness and parents and family members of individuals who live with mental illness.

NAMI-CT joins the state, the nation, and the world in extending our deepest sympathy and condolences to all those affected by the tragedy that took place at Sandy Hook Elementary School. We may never know what went so terribly wrong that lead to the school shooting. However, we do know that if any good is to come from this tragedy, it is in recognizing that we can and must do better in creating a community environment of well-being and which mental health is viewed as an integral part of overall health for everyone.

In order to be well, each of us requires access to supports, models and services that enhance our well-being.

Mental health is essential and the fact is, as we've heard earlier too, that mental health illness affects everyone. Nearly 60 million Americans experience mental health condition every year. Regardless of race, age, religion or economics status, mental illness impacts the lives of at least one in four adults and one in ten children across our nation. The good news is that mental illnesses are treatable and that recovery is a model that works. The recovery journey is unique for each individual. One of the most important principles is this: Recovery is a process not an event.

The uniqueness and individual nature of recovery must be honored. While serious mental illness impacts individuals in many ways, the concept that all individuals can move toward wellness is paramount.

Connecticut is a role model in the nation for its recovery-oriented system of care. In 2009, the National Alliance on Mental Illness published a "Grading the States," a report on America's health care systems for adults with serious mental illness, which measures each state's progress in providing evidence-based, cost-effective in oriented-services for adults living with serious mental illnesses. Connecticut received a grade B, out of only six B's in the nation and no A's.

Even more noteworthy is Connecticut's grade A, the only one in the nation in the subcategory of consumer and family empowerment. We can be

proud of this, but it doesn't mean that we can't do better because we can and we must.

And I have several recommendations that we feel very strongly about. The first one is that we must improve early identification intervention and ensure that essential behavioral and mental health services and treatments are available at the earliest of stages.

It is widely recognized that 20 percent of all children have a diagnosable mental health condition --

REP. WOOD: Ms. Giordano -- I'm sorry.

This is wonderful what you've written. It's very long --

DANIELA GIORDANO: Yes. It's very comprehensive and long.

REP. WOOD: It is comprehensive, and we much appreciate that, but we do have a time element and a number of other speakers. And I'm sorry that the time piece maybe wasn't clear.

Would you mind just summarizing the bullet points and, again, this is available online for anyone who wants to read this in its entirety. And we certainly -- this is the beginning of the discussion. So if you wouldn't mind just the section one, two, three that you bolded, read that and summarize as best you can.

DANIELA GIORDANO: Okay. I --

REP. WOOD: Thank you.

DANIELA GIORDANO: I can do that.

So we have heard that really early screening, both by pediatricians in the school mental health based centers, as well as by physicians, is something that we need to pay more attention to.

We, for example know that the impact of school based-health centers, like Jesse was saying, is really something that we need to expand, both in numbers, as well as in -- in the communities that they're serving.

And training is really crucial and that, I think, hasn't come up as much. I want to really spend a little bit of time on that, that we must do a better job of training school personnel, law enforcement and everybody who really come in contact with people. NAMI, for example, offers this training specifically for school personnel called parents and teachers as allies, which bring people together and really has people have conversations about mental illness in a very targeted way.

The -- another training that's available for law enforcement personnel is called crisis intervention team training, which is being done in Connecticut through the Connecticut Alliance to Benefit Law Enforcement and NAMI-CT and that is something we need to expand in more communities because it's been very successful.

Another offer that we have is to really do mental health training with probate court judges, as well.

The one thing that is -- also, doesn't cost a lot on money is accessing servicing that is already available, including the help line 2-1-1, which in the back of my packet, I've delineated some services that they do, that you can access or get referrals to through the website or dialing 911 -- 2-1-1, as well as emergency mobile psychiatric services which is available for both adults and young people and children. It also needs to be expanded in terms of where it's available in the communities because it's not available everywhere.

Young adult services is something that the Commissioner talked about that we have a good service system, but we do need to listen our young people of the gaps in services that they may experience as well as also making this available not just for people who are in DMHAS through DCF services and having transitioned but looking at all the children that may fall through the cracks between the transition or that maybe it won't get picked up in the first place.

Insurance coverage. I think Vicki Veltri, obviously, did beautiful job with that. We second all of what she had said. This is really something that we have found in our clients in the people that we serve. They really come across that a lot of times, getting denials from private insurance services.

We do also want to point out there are some service gaps in state-funded programs, including -- not really getting coverage for proven models as in like applied behavioral -- applied behavioral analysis for children with autism, as an example.

Supportive housing, something that hasn't come up yet. It's a program and it's a model that really works. It needs to be in combination with everything else that we've talked about because somebody needs a place to live and consider it a home before they can actually really engage fully in the recover process.

Peer supports and service and engagement is something that also works extremely well to have a person who's gone through something similar -- really have conversation, a relationship, with somebody and can really guide them through the process is something that is also extremely important. It's being done but, again, we could do more of it.

And number 7 -- I'm actually going to read: As a state, we must not take reactive or aggressive measures which would further stigmatize and discriminate against people with mental illness and reinforce people not taking treatment. We oppose reactive aggressive measures such as, involuntary outpatient commitment for numerous reasons, including that it conflicts with Connecticut's recovery-oriented system of care. It's expensive and diverts funds from needed and effective services, and it singles out people with mental illness.

What we should do instead, what I just had said before, and a lot of people have said, is replicate and expand the services in models that we know work and work well so that they're more available and widely available to everybody who needs them when they need them, regardless of the -- in the private or public system, whether people live in a small town in Connecticut or in

a city or whatever part of Connecticut because rural areas sometimes have also troubles getting the services and regardless of what age one person is.

This will create an environment that really is a caring environment where all of us, children, adolescence, young people and adults live the fullest life that they can possibly live with the services available.

REP. WOOD: Thank you very much, very -- again, available on the web site for all the details.

I just got a notice that Dr. Kenneth Spiegelman. He needs to get back to work. So we are going to go slightly out of order and ask him to speak along with Dr. Loftus.

We're there any questions, quick questions, from the panel for Ms. Giordano?

DANIELA GIORDANO: We're more than happy to provide any other responses.

SENATOR HARP: I just want to thank you for coming today and thank you for thinking about things that would this system better, and I think that we will keep all of these things in mind, and I want you to feel like we really appreciate -- your contributions --

DANIELA GIORDANO: I really -- thank you, Senator, Representative.

And we really are available at any time to provide more information on this and really also put you in touch with people who are directly impacted by this who can give that experience.

REP. WOOD: And I would echo the sentiments from Senator Harp, thank you.

DANIELA GIORDANO: And you will hear people talking about any of these points today, too.

Thank you.

REP. WOOD: Dr. Spiegelman and Dr. Loftus, they're representing the Connecticut Chapter of the American Academy of Pediatrics.

And Dr. Loftus is the Council of Child and Adolescent Psychiatry.

Thank you both for being here.

DR. KENNETH SPIEGELMAN: And I appreciate you changing the schedule around. This is indeed influenza season so I have an office filled with patients at around 1:15 so I really do appreciate it.

Well, good morning, Senator Harp, Representative Wood and members of the Mental Health Services Working Group.

My name is Dr. Ken Spiegelman. I'm a practicing pediatrician in Manchester, and I represent the Connecticut Chapter of the American Academy of Pediatrics. My colleague, right here is Dr. Mirela Loftus, who is a child and adolescence psychiatrist and who practices at the Institute of Living here in Hartford. She is representing the members of the Connecticut Council of Child and Adolescent Psychiatry.

Undetected and untreated mental disorders cause children unbearable suffering. I see it on a daily basis in my office, poor academic performance, occupational underachievement, school failure that can all lead to social deviance. They impose huge intangible and tangible costs on our society that are reflective in the enormous demands on your state budget -- in our state budget.

Untreated and inadequately treated mental health illness in children can impose very large burdens on state-supported schools, police departments, courts, prisons, foster care, and halfway houses. Parents and other family members are themselves driven to seek state services because their own physical and mental health, social adjustment and financial stability are undermined by trying unsuccessfully to care for a sick child when they don't have time to or when they are not receiving the professional treatment that they so dearly need.

Families come apart; small businesses fail; wage earners become unproductive or unemployed, all costing the state money in reducing the overall economic activity in tax income.

As mentally ill children grow into handicap adults, the state pays, again, directly and indirectly for deferred mental health and drug addiction costs. We all know that we all need to do something and that it's not about any one provider, like myself, not willing to do the work. It is not -- but it is about having enough providers in the right places and allowing them to work in a collaborative

fashion. Something that we will talk about more.

This means support for providers, in terms of team members, payment; and insurers paying for the treatment that they are obligated to pay for.

You know, it is not -- I don't go through a week in my office where I'm seeing ten kids with influenza, but I also get a call from a family member or have a visit from a family with a child who is crisis. This happened to me last week, when a mother called whose -- I think, 13-year-old adolescent girl was -- she noted her to engage in cutting behavior, she was depressed. We brought her into the office. I myself have gained additional training and screening for mental health. I screened her, deemed it was appropriate to have her see psychotherapist. I gave the family a list of around five to ten psychotherapists. The mother called me back about a week later that she could get into any one of them. This is a commercial patient. They either did not take her insurance. A lot of therapists out there are ear marking only one or two insurance companies and most of them -- or many of them are not taking any insurance at all.

So let's go on from that point. Let's say that individual did get in, she was in psychotherapy and the psychotherapists deemed it necessary for that child to receive medication, the parent would then call me up to ask me if I knew the name of any child psychiatrist that she could see. What we run into every single day of the week is that there are not enough child psychiatrists to treat the children that we

refer to and the burden falls on many of us as primary care providers.

Multiply this by the number of children in our state and you have a situation that exists presently at the Children's Hospital of Connecticut emergency room where we have 25 medical beds where I'd like to see my children with asthma, severe illness sent. But, on any given day, you may have ten to 15 to even two-thirds of those beds with children who are in acute psychiatric crisis awaiting assessment and awaiting placement. This puts a huge burden on our entire healthcare system on a daily basis.

One important way that can help ameliorate this huge crisis is through collaborative relationships between primary care practitioners and mental health specialists. The various types of collaborative relationships have been developed in 25 states, at the present time. There's an association that represents them. It does not exist here but one of the best systems that exists in this way is around 40 minutes north of here in Massachusetts, and we plan on bringing down those individuals to help us and speak to us in the future.

I'm going to turn it over to Dr. Loftus right now.

Thank you.

DR. MIRELA LOFTUS: Hi, good morning. Thank you so much for allowing us to voice our concerns.

I'm going to pick up with another story from where Dr. Spiegelman's patient is left off in

the emergency room and waiting to be either evaluated or sent to a psychiatric facility.

I work at one of these facilities at the Institute of Living, right up the road, where I'm going to briefly tell you how my morning looked like.

I work on a 14-bed facility for adolescents, age 13 to 18, that are in the hospital, in-patient. Out of these 14 kids, eight could have been discharged today if there were places to -- to send them for treatment.

So let me give you an example. I saw a 13-year-old girl for 13 days in the hospital. She has been her sixth hospitalization, whose grandmother had to give temporary custody to DCF because she was no longer able to keep her safe at home. She will be with us for awhile till we find placement for her.

I have a 14-year-old girl, days of hospitalization, 18; whose parents don't feel safe to take her home because she's cutting and purging. Her commercial insurance stopped paying for this hospitalization so the parents will either get a bill or the hospital will have to absorb the cost.

I have a 14-year-old boy; days of hospitalization, 7. It's his fourth hospitalization, who's waiting to be discharged to the court system. So his parents because, again, they couldn't keep him safe. He was aggressive. They were forced to press charges and are hoping that the legal system will give him the -- the mandatory and -- and treatment that he needs.

I have a 16-year-old boy, day of hospitalization, number 27. His third hospitalization, who's waiting for a bed at a specialized residential facility out of state. His parents are willing to pay out of pocket, but they're not able to keep him safe until a bed is available. It will last another month or two.

And the last, a 17-year-old, day of hospitalization, 104; she has been with us since October. It's her 11th hospitalization. She needs rehab following severe injuries sustained in a suicide attempt. There is no facility available that can treat complex medical and psychiatric patients.

So this is how my day looks like.

Now, we do have some solutions. We do have -- submitted a blueprint that we're working in collaboration with our pediatrician colleagues, and I'm just going to highlight the five points that we're -- we're focusing on this blueprint.

The first barrier is the poorly coordinated, and it's a fragmented care system which, by creating a regionalized, integrated system of care in which all the services, outpatient, in-patient, partial hospital, in-home services, school-based program could be under one care. And people would have access and know not duplicated care.

The second one, the prevention and early identification. This we would hope to be able to access the schools -- just as our previous colleague was talking about -- resources to day care and school settings.

The third impediment is having access to high quality mental health treatment that can be accessed by teachers, pediatricians, nurses and social workers. This is a model that my colleague, Dr. Spiegelman, mentioned.

The fourth barrier is to provide adequate number of high quality inpatient long-term beds. Our facilities intended to be only for seven to ten days. We don't have access to long-term inpatient facility. Our -- our recommendation is that we need to preserve this type of setting at Solnit Hospital at Riverview State Hospital.

The fifth barrier is failure to manage the behavioral care programs to provide sufficient resources to children with commercial healthcare coverage. And I think the Office of Healthcare Advocate addressed the commercial insurance, previously, but we believe that with a strong legislative and administrative initiative and not necessarily an increase in state funding, we can rapidly build a much more effective and efficient mental health system.

Our organization and over 1200 members are all ready and willing to help provide the best healthcare for the children.

DR. KENNETH SPIEGELMAN: Thank you.

DR. MIRELA LOFTUS: Thank you.

REP. WOOD: Thank you both very much. Appreciate the dimensions and the points you made.

Senator Slossberg.

SENATOR SLOSSBERG: Yes, thank you.

And thank you, Dr. Spiegelman and Dr. Loftus, for your work and for your testimony this morning.

You know, I've been listening to this for awhile and, you know, since -- since we began, and it seems to me that, you know, one of the areas and we're really struggling and I think you -- you talked about a little bit, but I think it even goes a little deeper than that is that we have a crisis among a population -- and I'm pretty sure that Senator Harp spoke about it earlier -- that 16- to 25- or 26-year-old population, that cannot, you know, is not getting services and cannot access services but, Dr. Spiegelman, you talked a little bit about it and I think you're the first person I've heard say it today. And that is, you know, even the -- even the kid who gets in there and gets referred to services, there aren't providers to provide those services.

We don't have -- we have a lack of child and adolescent providers in our state. And even if you can get a list of names, you can't find those people. They're not taking new patients.

And in addition to that, then when you talked about, okay, so you find a psychologist or a social worker or somebody to treat that child, then if they have to go on meds, then you have to go to a psychiatrist and there's a problem finding them. We've also -- but that's also a dual system and if you are private pay, people tell me that you have to pay out of cost -- out of your pocket upfront and then go for reimbursement, but you are now also sending that

child to, possibly, two days a week, maybe three days a week with a psychologist. And then they have to go see a psychiatrist for med management, and it is this incredibly layered system that costs an incredible amount of money, but there's nobody to provide it.

DR. KENNETH SPIEGELMAN: Absolutely.

SENATOR SLOSSBERG: In addition to the fact that there's no group therapy, there's no -- we know that we had discussions about Medicaid not covering ABA.

So my question to you is, we've got a crisis with this age group, but we also have a crisis, in terms of no providers. I understand what you're talking about in terms of collaboration and trying to eliminate the fragmentation and I agree with you because it's -- there's no one place to go to get these answers, but how do you deal with the provider crisis?

How do we, as a state, say we have to deal with the fact that there aren't people to provide these services?

DR. KENNETH SPIEGELMAN: One thing, first in terms of the child psychiatry crisis, that's not going to be settled anytime quickly, but what we have to learn through other states' collaborative programs is that we can retool our primary care practitioners and allow them to develop the skill sets, the comfort level, and the most important aspect, which is the collaborative relationships, such that, if I start medicating a child and if I feel like I'm running into a question or a challenge, I have someone I can call up immediately and say what am I supposed

to do? We tried this child on Zoloft, it's not working, do you need to see them or do I need to change?

The unfortunate aspect is that most primary care practitioners, like myself, never had formal training in behavioral psychiatric health unless you wanted to actually gain that, as I did myself, or engage in special educational programs.

So I think one, it begins really at the educational level, developing training programs that incorporate and embed behavioral and psychiatric skill sets into the skill sets of primary care doctors who are going out there. And once they're out there, allow these collaborative relationships to really flourish.

We are the frontline of defense for all of our behavioral problems. They come to us first. They know us best. We know their families and most -- a lot of pediatricians finds this too much of a challenge. It's very time consuming. Often the compensation doesn't suffice, and it's understandable and often there's a great deal of discomfort with using medications that they were never trained to do.

Every week, I have a patient of mine who does get in to see a psychiatrist. They're self-pay. They charge them 2 to 300 dollars per session. They can longer afford to see them, and they come back to me and they say, Ken, would you mind prescribing these medications.

It so happens that I've gotten some of my own special training, but I would say most pediatricians lack that comfort and that's why

you end with the kids in the emergency room where Dr. Loftus treats.

So I think we have to look at other models that have been successfully developed in the country. Like up in Massachusetts, and we'd be more than happy to share their work with all of you.

DR. MIRELA LOFTUS: Just to add quick about availability of child psychiatry. So there's a lot of barriers to -- to (inaudible) one of the mental health parity for the reimbursement that -- that people get for behavioral health visit compared to a medical visit to the number of services that, especially commercial insurances would not cover, like, for example, they would cover rehab for orthopedics, but they wouldn't -- they wouldn't cover specialized DPT program or eating disorder program, which is similar to a rehab after you come out of inpatient unit.

And then -- and -- and that is a barrier to why people would not choose to go into psychiatry. So if -- if we would finally be acknowledged and be at -- at par with our colleagues, there might encourage other people to come to the field, too.

REP. WOOD: Thank you.

Two more -- okay, Senator Kane, and then we'll submit questions to the clerk.

SENATOR KANE: Thank you, Madam Chair.

Doctor, I haven't gotten my flu shot. Can I follow back to your office.

DR. KENNETH SPIEGELMAN: You can. I'm even -- yeah, chicken soup is good, too.

SENATOR KANE: All kidding aside. I guess I have a two-part question.

Pediatricians, like yourself, when a child comes in or family comes into your office, is it then recommended -- you mentioned these medications -- and is it recommended that these children go or are put on medication rather than therapy? What's the process?

And second part is, is there any connection between these medications and violence?

DR. KENNETH SPIEGELMAN: I'll -- I'll answer the first part of that question in that I think except for the aspect of attention deficit disorder, which has really become part of the primary care and domain of pediatric care, most patients we see with affective disorders, with mood disorders, we will refer out as long as they're stable to a psychotherapist. And we will let the psychotherapist do the initial assessment in the evaluation, which is the way it should be.

There are now well evidence-based treatment plans for anxiety disorders. If that psychotherapist then feels that it would be necessary -- that they've gone so far with that patient and that they feel that that patient may benefit from the medication, they often will refer that patient to a child psychiatrist which usually doesn't happen because they're impossible to find for the majority of our patients.

That psychotherapist, in my practice, will then sometimes call me back and say, Ken, would you mind working with me with this patient. I believe they would really benefit from an SSRI, something that I feel comfortable utilizing and I'll work with them as long as I have a relationship that I know they're going to see them on a regular basis and see myself on a regular basis, too, but I have a limit as to what I'll do before I will refer out. But this why I need the help of a collaborative person, like Dr. Loftus, that I could call up at any time.

I don't know any pediatricians that I'm familiar with who will immediately use medication before going to psychotherapeutic route.

I'm going to let you answer the second question.

DR. MIRELA LOFTUS: And by the time they come to me, most likely, they either failed just therapy or they're severe enough that they need an inpatient hospitalization which would imply they would need medications.

So by the time I treat them, I -- most likely they will get medication as a treatment.

And as far as -- no. There are no studies that to point on evidence of linking the most commonly used psychotropic medication, such as antidepressants or antipsychotics to violence.

There's a black box warning for antidepressants that increases less than 1 percent the likelihood of having thoughts to hurt themselves but not someone else.

REP. WOOD: Thank you all very much.

We're way behind.

Sure quickly.

Representative Johnson.

REP. JOHNSON: Thank you.

Quickly, I just wanted to know, in terms of child -- as a diagnosis of the child having mental illness.

When you look to the future and you look at the treatment that they received as a child, do you have any longevity studies that address the changes in behavior that can be effectuated once adulthood is, you know, becoming apparent?

And there is a certain amount of brain plasticity and that sort of thing so the more effective treatment early on, perhaps, makes it so that when someone becomes an adult these issues are addressed or they're manageable. If you could just speak to that quickly.

DR. KENNETH SPIEGELMAN: I'll let you address speak.

DR. MIRELA LOFTUS: Okay. Yes, the more healthy of a child, the more they're going to learn. They're more adjusted, they're going to learn social skills, academics, they'll be more educated, the more likelihood, they will be functioning and successful adults, yes.

REP. JOHNSON: Thank you, Madam Chair.

REP. WOOD: Thank you very much and thank you very much to both of you for coming and for your testimony.

DR. KENNETH SPIEGELMAN: Thank you very much.

REP. WOOD: We have Dr. Gary Steck, who is the chair of the Board of Community Providers Association.

GARY STECK: Good afternoon. My name is Gary Steck and today I'm wearing several hats. It's true I'm the -- not a physician, but I am the chairman of the board of the Connecticut Community Providers Association. I'm the CEO of Wellmore Behavioral Health, which is the emergency mobile psychiatric service provider for Western Connecticut.

And I count myself among the hundreds of first responders to Sandy Hook along with two dozen of my staff.

Connecticut is confronted with the aftermath of a tragedy which took lives of innocent children and teachers. We are faced with discerning how we can reduce the risk of such tragedies and what steps as a society we can take to prevent violence against one and other.

CCPA represents nonprofit organizations who serve children, adults and families who are experiencing mental health or substance abuse disorders, as well as providers who serve individuals with intellectual and other disabilities. We are the core of the safety net.

And over 100 of our staff of our agencies were frontline, clinical first responders to the

Newtown tragedy. Many continue their work supporting children, adults, and families from Newtown, as well -- as well as helping local schools and others in the community begin the healing process.

The terrible events that occurred at Sandy Hook Elementary School go far beyond what we traditionally think regarding mental health services. They go to the heart of how we, as a society, regard violence, how we, as a society, regard those who may need to seek help for behavioral health services.

We first and foremost must address as a fundamental public health issue how to teach the resolution of conflict without resorting to violence. It is crucial that we understand what happened at Sandy Hook in the context of gun violence across the state and nation. We urge that as a state, we not take reactive or aggressive measures which further stigmatize and discourage people from seeking treatment. It's our perspective that is ill-advised to rush towards dramatic and heavy-handed steps, such as outpatient commitment, rather than thoughtfully consider and develop lasting solutions to the challenges that face Connecticut's mental health system.

CCPA recommends the following seven steps. There must be adequately supported and resource community behavioral health services so that those in need can get the access to the treatment that they need.

We want to establish a public health campaign that removes the shame and blame from seeking mental health and/or substance abuse care and

that emphasizes early identification and treatment. This campaign should be aimed to educate all levels of the community, churches, schools, law enforcement, physicians, and the general public. It should include understandable language about symptoms of mental illness, including early signs of depression in children, youth, and adults who may be at risk for suicide, the prevalence of mental health disorders, effectiveness of treatment and how to engage troubled people -- troubled young people in services.

We suggest an expansion of school-based behavioral health services and encourage direct collaboration between schools and providers to improve identification of children and adolescents showing signs and symptoms of behavioral health issues and then linking them to the community mental health system. This will assure the children and families who are identified with the problem are actually tied to a system of care. This would also build on the current system of enhanced care clinics, child guide clinics and the emergency mobile psychiatric services offered and funded by DMHAS and DCF.

Four, enhance the DMHAS and DCF emergency and crisis response service so that they can respond to anyone facing a behavioral health crisis. 2-1-1 is an access point for families of a child, a young person, in crisis should be as familiar to people as 9-1-1. The DMHAS-funded crisis service and the capacity to follow -- for follow-up treatment must be expanded so anyone facing a serious mental health crisis can have access to care.

For those who need more intensive services, we must address funding assert -- outreach programs, which have been withering due to lack of funding.

Five, strengthen services to 20 -- to 16- to 25-year-old young people with serious mental illness when serious mental illness often manifests itself and substance abuse increases, as well as suicide. Such services must be broadly available. The only targeted mental health service to this age group are through DMHAS program grants, which target youth transitioning from DCF as the commissioners previously said, and they're not available to the broader public.

Six, access to all behavioral health services is also hampered by lack or limited private insurance coverage for therapeutic outreach and engagement and in-home services, such limitations in coverage must be addressed as a part of expansion of healthcare reform.

Seven, examine the lessons learned from our response to Newtown and assure that the state's disaster preparedness planning includes the community response system, emergency personnel, and healthcare professionals who are the frontline responders.

And lastly, let us especially assure that children, adults and families and teachers in Newtown have the consistent and ongoing support they need to begin the process of recovering and the renewal of hope.

We strongly urge that whatever steps we, as a state, must address the underfunding of the

community safety net, which should be accessible to all those in need.

Thank you for the opportunity to testify.

REP. WOOD: Thank you very much. Very good points.

Questions from the committee?

Senator Kane.

SENATOR KANE: Thank you, Madam Chair.

Thank you for your testimony.

I think you're the only one specifically talked about Newtown in all your points so, thank you, I appreciate that.

My question is on the other side of the question I asked Commissioner Rehmer, which is about the access to care. And I'm -- you deal with people with private insurance, as well.

GARY STECK: Yes.

SENATOR KANE: And can you just speak to that, meaning, the Commissioner said that if you are on Medicaid or Medicare, and I don't know if she said unlimited access but pretty much there were not co-pays, there were -- there was the ability to get access to care, whereas private insurance you do not or it's very -- or it's harder because of co-pays or access or because of how many times you get to make these visits, let's say. So can you -- can you just speak to that difference for me.

GARY STECK: In my opinion, Medicaid and Medicare benefit is substantially better than what virtually anyone can get in the private insurance world. And there are services that the State of Connecticut purchases that are comprehensive, home- and office-based, school-based that are simply not available through private insurance and are not reimbursable under private insurance because they're not required by law to do so.

SENATOR KANE: How would we fix that?

GARY STECK: Well, we could mandate some of these services, or we -- or we could fully implement parity laws that exist that, actually, in language would require consideration of flexible use of benefits that were already available.

SHEILA AMDUR: Could I -- could I comment.

Yes, Senator Kane, I'm Sheila Amdur. I'm the executive director -- interim executive director of the Connecticut Community Providers Association.

I think they're two issues in relationship to access. First, let me just say to the latter question, I think, Vicki Veltri, who is the Office of Healthcare advocate is, I think, looking at trying to convene both private -- both the private sector, as well as state commissioners, around the whole access issue and looking how we can actually develop, finally, parity in our mental health system because, historically, the private industry from the time that we had state institutions in the 19th century -- maybe we didn't even have insurance then -- but since we've had private health

insurance, has always assumed that any child or adult with a serious mental illness should be treated in the public sector and that the dumping into the public sector is -- is really pretty atrocious, and it continues today even with parity.

The second issue is even though the benefit is much better under Medicaid, the payment system is terrible. So we have -- we have a system of community child guidance clinics throughout the state. They all have child psychiatric involvement. They have child psychiatrists in charge of the treatment. They have very well skilled staff. They take all comers, private or public payers. The problem is, first of all, that the private payers pay for very little; and the second problem is that Medicaid pays so little that they can't expand to meet the demand. And when we think of what's going to happen next year with the expansion under healthcare reform, how do we think those folks -- all of those folks are going to be flooding the system are going to get access? It's an issue that we really have to pay attention to and really think about it in terms of longevity.

Yes, it will cost us more to raise Medicaid rates, but if we really look at utilization and we look at the costs we save down the road, maybe it isn't so expensive.

REP. WOOD: Thank you. Excellent question, informative, illuminating answer.

Doctor -- Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

In trying to find the connection between adequate, appropriate mental health services in -- and trying to connect that to gun violence, I know we have no predictor for -- for any of these gun violence at all. We did hear from previous testimony depression was one entity where you may relate that to the possibility of gun violence. Since we are dealing with mental illness and gun -- gun violence in this particular task force, together, eventually, tomorrow and going forward, would you say that when we go to any of these private providers that -- of course, asking them to cover mental illness as a total, you know, would be great if they could do that, but are there carve-outs in terms of ages or particular groups of people that at least is a first step going to the private insurers so we can get better coverage for our children in terms of mental illness with concern to gun violence?

GARY STECK: I don't think so. I think that -- I mean, from my agency, we actually are a merged agency of an adult provider and a children's provider. And the reason that we came together was that the system is segmented and is difficult and we wanted to make it our problem when someone came and asked for care how we could make sure that we got them the care. And I think that the same exists on the insurance front.

I personally hope that it evolves toward an integration with primary health care, and that there's a seamless benefit for all members of the family. And I can tell you from our own experience that there are, if you will, different benefits for adults and different services for children. And if you were not an

expert or someone that sat at this panel, there's no way that you could possibly navigate the system yourself. So I do hope that it's looked at holistically. I'm hopeful for the future that there could be change in that fashion.

REP. WOOD: Thank you very much and also thank you for waiting. I know you were scheduled a little earlier.

Last on the private delivery system is Dr. Carolyn Drazinic, the -- she's Connecticut -- Connecticut Psychiatric Society president. Thank you. And again, thank you, too, for waiting.

DR. CAROLYN DRAZINIC: Thank you very much for inviting me to speak here today. My name is Carolyn Drazinic. I'm an assistant professor at the University of Connecticut, and I am the president-elect of the Connecticut Psychiatric Society, representing over 700 psychiatrists in this state.

While we sort out the facts of the tragedy in Newtown, this tragedy and many other tragedies that have taken place in the past, are not all due to mental illness, at least mental illness as we define it, in either a medical or a legal sense.

Most people say, quote, that person had to be crazy to do that, unquote, when referring to a tragic event, and then most people go on with their daily lives, without insisting on any meaningful change to our society. What we really need to do is turn our horror at these

tragedies into positive action. That is why we are here today.

A recent federal study revealed that one in five American adults suffered with symptoms of a mental illness in the past year; 1 in 20 suffer with severe mental illness.

It has also been well established that less than half the people suffering with mental illness are treated and often the treatment many do receive is less than adequate.

Let's speak for a moment about what it means to have a mental illness in the 21st century.

People with severe mental illness in the U.S. die 20 to 25 years earlier than the rest of us. This is surprising given the many health advancements in our country. For example, when President Eisenhower suffered a heart attack in 1955, this launched a nationwide effort to improve care for heart attack victims, and deaths from heart attacks dropped by 60 percent.

According to the World Health Organization neuropsychiatric illnesses are the leading economic burden worldwide, and depression is the number one cause of disability in the world in both males and females above heart disease.

As you may be aware, in the U.S., there are more suicides each year than homicides. There are more deaths by suicide in adolescents and young adults than by any other cause, including car accidents. Suicides by soldiers who served in the military last year for the U.S. are larger than the number who died from combat in Afghanistan -- and this just came out this

month. Most of these soldiers who committed suicide were between 18 to 24 years old, they did not seek help, presumably due to potential stigma to their military career.

These basic statistics barely scratch the surface of the high price of untreated and under treated mental illness for us, our families and our communities, as well as for those who were lost.

So what is it like for our patients who try to seek help here in the U.S. in the 21st century? I regret to report that our mental health system in the U.S. is broken. There are so many barriers to effective care for people suffering with mental illness that they are too numerous to list, too numerous to discuss, even in a hearing like this.

In a survey asking CPS members to list the barriers for our patients, the common theme was that there is a systemwide shortage in mental health resources. We need to build more capacity and increase both the availability and accessibility of mental health services for our patients.

As for specific details, first, Connecticut psychiatrists report that there are not enough inpatient beds, particularly intermediate and long-term beds to accommodate the demand and, as a result, patients end up sitting in emergency rooms for days.

Patients who are sent by their psychiatrist to emergency rooms for evaluation or even those patients who go on their own to the emergency rooms asking for help, looking for voluntary

hospitalization because they are suffering, these patients are often turned away after long waits, simply because they are not suicidal or homicidal at that moment in the ER.

For those who are hospitalized on inpatient units, short stays of only a few days are not sufficient for true psychiatric stabilization. Hospitalized patients often feel they are pushed out before they are ready because of pressures from third-party payers to keep the length of hospital stays shorter and shorter. We have reached a point where the length of the stay, the average length of stay, is one week, but the average length of time it takes our medications to work effectively is two to four weeks.

This leads to, quote, a revolving door mental health treatment, whereby patients that re-hospitalize rapidly after just having been discharged. In other words, they were not treated long enough in the first place.

Second, Connecticut psychiatrists agree that we need to expand community services for people with mental illness. We need to stop cutting finances of programs, like the ACT mobile crisis teams, partial hospital programs, intensive outpatient programs, addiction facilities, group homes, case management services, visiting nurse services, affordable medical transportation, respite beds, and long-term beds for the seriously and persistently mentally ill. Cutting these services increases the revolving-door treatment of our patients, when they do not receive sufficient support to be maintained in the community.

Indeed, many of our patients become homeless going from shelter to shelter, and as a result they lose access even to the most basic services here in Connecticut in a few months simply because they have no permanent address. It is well known that disabled patients who have stable and affordable housing have fewer hospitalizations and a better chance of living successfully in the community.

Third, Connecticut psychiatrists observed the recent placement of some new bureaucratic barriers to maintaining mental health stability in our community. These bureaucratic barriers can be removed with the help of all of you, our state legislators.

For example, renewals of medications that patients have been taking for years and commonly prescribed medications, too, now both require extensive prior authorization, leading to days or weeks of delays during which the patients go without their medications, potentially leading to re-hospitalization. These new requirements have become a significant barrier to maintaining stability of our patients in the community.

In another example, the lengthy process of obtaining preauthorization from third-party payers for psychiatric hospitalization is also a significant barrier to the care of our patients. If a patient needs hospitalization for a medical problem, when the doctor says the patient needs to be admitted, the patient is admitted without any lengthy discussions or debates with third-party payers to obtain their approval for the hospitalization.

This does not happen in psychiatry, our mentally ill patients wait in the emergency department for hours as we try to obtain preauthorization from third-party payers for the patient to be admitted to the hospital. This is a true mental health parity issue.

Another barrier to high-quality, safe treatment of our medical and psychiatric patients is the 90-day minimum prescription requirement. For patients who have suicidal impulses, patients who impulsively take too much medication when they're not feeling well, and patients who are confused or forgetful, a three-month supply of a medication has an overdose mortality risk that is inherently much higher than a one-month supply. Doctors should be able to prescribe the amount of medication necessary for safe patient care without our patients being penalized financially.

Psychiatrists are adjusting now to new billing code requirements that are equivalent to codes used by other physicians, except that other physicians don't do psychotherapy. However, some third-party payers have decided not to pay for psychotherapy as an add-on code, although the psychotherapy is in addition to our usual mental health services. Based on numerous research studies time invested in psychotherapy can help us assess the risk of our patients or treat our patients more effectively. The stigma against proper treatment of people with mental illness persists.

The passage of the Mental Health Parity law by Congress in 2008 was a great achievement, but the implementation of the law has been extremely

slow. Again, the stigma against people with mental illness persists.

It makes sense that early recognition and treatment of mental illness will result in healthier, safer populations. But cutting mental health resources means that our patients will be stuck in revolving doors between emergency rooms, short hospitalizations, dried-up community services, homeless shelters, and worse. The choices made by our leaders in our state legislature are never easy, but decisive actions to support mental health are clearly needed now.

In conclusion, the Connecticut Psychiatric Society is willing and able to help our legislative leaders expand the mental health services for our patients and eliminate barriers to mental health care. Expanding mental health services is by far the most cost-effective approach to treating mental illness because most patients who are treated get better. These mental health problems are solvable, so let's roll up our sleeves and work together with real commitment to solve them.

Thank you.

REP. WOOD: Thank you very much, Dr. Drazinic.

Any questions from the panel?

Dr. Srinivasan -- Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you very much for your testimony. And you restated what we've heard from the earlier part

of the day of a long list of things that need to be done so that we are able to deliver more effective mental services to our patients here in Connecticut. One of the concerns that was raised earlier on, and I did not hear you touch upon that and if you would be kind enough to do that for us, is the availability of psychologists, psychiatrists, you know, the medical profession and the paramedical profession because what we heard from the primary care physician earlier on is when a request is made, these people do not have a place to go to and this was consultation. We are not talking about inpatient, we're not talking about all the expanded services that you so eloquently referred to. Could you touch upon what can be done or needs to be done either at your society level or us here sitting at the legislative level to make sure that those services are also available because they're important. Without them, there is not going to be much of a follow-up of the other services if we just provide them.

DR. CAROLYN DRAZINIC: Thank you for that question.

As one of the previous speakers had mentioned, we definitely have a real lack of child psychiatrists here in this state and also nationwide. So that is something that if the State is going to support having more child psychiatry training programs, you know, I think that's something that could potentially be supported in terms of training more child psychiatrists.

In terms of other ancillary individuals, ancillary mental health providers, psychologists, et cetera, again, increase

support for training programs for individuals who have an interest in child psychiatry and adult psychiatry, as well, would be extremely important.

I think in order to get a handle on how difficult the situation is in terms of accessing mental health services, we routinely have difficulty finding an outpatient follow-up appointment for patients who were just -- just discharged from the hospital. Typically, we try to get an appointment ideally within seven days or within two weeks, but sometimes it can take months. And certainly, patients who come in from the community who have not been hospitalized, it can take months to a half year, and for a child psychiatry appointment it can take even longer. So there is a -- there does needs to be an investment in improving those resources and -- and supporting training of young people to go into this profession.

REP. WOOD: Thank you very much. Again, thank you for waiting and thank you for your testimony. Much appreciated.

Now we move to the next section which Senator Harp will chair.

SENATOR HARP: Thank you.

Our next speaker is Judge Robert Killian, Jr., from Hartford Probate Court.

JUDGE ROBERT K. KILLIAN, JR.: Thank you, Senator and distinguish members of this most important committee. My name is Robert K. Killian, Jr. And for the last 29 years, I've had the privilege of serving as the probate judge for

the District of Hartford. And recently, I had an opportunity to recollect in my involvement with health care professionals in the mental health area and was astonished to realize that I presided over 7,000 -- just shy of 7,000 hearings that involved determination of dangerousness to self, to others, grave disability in the areas of civil commitments and probable cause hearings, conservatorships, ECT applications, medication hearings, which kind of tells you what I've been doing for the last 29 years.

I've heard so little today with which I disagree, but I will honor my charge and speak to one thing that is dear to my heart and that's the issue of outpatient civil commitment.

Please remember that the probate courts' involvement is to do three things: to determine that somebody, because they meet the state standard, is in need of serious mental health treatment; to ensure that they are getting it; and to make sure that it isn't available in a less restrictive environment. And I would submit to you, the most restrictive environment is a hospitalization, and we strive mightily to keep people out of hospitals.

Having said that, I have to report to you that about 80 percent of the applications for conservatorships, which I hear, I concur with the judgment of the medical professionals if somebody needs hospitalization. Also understand that on the morning that a commitment hearing is scheduled -- and we usually have four or five scheduled on the days that I do commitments -- I am always pleased to learn that a significant number of those are going off because the

patient has been discharged, because I truly believe that, again, the medical professionals take seriously their obligation to keep somebody there only if they absolutely have to.

When I started 30 years ago -- almost 30 years ago, a stay at the Institute of Living, where I do 350 commitments a year, was in excess of 45 days. Actually, the first year I was a judge, I did as many annual reviews of patient commitments, those are hearings that we used to hold when someone had been in hospital continuously for a year, as I did new commitments. And now the number of commitments I do has grown tenfold since those days, but the number of annual reviews, for example, last year fell to one at a state hospital.

The biggest problem that I have concerns a small subset of the total population who are getting mental health services. Last year, the probate courts did approximately 1,000 civil commitments. That's out of -- what Commissioner Rehmer, Pat Rehmer, told me last year was about 45,000 people who at any time are actively involved with the system. So very few people civil commitment. They tend to be those who are most intransigent about receiving services. And it's amazing how well they do once they get them.

Today at the Institute of Living, the average stay is less than seven days, and that's because almost everybody who goes into hospital is treated with medication very quickly, and the medications work, and they are names attached to them that were unheard of 30 years ago. And frankly, any time you see a civil commitment, anticipate that there will also be medication

either voluntarily accepted by the patient or forced upon them through the in-hospital medication against will provisions. The proof of that is that there are two ways you can get those orders: One, with a bypass that uses an independent psychiatric review which is most prevalent, particularly at the private hospitals. And I'm told that around 90 to 95 percent of the applications for medications against will are granted. And the other alternative is to come to the probate court for approval. It's a more cumbersome process, but when we do it, the number is still in excess of 80 to 85 percent on the basis of my conversation with my colleagues who do this.

Now I know that people don't like medications. And virtually all medications have side effects. Advil, for example, warns against chest pain, weakness, shortness of breath, slurred speech, problems of vision or balance, coughing up blood or vomit, swelling or rapid weight gain -- that's one that particularly concerns me -- difficulty urinating, upper stomach pain, itching, loss of appetite, jaundice, fever, sore throat, headache, muscle weakness, increased sensitivity to light and/or seizures or convulsions.

I take Advil regularly for my arthritis and mercifully haven't had any of those untoward reactions but I know some people do. I'm not trying to minimize the significant side effects of psychotropic medications, just to point out that every medication has to be viewed with a risk-benefit analysis in place.

Now here's my hypothesis, Senator and members of the committee, psychotropic medications are

almost universally required for committed patients to be discharged. A significant subset of the most severely mentally ill, those who by history have multiple hospitalizations, are routinely noncompliant with meds in the community. And those who have serious recurrent hospitalizations, all of which require a finding of dangerousness to self or others are now routinely released after a matter of days or at most weeks while we engage in the legal fiction and the medical fiction that they are no longer a danger to self or others, even though we know that they will stop meds, all too many of them, and decompensate and shortly become dangerous to themselves or others again.

Dangerousness to others is another decided subset of the population. The most significant reason we commit people is because of grave disability; probably suicide alley is number two, and it's a very distant third, this dangerousness issue. Most mentally ill people are not dangerous to anybody. And if they are, it's probably to themselves because of neglect not because of any active determination for self-abuse, and even there it's a very significant subset of a population. But the current outpatient modalities don't reach this subset of the population. I support ACT teams. I'm thrilled that we have one in Hartford. I'm thrilled with the work they do. When a patient leaves the hospital, the probate court doesn't lose contact with them because overwhelmingly there's a conservator that we're asked to appoint to assist them in the transfer to the community, to finding housing, to getting benefits and to help coordinate their -- their health treatment. And I have greater frustration in that regard than anything else

because I know that for this very small subset of the thousand or more people we commit a year, it's going to be virtually impossible to secure their -- the services.

When most patients are discharged, they accept the need for medication, at least for an extended period of time, or they don't need medication, which is often the case, for example, with people who have attempted suicide. That's because they know they need it, or they view it as the way to avoid the future horrible interference with their life, which is occasioned by a hospitalization.

Outpatient commitment is not an idea, it's another treatment system, it's another modality. It takes the ACT teams that have worked so well for so many and extends their reach to this group of patients for whom it is not working. I commit some of these people two or three times a year and their stays usually aren't just the seven days but they're longer because it seems each time they start their medications, it takes longer for them to get back on them. Outpatient commitment is as different from the majority of the cases where they don't need that assistance, as assisted living is to placement in the skilled nursing facility.

Here's my proposal: only an individual who within the last six months was found by a court to be dangerous and hospitalized or jailed, as a result of activities determined to be related to severe mental illness would be subject to outpatient commitment. Now I've already told you we only do 1,000 of them a year. I can further tell you that probably about 250 of those that I do leave the hospital and go to a

nursing home. They tend to be severely demented, Alzheimer's type dementias and they are in the hospital only because medications can't be adjusted outpatient -- another thing that the committee should be looking at.

Another significant percentage are going to voluntarily accept treatment. So of that thousand patients, we may be talking about 100, 150 people who come into this category of having been committed because of dangerousness to self or others and it was within the last six months. They can have this only after a hearing in which a court appoints a special limited conservator who will have special training, training that will be approved by DMHAS and offered periodically without charge by the office of the probate court administrator -- my boss is here today, he's hearing me say it, sorry, Paul -- only if a DMHAS-approved service provider of the skill level currently required to be able to order a patient's transport to an emergency department for psychiatric review sees the patient at least once a week. This is a psychologist, a social worker, an advanced practice registered nurse. These are the people who can do it now. These are the people who would have to participate in this. There would be a court review mandated every six months so the order would terminate unless it's extended. And the only reason it could be extended is if the patient has refused medication at least three times for oral meds or once for the decanoates, the injectable forms of some of these medications during the previous six months. And there could be the substitution of an injectable medication only if there is a standing order from a physician. And the patient would have the option of receiving their

medication at home or at a regional mental health facility.

Now remember, for many patients who are accepting medication voluntarily, they have visiting nurse assistants and supervision for the medication process at their home. If they are brought to the emergency department and the emergency department doctor or an APRN, who are the unsung heroes right now I would submit of the medical care that people get for psychiatric illness, they can order a readmission to the hospital for the reinstitution of meds without finding that they are currently a danger to themselves but must find that the patient is subject to an outpatient order and appears to be in need of medications and has refused to take them.

Now I knowledge these are significant services, but they would apply to a very few people, and it would extend, I submit, significantly, their ability to stay in the community.

You know, the great New England sage, the poet Robert Frost, said that freedom is moving easy in the harness. And as a judge, I am frustrated that we have nothing to do for a severely mentally ill patient but the shackles of hospitalization or the luxury of release to a community where they will get no services. I'm sick as a probate judge at a conservatorship hearing of getting the report that they refused the services of the ACT teams so they have been discharged from the program.

Thank you for allowing me to vent my spleen.

SENATOR HARP: Thank you

Are there questions?

If not, thank you very much.

JUDGE ROBERT K. KILLIAN, JR.: Thank you, Senator.

SENATOR HARP: We're going to beg the indulgence of those that we've asked to testify and ask that the Commissioner of the Department of Public Health come forward. She has meetings that she has to attend and would look forward if folks would indulge us for just a moment.

Welcome, Commissioner, and when you're ready, you may begin.

COMMISSIONER JEWEL MULLEN: Good afternoon. I'm Dr. Jewel Mullen, commissioner of the Connecticut Department of Public Health. I appreciate your allowing us flexibility and for your benefit and the benefit of everyone who's letting me sit here at this moment, I will say that I'm here to address the specific question that you asked me to come which was to provide information on the school-based health center program that the Department of Public Health administers. So I'll do that.

The Department of Public Health currently supports 72 school-based health centers in 23 communities statewide. There are some school-based health centers in Connecticut that are not funded by the Department. In 2008/2009 a little over 43,000 students were enrolled at the Department of Public Health funded sites. For those enrolled students, there were a little over 100,000 visits. The most common reasons for the visits were mental health, accounting

for 37 percent; acute conditions, accounting for another 25 percent; 15 percent of the visits were for physical examinations, screening or immunization; and then less than 10 percent were for injury, oral health, or chronic condition.

There are some mental health services provided at all sites but the scope varies. The range of services includes the treatments of high risk behavior, self-injury, psychosocial problems, family or peer related, attention deficit disorder, victimization, trauma, traumatic stress, alcohol and substance abuse, delusional, psychotic or personality disorder, crisis intervention, assessment, individual group or family counseling, learning disorders, bipolar disorder, depression, conduct disorder, and anxiety disorder. The clinicians who provide these services comprise a broad array including license social workers, marriage and family counselors, professional counselors, licensed mental health clinicians provide direct supervision to those who are unlicensed. The services ordered -- offers include case management and linkages to community-based providers.

Services are confidential except in the cases of abuse and neglect, suicide, and homicide. All sites are required to have backup mental health services at the times that the school based health centers are closed and that backup starts with each site having a voice mail system with a message identifying the names of the backup providers and directions on how to contact them.

During the summers if the school-based health center is closed and the mental health clinician determines that a student needs services over

the summer that clinician provides a link. Referrals are made to community-based mental health providers if students need mental health care that's outside the scope of school-based health centers. And in a number of communities, there are psychiatric services that are available for use by school-based health centers.

So that's pretty much it, and I understand that you've already had the opportunity to hear a little bit from -- from some others who have spoken to the school-based health center programs in the state. So what I would offer you, as commissioner, is that I'm glad that we are having an opportunity to tell that the services are out there and what you have from my commitment and the commitment of my agency is that as we continue to hold ourselves to increasingly high standards around measuring our performance so we can know how we'll actually be doing, part of what we need to do with the school-based health center or mental health programs in general is to be able to report not just on how many students have sought services but what the outcomes have been. Or with any system that's put in place going forward, whether or not through your work or just to the work of the Department, if we don't look at that part of things, then we really aren't doing a complete job.

And then, finally, I'm taking my opportunity to share with you what my pledge is with my counterpart commissioners, particularly those in the Department of Mental Health and Addiction Services and with the Department of Children and Families, because we really have to remain intertwined in ensuring the well-being for the

services for mental health and mental illness statewide. So rather than give you my words, I'll just read a little bit from the Center for Disease Control and Prevention web site talking about the role of public health in mental health promotion, and to paraphrase it says that public health is challenged to identify risk factors, increase awareness about mental health disorders and effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services for all persons, particularly among populations that are disproportionately affected. Public health agencies can incorporate mental health promotion into chronic disease prevention efforts, conduct surveillance and research to improve the evidence base about mental health in the U.S.

The CDC also notes that mainstreaming the promotion of positive mental health and well-being into the school system and our health and social service programs is critical to overcoming the stigma that so commonly associated with mental health care.

So as we continue to do our work, not just in the school-based health center program but across the spectrum of the programs that we have at DPH, we'll do so with that framework as well and encourage you as you come up with some solutions and strategies that we can collaborate on for Connecticut to remember to -- that the public health and mental health models need to remain intertwined.

I'm glad to have had a chance to speak before you before you terminate your -- your public sessions, and I remain available for discussion

or consultation in the weeks to come if you think it would be helpful to hear from us in any other way.

Thank you.

SENATOR HARP: Thank you very much.

Representative Srinivasan has a question or comment.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you, Commissioner, good to see you here again.

COMMISSIONER JEWEL MULLEN: Thank you.

REP. SRINIVASAN: You had -- in these school-based health centers that we have talked about the model that already exists in several communities in our state, knowing that early detection is critical in our children, A; and we need to remove the stigma factor, B; both of them are extremely critical to be effective in delivering mental health services and seeing in these centers mental health was used quite extensively by people who came there, is it possible without overloading you extensively or what would you need where our children could be screened by these centers on a regular routine basis? Every kid goes through the center, gets screened, A, and followed up through their period in school, and the de-stigma does not happen because every child will be screened and then you would be able to have a better point of who needs attention, who needs special attention, and who needs a lot of help. Is -- could this model be

used for us in our children in our schools? Thank you.

COMMISSIONER JEWEL MULLEN: You're welcome.

So we've got 169 cities and towns, and we've got 23 communities that have school-based health centers so I think even in a good budget year, it would be hard to think about how we could scale something up to be able to do what you're talking about. But I also, having heard some of the testimony of others, think that as we talk about school-based health centers, we're talking about one component of a system but not the entire system that's going to necessary to serve children.

I'm not -- even scaling up school-based health centers, I'm not convinced that we know enough to say that that's -- that there could be a one-size-fits-all model for that, particularly, since enrollment in school-based health center is voluntary. So I'm not sure whether I fully answered your question. It was a long way of probably saying maybe not.

SENATOR HARP: Thank you very much.

Actually, I had another idea. We heard earlier from pediatricians, and I was wondering whether or not -- and the assumption always is but evidently it's not accurate -- that in medical school through their pediatric rotation that they did some mental health. So I was wondering if there were not assessments that are relatively accurate assessments that could be done at the time a child goes for their yearly examination and that, periodically, the State may require not the outcome but just

acknowledgment that a screen occurred on the infamous blue form.

COMMISSIONER JEWEL MULLEN: I think there are a number of examples of where different kinds of screenings have been called for for children at risk and that's something to think about. Having mentioned the public health approach, I think it's really important for me to also stress that as we talk about mental health we're not always just talking about screening for mental illness. So that the systems that we look at also need to be able to identify what the positive risk factors are for students so that at the same time a child is flagged for with having potential problems, we also see where the resiliency factors are that need to be reinforced because that can set up -- and remind us that the need for those other positive reinforcing systems, as well, so that we're really taking care of the entire population.

SENATOR HARP: Okay. Well, thank you very much.

COMMISSIONER JEWEL MULLEN: You’re welcome.

SENATOR HARP: Further questions?

If not, thank you very much.

Kristina Ragosta from Treatment Advocacy Center. And thank you for waiting, appreciate it. When you're ready, you can begin.

KRISTINA RAGOSTA: Senator Harp, Representative Wood, members of the committee. My name is Kristina Ragosta, and I am an attorney for the Treatment Advocacy Center. We are a national nonprofit located just outside of Washington DC and our

focus and expertise is on state civil commitment laws. Our mission is to eliminate barriers to the timely and effective treatment of severe mental illness before a tragedy occurs.

I hear from families every day who are struggling to get help for loved ones suffering from severe mental illness. And it's oftentimes the result of restrictive civil commitment laws.

I was asked today to address the court's role in the mental health delivery system. And the role of the court is often a function of how thoroughly and effectively any particular state chooses to provide treatment to this small subset of individuals we're talking about who are too ill to seek treatment voluntarily. You could have all the services in the world and this small subset of population is just unable to access those services. So the court's role is a function of how well they use the state civil commitment laws.

The role of Connecticut's court is quite limited in this regard from a national perspective because the state civil commitment standards are among the more restrictive in the nation. Earlier Commissioner Rehmer mentioned a survey of state laws -- I forgot to attach this to my testimony but I have copies of a chart that summarizes every state civil commitment criteria so you can see how Connecticut's law compares to the rest of the country.

As a practical matter, in Connecticut, judges are far more likely to see individuals with untreated mental illness in court on a criminal matter that occurred because of behavior resulting from symptoms of mental illness than

in the course of ensuring treatment before the act happened that landed them in the court.

Although we don't know what led to the tragedy in Newtown or whether the state's laws would have ever come into play, it's clear from our perspective that Connecticut's civil commitment laws are in need of reform. The law is restrictive in three ways that differentiate it from other states with better laws. The first one is an individual needs to be dangerous before intervention is possible. The standard in Connecticut requires that an individual be a danger to self or others or a danger due to grave disability before a commitment is possible.

Second, the State's standard for commitment does not take into consideration an individual's past psychiatric history, such as repeated hospitalizations or a history of violence or arrest or other symptoms of psychiatric deterioration that some other states do take into consideration.

And lastly, Connecticut is one of only six states that does not provide an option of assisted outpatient treatment, sometimes called AOT or outpatient commitment, as a mechanism for helping those who are living in the community adhere to treatment. By omitting this option, Connecticut is denying individuals with severe mental illness a less restrictive treatment alternative that has been shown to reduce consequences and save government money.

We work with legislators and mental health stakeholders throughout the country to reform civil commitment laws and to help better

implement those laws. I'm familiar with all the data and studies out there. The bottom line is that outpatient commitment is not a panacea. It won't solve all of the issues with your mental health system, by any means, but it is a tool that Connecticut is lacking and where it's implemented it works.

The court's role and the legal procedures related to outpatient commitment vary significantly from state to state. Typically, the court commits the patient to the treatment system but, more importantly, it commits the treatment system to the patient. It was suggested earlier that because AOT or outpatient commitment doesn't necessarily involve forcible administration of medication that Connecticut doesn't need it. This misses the point. One of the goals of outpatient commitment is to increase medication compliance to help people get and stay well and independent and be on that road to recovery.

The Department of Justice in 2012 deemed outpatient commitment or assisted outpatient treatment an evidence-based practice for reducing crime and violence. AOT laws reduce rates and incidents of hospitalization, arrests, emergency room utilization, victimization, suicide attempt and other violence. Just as an example one of the study -- study of results under New York's implementation of their law in the first five years found that 77 percent fewer people experience hospitalization, 74 percent fewer experienced homelessness, 83 percent fewer experienced arrests, 88 percent fewer experienced incarceration.

It's time for the state to reform its civil commitment laws so they prevent dangerous situations rather than requiring them. Of course, civil rights are important. This isn't about civil rights. There's nothing civil or right about waiting for someone to be so ill that they're homeless or dangerous before you can intervene.

Before I conclude, I want to clarify a few items. The first, the issue of cost has been raised. A number of states in recent years have passed outpatient commitment laws without any funding allocated specifically to those laws. I'm aware of no states that have spent millions of dollars on enforcement, in fact, the opposite. Where these laws have been implemented, cost savings has been seen.

The second, stigma, we've heard a lot about stigma today, and it's -- it's a real issue and it's an issue that we need to be cognizant of. And people receiving treatment are no more violent than the general population. I think the key words are "receiving treatment." Excuse me. But doing nothing to change how people and families that are dealing with psychiatric crisis are able to access your system and are thwarted by restrictive civil commitment laws is sure to increase stigma. I suggest that a more effective way to decrease stigma is to make sure people receive adequate treatment before a psychiatric crisis.

And the third point I'd like to touch upon is there's been a notion that outpatient commitment and reform of civil commitment laws is tantamount to regressive measures. And currently, there are twice as many people in the

Connecticut state jails and prisons than there are in psychiatric hospitals. I don't think anyone wants to go back to the days of institutionalization. That's not the goal. But I can't think of something more regressive than imprisoning someone with an untreated mental illness rather than providing treatment before they end up in jail.

And in closing, while the Connecticut mental health system does many wonderful things, it has failed to provide treatment to this small subset of its most vulnerable citizens. While the current discussion is largely a response of what happened in Newtown, your law enforcement agencies, emergency room directors, homeless officials and others would likely tell you that smaller, less publicized tragedies occur routinely in Connecticut as a result of untreated severe mental illness.

Improving your state civil commitment laws will not solve all of the issues of the mental health system and will not prevent all tragedies, but it is a critical component to any discussion of accessing your mental health system and public safety. Thank you.

SENATOR HARP: Thank you very much.

Are there questions?

I guess I have a question just based upon what Commissioner Rehmer said. She said that -- and maybe I heard it wrong, but she said that while there are 44 states that have outpatient civil commitment treatment that there are very few that have operationalized this. And so is -- is that your take on it, or do you -- or how do

you, I guess, how do you respond to that? Because I mean, I guess that that's what I have to balance what you've said --

KRISTINA RAGOSTA: Sure.

SENATOR HARP: -- with -- if you could, kind of, explain to us what you're saying and what the Commissioner is saying. It just seems like there's a disconnect.

KRISTINA RAGOSTA: There are 44 states that have statues on the book authorizing outpatient commitment or assisted outpatient treatment. Not all of those states use their laws well. New York uses their law better than probably any other state as far as broadly implementing it. But the fact is that Connecticut doesn't even have an option to use that law even if they wanted to. So, yes, states need to better implement their outpatient laws, especially with the severe shortage of psychiatric beds, it's going to become more and more relevant. It's a less costly, less restrictive alternative than hospitalization and -- and jail. So the use of the law is -- is not as good as it could be, but there are a number of programs throughout the country that are using these laws and implementing them well and have seen great results.

SENATOR HARP: Thank you very much. If you could provide information to us regarding those programs that you think work well and that sort of define how they operate, we would be happy to take a look at it.

KRISTINA RAGOSTA: Thank you for having me.

SENATOR HARP: Thank you.

Well, we actually have a couple more speakers and it is two -- almost two o'clock, and I thought that we would try to take Jan Van Tassel, if she's here, and then will start the public testimony.

JAN VAN TASSEL: I'm sorry. I was checking with Dr. Griffith, because I didn't know if he was on a short time frame.

SENATOR HARP: Why don't we do this? If you don't mind, why don't we let Dr. Griffith come and then --

JAN VAN TASSEL: It's fine with me.

SENATOR HARP: -- what we will do, we've got to start the public portion. So if he'll come now. Then we'll -- after we do the families, we will bring -- we'll weave everybody else in.

JAN VAN TASSEL: No problem.

SENATOR HARP: Okay. Thank you.

Good afternoon. You can begin when you're ready.

DR. EZRA GRIFFITH: Thank you very much, Senator.

I am Ezra Griffith, and I come from the Department of Psychiatry at the Yale School of Medicine.

Senator Harp, Representative Wood and members of the working group, I appreciate this opportunity to engage in a brief discussion with you about

the topic of outpatient commitment. It is a method that is intended to leverage mental health treatment. This is, as you know well, a form of court-mandated outpatient treatment for individuals suffering from mental illness.

I do not have to emphasize that this subject has been at the heart of an intense, passionate debate among members of many different constituencies in the United States and in both the lay and academic literature for many years.

I wish to enter the debate with the intent only of clarifying a number of principles that all of us should consider as we think about the subject. First, the publicity surrounding, for example, New York's Kendra -- Kendra's Law, has obscured the fact that the man who pushed Kendra Webdale to her death on the subway tracks on January 3, 1999, had been rebuffed by the mental health system in his efforts to seek treatment. So an OPC statute -- OPC meaning outpatient commitment -- an OPC statute was not needed in that case. And nothing we know so far about the Newtown incident cries out for an OPC law.

Second part, we should remember is that media portrayals of the mentally ill often frame them as violent, which we all know is a distortion of reality. And I note, Judge Killian's statement this morning that the vast majority of psychiatric patients are not dangerous.

OPC is only one form of coercion or leverage coercion applied to individuals with mental disabilities living in the community. It is, therefore, crucial that we all reflect on our interest in having the mental health care system as devoid of coercion as possible. Certainly,

we should appreciate the need to balance coercion with a commitment, our commitment, to patient autonomy and respect for the patient.

It is even difficult for many of us to understand and to discuss OPC thoughtfully because of the difficulties inherent in the definition. For example, Swartz and Swanson's definition emphasizes certain points, such as, that the target population addressed by OPC is ill; the population needs treatment that it won't seek voluntarily; and proposed services will improve medical and social ills. There, the definition ends.

Now, one could consider another definition which emphasizes that OPC is a legal tool that targets, for treatment, members of minority groups who are generally victims of social conditions; thus, OPC could be seen as primarily a means of social control.

There's another possible definition of OPC, another definition posits the following: OPC is a legal method of ensuring that a certain defined class of patients is given priority in gaining access to scarce mental health and social service resources. In other words, this group is potentially moved to the front of the line for service.

Hence, definition number one emphasizes treatment; definition number two pushes social control and ultimately will concentrate on the needs of the broader society; and definition number three prioritizes the needs of a class of patients caught in poverty, serious and chronic illness, and lacking a variety of social supports.

Understanding the range of values and assumptions will also help us appreciate why the 44 or so states with OPC statutes engage in varying levels of their use. And we must not forget that. Regardless of what the testimony sounds like. In fact, the states with OPC statutes implement them in varying ways. And only last night I reviewed another article on the -- New York City's Kendra's Law that everyone thinks is the panacea for -- for all our activities -- and it is amazing that in this article even the statute within the confined area of New York City is applied unevenly. So that the private hospitals use it one way, the public hospitals use it another way, and so on.

Now in thinking about these statutes, then I come back to the principles once more, and I say is it -- it's hard to decide whether the primary intended beneficiary of OPC is the individual or, alternatively, is the society? Is the emphasis on social control or on autonomy-enhancing community-based living? Are we committed to the task of enhancing the patient's right to living in the community and enjoying the privileges of the average citizen in this democratic society? And here I credit the thinking of colleagues, Michael Rowe and others at Yale who are emphasizing this notion of citizenship.

In addition, even Swartz and Swanson concluded in their review -- and they're the authors who have done such wonderful work on looking at the New York City -- the New York State statute -- they concluded in their review of OPC that, quote, OPC is not a substitute for comprehensive services.

And this conclusion was recently restated by Professor Richard Bonnie in testimony before the Governor's Advisory Commission on the incident in Newtown. In other words -- in other words, you can talk all you wish about OPC. OPC without effective community services and well distributed community services and without the money invested in these services it doesn't work as much as people are talking about.

A few last points deserve your attention. OPC is not a tool surrounded with magic. OPC statutes, for example, generally have no provision for use of involuntary medication. Patients may refuse to conform to the dictates of the OPC treatment plan with no serious consequences to follow. In other words, OPC is often a threat, but the threat, in fact, when you look at the statutes carefully, the threats mean absolutely nothing. So all the people talking about, there's not as much need for the statute since, in essence, in practice, the statue doesn't mean very much because if I refuse your -- your services, you can't do anything to me. The existing research findings -- I want to repeat this -- the existing research findings do not confirm that OPC is uniformly beneficial. Some studies say it is; other studies are waffling all over the place; other studies criticize the studies, the previous studies because of the methodology.

I am not saying, ladies and gentlemen, that there aren't some studies that have found that OPC is beneficial to some patients. All I'm saying is that the claims attributed to these studies are not justified. There are some findings in OPC research suggesting that blacks

are more commonly committed than whites -- I wish to repeat that -- there are some findings in OPC research suggesting that blacks are more commonly committed than whites.

Now listen to me carefully, the meaning of this work is not yet clear so I do not wish anyone walking out of here saying, Griffith had said that people are being biased and doing all kinds of things to black people in this country. I did not say that or although I believe that there's substantial evidence, I could say it, but that is not -- that is not, ladies and gentlemen, what I am saying here. All I'm saying is that there are some findings in OPC research suggesting that blacks are more commonly committed than whites. And the meaning of that is not yet clear; although, those data are there. And in fact, this is very interesting because the major finding related to the difference between -- the difference in application between blacks and whites is precisely in New York State, and the authors who have gone and looked at that are suggesting that, indeed, it is not in the application of the OPC statute that you get the difference, but in the way in which up-streamers, they call it, the way in which blacks and whites are allocated to treatment groups, and so on. So, in other words, they say that blacks naturally are predominant in the OPC pool because they are poor, they are this and they are that, and that's why they're in the pool. So that's the interpretation so far, but that needs to be, in fact, verified carefully.

I hope I've given you all some matters to ponder and that was my purpose in coming, not to add any more smoke and fuel and all that to the

debate but, indeed, to try and ask you to reflect and think about what it is you're contemplating and what is it you're trying to do.

In that light, I believe that at this juncture in time, we do well to think about investing, investing in our present care system and enhancing it in creative steps. The more comprehensive the care system is the less risk, in fact, we, ultimately, run as we work hard to provide all our patients the chance to be full citizens who avail themselves of the privileges to be enjoyed in this democratic society. Thank you very much.

SENATOR HARP: Thank you very much, Dr. Griffith.

Are there questions?

If not, thank you for waiting we appreciate your remarks. Thank you so much.

DR. EZRA GRIFFITH: Thank you.

SENATOR HARP: So I am going to turn the public hearing over to Representative Wood, and we have families who have been impacted by this awful event in our state who will be testifying.

Representative Wood.

REP. WOOD: Thank you, Senator Harp.

And also thank you to Dr. Griffith. It was very, very good testimony. Thank you.

We have one more person to speak in the informational section, but we're going to slot them behind the families who are here to speak.

First one is Taina Marquez.

TAINA AMARO: Good morning. My name is Taina Amaro and I'm reading in my sister's testimony.

My name is Nelba Marquez-Greene, and I'm a licensed marriage and family therapist. I am the coordinator for the Outpatient Clinic at Klingberg Family Services, and adjunct faculty of Marriage and Family Therapy at CCSU.

Today, I'm here as an expert, victim and grieving mother. My daughter was murdered in Sandy Hook on December 14th by a troubled man within AR-15. She is survived by a family and a community that are forever changed. My prayer is that she will be survived by a state and a country that will use this tragedy as an impetus for change.

Connecticut is in the position of becoming a model for the nation by improving its mental health delivery system.

There are three key points I would like to address in my testimony: first, the need to de-stigmatize mental health access and treatment; second, identifying and addressing gaps in the state's current mental health system; and third, implementing new family strengthening programs while enriching existing ones.

Connecticut must address the de-stigmatization of mental health access and treatment with simple, effective and economically sustainable

steps. Many families are hesitant to explore mental health services due to a lack of education or societal stigmatization of mental illness. This results in many families not getting the help they need.

One potential solution is to expose families to trained mental health professionals who are integrated in natural settings, like schools, churches, libraries, and community centers.

If having trained staff within each school is a work in progress toward an overall goal, we should at the very least, assist our schools in providing students with effective mental health supports. School staff should be aware of services available within the community they teach and receive comprehensive in-service trainings regularly to assist them in identifying concerning behaviors, such as increased isolation, limited social skills, threatening behavior, bullying or drug use that signal the need for further evaluation.

Along the lines of the country's successful It Gets Better campaign in response to the alarming rates of suicide within the LGBTQ youth, Connecticut should promote the implementation of PSAs that provide mental health resources and information for caregivers in a strength-based manner. We are physical and emotional beings, and taking care of our whole self should be the norm for Connecticut and our nation. Paralleling emotional wellness visits along with wellness visits to determine if children are reaching milestones and developing appropriately is an area where there is opportunity for the integration of both physical and emotional wellness.

There aren't enough trauma-trained therapists, crisis counselors and children psychiatrists in the state. The waitlist for seeing a child psychiatrist can be months long. This can be especially problematic for families that don't meet the strict criteria for community-based mental health programs. Psychological disorders usually emerge before people enter high school but only one quarter of children with problems see trained professionals.

There isn't enough funding for programs designed to help children and families. Many programs deplete funding they receive quickly because of the multiple needs of families. Other times the state will contract with providers and not reimburse them in a timely way, making it difficult for services to continue. Managed care companies need to be educated and encouraged to allow for flexible mental health structure as needs increase and shift within our communities.

Training and quality supervision from seasoned clinicians and leaders in the field is critical. More often, children are presenting with experiences that fall under the diagnosis of complex trauma. Forty-five minute session, one time a week are not adequate. A standard set of questions from page 46 in our traditional therapy books is not sufficient and can exacerbate trauma symptoms -- excuse me -- when one is not sufficiently trained.

Mental health professionals working with children often lack access to caregivers whose problems may contribute to a child's troubles sometimes due to their own mental health needs

or inadequate insurance coverage. In some instances when a child is identified as needing an evaluation, a parent will refuse treatment based on fear, mistrust, denial or lack of education. Clinicians who spend time with parents in natural settings with a focus on building relationships and gaining trust have a greater chance of securing parental involvement.

We must focus our attention on programs that increase empathy in the early years and build necessary skills that decrease risk and allow youth to thrive. Many children don't have healthy attachment bonds with caregivers. This typically results in challenges developing meaningful relationships throughout their lives. We must focus on finding ways to encourage relationships and consistently reinforce the importance of human contact.

Responsible, stable, and nurturing relationships between parents and children are the cornerstone of emotional well-being and are necessary for the promotion of healthy functioning and resilience. Parents face multiple stressors and for some, it is difficult for them to focus on the emotional and developmental needs of their children.

It is imperative that the state fully fund and support programs that offer supports to parents. Prevention efforts should include community-based parenting groups that provide a supportive environment for parents to share their experiences and work together to be the best parents they can be. It is much more effective to intervene early and promote health and wellness rather than repair damage that often results from warning signs that are ignored.

Peace promotion and violence prevention programming needs to continue to be funded and expanded for all communities. Many times these programs are implemented in inner cities with little attention given to suburban communities. Mental health access -- mental health issues exist everywhere. Promoting peace and teaching children and each other about ways to cope with the challenges we all face is vital. It is our responsibility to provide all children with an opportunity to learn how to develop survival skills to address the stress that they encounter.

In closing, I believe that if we de-stigmatize mental health services, address the gaps in our current system and focus on increasing prevention efforts, mental health efforts will improve dramatically within our state.

My Ana Grace was murdered. She was six years old. She was one of 26 innocent people massacred senselessly. This tragedy could have been prevented. As a state and nation, both personally and collectively and with organized action, we have to do everything we can to prevent this from happening again. We can achieve this by fostering compassion and treating everyone the way we would want to be treated.

Above all else, love wins.

REP. WOOD: Thank you. Your courage is exemplary. Your experience to share that is huge because you are a therapist. And we are here for you.

TAINA AMARO: I just want to clarify, although I'm also a therapist, I'm Ana's aunt. And I'm reading it for my sister who is also a therapist. Mental health kind of runs in the family.

REP. WOOD: Thank you for that clarification. We're here for all of you.

Ms. Marquez, would you be -- we don't have a copy of that testimony. Would you be able to submit that because it was quite well written? Thank you.

The next speaker is Jeremy Richman.

Go ahead. Thank you.

JEREMY RICHMAN: My name is Jeremy Richman, and my wife, Jennifer, and I lost our only child, a daughter of six years old, Avielle Richman, on December 14th in the Sandy Hook Elementary School atrocity.

Sickened with grief, we ask ourselves what drives someone to commit such shockingly cruel acts of violence. This was not an impulsive act of violence. This was planned with an apparent goal of achieving infamy. The shooters in Sandy Hook, Tucson, Aurora, Littleton, Blacksburg -- we will not grant them the respect of using their names -- were not in their right minds. Upon reflection, those who were familiar or crossed paths with these individuals consistently expressed the sentiment, there was always something not right about that guy. The shooters were all young men with a demonstrated lack of empathy and a strong desire to inflict great harm.

Jennifer and I are scientists. We try to make sense of our worlds in an empirical fashion. So in the wake of the shooting and from our grief, we need to understand why we have lost our daughter, her classmates, her playmates, her caregivers. Do you know how many letters from children and teenagers, my wife has received that simply asked why? Why or how can someone do such a horrific thing? We have read thousands. We believe it is our responsibility to them and to ourselves to find an answer. If we can know why, with that knowledge, we can prevent similar atrocities from claiming the lives of other vulnerable loved ones.

This desire to know why lead us to establish the Avielle Foundation. The Avielle Foundation's goal is to protect vulnerable groups from violence by supporting novel mental health research and fostering strong communities. The first objective of the Avielle Foundation is to understand the mental underpinnings that lead to violent behaviors and prevent them through mental health research, education and policy. Too little is known in the mental health area in regard to what drives these violent behaviors. Clearly, something is wrong with a person capable of such atrocities, and we are committed to building a better understanding of the biological and environmental, the nature and nurture factors associated with these pathologies.

The second objective of the Avielle Foundation is to foster community and ensure that everyone, regardless of their religious beliefs, political views or social ideologies, is a potential friend and valuable part of their community. It

is this open-minded and openhearted outlook that we instilled in Avielle knowing that a strong community is one where everyone belongs and is a valuable contributor. In such communities, individuals don't feel ostracized, stigmatized, bullied or alienated, and the propensity to act in desperate, destructive or violent ways is diminished or eliminated.

Once we gain a better understanding of the mental underpinnings of violence, we must educate ourselves and others to recognize those at risk. We must identify appropriate interventions. We must shape the institute -- and institute effective policies to prevent these violent actions. And we must ensure that our communities include and protect all individuals.

Citizenship in the community comes with responsibility. We must act to ensure this doesn't happen again. I ask you as a parent, as a responsible member of many communities and as a citizen of the United States of America to help craft policies that will protect our precious loved ones from this type of violence. Keep in mind that in less time that it took me to read you this statement, Avielle and 20 other innocents lost their lives at the hands of the mentally ill man who had access to firearms. This could've been prevented.

I don't represent any agencies, and I'm not a psychologist or a psychiatrist, but I would be glad to address any questions if you have any?

REP. WOOD: Thank you and I also applaud you for your courage in coming here to speak today.

Any questions from the committee?

No, but I think we all thank you.

Next family member is Jennifer Maxwell.

JENNIFER MAXWELL: My name is Jennifer Maxwell, and I'm a single mom who works full time, night shift at the hospital for over 20 years at Danbury. I have three sons. And one is my son Bryce who was one of the ones that was able to escape from Ms. Soto's class but lives with the nightmare every single day and talks about the events that has happened.

I have another son who is 11 years old, who's in the fifth grade who's doing remarkably well because I thought -- I don't know if it's the middle child thing, but he's actually okay.

And my oldest son who's 12 and a half years old is in seventh grade who has a battery of diagnose -- mental illness diagnoses that I have been trying for over nine years to get him the services that he needs. He has Asperger's, OCD, ODD, ADHD, PPT, NOS, XYZ, can I just go on? And I have been fighting for years to get him services. He does not have a very well social skills. He is abusive to his family. He's abusive to his brothers when he doesn't get his own way. He's been in therapy since he was -- I don't know -- we moved to Maine -- I'm going to go all over the place -- I'm sorry, I'm nervous.

I notice that Shane was a difficult toddler when he was two. He wasn't engaging the way a normal two-year-old was. He wasn't talking. He had an obsession with doors, in and out, in and out, and this lasted for years. We moved to Maine in

2003 for two years. And the state of Maine immediately noticed -- in his preschool -- they immediately handed me a sheet and said you need your son evaluated. And after all those testing, it was proved that he -- he was put on the autism spectrum. He had behavioral issues. He had perseverative speech. He had -- his gate was off, everything. So they put him into a special preschool and they worked on him. And they did a fantastic job.

When we moved back to Sandy Hook, in 2005, I had called the Sandy Hook School, it was the summer time, and I called for a PPT meeting for kindergarten. They told me they couldn't do it because everybody was off on summer and that they would get to me within the first few weeks of school. It was a month. He had no services.

At that point, Mary Sherlach, who was the school psychologist at the time, who has helped me through these years who was one of the ones that had passed, was going through the PPT meeting with me and kept on saying if he qualifies, if he qualifies, if he qualifies for services, if he qualifies for services. Yet, I had a stack full of documents from Maine of all the services he got. And you don't mess with a seven-month pregnant woman -- I was pregnant with Bryce, and I stood up and I said it's not an if, it's a when, and don't mess with me.

I know the system to a point, and they all looked at me and started to laugh. And she had told me a week later that, Don't worry, Mrs. Maxwell, your son does qualify because we're told to say that. We're told to say "if," because and that's -- I still remember her saying that and I'm just like that's not right.

And that shouldn't be it to save money. I understand budget cuts. I understand certain things but special education for my son and for other children, like him, is very important.

My son lives on -- as time has gone on, he has gotten the service he needed academically but not socially. He is socially inept. He doesn't know how to socially talk to people. He has no friends. He hasn't been invited to a birthday party since the second grade. He's alone. He doesn't go to the cafeteria. He doesn't do a lot. And I worry about him because he is very impulsive. If he doesn't get his way in the house, he will go after his brothers and hit them even though they don't have anything to do with it.

We have asked the therapist, he's been on a battery of meds for ADHD, which has worked. They put him on mood stabilizers, which don't work. We have two sides of Shane: the one where he's in school, where he's the golden boy, everybody loves him, he does what he needs to do, everything is great. You get him home, he's abusive. He goes after his brothers. He wants dominant control. And I'm trying to juggle three children and work nights and try to keep my son on even -- his behavior is up and down. His psychiatrist tells me -- who is a wonderful guy who's been working with him -- he says he's a very difficult case, and we still have not gotten through to him.

After this tragedy on the 14th, I couldn't find my seven-year old. I couldn't find my son for two hours. I was going crazy looking for him, crying, doing all sorts of things for two hours. Didn't know that he was one of the runners who

was found half a mile down the road with four of his other children when a mom found them. I know the mom. Thank God. She had brought them to the police station unbeknownst to me. I had just came off night shift. I didn't know what was going on. My phone was ringing relentlessly. It was Shane calling from middle school over and over and over again. I had to take my time out, go somewhere quiet and call the middle school because I had to calm my son down. He does not like changing routine. You get a change in routine, he goes off the deep end and you cannot bring him back for weeks. He was pacing in the middle school. And they said we don't know what to do with him. You need to talk him.

Oh, gee, I don't know what to do with him, put him on the phone, and I had to talk to my son as calm as I could and tell him he's in lockdown. He is in the safest place he could possibly be. I need to find your brother.

And he says, I'm scared, I want to come home, you got to get me now.

And I said I can't.

Because he has OCD and he has an OCD with time I had to also go up with him and tell him don't worry what time you get home from school. Do not go home, go straight to the neighbor's house because I know he would watch the TV and get scared.

He's a 12-and-a-half-year-old with an emotional level of a nine-year-old. He has no empathy when he hits his brother.

My whole thing is I have been asking the school system for help in the social skills because I have been watching him go down. And I don't want anything for him because he is very impulsive to do something drastic. He's 12 years old. His hormones are kicking in. It's getting worse. I can show you the bruise he gave me the other day because he wanted the remote and his brother had it. And I said it's his brother's turn and he didn't care. He goes to the hall and slams his seven-year-old brother, and I ran after him and he slammed me.

This is impulsive, but I need help for him. I called a PPT meeting and his school -- his psychologist and his psychiatrist, everybody is at a roundtable, and we need to do something now. It took something like this because I don't want another tragedy. Would I think you would do it? I don't think so but who knows? He's 12 years old.

But if I don't get him social skills to prepare himself for when he's 18, what am I going to do? What happened on the 14th? I had to use -- he doesn't learn by talking, he learns visually. After the 14th, I actually had to use that and tell him, see where anger gets you if you don't knock this off and get into some sort of control. For three weeks, he was okay. He's back to it. I called the school. He's in a social skills, finding out, it's not working. The kids there -- there's five kids, four of them get it in social skills when they give him a scenario what would you do. Shane has to be given the answer. I asked what are we going to and do? We don't have the money.

They want -- my psychiatrist wants to have him retested to find out where he's at. They asked for a neuropsych screen, and the school says we don't do that. We don't have the resources. This is all I hear is we don't have the resources in your area. He's been hospitalized. Danbury Hospital it's after five o'clock. There's no pediatric intervention. There's no -- nobody. We have to stay in a tank, and we call it the tank in the hospital for anybody -- for anything that needs to be held until they get the help they need -- with drunks, adult drunks, everything. A 12-year-old with these people in the hospital overnight. I asked because I work there, move us out into somewhere else because he doesn't belong here. And then we have to wait until the morning before somebody can talk to him and move him to Four Winds in Katonah.

He did fantastic in Katonah because he did what they wanted. They wanted to put him on Zoloft, I said no because it manifests bipolar earlier, and I didn't want that unless they're going to keep him for two hours -- 10 days. They discharged him in two days. And not one therapist could figure what was going on because everybody was on vacation, too many hands in the pot with my son. Five minutes later he hit his brother on discharge.

What I'm asking is I'm really getting tired of fighting with the school system. I understand about budgets, but it's the first that's cut with the special education from what I hear. I could be wrong. I have more friends that are fighting for children for services to prevent anything like this to happen again. I'm

reaching out as a mother with a son that's increasingly getting more and more withdrawn.

The insurance company, as soon as we're admitted they want to know how fast they can get you out. They don't care about your treatment. I believe if you have a child over the age of 18 and he's still in that -- and that person is still living in your house on your insurance plan, known to be a danger, behavioral issue, they should still have the right to get that kid help. Not because they're 18 and they can't do anything about it, they're still your kid living in the house.

I don't know. I'm babbling. I'm sorry.

HIPPA rules are drummed in our head working in the hospital. I don't know. It should apply -- I don't think it should apply for people who are known to be aggressive and violent and who have been identified to get them the help that they need before something like this happens again, whether it's here, Newtown, Aurora and anything like that.

I don't know. I just -- I think I just need help. I don't know what else to say.

REP. WOOD: I think you've -- you've said it pretty well. Thank you.

Are there any questions from the committee?

No.

Before we open the public hearing, we're going to -- oh, I guess we have opened the public hearing, but we're going to go back and catch

Jan Van Tassel, who is Connecticut Legal Rights -- executive director for the Connecticut Legal Rights Project.

JAN VAN TASSEL: Good afternoon. My name is Jan Van Tassel. I'm the -- yes --

REP. WOOD: Your testimony is wonderful. It's very, very long.

JAN VAN TASSEL: Oh, I'm not reading my testimony.

REP. WOOD: Okay. (Inaudible.)

JAN VAN TASSEL: There was a miscommunication about what I was supposed to cover, which is why you ended up with a supplemental. I will do my best to try and hit key points.

REP. WOOD: Thank you very much.

JAN VAN TASSEL: No, no. I don't blame you at all.

REP. WOOD: It's wonderful and rich reading but (inaudible).

JAN VAN TASSEL: No problem. Actually look at the attachments.

My name is Jan Van Tassel. I'm the executive director of the Connecticut Legal Rights Project. CLRP represents low-income adults with psychiatric disabilities on matters related to their treatment, recovery and civil rights.

I want to touch just very briefly at the outset about the nature of probate court proceedings. I think many people know this but in case you don't, probate court evolved from a very

paternalistic system where -- they only adopted the rules of evidence a few years ago -- although those few start to muddle as I get older -- the point was that they were acting as more as a parent than a legal system, like the criminal court. In fact, it's a little bit more -- for those of you old enough to remember this, it's more like Father Knows Best than Perry Mason.

Part of the issue for the people -- our clients in the probate court system is that some of that is carried over and, therefore, there have been issues about the nature of their representation and they're being heard in the system. And in fact, just last year, the Legal Rights Project successfully won a case in the state Supreme Court that actually clarified that -- or reaffirmed that attorneys are required to represent the client's preferences and not to be trying to decide what is best for the client. The point of all that is the probate court system generally is not a system that people with psychiatric disabilities feels hears them. And that's actually demonstrated by Senate Bill 614, which is proposing to have the public defenders take over the representation of people in probate court.

I'm not sure that's the right place for it, but I wanted to mention that just because the whole notion of expanding the authority of the probate court judge is troubling to us at the outset.

Also before I address the issue of outpatient commitment, I want to clarify a few things that were said because I think the impression may have been given that the commitment standards in Connecticut were pretty loose when, in fact,

they are broader than most states once you take aside the idea of involuntary outpatient commitment. Connecticut has, as prior speakers have said, a dangerousness to self or others but also a gravely disabled standard, which is pretty broad. So it's not difficult to get someone committed in Connecticut. I also want to clarify that Connecticut has some of the best jail diversion alternatives to incarceration and reentry programs in the country. We don't have enough of them. There are still people with mental illness who are being released from prison to shelters, but we have actually reduced the rate of people with mental illness going into prisons as a result of those programs. So I didn't want to create the impression that there is this continuing stream.

Given this context, I am concerned about expanding and implementing outpatient commitment, and I think people have made it clear, even the proponents of outpatient commitment, that it really has nothing to do with the violence in Newtown. It has nothing to do with random acts of violence at all. And in fact, as I think Commissioner Rehmer pointed out, there have been perpetrators of violence, including in Virginia Tech and some of the subway killings in New York, where people have been under involuntary outpatient commitment orders. I think it's important to understand what an outpatient commitment order will and won't do, and this is something that Dr. Griffith, I think, was making the point. And Commissioner Rehmer, again, noted that most states do not require -- they may on paper require that you take your meds or go to treatment, but, in reality, there is very little that can be done to enforce that.

And I want to emphasize you can already go to the probate court -- and again this routinely happens anyway -- to get a conservator. You've gone to the court; there is a conservator and the probate court judges routinely remind the person that they have to comply with treatment, they have to do what the person says. They've already got one piece of paper. Another piece of paper is not going to make the difference. What I believe that we need to do is expand the services -- and again as Commissioner Rehmer suggested -- probably develop some specific services for young adults who are experiencing their first break of a psychiatric illness. You know, they aren't really the focus of their young adult services program.

I am concerned that outpatient commitment is really a knee-jerk reaction. In fact, that's exactly what the Hartford Courant called Kendra's Law in 1999 when New York implemented it. And they criticized New York for moving quickly without regard to the unintended consequences that would result from that statute, including the stigma, again, that we've talked about today. The editorial went on to note that the real issue was the state's failure to keep its promise to put in place a comprehensive community-based system of care when they close state hospitals. And that hasn't happened and the Hartford Courant, again, concluded that we'd be better off putting money into services and that's what we need to do.

I want to actually mention three things, I think that -- you have some materials on them on the attachment that I think would be useful -- number one, I mean, there has been some talk

about housing. I think Judge Killian mentioned housing. There is some -- there are some materials there about a housing program in New York called Housing First or Pathways to Housing, which is targeted specifically to people with serious mental illness who have been resistant to medications and most of them are homeless. And the notion of Housing First is that rather than make a person earn each step to get their own housing, they give the person housing, they have interventions by a, sort of, community treatment teams which you've heard about from others, and I would suggest also peer support -- we'll touch that in a moment -- and that program, as you can see there, found -- they found that after a five-year study that 88 percent of the people who had been given housing, retained that housing, compared to those in residential treatment programs, which is 47 percent. It's a remarkably effective program and people build their own recovery from there but having that housing really is a foundation for a recovery.

Second, as I just alluded to, I think that we need to do more with peer support. Connecticut has an excellent peer support program, but -- and I attached some materials also from New York about what they called their Peer Bridger Program. And the Peer Bridger Program actually has a peer who goes into the hospital and starts building a relationship with the person while they're in the hospital, stays engaged with that person when they go into the community so there is that consistent kind of input; and then, hopefully, that person would realize that there are problems and be able to relate to them. Peers need to be a critical component of anything you do and because they're the ones who

can really call people on it, and they can really say things that -- a clinical person says it, it sounds coercive, when a peer -- when somebody has been through it says it to you, it makes a world of difference. So I think that's another component.

Lastly, I want to mention the advance directives because advanced directives are not unique to people's psychiatric disabilities. They are simply the legal document that allows a person to control their health care decisions when they're not able to do so. And you execute an advance directive; you can spell out what your medication preferences are; what kind of treatment preferences; even what kind of interventions work for you. If you're upset, do you like to be hugged or is that the kind of thing that's going to set you off, and it does vary. It allows you a point -- a health care representative who will then be able to control your health care decisions following your instructions if you're not able to do it. And that actually circumvents the need to go to probate court and get an order.

If we can have people executing more of the advance directives, which are our program does for clients, we think that is actually consistent with the recovery model system of care that we have in Connecticut, allows the individual to have some autonomy and control over that decision making but gives a tool to be able to try and have that person get the right services.

And one last comment -- oh, I'm sorry. I have two -- one is on the studies. And I do want to make the point that I think Dr. Griffith has

made this point but there are no studies that have had a really valid control group to compare whether it is enhanced services that the person gets, and in every state -- except Judge Killian's -- the person gets an enhanced set of services, not just medications. In other states, there is an enhanced set of services that go along for the person who is under the outpatient commitment order. That's one of the reasons a lot of states haven't implemented it because it's -- it's very costly, but you get the advance -- and then can create an incentive to go to the head of the class.

But there is a study that claims to have had a control group, one in North Carolina, but the fact is the group that was voluntary were actually people who were told if you don't volunteer, you're going to be put under court mandate. That's sort of the way they volunteer in the Army, but it's not really the way you actually get a scientific control group. So I -- I think those claims -- what they have not been able to do is separate out, effectively, what's the impact of the enhanced services and what's the impact of the court order. And that's the big debate, and it can be a glass half empty, half full. They do show strong outcomes, but we don't really know the causal relationship for that.

Okay. I knew I was going to tell you one other thing, and I lost it so.

I think that's all I have to share with you. Hopefully, you will look through the materials, and if I can help at all in the discussion, I'm around. Thank you.

REP. WOOD: Thank you. And one more speaker for the informational session, Dr. Karen Kangas, executive director of Advocacy Unlimited.

DR. KAREN KANGAS: Good afternoon. Thank you. I'm sorry that I -- this morning I didn't have this shirt on. This afternoon I have this shirt on because this is what our agency is wearing, and we're wearing this shirt because what's happened to all of us with our voices is that we are really being targeted by the media, "the mentally ill, the mentally ill, and we're being targeted by the guns and the mentally ill," so -- and I'm -- I'm really here to talk about discrimination and stigma, and we've talked about it all morning. And I -- it's interesting that I'm the last speaker, and I'm going to be the only speaker of the morning session that's going to tell you, when you think about discrimination, I'm the only person that's going to can tell you I have mental illness. Isn't that interesting? And you wonder why there is discrimination.

I'm going to tell you that I'm 70 years old, just had my 70th birthday, and I started -- I was a teacher. I was a principal of a school so you can imagine what Newtown did to me, not only in one career but in another career, as well. And so to think about all of that and to think here I am -- what discrimination does to all of that is to think -- because when they found out in the school system that I had been diagnosed with mental illness, my job was gone. They didn't want anybody with mental illness, certainly as a principal. They didn't think I could do that job. This is prior to ADA. So I'm just telling you that discrimination is very real. It hurts; mental illness hurts. It's

very real; it's very painful. And you think about what happens -- and the last -- I was speaking about when I started speaking before legislators -- and I'm really happy to be here -- actually, I talked about my friend who went with me 30 years ago, we were asked to come to the LOB to speak about the DMH budget. And I said, Would you come and speak with me?

And she said, Oh, I'll come. One other person I could get to speak with me. She said, I have mental illness.

And I said, Okay, I have mental illness.

And she said, My husband has mental illness. My kids have mental illness.

Finally, I kicked her and I said, That's enough, that's enough. You don't have to tell any more family members. That's enough.

But we didn't have people to do that. We didn't have people to do that. Now we have people to do that. Does that make a difference in terms of where we're going to go? It makes a difference. It makes a difference. In my 30 years of working in this field, I can tell you that if -- if I had 30 more years to live or more than that, I know we're starting to turn the corner of helping people. We're helping people in a real way, not by doing outpatient commitment, by reaching out.

I can't tell you how many people have called me and said, would you ever visit my family member? Would you ever visit my uncle?

I remember visiting somebody in Colorado. I didn't know the person in Colorado. I said, Sure, I'll visit your family member in Colorado. We have -- Borders Book Store was a good place to visit people, by the way.

And I said, Where do you want to visit?

Borders Bookstore.

Very good, good place to visit.

What did I visit people about? What do you think they wanted to know? They wanted to know about hope. Is there hope? There's hope. Is there recovery? Do I get to have a life? Yes, you can have a life. Can I get a job back?

Those were the same questions that I asked about when I got diagnosed. Can I have a life back? They took my job away, and I thought do I ever get to work? Yeah, I have a doctorate in education and a psychiatrist -- this is the part of my testimony this afternoon and I'm going to leave out now -- but the doctor said to me you'll never work again. That was 35 -- 40 years ago.

And I'm thinking, Oh, my goodness, I'm never going to work again. What am I going to do with the rest of my life?

Do you know what? I've never stopped working. I've had wonderful jobs. Sure I've had lots of support and lots of help, but I know there's some good things that can happen.

One of the things that we've never done very well that we're just starting to do, and I'm now

the executive director -- I work for the state for 25, 30 years, I worked with the commissioner's office. One of the things that I do now is I'm the executive director of Advocacy Unlimited. And Senator Harp came to one of our graduations at Recovery University. We're very proud of that program, and I think you have that on one side of your page. At Advocacy Unlimited, we have some really good programs. One of the things that we're really stressing is there's a lot of ways that you can get well and a lot of ways you can live your life. There's a lot of holistic ways of living your life besides just medications. That's just one way. That's one tool. There's lots of tools. And there's a lot of ways of getting back your life. A lot of it is with friendships and support. And so we really talk about things that I certainly need to do more of, lots of yoga, lots of healthy living, healthy eating, thinking, meditation.

I actually teach at Central Connecticut State University, which is really -- so not working again, I do work again. I teach mental health counseling so I talk about mindfulness and thinking and meditation. And all the students look at me, and then I get little secret e-mails that say, oh, I wish I had your courage, I'd love to tell you. And I know that this morning, and I know that legislators in this building have seen mental health professionals. How do I know that? Have you all told me that? Maybe, maybe not, because I'm not going to -- I'm not going to out you, so don't worry. I'm not going to look at you and say, oh, yes, I know you. I won't do that, I promise. You don't -- you can trust me. Because I know that because there are so many of us -- we live -- probably one out of two of us has seen somebody and good for you.

I always go to audiences and say good that you've gotten some help because that's what you need to do is to get some help, is to talk to somebody, it's okay. It's really okay to talk to somebody and get some help. That's what we need to do. That's what ends it, and then it's okay to talk about it. It's really okay to talk about it. And we shouldn't be afraid to say something about it.

And so for 30 years, I say I have mental illness, and I'm thinking sometimes I forget say my name is Karen. I don't think I even said that, did I? I forgot to say what my name is. Because I'm so used to saying I have mental illness, and I'm thinking, well, I actually do have a name. But anyway -- and I -- when people say I have mental illness, I say oh, good, good, good, and they look at me like, it's not so good.

And I know it's not so good but for me it means it's a good chance for us to get together and see what would we can do to fight. And I don't mean fighting to win something, to get it better, to make it better. And it makes me happy to think about the fight that we have fought together and the fight that we will continue to fight because I know how important it is.

So I'm not going to go on and on, but I know Recovery University and all the programs that we do at Advocacy Unlimited, including all our peer support teams have really, really worked for people. We have people that call us. We have 900 people on our database that want to take our programs. And the people who want to take our

programs want to talk about their recovery. They want to work in the system because they want to help somebody else. They're okay about sharing. They don't want to share their whole story, of course not. No one wants to tell the whole story, but they want to share. I've had that experience, and I want to share that part of the story.

I'm going to end this discrimination. I want to end that stigma. I want to help somebody else. And if we can do that, maybe it wouldn't be so bad and maybe we could go back, and maybe in those school systems we could help.

I remember teaching young children, and we didn't have so many children diagnosed. They just didn't get diagnosed. Did they have some difficulties? Of course, they had some difficulties. We did lots of different things. And as a teacher and as a principal, I did a lot of different things. You have to be kind of creative and think about all the things that you can do, certainly not to punish, and certainly not to outpatient commit them. I would have never have thought of that, or hurt them. I would be kind and caring and bringing in family members and bringing in the support and seeing what I could do. I've done a lot of speaking in schools since I've had my jobs of 30 years. It's amazing when I go into schools and talk to kids, and I say, guess what? I've been hospitalized at the IOL, I've been hospitalized at wherever.

Really?

And I'm thinking, well, I'm kind of old now, but I have been. And kids come back to me in the

afternoon, and I said, But you were in the morning class.

But I'm coming back in the afternoon because I never knew anybody would come back and talk about it again.

And I'm saying we need to do that.

I have people that work at AU and all of us are in recovery at AU but many people are going back and getting their MSWs. They're not going to be here to talk today because they don't want to disclose, they don't want to open up anymore because, you know what? They're afraid they're not going to get jobs. I know some interns that work in the Hartford area. They have wonderful practices. Guess what? They're not can tell you because they're afraid they're going to lose you as patients because you're not can go to them anymore.

I had a wonderful discussion with somebody one night because somebody called me from OPM -- I don't think you know what OPM is but I'm sure you might know that -- and she said, would you ever talk to my brother?

And I said, Of course, I would talked to your brother.

So we went to one of the bookstores, Barnes & Noble's -- I think we went to -- no, Borders, Borders -- we always go to Borders. And by the time we finished talking, he told me his story and we just talked and talked and pretty soon he said, You know, I've never told anybody my story. By the time we finished, I had his office phone, his cell phone, his business

phone, and he said, This has been great, I've never shared this story. I've never told anybody but my family.

And that's the kind of thing that we need to do for each other because we need to be open and we need to have role models, so that's what discrimination is and that's what stigma is, and we live with it all the time.

And so not to be able to talk about it and to be the last person here is kind of sad that I'm the last person, but I'm glad I'm the last person. My father was a wonderful basketball coach. He actually was my best psychiatrist because he believed in winning and, boy, was he great about helping me win because he said, Don't give up, and here's another strategy for winning. And I'm glad I'm here and I'll -- you'll see me later because I'm coming back to tell you my real story, some more thing. Thank you, thank you.

REP. WOOD: Back to the public section, we are going to switch between legislators and the sign-up group.

First to speak is Tinia Rodriguez for Bridge House, and then Alice Forrester of Clifford Beers, and Representative Brenda Kupchick will be in between them.

TINIA RODRIGUEZ: Hello, good afternoon. Thank you so much, members of legislators. It's an honor and a privilege to be here in Hartford and to advocate for many mental health persons and young adults, as myself, and to share my testimony.

When people have the capacity to choose, they have the ability to change, quote, from Madeleine Albright.

Put yourselves in my shoes, a young child put into circumstances and traumas with no fault of her own.

Now picture this, a young adult brought about, brought up without any support or guidance or mentor to look up to. What do I do? That is always the question all young adults ask being transitioned to adulthood.

But, thankfully, there are services, agencies, and nonprofits that are available to direct our young adults to a positive, fulfilling, and productive life. However, much more funding and supported programs are needed to help maintain a safe and secure haven for those with mental illnesses.

In my case, thanks to the clubhouse called Bridge House, with 250 members strong, 40 young adults, as myself, I was able to succeed and maintain recovery. In Bridge House, I am not a client or treated differently because of my mental illness. I am a whole person. Caseworkers are called staff; and clients are called members. Each work hand in hand to cater to the needs and goals to fit each individual, such as housing, education, employment, socialization, and a place to belong.

Without these mental health services, I would not be able to function a normal and successful life. By cutting mental health services, it would ruin the infrastructure of our mental health system. As a person, we have the freedom

to choose to realize our condition and wanting to seek help, not because we are forced to. As young adults, we are already rebellious and seeking to find our way in society. Taking away our right to choose a mental health service that best fits our own personal needs will only cause us to shut down and isolate ourselves from others and lead to hurting ourselves.

Again, I thank you so much for this opportunity to speak out and advocate for all of us who are needing assistance in the mental health. Please, we need more support and funding for our recovery and the right to choose what services best suit our personal needs. Don't tear down our safety net please. Thank you so much. God bless everyone.

REP. WOOD: Thank you. And for the record, would you state your name. I forgot to ask that up front.

TINIA RODRIGUEZ: Yes, ma'am. Tinia Rodriguez.

REP. WOOD: Thank you.

A couple of guidelines we also forgot to mention. One, speakers are limited to three minutes, and we have well over 100 people lined up to speak so we will be strictly adhering to that; and two, we ask for no applause. That's standard SOP in this building so thank you very much. And please announce your name up front of the testimony.

ALICE FORRESTER: Good afternoon. My name is Alice Forrester. I'm the executive director at Clifford Beers Clinic in New Haven, the child guidance clinic, and I'm a mother of three children, adopted through DCS. And I'm honored

to have a few minutes to speak to you this morning about an issue at that clinic that we're gravely concerned about.

Clifford Beers, any of the people in the room understand that he was the founder of the outpatient mental health movement, mental health advocacy, the first psychiatric patient to write a book about his experiences in the hospital. And at the clinic, we're celebrating our 100th anniversary this year. And what we're trying to do is understand what does the next hundred years for mental health look like. And I need to tell you that we see over 1600 children a year, and 70 percent of those children come at intake reporting adverse childhood experiences. They report that they have witnessed domestic violence, community violence. They have been physically abused or sexually abused, emotionally neglected.

Our children at intake are reporting these bad things are happening to them. And they're coming to a mental health clinic because they have been -- because of those bad things, have experienced -- they are now in -- needing mental health services. We are looking at this as a public health epidemic. We believe that -- at a clinic, we started to look at kids at 16 who are in residential treatment facilities, and we said what could we have done to have -- not have them be put into residential or bring them back? And when looking at the records, we were saying that it was that age 3 -- three, four, five years old.

Our children are having bad things happen to them and no one is asking them until they start evidencing negative behaviors. We don't -- we

believe that this is -- needs to be treated like a public health -- public health epidemic, absent a cure. We need to have an answer to address these lifelong health and mental health effects of adverse childhood experiences. We need to conduct a public health campaign to address and reduce the ACEs. We should form, in Connecticut, a trauma coalition. We've been working in Newtown, in Sandy Hook, and they are very honored to participate in the healing process there, but I have to tell you that -- that what happened in Sandy Hook was extraordinarily awful, but our children come into the clinic who have witnessed violence themselves and they are -- they had -- did not receive assistance right after the aftermath.

We need to create a system, a public health system, in this state that addresses the trauma immediately effective after the experience. We need to create a system -- pediatricians, the schools need to assess for ACEs. We need to be brave enough to ask Are these bad things happening to you? well before any of the mental health experiences happen as they grow older?

We recently were part of a project that assessed 160 kindergartners in a New Haven public school. We found that 90 percent of the kindergartners reported high levels of stress in their lives: worried about their parents, worried about money, worried about food and worried about violence. Only 23 percent of those children were actually evidencing behavioral problems, that left 67 percent of the children who may be do fine, who may never have a behavioral health or a mental health problem later on in life. But it also leaves them a long path of

developing them if they don't receive any help or services.

We need to, as a state and as a nation, take adverse childhood experiences, bad things that happen to our children, extraordinarily serious and work together to create a system of care that actually addresses them. I think that all of the systems, the commission -- the agencies need to work together to form a trauma coalition. Unfortunate reason to do it now is because of what's happened in Sandy Hook. But at this point in time, we need to create a system -- we already have some beginning -- and access to services. It's the private providers in the community that step up that are trying to deal with these services across the -- the state. And I think at this point -- I think I'm way past three minutes but, well, maybe the timer is wrong, I'm going to keep talking -- no. But in general, I think that we have to create a system that addresses this immediately before the child has to show evidence of problems.

This is something we're extraordinarily passionate about at the clinic and, hopefully, can affect you -- infect you and -- well, my testimony says it in more detail so we need to ask every child and educate everyone around how to deal with it.

REP. WOOD: So, anyway, it's really to see you, Dr. Forrester. And I just -- one of the things that I learned at one of your events, is about these adverse childhood experiences, and not just mental health problems, but also physical health problems. So can you talk a little bit about that and --

ALICE FORRESTER: Sure.

REP. WOOD: -- why we should be concerned about it, just in terms of health care altogether?

ALICE FORRESTER: Sure. The research that was done at Kaiser Permanente in California, which is called the ACEs study, the Adverse Childhood Experience study that the CDC has now adopted, that over 18,000 white middle-class folks, that they were asking people on the number of adverse childhood experiences they had: was your parent an alcoholic; did you have a traumatic loss in your childhood? And they found people who had three or more adverse childhood experiences had 50 times more likely to deal with diabetes, obesity, cancer, heart disease, substance abuse -- 4,000 more times likely to inject IV drugs.

They've done studies of folks sitting in prison, 95 percent of the women and 90 percent of the men also had -- have ACE scores of four more -- higher. So the lifelong health impact of both mental health and physical health of adverse childhood experiences is severe. So I feel like if we were able to address this in a direct way and not be afraid to ask children about bad things and not be afraid to help the families and support the parents. Parents just want to do the right thing by their children. They need support, they themselves have had ACEs and they've not been treated, the folks that we work with. If we could address this, we would be able to have an impact, both on the health care cost, on Medicaid costs, costs of incarceration, reduction in juvenile justice -- I don't mean to be as grandiose as my founder Clifford Beers, but I have to tell you that if we were able to

actually address this, I think we would have a reduction of healthcare costs within 10 years.

REP. WOOD: Thank you very much.

ALICE FORRESTER: Thank you.

REP. WOOD: Yes. Thank you for your testimony.

Next is Representative Kupchick.

REP. KUPCHICK: Thank you. I am requesting to have my constituent from Fairfield, who is a caregiver, who is going to provide some testimony.

KRISTEN TIERNEY: Thank you very much. My name is Kristen Tierney. I'm a mental health advocate, a lifelong caregiver of a mentally ill loved one. I represent caregivers, my loved one and my business Turtles and Lemonade, which I started to support and give information to caregivers because I feel that it's a hole and we need support also.

Thank you for holding this hearing and listening to our voices. I feel the voice of the caregiver is the most important one to have at this table when discussing access, the successes and failures of mental health services. We navigate the public, private and insurance system year in and year out.

I ask you to look at the bottom line issues and the true costs of offering parity in mental health services. Parity certainly isn't easy to define. The numbers speak for themselves. Connecticut lost between 31 and 17 billion dollars in income tax revenue from caregivers

over the last 15 years. Over that same time period, insurance companies have steadily reduced coverage for mental health services, have posted unprecedented profits and health insurance premiums have increased 131 percent in the last decade. The insurance company's practice of having administrators, not doctors, recommend what is best for our loved ones is unacceptable. This practice reduces their cost, while increasing -- while reducing Connecticut's tax revenue and my personal income.

As a caregiver, I've had to fight for covered hospitalizations, secure exceptions for services denied my loved one, that are covered, research and find ways to access public services to add to the sparse services and therapies available for my insured loved one, pay co-pays and bus fares while building my loved one up who is unable to advocate and speak for herself while trying to work, take care of my family and volunteer.

We need a zip-line to services when someone with chronic mental illness reaches out. Neither the private, nor the public system, can expect a person with chronic mental illness to properly fill out disability insurance paperwork, advocate and be tenacious enough to break through a cumbersome system in order to access covered available services.

Information on services and support need to be advertised and publicized to caregivers more so than the chronically mentally ill. As an informed consumer until I came out of the closet as a caregiver, I, too, had little true information on the valuable services available for my loved one.

I urge you to read the Connecticut Office of the Health Advocates, January 5, 2013, report, and the Blue Ribbon Commission report of 2003. These reports were very difficult for me to read as the obstacles and problems I live and navigate daily were clearly spelled out 10 years ago and have cost Connecticut and my family quite a bit.

Please look at the true costs to properly ensure mental health services, examine the real costs to our state when care for our mentally ill loved ones is pushed onto nonprofessional caregivers.

Proper mental health care coverage will decrease, not increase, insurance costs -- that's a fallacy, and it's proven. I urge you to look at the MetLife study on that.

Thank you for your -- thank you for your -- thank you and your commission for holding this hearing. I urge you to stay the course and reach out to the caregivers.

Legislators, caregivers, mental health professionals and insurance companies should all be coming together to solve this problem. And the money will be there for the state programming if we fix this program.

Thank you.

REP. WOOD: Thank you -- no, please -- I know the applause is well intended, but it -- it's just standard operating procedure here in the building not to.

Thank you very much.

Any questions from the committee?

Thank you very much.

KRISTEN TIERNEY: Thank you.

REP. WOOD: Next is Mike Papa, followed by Representative Sean Williams and Dan Olguin.

MIKE PAPA: Oh, hi, my name is Mike Papa, and first of all, I would like to thank you all for -- to be -- to volunteer on this job. It's not easy to listen to everybody.

Okay. Basically my -- I'm a landscaper, ecological landscaper, and you may ask why am I in this meeting actually. To -- I hope that through my observations we may be able to -- to do some improvements because we do live in this perfect universe and when I say perfect universe, it means we are not the only one living there. There's also, you know, like flora and fauna. There's so many organisms living with us, and so I did bring some papers over here to give you some ideas. If we could be able to, you know, to learn more about the 30-year study that's been done, the organic could feed the world. And also if you want to look, you could see that in Cuba, they do actually use a permaculture, so they are in the middle of doing a revolution over there. So what happened is we -- and also in the back over here I explained pretty much of microbiology the way it works. So we -- when we got the system work with more our money, I think we do have more high-quality with the farms, and so people could be able to feed with the better food,

which as you know nutrients will heal or regenerate the cell walls, and as all we could automatically will -- won't have to treat all the symptoms that everybody's talking about right now.

So, basically, as we come more closer to nature a little bit, we can work with more discipline about -- about farming and also about landscaping. As I'm an ecological landscaper, you know, right now, you call it -- you call it, the Department of Labor, probably don't even know what ecological landscaper means. You know, so that's -- we want to -- what I would recommend is change always comes from the bottom, okay, so now we have to be very fair to the clients. They say that you license people for ecological landscaping with no pesticides and then we'll -- another license for pesticides. So it's very clear to the general public which system do they want to choose. Because right now they -- they choose -- they offer integrated pest management. It's almost like a Trojan horse, fool the general public into something that it's safer but then actually the landscaper that come and do things that's not safe. So we need to be very fair to the general public to offer ecological landscaping with no pesticides and pesticides and then the customers will make a decision and to do whatever is best for them.

Okay. That's it. And I do have something over here for you to share, especially with the 30-year study, you know, organic will feed the world actually. That will solve a lot of problems over here. And I would like to thank you again for all your volunteers, I mean, it it's not an easy thing. I tell you I would be

in trouble doing a job like yours. Thank you, okay.

REP. WOOD: Thank you.

Representative Sean Williams.

No. Thank you very much.

Dan Olguin, and after Dan is Patricia Benedict, and then Kerri Lynn Dirgo.

DAN OLGUIN: Hi. My name is Dan Olguin. I guess that's Daniel to you guys.

REP. WOOD: I'm sorry?

DAN OLGUIN: I said my name is Dan Olguin. I just said it's Daniel.

REP. WOOD: Thank you.

DAN OLGUIN: So I would like to speak out against mandatory outpatient therapy or forced outpatient therapy. As someone who has gone through it myself. And my argument is simple, I just don't think it will work. A lot of the people who have trouble are those who make poor decisions and haven't accepted that they needed help and making them attend outpatient therapy won't change that.

I'm sure you have all known, like had a family or friend or someone, who needs to change or needs help. And you can tell them that until there blue in the face, and they won't listen. They need to know, you know, they need to hit rock bottom to realize that I need help and to be able to let the recovery and the change in.

Also, having someone there, like when you're in an outpatient setting, you're sharing really painful and personal stuff and you need a secure environment. Everyone needs to be on board. And if you have people who are not participating or participating negatively, it really -- negatively affects the whole group. So that's my thing. Thanks for listening.

REP. WOOD: Thank you very much.

Any questions from the panel?

Thank you.

Patricia Benedict, followed by Kerri Lynn Dirgo.

PATRICIA BENEDICT: First, I'd like to thank Senator Harp and Representative Wood, and the members of this group for asking me to speak this afternoon.

My name is Patricia Benedict, and I'm the director of a project called Citizens Project. I'm here to tell you about this wonderful project and what we've done over the last 12 years. I'm not going to say all of that, mind you, I know I only have three minutes.

The citizens Project is operated by the Connecticut Mental Health Center and the Yale Department of Psychiatry through its Program for Recovery and -- Recovery and Community Health. It's funded by DHMAS, but I'm not speaking to you as a DHMAS representative.

This project began as a two-year study which, in fact, Michael Rowe, who Dr. Griffith has

mentioned -- is one of the founders of this project.

It began as a two-year study for people with serious mental illness, co-occurring substance abuse and recent criminal justice histories. The results of the study were so positive that it became an ongoing program. The Citizens Project has four components, which serve 15 to 18 students for a period of six months. The first component is wraparound peer support provided by Forensic Peer Mentors. The second are classes focusing on life coping skills, resources in the community, and even public speaking. The third is a group held in the beginning of each of our classes that our students created and coined "What's Up." It facilitated by the students who share -- what's happening in their lives -- and that means everything that's happening in their lives, whatever they feel comfortable with. They receive open and honest feedback from each other, as well as the staff of the program.

"What's Up" provides the students with -- as they have stated to us, again and again -- a safe place to talk about their feelings, a place where they don't feel judged and where they can express themselves honestly.

The fourth component of your program is the valued role project. The valued role projects are done at the end of their six months. And what it is is a way for them to give back to the community, people using and sharing their talents, their experience and their skills with members of the larger community. In my brief, there is examples of that.

For many of our students relationships are a major difficulty. When one of our students first came to the project -- just recently actually, he was extremely quiet and physically hid himself in the dark clothing, using dark clothing -- a hood -- dark glasses and a beard. Eventually, he opened up even becoming a group facilitator and role model for the other students.

Anger is another difficult challenge that our students face. A graduate of ours who is a previous gangbanger on the streets of Hartford and who normally ran or hid from the police, after participating in our program, he was faced with a situation where in the past he would have reacted very differently. Instead, he turned to the police for help. This individual is currently taking of his family, attending church and volunteers at a soup kitchen.

If we had more time I could tell you so many stories that speak to the difference that Citizens Project has made in students' lives and the positive impact they've had in our communities. Many of our students have gone off to school, obtained housing, obtained employment, renewed family connections and built positive social networks.

Our project serves as a mini community that prepares our people for full citizenship in this society. Our students are people of value, worth, intelligence and integrity. Through this process, we help them to honor their life challenges whether they are mental, physical, or spiritual so that they take care of those challenges and not reject them. We help

students to believe and they continually teach us -- because this is a mutual learning program.

REP. WOOD: Would you mind wrapping it up because the three-minute bell rang awhile ago. Again, we have a lot of people.

Thank you.

PATRICIA BENEDICT: That's okay.

That every human being has something to value -- to contribute to this society -- our vision for the students who have shared equally with us in creating this program, includes projects, like ours, in every large Connecticut community.

Thank you very much today.

REP. WOOD: Thank you, any questions from the panel?

Thank you

Next speaker is Sara -- oh, thank you.

Patricia Benedict.

No.

Kerri Lynn Dirgo.

And after that is Sara Krolikowski, and after that Judith Meyers.

KERRI LYNN DIRGO: To the members of the bipartisan task force on gun violence prevention and children safety, my name is Kerri Dirgo, and I live in Bridgeport, Connecticut.

I'm here today to respectfully request that you take a position against proposed legislation that would limit the rights of young adults with a mental health diagnosis, specifically bills that resemble outpatient commitment.

I feel this way because as a young adult with a mental health diagnosis this could affect me and the way I access treatment. The positive experiences I've had while voluntarily receiving mental health treatment cannot be quantified. Having the opportunity to choose recovery and accept support has given me a sense that I'm in control of my own life, resulting in me taking initiative, being more eager to get involved in the community beyond treatment and seeing the mental health system as tool for my success as opposed to a punishment or sentence as if I've committed a crime.

When I was minor within the DCF system, my choices were made for me. I was forced to go to therapy despite the fact that I lacked the maturity, insight, or even knowledge that I needed treatment.

If a person does not acknowledge they need help, any attempt at providing treatment will be futile. In the end, will this just come down to forcing people to take medication? Is it about medicating people to keep them docile so the public can believe that they are safe from the crazies? Are we going to allow our state to regress to institutionalization in a community setting? What about the financial cost that is intertwined with mental health treatment? Mandating those with mental health diagnosis to comply with treatment would place a long-term financial burden on the state because many of

the young people who would be candidates for outpatient commitment are already dependent on the state.

A second consideration is the fact that the roles and relationships between care providers and those receiving care would be greatly impacted. The providers go from being a support, providing guidance and encouragement, to an authority figure that cannot be trusted.

Setting up a punitive system will inevitably lead to punishment without support, further marginalizing those who already feel shame, humiliation and self-doubt on a daily basis. Will you encourage negative stereotypes and discrimination against individuals who are struggling to regain a sense of purpose in our community?

Since I made the decision to seek the support that I needed to achieve recovery, I am now a young woman with a sense of ownership in my life. I take responsibility for my actions and I do not use my diagnosis to avoid negative outcomes for the decisions I make. I've become a leader in my recovery and a leader for my peers, as well. Empower us with the choice to make recovery supports available to us within our local communities. Help us to spread the word that recovery is the solution.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel?

Seeing none, thank you very much.

Next is Sara Krolikowski, and after that is Judith Meyers.

SARA KROLIKOWSKI: Good evening. My name is Sara Krolikowski. I'm from New Britain.

Thank you for taking the time to sit and listen to my testimony regarding mental health in our state. I am here today to respectfully request that you take a position against proposed legislation that would limit the right of young people to decide what time and where they choose mental health access. This would include bills that include outpatient commitment. I am making this request as a young person with a primary mental health diagnosis of major depression disorder.

The reason I am testifying today is because I am confident that I would be -- that I would have been a strong candidate for an outpatient commitment since I met the criteria for a serious mental illness. Before I accepted I had a mental health diagnosis, I denied anything that was wrong. Instead of acknowledging that I was benefit from the treatment, I turned instead to working out and keeping myself constantly busy. It was tiring trying to stay occupied so no one would suspect that anything was wrong. I would finally burn out and fall asleep only to wake up still frightened.

I worry constantly that people would view me as weak or crazy if I accepted help. I know that mental illness are viewed as taboo, even by today's standards, and are not considered the same as other disorders, like heart disease or diabetes. My fears have been reinforced by a

number of bills currently proposed to the judicial public health and children's committees that include various forms of outpatient commitment.

The onset of my illness occurred just after I finished college with a bachelor's degree in criminal justice. At this point, it was likely my illness has taken control of my life. I was so frightened that I didn't know what to do. I had come such a long way in the past two and half years with the help of many people, making the decision that I wanted support made the difference in my recovery because it made me feel whole.

If I had been forced to comply with a treatment plan, I would have felt that I was nothing and my self-confidence would have been crushed. My experience has been that I need to make decisions to accept mental health treatment and seek doctors that are right for me. By establishing a trusting relationship with disorders, the worker and partnership, with them, to develop my treatment plan. A concern that I have with the outpatient commitment is that it is too easy to force individuals to comply with their treatment plan and how will you make sure that those treatment plans reflect the goals of the individual?

Right now, I have my professionals who answer the phone calls. I know me and I don't have to wait six weeks for an appointment. Many times it could be just a three-minute phone conversation and I am reassured I am safe. My health care providers are helping me reach my goals on a timeline that I -- that my health allows, not a timeline that is dictated by a

system that has virtual no training or experience with personal connection, consumer driven, shrink-based recovery oriented services.

My providers treat me as a person not a number. Will this not be an option for individuals who will be profiled and gravely disabled through outpatient commitment, all in efforts so that we can protect the public from those crazy people. I ask you to consider the reinforcement of this approach with development strategies to supporting an individual with mental health diagnosis achieve recovery.

Please take a position against proposed legislation that would limit the rights of young people -- adults to decide at what time and where they choose access to mental health services.

Thank you.

REP. WOOD: Thank you very much.

Any questions from the panel.

Senator Kane.

SENATOR KANE: Thank you, Madam Chair.

I do, not of the person giving testimony -- I apologize. But through the Chairs, a couple people have come up and mentioned bills. Do we have bills, in particular, bill numbers, in particular that this is carrying the scope of?

REP. WOOD: No. Good question but no.

It's generally to the topic of mental illness as it plays with gun violence.

SENATOR KANE: I know there are speakers mentioning certain bills, and I was curious if we're undertaking those bills at this time in this committee.

REP. WOOD: No, point well made. This is not about specific bills and, also, if people would really be cognizant of the three minutes, because the bells going off and almost everyone's gone over. So thank you very much. And again, we are just trying to accommodate -- and want to accommodate everyone to speak.

Thank you.

JUDITH MEYERS: Good afternoon, Senator Harp, Representative Wood and members of the task force. My name is Judith Meyers. I'm president and CEO of the Child Health and Development Institute of Connecticut, a research and policy institute that focuses on policy systems and practice related to the health and mental health care systems for children in our state. I'm also a licensed clinical psychologist in Connecticut.
We commend Connecticut policymakers for examining the capacity of the state's children mental health system. To identify and support all children with mental health needs.

To hit the highlights of my testimony and leave details for your reading, let me summarize with three key points. To be truly effective changes to Connecticut mental health systems must be: One, well informed and derived from the latest evidence-based research; two, build on what is

already in place that is of high quality and working in Connecticut; and three, include strategies that address children from birth to optimize social and emotional development and allow for the earlier possible identification and treatment.

We hope legislators will take the opportunity to familiarize yourselves with Connecticut's efforts in considering improvements and enhancements to the system, bringing these efforts to scale to fully meet the needs to children and families may be the most effective and cost-efficient approach.

What is working in Connecticut? These efforts come under six headings: One, supporting a child's optimal social and emotional development from birth, including a public/private partnership with funds from the State Department of Education and private philanthropy that supports communities across the state to develop comprehensive plans for early childhood systems to assure that children's full range of developmental needs, including social and emotional are met at home and an early care and education settings.

The Connecticut Infant Mental Health Association has an approach for training and endorsing professionals at all levels who interact with children in a competency-based approach to promote infant mental health. A number of strong outreach screening prevention and clinical mental health programs for our youngest children include: Child First, Early Childhood Consultation Partnership, Early Head Start, home visitation programs and Help Me Grow.

Two, promoting early screening and identification of children with mental health concerns. Educating Practices in the Community, or EPIC, operated by our institute, trains pediatric providers throughout the state to screen children for a variety of health and mental health issues. Okay --

Three, building a statewide system of trauma and form care. There are many programs that are already in place that are training people in trauma and screening children for trauma.

And four, improving community-based mental health care, including evidence based practices.

Five, diverting at-risk children in schools to mental health services through the school-based diversion initiative.

And six raising public health awareness and offering resources for families through a website called KidsMentalHealthInfo.com

Please consider bringing these existing effective programs to full capacity. As you heard this morning there are numbers of programs that -- in Connecticut are small and the need in demand is high.

I have a list of recommendations in my testimony, I'll leave that to you to consider. I'm happy to answer any questions about that, and we are available to provide any kind of consultation of information to you that would be helpful in your deliberations.

Thank you very much.

REP. WOOD: Thank you very much.

Are there any questions from the panel?

Seeing none, thank you very much.

Next is Dr. Harold Schwartz, after that Michaela Fissel, Paula Seivers and Valerie Raggio.

DR. HAROLD SCHWARTZ: Members of the Mental Health Services Working Group, I'm Dr. Harold Schwartz. I am a psychiatrist and chief at the Institute of Living and vice president for Behavioral Health at Hartford Hospital.

I also serve as a member of the Governor's Advisory Commission on Sandy Hook so I am not speaking here in any way as a representative of that commission.

We are all devastated by the deaths at Sandy Hook and dearly hope that the window opened by this terrible tragedy for discussion of our mental health system will lead to some real and productive change. Given the many aspects of mental health which warrant discussion and the limited time for testimony, I'll limit myself to the discussion of involuntary outpatient treatment, mental health parity in the private delivery system and mandatory reporting.

I highly recommend that the Connecticut Legislature adopt the statute authorizing involuntary outpatient treatment. Chronic schizophrenia and certain other chronic and severe mental illnesses are often marked by denial of illness. The failure to recognize illness and the need for treatment, known as agnosia, is a function of the disease's impact

on the brain. Not unlike the stroke victim who's unable to recognize that one side of the body is paralyzed.

For many individuals hospitalization becomes a revolving door. A psychotic episode leads to hospitalization, discharge from the hospital is followed by noncompliance with treatment, which leads to the next hospitalization. With each psychotic episode incompletely treated, the evidence suggests that the long-term prognosis the recovery is worse. Estrangement from family and friends frequently occurs along with homelessness frequent arrests and often imprisonment.

Is that my three minutes already?

I'm sure that many people here would rather that I not finish -- this testimony.

REP. WOOD: Yes, please just finish up.

Thank you.

DR. HAROLD SCHWARTZ: Let me just say that I deal with the families who call in desperation about their 21- or 22-year-old children who are unaware, unwilling to accept treatment, out on the streets and there is nothing they can do.

I get those calls. I'm on the other end of the line with Judge Killian. I completely agree with the testimony that Judge Killian provided. I also want to say that these programs apply to a very, very small portion of the population of patients with severe psychiatric illness. I think most of the individuals who were here testifying and with mental illness -- I commend

them for doing that and I suggest -- that I doubt strongly that these bills would apply to them in anyway shape or form.

I believe that the studies that demonstrate the effectiveness are somewhat ambiguous but that their take-home message is that when done right with adequate resources, these programs are another part of the larger piece of the pie.

I wanted to speak, also, about mental health parity in the private sector and gaps in coverage. I think that individuals in the private sector often have fewer resources than people in the public sector. They're faced with any number of policies that are in conflict with the concept of mental health parity. Precertification for hospitalization, do we require precertification for hospitalization for an individual who requires an appendectomy, or somebody who is being admitted with pneumonia? No, we do not. Does the doctor who has admitted a patient for surgery get a call from the insurance company on the second day of hospitalization asking for a recertification of the need for hospitalization for patients who may be psychotic and suicidal? No, they do not. Are we told by insurance companies on the fourth day of hospitalization that the individual with pneumonia really doesn't qualify for payment any longer, you can keep him in the hospital if you want to, but we're not paying.

What happens in the psych hospital is we're told on the fourth day, Well, the patient who expressed suicidal ideation on days 1, 2 and 3 said today -- it's in your record -- Well, I'm feeling kind of better today maybe I'm no longer

suicidal; therefore, the patient no longer requires hospitalization.

This is a crazy system -- pardon the expression. I probably shouldn't use that word, and I apologize to anybody who might be offended by it. But it is no way to deliver care in a true parity fashion.

Lastly, there's no parity in the kinds of programs that are provided. We provide physical rehabilitation to the individual who has come out of the hospital after a heart attack, myocardial infarction. Do we provide psycho-social rehabilitation and vocation rehabilitation to the commercially-insured patient who is discharged from a hospital after a psychotic episode? No, we do not. If you are a patient in the DHMAS system, you can get those programs. If you are a patient reliant on commercial insurance, you can't.

I could tell you much more but -- there is -- my testimony. I submitted testimony to you about this issue.

With regard to mandatory reporting, the last thing I want to talk to you about --

REP. WOOD: You know what? We really do -- we've got a tremendous number of people. You've gone well over three minutes.

DR. HAROLD SCHWARTZ: I understand -- two or three sentences.

The New York State law on mandatory reporting was very thoughtless. It will damage the

doctor-patient relationship. I recommend serious consideration --

REP. WOOD: Thank you. Thank you for that comment.

If I could just reiterate, the mental health issue is a large one and that is why we are here. But today is just the first step in what will be a long and, hopefully, very productive road. We really do need people to stick to the three minutes. So be very specific about, hopefully, addressing the gun violence and mental health piece that will be very helpful because there are a lot of people that have every right to be heard today.

Thank you.

We are going to be taking two other people out of order. They've got -- one has a plane to catch and one has a special needs child: Dr. Yann Poncin and then, Susan McGuiness Getzinger. And then we will go to Michaela Fissel and Paula Seivers.

Thank you.

DR. YANN PONCIN: Senator Harp, Representative Wood, members of the Legislature, thank you for accommodating us and getting out of schedule.

Yale-New Haven Health System is the state's largest provider of acute inpatient psychiatric care services. Let me introduce myself, first. I'm Yann Poncin, medical director for the Child Psychiatric Inpatient Services at Yale-New Haven Hospital, along with medical director for child psychiatric consultations in the pediatric ED;

and Dr. Frank Fortunati is medical director at the St. Raphael's campus.

As I mentioned, Yale is the largest provider of inpatient psychiatric beds in the state. Between Bridgeport and Greenwich Hospitals, we provide substance abuse care, treatment for pervasive developmental disorders in the outpatient clinic and a range of other services. We work to provide compassionate care in partner with families. In 2011, we created one of the nation's first patient and family behavioral health advisory councils comprised of formers patients in order to enhance collaboration between service providers and patients to reflect patient needs.

Part of the challenge of offering patient in family centered is the value and scope and need of mental health services in Connecticut. Last year, the now joint campuses of Yale-New Haven Hospital and St. Raphael had over 8,000 psychiatric emergency department visits, and today despite our more than 150 inpatient beds in Bridgeport and Yale-New Haven, we are frequently at 100 percent occupancy.

In terms of children and adolescents, there are times where we board -- have children boarding on the pediatric medical floors, instead of receiving acute inpatient psychiatric care because of this intense volume. In our emergency department, we are flooded with children that are sent to us by schools, families and police for psychiatric evaluations with less than 40 percent of these children requiring an admission, and there is a strong seasonality with school in-session.

Adults and children who are experiencing behavioral health crisis are overwhelmed by the medical emergency department environment and it does not provide the calm, private and space necessary for psychiatric assessment. In the absence of an urgent community-based assessment service, we are exploring the possibility of creating a unit that will separate children from the overly stimulating medical environment and provide a safe environment and privacy for psychiatric assessments to improve care. This similar initiative --

Thank you, legislators. At the end of our handout, we provided very specific mental health system improvements to you. Thank you for your time.

REP. WOOD: Can you briefly summarize what those suggestions are?

DR. YANN PONCIN: Thank you for giving us some time here. We proposed -- I summarize some of my other statements as it's not so much that our beds are 100 percent full, and we need more psychiatric beds. What we need is quicker, better services in the community, better collaboration with community service providers and among providers so that patients can leave the hospital. The beds are often full because they are waiting for supportive housing. They are waiting for the appropriate level of community services so the focus should really be on community services.

And the specific recommendations include the following: establish a fast-track connection to community-based psychiatric services; increase substance abuse treatment programs for

adolescence/adults and their families; increase support -- establish school-based mental health services and develop training programs for police and school personnel to provide skills to better manage situations involving children in crisis; establish enhanced urgent psychiatric assessment services in a nonmedical emergency room setting; improve system of care to better connect patients and their families with psychiatric services as they move from childhood through adolescence and into adulthood; and insure that all people with severe and persistent mental illness have primary medical care providers.

REP. WOOD: Thank you very much.

And questions from the panel?

Thank you, much appreciated.

Next speaker is -- I think is Susan McGuiness, and then after that Michaela Fissel, Paula Seivers.

SUSAN MCGUINESS GETZINGER: Hello.

Thanks for taking me out of turn. He has been very patient. This is one of the good kids that we are all fighting for. We are from Newtown. I'm going to go out of order because I'm going to talk fast I have three minutes.

My son's allergic to almost all foods on the planet. We are all meeting more kids that are allergic. We are all meeting more kids that are learning disabled kids: dyslexia, blah, blah, blah. I am living with it every day. I avoid food like the plague. It's not funny. Mercury

poisoning symptoms match dyslexia -- ADHD, autism and several learning disabilities. We did not get services in Newtown, Connecticut. I walked by five babies' graves from the tragedy every time we visit his daddy's grave. He was killed in a car accident on the Merritt Parkway on Good Friday. I told the board of ed in Newtown Connecticut, the night before my husband never came home again, that we did not get services in Newtown, Connecticut and they fought me three and half years. The superintendent refused to allow a bus to stop so he could sleep -- to help his immunities, even though the bus was passing our house every day as she designated it. They rigged the hearings. I tied the firms -- 169 districts, five law firms controlled the bulk of it. Two of them, I tied together and I showed it. I told Governor Malloy, nine months before the tragedy, Your Department of Ed is corrupt and that Newtown schools are corrupt and it's systematic problem.

They rigged the hearings. They hired the judges out of subject matter jurisdiction. They -- 504s are disabilities. My kids are substantially limited or severely restricted in one or more major life activities. This is school choice week. I say like Gandhi, we don't wait for you guys because our kids do not have time -- 20 of them our dead. We walk out of the public school systems. We bill the board of eds because the superintendents might be in on it, like they are in Newtown, Connecticut. And check the evidence. It's in public record 4/5/12; I put it on public record. It was this big and that's just what I could fit in. I have doctors' papers, like the first woman that testified in Newtown. Not if, when? We never got them. I took my kids out because they said

be careful. They are going to call child protective services on you because you are speaking out against the district.

This is systematic. One of the law firms is Senator Chris Murphy's father's is a partner there.

REP. WOOD: Applause is not appropriate. Let her finish her comments. Thank you.

SUSAN MCGUINESS GETZINGER: Thank you everyone.

Senator Chris Murphy -- I told the problem to, he told me his wife fights for these kids. He did not disclose his father's a partner at the biggest law firm, has 80 school districts, Shipman & Goodman -- thank you very much. Bercham, Moses & Devlin is the one that fought me. Thank you.

REP. WOOD: Thank you for your testimony.

Does anyone have any questions from the panel?

Thank you.

The next speaker is Michaela Fissel, and following Michaela will be Paula Seivers, and then Valerie Raggio.

MICHAELA FISSEL: Okay. So hi, my name is Michaela Fissel, and I am a current resident of Windsor, Connecticut. I'm here to respectfully request that you take a position against proposed legislation that would limit the rights of youth or young adults to access -- to choose at what point and where they access mental health treatment. I say "proposed legislation" because

I was informed that you would be looking at the laws and legislation and listening to how the public kind of perceives that. And as a young person who is in long-term recovery from a primary diagnosis of bipolar disorder and as someone who denied my illness and refused to comply with treatment on multiple occasions, I am confident that outpatient would have been the solution that my family would have sought.

I can recall the desperation, anger and helplessness of those around me as they watched me cycle through mania and into psychosis on multiple occasions, followed by deep depression; and on two occasions, attempted suicide. I can only imagine their terror as they found me on the bathroom floor unconscious due to an overdose of prescription medication. That's right, prescription medication.

I complied with a treatment plan for six months, and after I finally couldn't take it anymore. I was too tired to make it from breakfast to lunch because of the mood stabilizers. I couldn't write a legible word because the muscles in my hands were too rigid from the antipsychotic medications. I couldn't even form a single cohesive thought. It was like I had spent my entire adolescence experiencing the untreated symptoms of a serious mental illness only to reach adulthood and find the best next thing to being crazy -- was to be completely unresponsive. Is that what we are trying to seek here, or is that maybe not what you are trying to seek, but is that what's going to be the outcome of this?

I believe that our system would greatly benefit from continuing to support of enhancing the

culture of recovery in our state by completing the recovery orientated system of care. I am here today because of peer support. Thank you very much for considering my testimony.

REP. WOOD: Thank you, for your testimony.

Any questions?

And that you for sharing your story.

Any questions from the panel?

Great, thank you very much.

Next speaker is Paula Seivers, followed by Valerie Raggio and Donna Krupa.

PAULA SEIVERS: My name is Paula Seivers from Branford Connecticut. In response to the Sandy Hook tragedy, I would like to take this opportunity to dispel the misunderstandings that surround it, the unjustifiable culpability attached to the mentally ill population.

The root cause of many assailants has stemmed from anger, feelings of abandonment and lack of love. In other words, they often come from dysfunctional homes and had none of the symptoms of chronic mental illness.

I have suffered 40 years on the debilitating rollercoaster of bipolar schizoaffective disorder. For the first ten years of my struggle, I was devastated. I was depressed, empty, without hope, fearful, guilt-ridden, delusional and unable to go to school or hold a job. It was only with psychiatric help, medication, and the love and willingness to

understand on the part of my family that I survived.

Because of my personal testimony, I feel well qualified to bring to your attention these three things in order to assist you in dealing with mental health issues in the schools. First, people suffering with mental illness that I have met -- and there have been hundreds -- struggle with their own demons inside. They do not blame, hate, or exhibit anything but humility in their desperate fight to experience some kind of normal functioning. Oftentimes, they are self-destructive but not aiming their frustrations towards others.

Second, if the mentally ill have loving reliable caregivers, they are extremely fortunate. Countless victims, however, live in poverty, seclusion, and are homeless. Others are involuntarily incarcerated or die. We must address this issue. Medical attention is so expensive that it is an impossibility for many to take advantage of it. The paperwork involved in obtaining any kind of social employment of monetary assistance is complicated and often difficult for a mentally handicapped person to complete. The time lapse between applications and assistance is so long that many consumers fall through the cracks.

I would like to thank each of you on this committee and may God bless you and grant you his wisdom as you proceed. I have written a book called "The Bipolar Song." If anyone is interested it's on Amazon.

REP. WOOD: Thank you very much for you testimony and the ad for your book. It's on Amazon for those who did not hear it on the loud speaker.

Next speaker is Valeria Raggio, followed by Donna Krupa and Sheila Matthews.

VALERIE RAGGIO: Good afternoon, Madam Chair. My name is Valerie Raggio. I'm a mother and a licensed clinical social worker. I've been working in hospitals in Connecticut for 25 years, and I currently -- for the past 15 have been working in a local emergency room in Connecticut.

My primary responsibilities are providing psychiatric evaluations for adults and children. So on the frontlines, every day we see are numbers increasing in the ERs because families cannot find services -- outpatient. The debate about mandating treatment is a distraction from the real causes and solutions to mental health crisis that we see every day. We are wasting millions of dollars and cause infinite suffering because of these gaps that we've created with mental health care.

The mental crisis we are experiencing in Connecticut is due to once as everybody has been saying here, a lack of appropriate effective and timely outpatient services. About half of those who come to the emergency room with mental health issues are experiencing a crisis, and it could have been averted if they had timely accessible outpatient services.

That's several thousand people a year in our ER alone, and using the ER for nonemergency care is extremely costly financially, emotionally, and

socially. It creates daily gridlock in an already overburdened health care system. And it is not their fault. Sometimes it's the only door open and every ER in the state is seeing longer and longer waits with people using the ER as an entry point to the mental health care system.

On weekends in ERs, if somebody needs an inpatient psych-hospitalization, it's very likely that they will be there for over 24 hours waiting for an inpatient hospital stay. This weekend, like most weekends, there was not one bed left in the state so people are waiting in emergency rooms and this adds incredible stress to families who are already experiencing crisis.

I live lots of the gaps in services that people have spoken about: lack of funding for outpatient, manage care insurance, long waiting list, three to six months for outpatient psychiatrist, and it goes on and on. So we need increased preventive services. We need enhanced services. When we transitioned in Connecticut out of having state hospitals, we were promised a lot more services for the chronic mentally ill. We have some, but we simply do not have enough.

So I want to thank you very much for your time, and this is a really important conversation so we can move beyond the stigma of mental health, and people can get the services they need. Thank you.

REP. WOOD: Thank you very much.

Any questions from the panel?

Thank you.

Next speaker Donna Krupa, followed by Sheila Matthews, followed by Marc Fecteau.

DONNA KRUPA: Hello, my name is Donna Krupa, and here is my story. I came to BH Care in 1993. My first experience with mental health services was -- that I was married to a very domineering man and I had to call 211 for help. What I would have done -- what would I have done with myself was no telling -- or the man I was married to. Since I was living in Trumbull, I went to a Bridgeport mental health agency for help. During that time, I started going to college and part time towards a human service degree. I was able to leave my husband and move to Ansonia, where I transferred services to BH Care. I moved in with my mother and was told about domestic violence that helped me understand the services that I got. Then I participated in the Valley Social Club, where I found a safe place to hang out and was able to make friends and participate in activities. I became an executive member recently. I was able to work for the community peer-to-peer warm line operator for four years. This was the beginning of doing something that I went to college for. I even worked as a personal care attendant which is going on three years.

I help people in their homes, and I'm also a justice of the peace and notary public. I do go to church regularly, being able to do the things really makes my life better.

Lastly, if I was not able to access these services, I would have done something at the beginning of my journey to end up in prison and

continue to make bad choices in my life. Instead, I help people. I try to make their lives better, too. I enjoy the jobs I have now. I even want to be part of the change for PCAs that make our job more respected during -- since we do not receive any benefits or Workman's Comp. I would like to thank you for the opportunity to talk to you today.

Thank you.

REP. WOOD: Thank you very much, and thank you for sharing your story.

Any questions from the panel?

Great, thank you.

Next speaker is Sheila Matthews, followed by Marc Fecteau, followed by Barry Simon.

SHEILA MATTHEWS: Hi. I am Sheila Matthews, co-founder of the Ablechild, a national nonprofit organization with over 25,000 members. Our mission is a full informed consent and the right to refuse psychiatric drugs and services. Ablechild is funded by parents and does not take special interest money.

Psychiatric drugs and mass murder:

Huntsville, Alabama; February 5, 2012; 15-year-old on Prozac, Xanax, Ambien; school shooting.

Cleveland, Ohio; October 10, 2007; 14-year-old stormed through his school with a gun in each hand, shooting and wounding four before taking his own life; anti-depressant, Trazodone.

Red Lake, Minnesota; March 2005; 16-year-old shot and killed his grandparents then went to his school where he shot dead seven students and a teacher and wounded seven, before killing himself; Prozac.

The list of mass shootings and the link between psychiatric drugs and violence goes on and on. In fact, the common denominator in these shootings is that all of the shootings, nine out of ten times, is on psychiatric drugs with violent side effects.

We strongly urge you to look at the data. Stop turning a blind eye to the obvious link between psychiatric drugs and mass murders. Since your disregard can only lead to future crimes against the innocent. We ask that you start demanding with us that Adam Lanza's medical records be released in the interest of public safety. Lanza's medical records are pertinent to any legislation and should come before any pen hits the paper on more mental health spending.

Drugging children with psychiatric drugs linked to psychotic episodes, aggression and violence. Drugs which are many times not approved for use in children is clearly not working. More subjective mental health screen tools to target innocent children can lead to more carnage.

It is a shame that the facts in this mass murder suicide investigation have eluded the state police and Governor's office. The media that relies heavily on advertising dollars from the pharmaceutical industry lends little help in getting this critical information out to the public.

As legislators this does not mean shifting the blame to more gun control or too little mental health services. Ablechild had sat on the Behavioral Health Oversight Committee in this state in which we have been advocating full informed consent relating to psychiatric drugs linked to dangerous side effects. We have promoted the MEDWatch Program for over 13 years.

Your failure to act without questioning psychiatric drug side effects and their link to mass shooting is inexcusable, inexcusable. And this failure will continue to cost our children their lives -- their lives.

Thank you so much. I stand ready to help this committee and the State for legislation, but we cannot do it without the evidence. There is no reason to hold these records sealed, absolutely no legal standing for these records to be held. Please release them and let us help you to protect our children. Thank you so very much.

REP. WOOD: Thank you very much for your testimony.

Please -- any questions from the panel?

A VOICE: I have a question.

REP. WOOD: The panel -- I'm sorry. I'm sorry. You will wait -- we all -- everyone is waiting their turn. The questions are for the panel. I know you have signed up to speak and we look forward to hearing you speak, but unfortunately, you're going to have to wait till then.

Thank you.

Any questions from the panel?

Next person is Marc Fecteau, followed by Barry Simon, followed by Maggie Adair.

MARC FECTEAU: Thank you for your time. I would ask please if you would pay me some extra attention. My name is Marc Fecteau, and I am proud to stand here today or sit here and tell you that I suffer from autism. For my entire life, I have suffered ostracization, and I have been characterized to be unworthy of being part of my community even though I am exceedingly intelligent.

Now you might also keep in mind constitutional values. It is important and imperative to realize that people have a fundamental right in our society, in a free society under constitution, to feel free from the threat of imminent danger to themselves and unnecessary incarceration without such due process has been afforded them. I hear nothing of due process. Also if you force people to do anything, Albert Einstein would say, You cannot accomplish anything through force, but you can achieve through understanding.

Without such understanding that labels, as such, do alienate from society us such understanding please that you understand you will push people into the shadows if you will relate this to mental health. There is no tangible reason, Ms. Hovey, that this can be related to mental health in any way -- that you can say that it would prevent the general population from committing similar acts.

Shall we put everybody in our country under observation; shall we form a police state that

will put people in jail or call them unworthy because they have political or social diversity? That has happened to me in my community in Tolland, Connecticut. I assure you, you cannot. If you force people to do anything, they will go to the shadows. They will hide. They will flee. They will not come forward for care. They will fear you.

I have been in state care in psychiatric facilities and other institutions since I was five. I have been raped under the influence of narcotics given to me by staff members. I have been beaten. I have been assaulted by fellow students within state institutions. Without such that we offer severe oversight from our state to these institutions, such abuses are and have been manifest. History will tell us that abuses within our institutions have been historically manifest.

From Sweeny Todd, to One Flew Over the cuckoo's Nest, and I can give you assorted 100 or 1,000-year history of the use of psychiatric orientation towards an individual to discredit them, to institutionalize them, and to prohibit them from having participation in society.

It is wrong. It is palliatively the wrong thing to do. I can assure you, from my experience event to today, I do suffer social ostracization. I am not allowed because I am (inaudible). I have never shut up since I was three -- to be a part of my community.

And I will tell you one last thing, please. The police, even to this day, use psychiatric incarceration as a tool of intimidation, coercion, and improper use to eliminate homeless

people from their communities, those that they do not see as desirable to be in their communities, and I implore you, please, give due oversight and at least give a voice. We have no voice. We have no place that we can complain or that we can file a report that will be looked into. I have filed several, numerous reports upon all government agencies and -- I be with DMHAS, I have been forced into incarceration without proper due -- I have had the state protection and advocacy say such incarceration was unnecessary and unfounded, and I have, while incarcerated at Johnson Memorial Hospital, even though I remained completely peaceful. Then given the option of receiving an injection or medications even though every record of my stay there says it was not warranted and that such medications were not warranted because I was not acting out. I was completely compliant.

These are abusive practices that have taken place since I was a child, and I will confer with you, Ms. Hovey, please do not take your rage and I understand your pain out upon those who already suffer in the shadows. Thank you.

Any questions?

REP. WOOD: Thank you for your testimony.

Any questions from the panel?

Thank you.

Next speaker is Barry Simon, followed by Maggie Adair, followed by Elaine Zimmerman and Julianne Marinelli.

BARRY SIMON: Good afternoon, members of the Mental Health Services Working Group. My name is Barry Simon. I am the CEO of Gilead Community Services. We provide high quality health and human services to almost 600 children and adults, employing 250 people. I am also the co-chair of the Behavioral Health Division of the Connecticut Association of Nonprofits.

Gilead has been part of the public-private partnership in the community health care system for 45 years. We and all the other nonprofits community providers are part of the safety net that helps people live as full a life as possible.

The terrible events that occurred at Sandy Hook Elementary School go far beyond of what we traditionally think of as the mental health services. They go to the heart of how, as a society, we are regard violence and how, as a society, we also regard those who may need to seek behavioral health conditions.

My point is simple: mental health treatment is a good investment. The safety net services need to be funded. The services work when they are there. And our services are good fiscal management, compared to the cost of crisis and long-term services.

In more detail, the State asks us to deliver these services, but it fails to give adequate funding or backing the needs to provide these services.

I want to thank everyone for recognizing the importance of the safety net and the need to modernize it, but as we use more and more of our

resources for the administrative burdens and increased costs of doing business, there are less direct services delivered to our clients. And has been a part of my testimony for 19 years, there will be significant consequences if this pattern keeps up.

Now is critical moment in time, higher costs, more regulation, lack of state support mean programs and service reductions at the very moment that we should be looking for less costly early interventions and identification and more productive alternatives. I can say that the system of care continues to be at risk. As a CEO, I know this firsthand. And as you know, there's been no cola for many years.

Programs have closed in the last few years, and we will continue to do so. This is not a false alarm. You can see from the attachments that I put with my testimony. As an agency, we have closed a program and made reductions in others due to the shortsighted approach of state budgeting, which ultimately leads to dire consequences.

We are currently contemplating decreasing even more programs and reducing more staff to cover the growing deficit created by years of stagnant funding. We all know that funding issues create staffing issues. We know that when individuals with chronic illness do not receive proper treatment, they are likely to end up in emergency rooms, prisons, and more expensive and less appropriate residential settings, like nursing homes, and these cost the state even more money.

Nonprofit providers are part of the solution for the future of the service delivery system, preserving the investment made in quality cost effective community care.

I thank, Commissioner Rehmer for her support in ensuring these difficult fiscal times did not make immediate cuts. Our agencies and others, like us, the employees and the clients that use our services want the systematic issue solved. Given adequate support, we can provide the services needed. I thank you for your time.

REP. WOOD: Thank you very much.

Any questions from the panel?

Thank you again for your testimony.

Next speaker is Maggie Adair, followed by Elaine Zimmerman, and then Julianne Marinelli.

MAGGIE ADAIR: Good afternoon, Senator Harp, Representative Wood, members of the Mental Health Working Group.

Thank you. I appreciate the opportunity to testify about mental health services and gaps for our youngest children, birth to age five. I am Maggie Adair, the executive director of the Connecticut Early Childhood Alliance. The Alliance is a statewide membership and advocacy organization committed to improving the developmental outcomes for children, birth to eight, in the areas of early learning, health, safety, and economic security.

Even very young children, infants not yet one-year-old, can and do need mental health services. Strong persistent adversity -- such as psychical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence and trauma and the accumulated burdens of family economic hardship can have a cumulative toll on physical and mental health for a lifetime.

What we know from a large body of research about early childhood is that identifying the need early and getting treatment early avoids intervention and most costly treatment later. Eighty percent of the brain growth is complete by age three. The older the child, the more difficult to change brain structure; therefore, the greater expense and the poorer the outcomes, early detection and prevention is essential. Especially with our youngest children, intervention must include the whole family: The mother, father and siblings. We cannot treat children in silos.

In Connecticut we have a number of strong outreach screening prevention and clinical mental health programs. However, despite the high quality of these programs, there are challenges. These programs only reach a very small segment of children who need services. They are fragmented over several agencies with little coordination, and there is a shortage of clinical professionals with expertise in working with very young children. In short, capacity is grossly inadequate. We have very long waiting lists.

As you look to find solutions to these challenges for our state, the Alliance

recommends the following for our youngest child: build on Connecticut's strong foundation of programs, outreach screening prevention and clinical health programs for our young children, including Nurturing Families, Home Visitation programs, Child FIRST, early Head Start, Head Start Collaborative, Early Child Consultation Partnership, Child Guidance Clinics, Birth to Three, and Help Me Grow and there are others.

Improve access, we must reach every child who needs these services, and we must reach them early on; implement screening for mental health concerns are pediatric well-child visits; ensure that those screenings are reimbursable for pediatric providers.

Increase clinical professionals, part of the problem in Connecticut is that we have few clinical professionals with specific expertise in treating young children, ages birth to age five. We need to build incentives for clinical professionals to get specific training to work with very young children.

Address the issues of private insurance, mental health parity cannot just be on the books, it must have teeth.

Improved coordination, prevention and mental health services for children birth to five are fragmented and piecemealed, spread over several different agencies. Service coordination could be improved.

And my final two recommendations is consulting with a Child Health and Development Institute of Connecticut. They have done a lot of program research about best practices, such as training

pediatricians to screen children for a variety of health concerned and mental health issues.

As another promising example, CHDI has searched and piloted a mid-level assessment that connects at-risk children to early mental health services more quickly without waiting for a comprehensive evaluation which is more often more costly, not readily available and often unneeded.

And finally, consult with the Connecticut Infant and Mental Health Association about a curriculum designed to train and endorse professionals at all levels who work with young children through a competency-based approach promoting working with young children. Thank you very much.

REP. WOOD: Thank you.

Any questions from the panel?

Thank you very much, Maggie.

Elaine Zimmerman, followed by Julianne Marinelli, Carl Schiessl, Charisse Townsend.

ELAINE ZIMMERMAN: Senator Harp, Representative Wood, members of the committee, my name is Elaine Zimmerman. I am the executive director of the Connecticut Commission on Children. I spent the weeks after the Newtown shootings in Newtown, co-directing the play station and art station for children and youth with Save the Children and IPPI at the John Read Middle School while parents sought advice and counseling for their families.

The day after the shooting, several children were playing with play dough. They had visited

the families who had lost children the night before. They were counting the number of children who were dead. They were reiterating the friends they had who were dead. And at one point a little child, a tiny pipsqueak of a kid, first grader, looked at me and said, There is nothing you can say or do that will convince me that this is not going to happen again.

So this is the first grade image and task, and I think it's the task of all of us to make sure to answer to him that in our state it is not going to happen again.

I have many recommendations, in the interest of time, I'm not going to go through them except to raise the one item that hasn't come up so far as I've been listening because I fully agree with those who have talked about the importance of early is best that was stated, you know, by Dr. Forrester, in New Haven, that we need to focus on prevention, assessment and a coordinated system and that our system is thin, spindly, scattershot, under resourced, not coordinated.

So that the system -- one of the areas where there is actually federal dollars and where we could be doing early intervention is in home visitation. Our state, this past year, received 27 million federal dollars in home visitation. The Department of Public Health conducted a statewide needs assessment. There were 17 towns identified as high needs. Home visitation is a model, prenatal through age five, that reaches the most vulnerable families. And these would families that are facing the stressors that have been talked about today. That are facing substance abuse; that are facing violence. For intervention assessment, the problem is not

unlike what we discovered though in early childhood in our school readiness system. For years, we funded programs in school readiness and only recently are we talking about needing a system of early childhood. We don't have an adequate system in home visitation so we are funding program, program, program, in different towns. It's not coordinated. It's not full aligned. The professionals are not trained together. It's not at all integrated with out early care system so there's been national meetings to talk about integrating this because our home visitation system is our way to do the earliest assessment in a family friendly way, at people's homes, in coordination with them. It's voluntary. There is no intrusion as so many people are talking about today that they don't want. It is strictly voluntary; but it has the opportunity to reverse and offer assessments if properly aligned with birth to three, and some of our other models we could actually create a system in the earliest years.

I'm sensitive to time, the other recommendations are in my text. Thank you.

REP. WOOD: Thank you very much.

Senator Harp.

SENATOR HARP: Thank you very much, and I enjoyed your testimony. You are about the fifth or sixth person, maybe the tenth person, I don't know, wasn't really counting, talked about the lack of coordination. I think you were talking about the lack of coordination at earlier years. And I think others were talking about the lack of coordination between DCF and DHMAS. So how

would you see a coordinated system looking, what would that look like to you?

ELAINE ZIMMERMAN: Thank you, Senator Harp.

Well, in the area that I'm specifically focusing on today in home visitations, we have these people who are actually trained to be with families, do assessments, coordinate, but they are not coordinated with the pediatrician, and none of them are coordinated with the early childhood field. So who I, as a mom, might select, or how I would even work in concert with a childcare system, none of it is coordinated. So I think one would be coordinated training across silos in these domains. Another would be intentional training of pediatricians in mental health, but in coordination with home visitations. So some of this is communication, but much more it is also coordinated goals. So the State of Michigan has just passed a law coordinated their home visitation system. And they are requiring every model together have shared data points, shared outcomes to present in appropriations together so that the goals are all coordinated and they are, essentially, steered into one train working together with the same goal. I think that through coordinated and well used training communications, a shared outcomes system that isn't just cosmetic but truly what they have to work on together, we would diffuse competition turf, silos, and remember that the child is actually the only customer.

REP. WOOD: Thank you very much.

Any other questions from the panel?

Yes, Representative Abercrombie.

REP. ABERCROMBIE: Thank you, Madam Chair.

Good afternoon, Elaine.

ELAINE ZIMMERMAN: Good afternoon.

REP. ABERCROMBIE: I think that is really interesting the way you talk about the coordination because on the home visitation, the grant that is coming through Public Health, you know, we've got two agencies that I know of that are working on that. So we've got Public Health, who got the grant. Right? And then you have SCE, which is where the family resource centers come through. So I think you are absolutely right as far as, perhaps, the time has come for us to do a coordinated-type system when they come before Appropriations so that we know that everybody is on the same page with that. I think you are absolutely -- I think that's the key point that you are making there.

And I think that, you know, what I have read about that grant, it's also what the feds are looking at, doing a coordination across the systems so you've got the early intervention, with the nurturing families who see the prenatal; then you've got the family resource centers, who see the families once the child is born; and then you use places, like in my community, like the child guidance, who does the clinical part, which is very important because once you have seen that a child needs services or that a child needs to get diagnosed is you need to have someplace to go. So I think you are absolutely right, and I think that under the

home visitation that is something that we really need to look at carefully.

How long a period of time is this grant that we received from the feds, do you know?

ELAINE ZIMMERMAN: Well, there is opportunity to keep applying for dollars. There is some competitive dollars, and there is some just dollars that keep coming to a state that has been awarded. It is for a few more years and, unlike many of the issues that we are discussing today with the fights that are going on in Congress, the dollars for home visitation -- and the whole language for home visitation was in the Health Care Bill. So now that the Health Care Bill is just moving along full steam, they had the wisdom to see what you are talking about and to understand that you could actually align early intervention to schools, et cetera, through home visitation. And most states are getting ample dollars and those will continue. But I'm fearful that we've just created a case of pick-up sticks, and we are not leaving it together for this school year. So I'm glad to help, Representative Abercrombie, in any way. And the Pew Foundation has been holding meetings on creating a coordinated system, and so I am also glad to connect them to you if you would like that.

REP. ABERCROMBIE: That would be great, and I think it might be helpful for us members on this task force to also look at the Michigan proposal.

ELAINE ZIMMERMAN: I'd be glad to get that.

REP. ABERCROMBIE: If you could send that it would be great and thank you for being here today and waiting all day to testify.

Thank you, Madam Chair.

REP. WOOD: Thank you and, yes, ditto about the Michigan study that would be very interesting.

Thank you.

Any other questions from the panel?

Seeing none, next speaker is Julianne Marinelli, followed by Carl Schiessl, followed by Charisse Townsend and John Lewis.

JULIANNE MARINELLI: Good afternoon, senators and representatives. My name is Julianne Marinelli, and I live in Shelton, Connecticut. My hell started when I lost my husband of 26 years. I had a nervous breakdown and ended up in the hospital. I was in and out of hospitals for years. I was sent to day treatment where I remained in the program for two years. I was in and out of that. My life was destroyed and I could not get on my feet. I was so bad they told me I would be hospitalized for the rest of my life.

My diagnosis was major depression melancholy so they tried one more attempt to help me stay out of the hospital. I was referred to the Valley Mental Health Center, which is now in Ansonia and Branford. At first, I could never make an appointment on time or at all. I was always forgetful when they were -- I felt so messed up.

My case manager then helped me get on track, then I started seeing my therapist on time and my psychiatric which I had many of both. They then told me about the Valley Social Club. I reluctantly tried it. Then I went more frequently, I went so much I decided to become president for the past 20 years. And I have been for 20 years. We started with a staff held executive board that did things more on our own. I was asked to be a new kind of peer-to-peer line called, warm line, which I was on for 15 years. I am the oldest warm line worker in Connecticut. I am the coordinator of the line, and I have worked it since 1955.

I love what I do. I even am a peer driver and that, as well, has been for many years. I am 70 years old so I don't know how long I will keep this up. With vocational help, I held many jobs in the community since -- as lunch lady and babysitter. My last thought on my journey to this point makes me wonderful that I had happened to me, if I didn't have the services I had -- where I would be and would I be able to live in the community? Would I have enjoyed my daughters? Seeing my grandchildren and great grandchildren grow up? I do not really know. This is where I am and want to be I know that. Thank you for listening to my story.

REP. WOOD: Thank you.

Any questions from the panel?

Seeing none, thank you again.

We do need to take one other person out of order right now: Chief of police from Manchester, Marc Montminy.

Forgive me, if I have mispronounced it.

And then Carl Schiessl and Charisse Townsend.

Thank you.

MARC MONTMINY: Thank you very much. It was very close. I was supposed to be speaking -- there she is. My partner is here to start our speech. So if you could just give me ten seconds to have her sit.

KAREN HANLEY: Thank you so much for your time. My name is Karen Hanley, and I am the practicing supervisor of CHR, mobile crisis response team, and I am a licensed clinical social worker. And today I would like to stress the importance of the relationship between law enforcement and the mental health profession. I am a member of the Manchester Police Department's Crisis Intervention Team, known as CIT.

It is a 40-hour training program that provides police officers the knowledge, training and skills to safely and effectively assist people in psychiatric crisis while connecting them to community-based services.

The Department of Mental Health and Addiction Services funds the Connecticut Alliance to benefit law enforcement to provide the CIT training in partnership with NAMI-CT. The Manchester Police Department's CIT team meets on a monthly basis to review mental health calls, to review persons in the community who may come to the attention of the police yet may need mental health support to avoid entry into the criminal justice system and to discuss unusual

patterns or safety concerns that arrive from the community.

This working collaboration between CHR and the Manchester Police Department does not end with these monthly meetings. Due to the ongoing commitment and relationship of team members, each professional is proactive and will seek out the assistance of each other as needed. Recently, the crisis team and the police helped divert a potential workplace homicide/suicide with a gun by working closely together. The proactive rather than reactive nature of the CIT team is essential in ensuring our communities are safe.

I urge you all to continue your strong support and full funding for the community-based mental health treatment, CIT and local law enforcement in order to better serve persons in psychiatric crisis.

MARC MONTMINY: Good afternoon. I am Marc Montminy, chief of police for the Manchester Police Department. Over my 27-year career in law enforcement, I have seen dramatic change in public expectations of police officers. There was a time when police officers were simply required to arrest criminal wrongdoers and break up barroom brawls. No more. Now police officers are part social worker, part substance abuse counselor and part crisis intervention specialist.

Perhaps, as an unintended consequence of the reintroduction of those with mental health issues into residential environments, police officers are now psychiatric first responders, a role for which they receive little or no

training. When the Manchester Police Department calls for mental health service jumped from 370, in 2005, to 883, in 2010, I knew I needed to take action. We contacted the mobile crisis response team and CABLE, in order to get training for our officers. At the time, few police agencies were crisis intervention trained.

The initial class was, approximately, 15 officers, and we now have well over 35 Manchester police officers CIT trained. Thanks to NAMI-CT and other agencies that stepped up to the plate.

Manchester now boasts one of the most efficient and effective response protocols for those with mental health issues. As the tragedy in Newtown has taught us, failure to provide resources for those in crisis can cost more than any of us are willing to pay. I, too, urge you to support full funding for community-based treatment and intervention and would be more than happy to take questions if you have any.

REP. WOOD: Thank you very much.

Any questions from the panel?

Thank you, good important topic.

A legislator has come into the room that is between hearings so, Art O'Neill, followed by Carl Schiessl, Charisse Townsend and John Lewis.

REP. O'NEILL: Thank you and thank the members of the task force for your endurance.

I am testifying here in part because I was asked to because I have a bill that relates to the subject that was being screened, and it was suggested that I might come before you to talk a little bit about it. The subject has already been touched upon by one of the earlier witnesses of the person who spoke from the organization Able Child.

But one of the things that we have gotten -- and I have gotten and I think many legislators have gotten are a lot of e-mails suggesting that the shooting episodes that we've seen in many parts of the country, the number that keeps getting cited is there are 131 school shootings, plus many others of these mass shootings, are in some way or another related to either the use or misuse of psychotropic drugs, possibly people being taken off of psychotropic drugs and having some kind of serious reaction to it, or/and related also to violent media content, particularly violent videos.

And what the proposal that I have -- and I think should be looked at perhaps by the task force as it's going along here, is the relationship these things may have to the episodes such as we've seen, and certainly the massacre in Newtown is what's at least obviously brought us all here today.

The evidence on this is unfortunately not all that clear, that there's one study that -- an effort to sort of do a literature review that was done by the Australian government about the role of violent media and video games and how much of an impact that has. And the conclusion of that summary or effort to do a literature review of all of the studies that have been done

and most of them -- even though the literature review was done by the attorney general's office in Australia, most of the research is done here -- was that you can't really reach a conclusion.

That the researchers are all -- in some kind of conflict, but frequently when the researchers are doing this they're quibbling about the size of the study and exactly how the numbers were calculated and that sort of thing. And it would seem to me that if there's enough research out there that perhaps another look at this could get us closer.

And if not that, then we have -- and I note Senator Harp frequently likes to refer to the CASE organization -- we do have people who do do scientific research that could try to make sense out of the issue, at least where the video issue exists.

The psychotropic drugs one it seems, again to be repeatedly referred to, but -- and I've been checking around and cannot find where anyone has actually done a study, a serious study of the impact of psychotropic drugs and whether they, in fact, are related to the what seems increasing number of mass shootings.

So I would hope that the task force and this working group would take a look at this issue as part of the overall approach to how we deal with the problem and avoid, if we can, more Newtowns.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel?

Representative Johnson.

REP. JOHNSON: Hi. Thank you for coming and testifying before us this afternoon.

Just one question. There have been reports from time to time of people who have been put on antidepressants and then had to be watched when they're being taken off the antidepressants because that they may have suicidal tendencies. And it's even reported on some of these ads from pharmaceutical companies. I just wondered if you had listened to that.

REP. O'NEILL: Well, other than the degree that you just discussed, that when you look at the list of side effects and/or do-not-discontinue-this medication kind of things, which frequently are attached to the ads that are done on TV and elsewhere, no, I haven't done that.

And apparently no one else has either -- a systematic study to determine if the -- one of the consequences is a suicidal -- obviously there's a potential for suicide, otherwise they wouldn't be mentioning it, but also whether there's a tendency towards violence directed at other people.

And I think that's one of the questions, as I say, the -- and you may have gotten the same e-mails that I've gotten where people will have a long list of episodes of mass shootings and massacres and that sort of thing. And then you will see a relationship saying, was using psychotropic drugs, or stopped using psychotropic drugs X days before the event occurred.

And of course the problem is the reason why the psychotropic drugs were prescribed in the first place was that this person may have had some kind of serious problem, that's why they started taking the drugs. But many people have serious problems and they don't engage in these kinds of acts of violence.

And what I wonder about specifically is the interaction between violent video games or other media and psychotropic drugs with someone who has some sort of underlying problem. And if you pile all three you may not find a relationship between the psychotropic drugs; you know, millions of people take them, stop taking them and we don't have millions of massacres, we only have a few hundred, thankfully.

But if you start looking at the cases where people have had this -- that's what I'm wondering about, the purpose of my proposed legislation and what I think the committee might try to find out if there is a, in effect, a scientific answer to this question that so far no one has really been bringing forward, which is we think there's a connection, but as far as I can tell no one has actually done the research, which is a little surprising given the number of people that are given these psychotropic drugs in this country, that no one has checked to see if beyond the suicidal tendencies, if there's any violence towards other tendencies.

REP. JOHNSON: Thank you so much.

And thank you, Madam Chair.

REP. WOOD: Thank you.

Senator Harp followed by Representative Srinivasan.

SENATOR HARP: Yes. Could you tell us exactly what your bill does?

REP. O'NEILL: It would call for the establishment -- this is before this task force really got going -- call for the establishment of a task force to work with the Connecticut Academy of Science and Engineering to study the potential relationship between the use of psychotropic drugs and incidents of mass shootings or attempted mass shootings, and any correlation between the use of violent media, including violent video games and mass shootings.

Those are the two things that seem to keep cropping up. People say, well, it's the violent videos. It's the psychotropic drugs. It's not -- and then plug in what the thing is that they're saying it's not.

SENATOR HARP: Okay. Thank you. I just was curious.

REP. WOOD: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you, Representative O'Neill.

We had heard earlier in the day very passionate testimony connecting mass murders, mass shootings with the use of psychotropic drugs, A, or being taken off the psychotropic drugs, a combination of the two.

And if I'm hearing you clearly, just for myself I want to make sure that in your research you've

done so far and the reading you have done you have not found that relationship between mass shootings, mass murders and the use or tapering of these psychotropic drugs. Is that what you have observed?

REP. O'NEILL: Well, what I've found is that there are no studies that clearly do that. There have been studies by the FBI, by various federal health agencies about the fact that people who are involved in mass shootings have some history of drug use. They may be recreational drugs, they may be other things, but they -- no one has actually taken, apparently, the time to study whether or not the psychotropic drugs are a factor, potentially a cause, maybe just a correlation in the mass shootings that we've been seeing.

And so given that this is something that we're spending this much time and effort and attention on, it would strike me that we ought to either rule that out or rule that in as a factor. Because if this is being caused by people misusing or being prescribed the wrong psychotropic drugs or psychotropic drugs when they really shouldn't be, then that tells you the problem isn't necessarily more law enforcement or necessarily rebuilding the institutional mental health system, but reconfiguring how these drugs are prescribed to people and giving better and more complete warnings about certain -- perhaps certain people shouldn't be receiving these drugs with certain underlying conditions.

And no one seems to be looking at that on the government side of things. Maybe somebody in the pharmaceutical industry has been doing some

research, but it apparently hasn't been published anywhere to indicate that there is this -- if there is a linkage or if there's clear-cut evidence that there is no connection whatsoever, that there's no correlation between the two.

And clearly there is a significant belief that people have that there's some kind of a connection because the number of people who have committed these mass shootings appear to have been on psychotropic drugs. One of the problems is availability of medical records. That was alluded to pretty strongly by the earlier witness, is it's hard to know for sure unless you have a complete set of records for the people who have been doing these shootings.

I'm not sure that that necessarily -- even if we found that every single person who was involved in one of these mass shootings had received psychotropic drugs, that that necessarily proves that that's what caused it, but certainly that would start to suggest that you ought to investigate down that particular path just as much as anything else that we -- we were looking at a whole bunch of different things as to what could be done to avoid these things in the future.

And you know, certainly one of the things that seems to be happening is a lot of young people, especially males have been receiving psychotropic drugs in the last 15 years seems like it coincides more or less with the increase in the number of these kinds of mass shooting incidents. It may be a spurious correlation. I mean that, you know, I know enough to know that

you can't just say A happens, B happens, therefore A caused B.

But it seems to me that there's at least the potential given what we -- what little we do know, that at least if something is worth investigating as to whether that was a cause of this.

REP. SRINIVASAN: Thank you.

Thank you.

REP. WOOD: Thank you.

Any other questions from the panel?

Thank you, Representative. Very well done.

Next is Carl Schiessel. And thank you for waiting and being patient.

Followed by Charese Townsend, followed by John Lewis.

CARL SCHIESSEL: Good afternoon, Representative Wood, Senator Harper, ladies and gentlemen. I'm director of regulatory advocacy at the Connecticut Hospital Association. My name is Carl Schiessel.

We thank you for the opportunity to testify today, given the critical role that Connecticut hospitals play in the healthcare safety net. And I'll be offering an abridged version of my testimony and hopefully get it in within three minutes.

Connecticut hospitals offer mental health services in inpatient and outpatient settings and in our emergency departments and the demands being placed on hospitals for these services is growing. For years we've been talking about the lack of access to mental health services and the consequences of ever diminishing funding. A patient may spend days or weeks in an emergency department waiting for a bed in an appropriate facility, for a spot in the right outpatient setting or for appropriate housing simply because there are not enough resources available. This unmet need is not new and is well known to hospitals, community providers and social welfare agencies.

There are long-standing defects in the payment system for mental health services. Psychiatric care in a hospital setting loses money because the cost per patient is higher than the reimbursement rates provided. Private insurance rates are too low. State Medicaid rates are strikingly inadequate and it's an ever escalating struggle just to maintain reimbursement rates from the managed care companies. The annual loss to hospitals for unreimbursed and under reimbursed mental health services amounts to millions of dollars a year.

And as the State has trimmed its budget, resources for mental health patients have been among the casualties. As recently as last month hospital funding was reduced by $103 million. This cut will impact our ability to provide care for patients including those who require mental health services.

In the past hospitals have filled the financial gap by subsidizing mental health services from

other programs that have a stronger reimbursement structure. This is no longer an option as the cuts have made it impossible to sustain all hospital services, including subsidized mental health services even at their current inadequate levels.

As you review and analyze recommendations -- and you've heard several excellent ones today -- I know you will acknowledge the consequences of the financial pressures being brought to bear at all levels of the healthcare system. Hospitals and other providers are truly at their tipping point. We cannot sustain the healthcare safety net, let alone expand it without dedicating additional resources to the system.

Let me close by offering you some statewide data on hospital utilization and mental health services over the past five years. These --

Oh, shall I? Thank you.

These data indicate that while funding is decreasing the number of patients is growing with an alarming spike in the number of younger patients seeking mental health services.

From 2008 to 2012 inpatient mental health discharges, patients admitted to the hospital treated and released over that five-year period for patients of all ages increased by 13 percent. The largest increases incurred among children aged 12 years and under, 25 percent increase. And for adolescents aged 13 to 20, a 36 percent increase.

ED non-admissions that involve a mental health disorder, those are patients that come to the ED

are treated and then released; increased by 40 percent over that five-year period with the largest increases incurring among children under the age 12 at 48 percent.

And I'll be closing off with some statistics about the Medicaid side. Over this five-year period by payer type inpatient discharges with mental health diagnoses increased by 35 percent among Medicaid patients. This compares to an increase of only 13 percent among the other payer types so clearly Medicaid patients are resorting to the hospitals in order to be a first-time provider of their mental health services.

And finally, Medicaid ED non-admissions, again, those patients that come to the emergency department are treated and released. Those that present with behavioral health diagnoses increased by 71 percent over that five-year period. This compares to an increase of 40 percent among payer types. So clearly you've heard anecdotal testimony about some of the facilities and the volumes they're facing in their ED. And I've offered you today some statewide statistics representing all 29 of our acute care hospitals.

Clearly this is a statewide problem. Connecticut hospitals look forward to working with you to develop recommendations to improve access to care for patients in need of health services and help find ways to fund these services.

And I'd be happy to take any questions you might have and thank you for the opportunity to testify.

REP. WOOD: Thank you very much.

Senator Harp.

SENATOR HARP: Thank you.

On your Medicaid increase have you separated out the SAGA folks? Because I think you would have a different increase if you recognized that we rolled SAGA into LIA which is Medicaid.

CARL SCHIESSEL: Right.

SENATOR HARP: Or did you control for that in the number that you have?

CARL SCHIESSEL: No. It represents -- no, it's represented in the 71 percent increase. We could certainly try to break that up for you to give you a sense of what the impact of that transition was. That's something we'd be happy to provide for you, Senator.

SENATOR HARP: I think it's important to do that. I also think one of the things that we've had to grapple with is the fact that LIA grew so much faster than SAGA ever would because of the increased population.

But prior to that time hospitals were treating these folks through uncompensated care, free care, that sort of thing. And I think it's really important -- while I understand that the whole healthcare delivery system is hurting, I think we've really got to be able to, as

legislators, look at apples to apples and oranges to oranges so that we really can see what the impact of our various policies are.

CARL SCHIESSEL: Uh-huh. Well, we'd be happy to help, try to bring the light and share the information with you.

Thank you, Senator.

REP. WOOD: Any other questions from the panel?

Great. Thank you very much for your testimony.

CARL SCHIESSEL: Thank you.

REP. WOOD: Charise Townsend followed by John Lewis.

Michael Mackniak and then Peter Brown.

CHARISE TOWNSEND: Hello. Hi, Toni.

It's really an honor to be here because I've been trying to get to someone. I have a son that is 26 years old and he's schizophrenic. I've been in the New Haven system for at least 40 years and I can help everybody's child and I cannot help my own.

The system that you have -- I listened to all the goody two shoes, so it does not work for my son. Every one in here is painting everything to look so good, they're doing so well, but my son is technically in that hospital at least four or five times a month, then he has to go to probate.

If it wasn't for Mr. Keyes trying to help me I would go crazy because they pump him up with

pills, put him back on the streets. There's no services because they say, he's schizophrenic, the guy says. So what does that mean? Do you lock him up in a room for a month? You pump needles in him, give him the medication and then you take him and put him back on the street and say, you know, that's your responsibility, you to take care. So I sit here and I have listened to everything everybody is saying.

It ain't about my son no more. I know my minutes is over, but my son needs help. He don't need nobody with a new job or more money to help him make more people to get hired into probate. I need help for my son and I'm asking you to help me to get the service I need.

Because if I didn't have Jack Keyes I would go crazy. I'm constantly in his court because he's constantly -- the police is picking him up because no one has services for him. They say, oh, we don't do that kind of service.

I said, so you're telling me if he go out there and shoot somebody you want to lock him up? I'm telling you my son needs services for schizophrenic. I'm tired of listening to the bureaucracy. I'm truly tired of we are doing -- they're not doing shit. I'm sorry. I'm tired of it. Nobody ain't doing shit.

JACK KEYES: Hold on Charise.

My name is Jack Keyes. I'm the probate judge in New Haven. Charise does that to me once or twice a week.

My fear that everyone talks about more and more, we have to do -- make do with less and less.

And every day I have less and less to offer the people who are chronically mentally ill. I don't know that I have the answer, but I know that I believe that medication in some form is the answer with services, a treatment plan, not a putative plan. Thank you.

REP. WOOD: Thank you both for testifying today.

Any questions.

I'm sorry. For Mr. Keyes? Yes, Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair.

Thank you for your testimony today, and thank you for the brave parent bringing her in to have her speak of the difficulty she's having.

Could you go into a little more detail about the type of service her son might need and what types of services? Is it because there's a lack of coordination of the services New Haven? Or is it because there's a lack of bed space for a longer period of time? Supportive housing?

JACK KEYES: It's all of those. Part of it is, is that he's resistant to medication. Part of it is, is that no one interacts with him on a human basis. I mean, his treatment is the emergency room by being picked up with a police officer. And part of it is, is that no one can make him do anything at this point in his life. So it's all of those.

REP. JOHNSON: Thank you.

Thank you, Madam Chair.

JACK KEYES: Thank you.

REP. WOOD: Thank you.

Any other questions from the panel?

Again, thank you very much for your testimony.

Next is John Lewis followed by Michael Mackniak, Peter Brown and Betty Guiles-Smith.

JOHN LEWIS: All right. Thank you for having me. My name is John Lewis. I've been getting services for over 20 years at BMH care, formerly known as Birmingham Health Services. The services have helped me to stay out of the hospital and have an independent and healthy life.

I came to be at BH Care, formerly known as Birmingham Health Services to be trained in a vocational program called janitorial training program. I learned skills to be a janitor in 12 weeks. They even employed me as a janitor after that.

I work at (inaudible) for two years. I had case management service for many years until they graduated me. I do most things on my own. I continue to use the therapist and psychiatric services at our clinic. Staff encourages me to have a voice about my treatment.

I use our benefit counselor to help me to manage my benefits. When I first went to the Valley Social Club staff and members were very welcoming. They treated me as a person, not as a person with an illness. They encouraged me to try different activities and participate in just about everything. Staff encouraged me to be a

greeter at our "May is Mental Health" Luncheon with the commissioner of mental health.

I really like doing this because I can welcome other clubs and staff to our club. I like going to other clubs. We have been able to make new friends all over the state this way. I enjoy going to the LOB with staff and meet our legislative representatives.

The club is helping to stay healthy with activities such as hiking, nutritional groups, et cetera. When I go to the social club we get treated respectfully. We get to learn good social skills. We go on trips. We have fun (inaudible).

Being around positive people at the center helped me to be on the right track. It's helped me to feel positive about myself and keep believing that there's always help for recovery.

Thank you all.

SENATOR HARP: Thank you, Mr. Lewis. Really appreciate it.

Are there any questions?

Yes, Representative Hovey.

REP. HOVEY: Good evening, Mr. Lewis. Do you mind if I ask you a couple of personal questions?

JOHN LEWIS: Sure.

REP. HOVEY: Thank you. Because we're really trying to understand this whole situation better and to trying to find some sort of either legislation

or action that we could take that would improve people's lives.

And you sound like you're doing very well. So that's great. In doing really well, do you ever -- you said that you take some medications?

JOHN LEWIS: Yes.

REP. HOVEY: When you're doing well, do you ever think that maybe you don't want to continue to take those medications?

JOHN LEWIS: No.

REP. HOVEY: No? So for you, you understand that medications make you feel better and make you feel more well and that's a part of your lifestyle?

JOHN LEWIS: Right. Well, I was told that each person is different, how the medications react depend on their body and their age.

REP. HOVEY: Right. I guess what we're trying to understand is how if someone has a medication that makes them feel better, makes them well, makes them productive in our communities and things, why they stop taking that medication. There's been some conversations about, you know, mandatory medicating and that kind of thing and how to help people. So I was just trying to understand that a little bit better.

JOHN LEWIS: Well, a lot of people may stop their medications because they're angry and want attention.

REP. HOVEY: Okay. Okay. Great. Thank you very much.

JOHN LEWIS: Thank you.

SENATOR HARP: Thank you.

Michael Mackniak followed by Peter Brown.

MICHAEL MACKNIAK: Senator Harp, I came off the operating table to talk to you about coordination here today.

I am attorney Michael Mackniak. I'm here to talk to you about a program called Melissa's Project which was founded in -- or began in 2001 as a collaboration between the probate court administration and the Department of Mental Health.

Since 2001 Melissa's Project has garnered a tremendous amount of national and serious local recognition for the work that we do in doing exactly what Senator Harp was questioning before, acting as a coordinating body among the various parties that may be in the treatment team, if you will, in the lives of persons with mental illness.

What we do is we act as a non-interested third party who will come in and monitor and report on the progress or lack of progress in anybody's treatment plan or care plan for folks who are involved in living in the community who have severe and persistent mental illnesses.

Again, this was an idea that was fostered between probate court administration and the Department of Mental Health and we've been doing it since 2002 and we have -- I've provided you with graphs showing our success rates. And I could -- I will highlight those in a second, but what we're showing you is that for that 10 percent of the population that requires 90 percent of our resources the enhancement that you're carrying -- so many people calling for today -- this enhancement that we have designed for the 10 percent is working. It's absolutely working. It needs more attention and we need to -- I'm here to ask you that you allow us to continue to talk to you about it, tell you what we're doing and how are doing it and why we're doing it.

And just to hint on a couple of things, for the cost of one -- the annual cost of one small group home in Connecticut, we're providing services for 130 some odd people a year. Okay. We act in this approach that we've undertaken -- it's a very nontraditional approach to case management, case coordination.

And again, by coordinating and monitoring teams of individuals that are involved in the lives of loved ones we're helping individuals cope with their illnesses. We're helping them on their own road to recovery. We're empowering them, we're informing them and their loved ones and the courts as well as the service providers that are out there working with them on a day-to-day basis.

As monitors of the team we're making sure that everybody stays invested. You hear a lot of talk among agencies, we want to work. We want

to collaborate, we want to work together and as soon as we walk out of the room very often that goes by the wayside.

Melissa's Project stays involved no matter where a person may fall in lives continuums. We're not here as a quick fix. We're not here because of your involvement with probate. We're not here because you're involved in DMHAS. We're here for the long haul.

You go to jail, we're going to be there. You go to the hospital, we're going to help you figure out a way to transit -- what went wrong to get you there? How can we help to get you out and keep you out?

A study was begun by Yale University when we started, started in 2002. A lot of data has been collected since then. It's now being compiled and analyzed by a statistical analysis at RIT. Preliminary studies show a decrease in our clients and incarcerate -- I'm sorry, in interests by 50 percent, incarceration days by 84 percent, emergency-room hospital visits by 8 percent, 18 percent decrease in state hospital beds, 51 percent decrease in hospitalizations and private hospital beds, which constitutes an overall institutionalization rate decrease of about 51 percent.

Obviously I'm out of time. You heard the ding. So I'm happy to get involved. I've been banging my own gong with this for ten years to try to talk to people about this as has the probate court administration as has DMHAS. We're ready. This is the perfect time this year about how this program and this enhancement to this

service system works and we need more funding. We need to implement it on a statewide basis.

So thank you.

SENATOR HARP: Thank you.

Representative Abercrombie.

REP. ABERCROMBIE: Thank you, Madam Chair.

Hi, Michael. Thank you for being here.

MICHAEL MACKNIAK: Hi. Thank you.

REP. ABERCROMBIE: So just a couple of quick questions. I haven't had a chance to look through all your testimony. So are you involved from the probate portion on? Is that where your first intervention, like, how do you get involved at the beginning?

MICHAEL MACKNIAK: Most often, yes. Most often we're involved because the probate court has identified us as an agency that could enhance the services that an individual is already getting. But there's another avenue in; that would be through the clinical department at any local mental health authority. The local mental health networks clinical directors also work with us very closely about how we can help their more troubled individuals that are living in the community.

REP. ABERCROMBIE: And who are you funded through?

MICHAEL MACKNIAK: Probate court administration funds us a little bit and DMHAS funds us the majority.

REP. ABERCROMBIE: So I assume you report to DMHAS?

MICHAEL MACKNIAK: I report to DMHAS and probate court administration regularly. In fact, we have a -- in our office we have a monthly reporting requirement. We have a quarterly report requirement that goes out that anybody that is involved on the treatment team can log into our computer system to get quarterly reports about the goings-on with a particular client.

But as far as formal reporting we report to DMHAS and probate on a regular basis. Probate statutorily -- or not statutorily, contractually has asked us to give them demographic information on a quarterly basis. And DMHAS, we're constantly updating our reporting with them.

REP. ABERCROMBIE: So since you're doing -- it sounds like wraparound services?

MICHAEL MACKNIAK: Yes.

REP. ABERCROMBIE: Do you also do the housing part of it?

MICHAEL MACKNIAK: We do not provide housing. What we try to do is to work very closely with the care providers and the local mental health networks and their subcontracted agencies to find the right fit to say, what would be best? A group home? A rest home? Assisted supervision? Wraparound services? RSP type services?

Explore all of the options, place an individual in that option and then make sure that all the

services are well coordinated and that individual is not forgotten and they don't fall through the gaps. We just don't want people forgotten and falling by the wayside, which is a huge component.

And I heard Commissioner Rehmer say this morning, engagement, engagement, engagement. Like location, location, location; engagement is key.

REP. ABERCROMBIE: So you're sort of like a case manager type?

MICHAEL MACKNIAK: What we do is we sort of manage the -- we manage the managers. We're coordinating overseeing body, if you will. So it's not a duplication of services. We're not going to tell the case managers or the clinical people which way to take their particular case or which -- what's best for their client.

But if we all agree upon a treatment plan and the court is with it and the conservator is with it, we're going to come and we're going to monitor that treatment plan and make sure that everybody is doing what they're supposed to for the benefit of our mutual client, if you will.

And very importantly, we stand and empower that client to be a part of that planning process, because that -- I can't tell you how many times that is not done and you can't get investment into or a goal from somebody if they're not going to be invested in achieving that goal.

So we do all of those things, but we really are a monitoring -- we're the umbrella that's

overseeing individuals' progress throughout life's continuums, if you will.

REP. ABERCROMBIE: So this program is really geared, it sounds like for adults?

MICHAEL MACKNIAK: It is. We work with young adults into the mental health system. So basically it's 18 all the way to 70, whatever.

REP. ABERCROMBIE: So do you have any thoughts about, you know, one of the areas that we're looking at right now is, you know, starting earlier in life with these individuals?

MICHAEL MACKNIAK: Right.

REP. ABERCROMBIE: Granted they're still at home because they're juveniles and stuff, but do you see any of your proposals in here that we might be able to model for the younger population?

MICHAEL MACKNIAK: The model that we've designed, Representative, is absolutely transferable to various types of human service fields. For instance, DDS, elderly protective services, Department of Children and Families.

The ideal -- the idea that came to me not too long ago was with our probate's children's courts. They are very good at identifying families in need at a very early basis because of the nature of the probate court system.

Judges like Killian and Jack Keyes who see their clients and know their communities, they identify folks at an early basis. And they see problems with families and they can identify people in specialized needs, be it mental

illness or otherwise. That's a great place for us to start to try to get involved to assist those families and getting services that, frankly, they don't know are out there for them.

And if we can help them identify services for their children we can start to do dramatic changes and great work in making sure that we're lined up well into the future for these kids who are going to be our DCF wards and our young adults and finally our adults.

But yes. So I think that an ideal place for us to start since we're already working with the probate court system is in the children's courts, if that were some -- a way that obviously the committee and probate court felt would be appropriate.

REP. ABERCROMBIE: One more. And if -- what's your annual budget?

MICHAEL MACKNIAK: $735,000 right now.

It comes out to about -- I'm sorry.

REP. ABERCROMBIE: How many clients do you serve? About would you say?

MICHAEL MACKNIAK: About 130. It's a little less than $7,000 a year per client, 6,000, something like that, per client per year.

REP. ABERCROMBIE: Thank you.

Thank you, Madam Chair.

Thank you, Michael.

MICHAEL MACKNIAK: Thank you.

SENATOR HARP: Thank you.

Senator Gerratana.

SENATOR GERRATANA: Thank you. I think my questions have been answered, but you function as a guardian, a guardian ad litem service in the probate court system?

MICHAEL MACKNIAK: We don't. Guardian Ad Litem Services, Incorporated, is the name of our corporation. Frankly, I needed a name when I was incorporating and Guardian Ad Litem sort of captures what it is that we do. We step in and act as a coordinating body, as a collaborative piece to help these teams of providers, if you will, to better communicate and collaborate for the benefit of their mutual clientele.

We are not appointed as guardians ad litem. We are not --

SENATOR GERRATANA: Okay. I was wondering. I was very confused.

MICHAEL MACKNIAK: No. We do not have a fiduciary responsibility. That's why I refer to us more frequently as Melissa's Project, so as to dispel the confusion about what our role actually is. We are not in a fiduciary capacity.

SENATOR GERRATANA: Okay. Thank you for that clarification.

MICHAEL MACKNIAK: Sure.

SENATOR HARP: Can you just tell me real quickly what towns' probate courts you operate in?

MICHAEL MACKNIAK: We were founded in -- and started in Waterbury. We expanded then to Torrington and Danbury. We then expanded to New Haven and West Haven. We've received a contract from DMHAS for community integration when the Cedarcrest Hospital was closing. It's a small contract so -- but it brings us very often down to Norwich, so we go from the Route 8 corridor, I call it, that we go down to Norwich. Those are the towns that we're servicing at this particular time that we're contracted to serve.

We do go out of those areas for private-pay clients. We're in Fairfield County. We're in other regions, but those are the Melissa's Project funded cities.

SENATOR HARP: So you heard Judge Killian's testimony and Judge Keye's testimony?

MICHAEL MACKNIAK: I did.

SENATOR HARP: Do you at all work with them on those issues? Because I mean, I guess they feel like in spite of what is currently going on in the services that are available there is this small group of people who need greater intervention.

So I'd like to hear you respond to that, that issue because they are obviously very concerned about this small number of people who refuse treatment.

MICHAEL MACKNIAK: There is no question in my mind that there is -- and I say this -- this is sort of my euphemism -- there is 10 percent of the

population that takes 90 percent of our resources, Senator Harp. Those are the -- and I work with Judge Keyes constantly. I've been down there for almost my entire legal career. Absolutely there is a small segment of the population that takes up a tremendous amount of needs.

And if you read some of the literature that's put out by the consensus project and those types of national studies, they will tell you that there is a segment of the population that absolutely has to needs that go far beyond the standard cookie-cutter treatment that we're accustomed to in the mental health field.

And I think this paradigm shift that we have to start to think about is we've got to start putting more emphasis on the systems of care as opposed to the clients and relying on the clients to get the care. We really need to worry about how the systems are going to be enhanced to fare better for the individuals.

SENATOR HARP: I guess at some point maybe I would like to talk to you later, because I think I really didn't understand what you just said.

MICHAEL MACKNIAK: Geez. I thought it was eloquent.

SENATOR HARP: It sounded great. It's just that I couldn't kind of keep it together in my mind. I couldn't figure out what that would look like.

MICHAEL MACKNIAK: With what? I'm sorry.

SENATOR HARP: Well, instead of considering the individual we need to consider systems, I think I heard you say.

MICHAEL MACKNIAK: Right.

SENATOR HARP: And so -- and I recognize that our systems are not coordinated.

MICHAEL MACKNIAK: Yes.

SENATOR HARP: But on this small group of people who I was sort of relating to, I'm not understanding how focusing on systems will help us with Charese's son.

MICHAEL MACKNIAK: Well, Charese for example -- and I'm -- frankly, I'm kind of surprised that I have not had a conversation with Judge Keyes about Charese to this point.

What we do is -- what we need to do is we need to put more onus on the providers that are in her -- that community to do more outreach to Charese's son. We need to make sure that there's follow through.

And we can't rely on Charese -- actually it's not rely, that's a poor choice of words. The expectation should not be on Charese or Charese's son to be able to come to the hospital and get the help. We need to rethink the system of care in New Haven to reach out and send people out to Charese and to her son to engage with him better to help them understand what his needs are while he's in the community better.

That, from what I'm hearing with Charese's case, doesn't happen. Is that better?

SENATOR HARP: I think that that helps.

MICHAEL MACKNIAK: I can certainly expound upon it in a great deal of detail with regard to New Haven. I'm trying to speak more generally.

SENATOR HARP: Okay. So at some point I'd really like to hear your thoughts because, you know, unlike many places New Haven is service rich. So it's really troubling that these kinds of things happen and it's a major concern of my probate court judge, who I respect very much.

MICHAEL MACKNIAK: Right. And so do I. So do I. Absolutely.

SENATOR HARP: Representative Ritter.

REP. RITTER: Thank you.

And some of this might be a bit at odds to what Senator Harp just said, but I would be interested in your thoughts on translating this into other parts of our -- the less densely populated parts of our state through the probate court system. Because the challenge, while there may be perhaps fewer people to deal with, the volumes aren't so great. I think there's some other challenges that -- for the courts -- for you all to think about, I guess.

MICHAEL MACKNIAK: And I would agree with that particularly. Well, we are up in the northwest corner up in Torrington, and out in that area in New Milford, in that area. But every city has its own challenges. Every region absolutely has challenges. This region can get conservators to act. This region can't. Family members are involved here. Family members are not involved here.

It's not -- there's no good way to say that this is what happens in the northwest corner versus the east corner. It's interesting.

REP. RITTER: Thank you. Because I also am very interested in the work that you're doing and I think we will have some more conversations about it.

MICHAEL MACKNIAK: Thank you very much.

REP. RITTER: Thank you.

SENATOR HARP: Thank you.

Peter Brown followed by Bethy Guiles-Smith.

You may begin.

PETER BROWN: Before I begin, I'd like to ask if you have my written testimony in front of you? It's a manila envelope like this with my name and address on it, Peter Brown, Middlefield, Connecticut.

SENATOR HARP: We don't have any manila envelopes.

PETER BROWN: Then with permission of the chairwoman, I'd like to request that I be taken out of --

It's got my name on the front.

SENATOR HARP: What was your request?

PETER BROWN: My address is on the front.

SENATOR HARP: We have it?

PETER BROWN: If it pleases the chairwoman, I'd like to request that my name be taken out and then reinserted at a point in time when the clerk can deliver my written testimony to you.

It contains a CD, which I doubt if is available to you online.

SENATOR HARP: We will -- I'll look for it. As soon as I find it I'll call you up. How's that, if you don't mind waiting?

PETER BROWN: Thank you very much. Thank you.

SENATOR HARP: Bethy Guiles-smith. It's your turn.

BETHY GUILES-SMITH: Thank you. I'm reading from this. Sorry.

SENATOR HARP: Okay. That's fine. We live in a technology world. So you may begin whenever you're ready.

BETHY GUILES-SMITH: First, I would like to know why it takes a tragedy to happen in the suburbs before there's a big huge outcry for civil justice? That kind of special attention on one community, specific community troubles me.

As far as mental health issues, far too much research is conducted on Caucasian children than applied to all children when it comes to diagnosis regardless to what their race is. There are massive crimes in the big inner cities daily that peaked in the late 1980s and not once have you convened or gave special legislative attention to develop ways to reduce the horrific crimes that occur daily in the urban communities.

Is it because the folks in the suburbs are privileged? Or are they considered normal and just people? You can't legislate to reduce crime. These crimes are out of your control, police officers' control, state troopers' control the Department of Public Safety's control, period.

Although I voted for President Obama and I love him dearly, but he did you an injustice towards your political careers as legislative leaders by ordering and advising you to legislate gun control as it pertains to folks with mental health issues.

First, we have enough gun control laws. We don't need more legislation. We need help to reduce crime in the urban community. The laws that you legislate to reduce crime in the suburbs will not work in the big inner cities. Or is this legislative session just to help the suburbs diminish crimes in their community?

Several African-American children and teenagers are constantly diagnosed with ADHD, personality disorder, bipolar disorder, more specifically black male and females released from prison and they've been untreated since birth. So now this means that they will continue to be totally out of control in their communities. In fact, someone is being assassinated right now as I speak, but you won't see people from the media running around with multiple cameras, nor have we ever seen the president descend on Air Force One into an urban community.

If you are truly looking to reduce crime in the inner cities and you want it to work, as representatives for our communities I believe

you should be honest with the President and let him know that you need help. There is a war that's been going on in the urban community since the late 1980s up to and including this date. The last I checked, only Congress can decare war. There is an outcry that military troops needs jobs to come home to. Great, because they need to disperse them in the urban communities because they are the ones trained to reduce crime. For example, there are of great assistance in other countries like Benghazi, Afghanistan and Iraq.

I am demanding that you request federal help from the President to end the war in the urban community. Effective tomorrow your phones, your e-mails, your small subcommittee meetings and this building will be filled with African-Americans and Latinos who were diagnosed and misdiagnosed from bipolar to ADHD personality disorders demanding your help to reduce violent crimes in the urban community until this legislative session is over. Perhaps President Obama will make a special flight arrangement to descend on Air Force One in the urban communities.

It troubles me that you are paying so much attention to this crime that happened in Newtown when there's crimes in the urban community every day. Little black children are killed innocently, too. You've never paid this much special attention to the urban community when little black kids are killed.

You show them on the news for about five minutes and you don't hear or see any of you -- I've never seen any of your faces in the black community. I've never seen anyone pile up in

the Legislative Office Building demanding help and support in the urban community to stop the violence. We have a war in our community and you're ignoring it.

Obama has been in office for four years now. He's never ascended in the urban communities and neither have you to help our people and our communities. These diagnoses and stereotypes need to stop. Black children and white children are different. They're raised different. They're indifferent to violence. They see different things and no attention is being given by you.

So therefore beginning tomorrow -- and I promise you, black people with mental disorders are just going to start showing up to your public committee meetings even if it has nothing to do with mental health. They're going to do exactly what the system wants them to do, start doing things that people with mental disorders do. Just show up unexpectedly and not know where they're at and then maybe -- maybe you'll start giving them attention because I'm telling you we're going to get some weirdoes to show up at your public meetings.

SENATOR HARP: Thank you for your testimony.

BETHY GUILES-SMITH: Thank you.

Frank Fortunatti, he may have been here earlier.

Janis Golan followed -- oh, Janice Golan? And then from the Community Health Center, Dr. Nwando Olayiwola. Sorry. Come on.

J. NWANDO OLAYIWOLA: Great. Thank you. Senator Harp, Representative Wood and the members of the mental health services working group. I was going to say, good afternoon, but good evening to you all. Thank you very much for the opportunity to speak to you all.

My name is Dr. Nwando Olayiwola. I'm the chief medical officer for Community Health center, Inc, which is a federally qualified health centers serving many underserved and urban communities here in the state of Connecticut.

I'm joined by Jane Hylan, Director of School-based Services and Alison Urban, who's a clinical social worker at our school-based health center in Smalley Academy which is an elementary school of 700 students in New Britain.

We're here today to talk, as everyone else is, about the serious issue of mental health problems particularly in our school-age population and our program responds early and upstream to these issues and we were going to offer a few recommendations for you to consider. So Jane will give details on specifics on the services provided in the schools. Alison will give a first-hand testimony and I will wrap it up with recommendations, hopefully in three minutes.

JANE HYLAN: Good evening. CHC's experience in providing mental health services in schools date back 20 years when we opened our first school-based health center at the McDonough school in Middletown. Since then schools across the state have asked CHC to provide mental health services in their schools.

Today CHC has mental health providers, mostly clinical social workers in 36 schools. In 2012 they cared for 1,600 students from kindergarten to seniors in high school. In total CHC saw over 5,000 students for all school-based services across the state.

The research is clear, students are more likely to participate in mental health treatment in school-based settings than they are outside the school walls. We remove waits and delays, eliminate the barriers of access and respond to requests from teachers and administrators for help. Alison Urban from our school-based health center at Smalley Academy in New Britain offers an example.

ALISON URBAN: Hello all. I'm honored to share with you today the story of one child whom I will always remember. When Kevin -- not his real name -- started kindergarten he said that he wanted to kill himself, shouted that he would kill everyone in the class and even drew a picture of a murder which he showed to another child and explained, look, my dad is killing your dad.

Kevin's history included many losses including the death of his mother while he was in foster care. Kevin suffered from separation anxiety, grief and the variety of trauma symptoms. His father's demanding work schedule made it difficult for him to participate regularly in Kevin's treatment.

During therapy Kevin's play depicted gun violence over and over. During one shooting scene I commented, I wonder if anyone was around

to see that. Kevin answered somebody saw, but he's hiding because he's scared.

It's okay to feel scared, I said. In a later session Kevin asked if some of the army soldiers wanted to kill each other. I answered that I didn't know. Then Kevin said, once I saw a teenager kill another guy when I was a baby and I lived with my mom.

After this disclosure Kevin continued to use play therapy to process his mother's death, his separation anxiety and the trauma of the murder. Within six weeks Kevin's aggressive language and behavior in the classroom had stopped. By the spring, even his play during therapy sessions was no longer violent.

Kevin is just one example of the many hundreds of suffering children that my colleagues and I are able to treat early in their lives when we can make a big difference on their outcomes.

J. NWANDO OLAYIWOLA: Thank you, Allison.

As a family physician I know firsthand that early recognition and prompt treatment is essential. So we're urging you to support -- for three major recommendations. One is to support the inclusion of school-based behavioral health services, whether as part of a comprehensive school-based health center or as a standalone service. We operate both models based on the community's wishes.

We also ask you to consider automatic enrollment with a provision for opting out by parents to further reduce the barriers and the stigma as

well as improved notification of parents about school-based health center services.

Thirdly and finally, we know that some children require additional care from psychiatrics or psychiatric APRNs, as we've heard today. And we're asking you to consider adding coverage for psychiatric services delivered via telemedicine when a school-based mental heath provider needs to get such services for a child. This has been demonstrated to be effective in 40 states already and working together we can do a better job of identifying, treating and helping school children with mental health issues.

Thank you very much.

SENATOR HARP: Thank you. Are there questions? If not, thank you very much.

Mr. Brown, I think we have your package. Do you want to come forward?

PETER BROWN: Thank you very much, Madam Chairwoman.

My name is Peter Brown. I'm from Middlefield, Connecticut. I've put together this small packet for you today.

We're all here for one reason, because of the terrible tragedy in Newtown. We're all trying to find answers. The main question that I faced trying to answer myself was, how could someone do this? And I came across -- in my search on this I came across certain things I'd like to share with you, a number of which is the printout on page 3, SSRI stories. It gives a list on that website. It gives a list of over

4,000 incidents of drug -- SSRI drug violence incidents.

And as Representative O'Neill questioned, that there wasn't enough studies to determine causality, I would submit that you don't actually need to prove that on a scientific level. And that you can very easily on the next page -- which is also on the DrugAwareness.org page, this one here, it's -- go to that website and watch the video which is entitled, Why I Took a Gun to School.

And it's a 16-year-old Corey Baadsgaard -- took a rifle to his high school and held 23 classmates hostage. He got talked out of it before any tragedy happened. And you can watch his statements right there. So before we can extract a perfect scientific study we can take people's testimonies that have been on the drugs and there's one example right there.

The CD that I put together for you is three hours of a radio show featuring two experts. I'm not an expert, but these people are and I'd like to just share that with you if you feel like listening to it. Dr. Ann Blake Tracy who was a -- specialized for 20 years in adverse reactions to serotonin (inaudible) medications including Prozac, Zoloft, Paxil and the rest of the list.

The third file, MP3 file is from the same radio show, but a different night with Dr. Peter R. Breggin who also shares the same sentiment as an earlier speaker today, which was Dr. Harold Schwartz on one of his concerns with his testimony.

So -- and with my remaining time the question I'm facing is I hear a lot from a lot of people, it's the guns. And even the title of this group, it says, gun violence. I think that's a predetermined outcome. I would just submit a simple test. If you yourself, if the police officer who has a gun handed you his weapon and you were in front of a class of kindergartners, could you do what would happened in December by this person? And I would think, I would hope the answer would be no.

Therefore that simple test means that it's not the object, it's the person. And so what would drive that person to do that? So incomprehensible. That's really the answer to the question. If we don't find that answer this will happen again and again and again.

And the best way to do it is to watch this, why I took a gun to school. It's from a person that was there under these drugs.

SENATOR HARP: So thank you very much.

What would you like for us to do? What action does this sort of recommend from you?

All of these drugs, I'm assuming, are prescribed by medical providers and I don't know whether or not it's the drugs themselves or discontinuing them without a transition that is causing the problem, but what kind of policy change would you like to see happen based upon the information that you're presenting us?

PETER BROWN: Thank you.

Based upon the information that I've found -- and I'm just a private citizen concerned as we are it makes you think -- if we go back to the SSRI stories, that compendium, the list, it's -- I think just the evidence is quite conclusive that we have all these school shootings of late within the last 30 years or so and this list pretty much shows that Columbine, you know, you have Luvox and Zoloft antidepressants used and you have these people and then you have the actual testimony of someone who was on them that actually brought a rifle to school that could have been a next mass murder, that was talked out of it, thankfully, and you get to listen to that person.

So I would like to say in answer to your question that we look at the effects of these drugs because I'm submitting to you that in the course of a hundred years and longer of the availability of the weapons, it's not the weapons because if you put a timeline across history you show that a hundred years ago you didn't have this action. So it's not due to the availability of the weapons because they were always available.

You could also show that it was -- that you didn't have these school shootings before the invention of these chemicals, and put together in these drugs because you didn't have these events in the fifties. And these, the first of these from what I understand -- and don't quote me specifically of the exact date -- but it was 1959 and started getting used in the early 1970s.

So I would like to see -- and it's of course your purview that you look into this, and if you

see merit in my presentation to try and answer this question, that you would go down that road and then ask yourself, all right. We have -- we either have a problem with this or we don't. And if you find in your findings that you do have a problem, that you would take them and answer the next question, what can we do about it?

If you say, well, you know, it's all prescribed and that's that, you can't do anything, then we're just going to have to wait for the next tragedy unfortunately because nothing will have changed. That's as honest -- answering your question as honestly as I can.

SENATOR HARP: Thank you.

Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Thank you for your testimony.

PETER BROWN: Thank you.

REP. SRINIVASAN: You're touching upon the same subject again from earlier in the afternoon.

PETER BROWN: Yes.

REP. SRINIVASAN: I do agree that you -- each of these killings are horrible events that happened, but the relationship is not what I'm able to connect. You know, thousands and thousands of people are on all of these medications and that these instances have happened, agreed 113 school shootings in school and so on and so forth.

So there's one missing component. Is the drug? Yes, along with something else that has caused these people to do what they did. Just like you give an example of handing a gun to me and hoping that I will not do what happened. Similarly just a drug alone and handing a gun to a person, you know, taking your analogy to the same situation doesn't necessarily mean that the person is going to commit the crime.

So it is, A, the medicine in a particular kind of a person which we do not know and that is where I think the missing part of the puzzle is which we need to figure out.

PETER BROWN: Yes. I totally agree. And that would be of course within your purview as an investigative body and of the State of Connecticut. And I do encourage that you made strides along answering that question.

If I may just throw in another observation, that these drugs don't come in from jungles. They're not outside and then brought in clandestinely. They originate in a controlled environment. They are distributed within a controlled medical distribution network and so all of those characteristics of this are -- please correct me if I'm wrong -- are within the control of your Legislature. You have the ability to regulate these things. And so it's completely up to you what you can do about it.

If you find that there's merit in answering your question with further deliberations that you may have in the future, if you find merit then maybe -- just throwing this out for conversation -- maybe you would want to eliminate the direct marketing from the drug companies through TV ads

and magazine ads that go directly to the consumer and say, you're not feeling too good. You're having a little bit of, you know, depression that we all face. We're all human beings. Try -- ask your doctor to give you one of these drugs. I mean, I think you've seen those advertisements. Maybe that would be a step.

I mean, I'm not trying to say that everything is bad in a universal way, and certainly these drugs may indeed help real people with real problems, but I think perhaps we're seeing the overprescription of these for financial gain to people who may not even have problems.

I think part of the problem here is that we might be over diagnosing something that doesn't exist. Sure, we're all human. We all feel joy and sorrow and depression and that's part of life. It doesn't mean every time you feel a little bit down you need a prescription for a chemical from a doctor.

I mean, so I would think that there's the possibility that there's overprescription which could be maybe even a hundred percent of the problem we're facing with these people who are flipping out obviously in a mental state that is not rational. Can we agree on that? They're not rational. Who could stand there and conduct the murder of what happened? It's irrational.

So we have to find out why someone is in that mental state and I would say with what I have provided today this may be a good place to start looking good.

SENATOR HARP: Thank you.

Further questions? If not, thank you very much.

PETER BROWN: Thank you.

SENATOR HARP: Janis Golan followed by Kristen Tierney followed by Alyssa Goduti.

Is Janice here?

A VOICE: (Inaudible.)

SENATOR HARP: Oh, she didn't come. How about Kristen Tierney? How about Alyssa Goduti? Is Alyssa here? How about Lee Parker? Lee Parker? Did Lee Parker get here?

Mary Stone? Mary Stone? Bill Shortell?

Welcome.

BILL SHORTELL: Good evening. I'm Bill Shortell, Political Director of the Eastern Territory Conference of Machinists. We do not have a position on this issue and I'm speaking as an individual.

As a longtime member of an organization of mostly working-class men I have insights into the collective approach to troubling questions like this. I support the proposed guns legislation. I also believe that the wide chasm in our nation about guns will not be bridged by insults. Those of us who say humanity can live without guns should never taunt or inflame the other side.

In the machinist union our constitution prohibits personal attacks against fellow members. This solidarity brings us through a

lot of turmoil. I have personal experience dealing in a brotherly way with -- excuse me -- dealing in a brotherly way with people with guns who scared my fellow members. These are best shared in private if any legislators are interested.

If we really expect to solve the crisis we have to focus on support and guidance for the whole community, not simply on the very small number who are at risk for violent behavior. People my age have lived through a breathtaking collapse of community. Although there are some exceptions especially among new immigrants, we have seen the neighborhood, the extended family and even the nuclear family full apart. This means that millions of lonely troubled people have nowhere to turn except to professional help, which will never be enough to cope with the enormous need, or to drugs which mostly mask the problem and often produce, as people have said here, terrible side effects.

I want to propose here a much more radical approach to tragic violence than gun control or increased police or social work. I think that our legislators need to examine rebuilding community-sized groups with material subsidy and professional guidance. It's only in community that troubled people in a natural informal way can find the nurturing that will integrate them rather than eject them like a missile aimed at our innocence.

We're used to breaking bonds, forced to find jobs thousands of miles away. To reverse this, to encourage people to stay put long enough to get to know and love a whole community of hundreds of people is a revolutionary project.

We have a beginning of an understanding of how to do this in our churches, our unions and our social service system.

I propose we take our collective memory, energize it with a vow of, never again, coming out of Newtown and begin plans now for a new secure and loving community for our children.

SENATOR HARP: Thank you very much. That's a beautiful concept.

Are there other questions?

Yes, Representative Hovey.

REP. HOVEY: Thank you. That was a beautiful concept. And what I will say to you is that the reason why Newtown has done as well as they have in this crisis is because it is a faith-based community and it has rallied around each other individually and as groups. And so much of what you say is absolutely true.

Thank you.

BILL SHORTELL: Could I respond to that once? Maybe some of you have heard of a strategy called therapeutic community. I did a study on that about 30 years ago and it kept ringing in my head as I was hearing the testimonies here.

They have them in northern Europe. This is not taking one person and trying to treat one person like Charese's poor son. This is finding a whole community supported by government funding that has healthy people, people with special needs and people with professional skills all together in one community with an economic base

of work to be done to support the community as well.

That's the model of the kind of thing I think this whole country needs at this time. We need to get back to community. We need to find ways to support a whole community, not to stigmatize and isolate people that we think have problems and try to deal with them one at a time. It's not working.

SENATOR HARP: Thank you very much.

Further questions? If not, thank you so much.

BILL SHORTELL: Thank you.

SENATOR HARP: Billy Bromage. Karen Kangas. Andrew Woods.

A VOICE: (Inaudible) Karen is here.

SENATOR HARP: I know. I'll get back to her. I'm sure she won't let me forget her.

Is Andrew Woods here? James McGaughey.

JAMES McGAUGHEY: Good evening, Senator Harp, Representative Wood, members of the working group. My name is Jim McGaughey. I'm the director of the Office of Protections and Advocacy for Persons with Disabilities. And I have submitted written testimony and it's been a long day, so I have no intention of reading it.

But I began it with a question that has been sort of hunting my mind ever since I first heard it posed by a minister on the Sunday following the shooting at Sandy Hook Elementary School,

which is, how did we miss him? How did we miss Adam?

And I don't mean by that, how did we miss his propensity for violence or something like that, because I think we've heard a lot of testimony today and there's certainly been a lot written about how it's really hard for clinicians to predict risk and violence and so forth and we don't really do that very well.

What I'm referring to is how did we miss the opportunities when he was younger to include him in a positive vision of his future? And I think that's a question that resonates with advocates a lot because we see -- and my testimony goes into it in some detail -- that fact that in spite of the fact that we have a lot of services and we have a lot of legal -- legally required programs, special education programs and things of that nature, and in spite of the fact that we have a lot of knowledge about how to help people, and in spite of the fact that we have good examples of both people with developmental disabilities and people with psychiatric disabilities who are achieving wonderful things and making really outstanding contributions in their communities, we still know that the reality is that an awful lot of the families, that we heard from some of them today, are lost and struggling.

And we know that a lot of people who are adults with psych disabilities are facing marginalization, poverty, poor healthcare and outright discrimination. So I think we have to ask those questions if we're going to seriously address the underlying causes of this tragedy.

And I had two recommendations which are outlined in the written testimony. The first is that I think it would be a great idea to support a comprehensive initiative to help school systems understand and fulfill their obligations to educate students who manifest signs of emotional disturbance or other disabilities that sometimes present behavioral issues. It has been a requirement of school systems here in Connecticut since the late sixties.

If they were going to get they would have got -- by themselves, they would've done it by now. And I think you can hear -- you've heard a lot of testimony from parents that they really haven't -- they need help. I mean, I've been an advocate for 30 years. At first I thought what they needed was lawsuits. I now realize that's not going to help them a whole lot.

They need technical assistance. They need people who know how to do this to come in and model it for them. They need to figure it how to integrate this with all the other demands that are placed upon them, so they need help to do that.

And the other recommendation, which has been inadequately addressed by a number of other people who have come and testified today, is to expand the community-based recovery oriented service system.

And so I won't take any more of your time, but I wanted to say those things.

SENATOR HARP: Thank you very much.

Senator Crisco has a question.

SENATOR CRISCO: No.

SENATOR HARP: Oh, you had your hand up.

Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair.

And thank you for your testimony and waiting so long to provide it. I'm very interested in seeing what types of comprehensive settings we can provide in a school because that is one of the central places all of this -- all our children go pretty much.

And I'm just wondering, do you have a vision for what might occur? Would it be in each school or would it be in a district? And would it be, you know, a general health center like we have federally qualified health centers in some places; other places have their own school-based health clinics?

How would we be able to coordinate something that would provide the technical services and also be consistent throughout the State?

JAMES McGAUGHEY: I think there's two components to that. I am aware of the school-based health centers and the work that they've been doing and I think you heard earlier from the director of the statewide operation. And the fact that part of what they do is provide mental health support in the school and I think that's very useful.

But it isn't enough to just bring it in and have it be in an office down the hall somewhere. This is also a question of school climate. And so the leaders in the school have to sort of

embrace the idea that all kids belong, that all kids have a right to an education and that if they don't know how to do something they're not going to be afraid to ask. And so I think that's -- a lot of it has to do with school climate.

The State Department of Ed does have and has sponsored some projects to assist with this. There's a gentleman, Dr. George Sugai from the University of Connecticut who's actually something of an expert on school climate, but he will only consult in a school where there is a request from the school. He's doesn't -- it's not something you could impose on a school environment. You have to -- people have to want to embrace this direction.

But it has a lot to do with the way the adults treat each other as much as it does with recognizing the problems that a child might be having outside of school. It has to do with not responding with harsh discipline and/or seeking the arrest of somebody necessarily who's having a tough time probably because something at home is going wrong.

It's recognizing all of those things. So it's sort of a change in the school climate plus bringing it -- the people with competencies to actually deal with folks who are having a tough time, kids who are having a tough time. Because that's not hard to do. That's not easy.

REP. JOHNSON: What do you think about classroom size? What would be an ideal size?

JAMES McGAUGHEY: Well I mean, you know, I think that's really -- particularly when you're

including children who may have a tough time being in a room with a lot of other people, if you put a whole lot of those people in one room --

I have seen situations where you'd have five or ten kids with autism spectrum disorders in one classroom and a whole bunch of other kids that don't have any particular labels in that same classroom. And it was basically having two classes. And it was not -- it did not work for anybody. And so I think that's what I'm saying, schools are struggling when they're resorting to those kinds of approaches they don't know what -- how to do this very well and they need help.

So classroom size, I don't know about total classroom size, but I know that, like, overloading a classroom with kids who have behavioral issues and so forth is generally not a very wise thing to do. So --

REP. JOHNSON: Just quickly following up on that, that whole concept because that's my impression. When we mainstream children that have emotional behavioral disorders with children who do not, I mean, is there a good classroom size? And also what should be the mix? Or what type of a mix of should we have?

JAMES McGAUGHEY: You know, part of difficulty in prescribing here is that the terminology that is used, the educational terminology which is emotional disturbance -- ED is the label that's recognized in special-education programs -- is it covers such a wide range of conditions or experience.

You can have a child who's very withdrawn and depressed or somebody else who's bouncing off the walls and is really, you know, quite a handful. And they would both have the same label from the educational perspective.

So it's hard to -- it's really individual and that's what special-education is supposed to be about, is an individualized program because the eligibility criteria is you are categorically somebody who cannot benefit from the general curriculum unless it's tailored to you and because of a specific disability.

So that's -- I don't know that I could prescribe programmatically. There are people at the department of ed who have some greater expertise than I do on that. I'm more of a critic than I am the fixer here, the consultant. So --

REP. JOHNSON: Thank you so much.

Thank you, Madam Chair.

SENATOR HARP: Thank you.

Are there further questions?

You know, one of the things that I think would be very interesting is to see what happens to the kids that have emotional disturbances. I suspect that they're pushed out of the system because it's so difficult for the system to accommodate them.

And especially at a certain age I think that they're the kids that we see who are moved to alternative schools and then they're there for a well and then they're finally moved out by the

time they're 16. And so I think you're absolutely right, that we absolutely failed these kids.

JAMES McGAUGHEY: Funny you should mention that, Senator Harp. The State Department of Ed actually has produced some information that I got -- it's actually a little bit over a year old. It was submitted to the Office of Special Education Programs, a federal agency they have to submit reports to. But it shows that the dropout rate for kids with ED labels is second only to the dropout rate for kids with learning disabilities and that's a -- and learning disability, the vast majority of kids with special education needs have learning disabilities.

Dropout rate, failure to graduate -- and that cuts across all environments urban and rural and all other groupings, racial and ethnic groups. So these kids are really being failed educationally as well as in every other way.

SENATOR HARP: Thank you.

Further questions? If not, thank you so much.

JAMES McGAUGHEY: Sure.

SENATOR HARP: I believe I skipped over Susan Gallagher. Is Susan Gallagher here? Okay. All right. You didn't jump up fast enough.

A VOICE: (Inaudible.)

SENATOR HARP: Okay. And then it will be Caroly Gibson.

SUSAN GALLAGHER: I want to first thank you for having me have my voice heard. I am here today to talk about my journey with my son who's now 23 years old.

In 2011 he was diagnosed with schizophrenia after a very serious psychotic episode. He spent three months in Yale Psychiatric Hospital. He was discharged three times and readmitted twice because of suicidal thoughts and an attempted suicide.

I've been trying to get my son help since 2006. Each time the psychiatrist would spend a short time with him, diagnose him with depression or social anxiety and put him on medication. There was no therapy. The only doctor that talked about real therapy did not take insurance. Thinking back now I would there's no deep probing giving the history of mental illness on both side of my family -- of his family, I'm sorry.

My son, a gifted artist, was never a problem in school or at home. Violence and belligerence are not part of his nature, but beneath his peaceful exterior were thoughts that needed to be explored. I'm thankful he wasn't into violent videos or video games. Instead he was into art, but what I want to make a point is that he did read a lot about artists and some of the stories did influences is bizarre behavior, because his mind is vulnerable as many are.

Once he turned 18 that was the end of my being able to help them. I couldn't even get an appointment with a psychiatrist. I remember trying to make an appointment crying over the phone, pleading, but no, they sent me he needed

to call. Now this was a kid that couldn't keep it together. He was sleeping all day going for long walks and drives at night.

Now he had an arrest in 2008 and at that time a well-intentioned person called me and he said your son has a problem and I thought, yeah. But there's nothing I can do and that's the truth. Once they're 18, even if they live with you and are financially dependent on you, you're helpless. You live day to day with the darkness, scared. It's almost like -- just like your child is denying he's sick; you have no choice to deny because there is nothing you can do.

Now in 2011 clearly he was in a psychotic state. He was caught trespassing and he was arrested. He was picked up by the -- actually he ran home, the police came over. They looked at him. They said is he okay? They never talked about taking him to the hospital. There was no real outreach to us as to what to do.

Now the next day we did take him to the hospital and he was very passive. He came along, but at the last minute he said, oh, I don't need to go. And I was like, oh, and I leaned over and I said, you know, I suspect he's been abused and I did at the time. I don't want to get into the circumstances and that was the only reason that he got in.

When I took him the next (inaudible). Sorry, I have to find my place.

After being discharged and then looking for a high place to jump from I brought him back and they just upped his meds and were going to send

him home. But I pushed back and they agreed to take him for observation. He was admitted the next day. The next time he was discharged he attempted suicide.

While my son was in the hospital I saw patients come and go. They stick them on meds, send them out, much like the earlier experience with the psychiatrist. These are very dangerous medications and until they find the right one taken regularly it can lead to tragedy. They did bring that up before. What do they say? Four days and they're out, but it takes -- a week is the average stay, but it takes two to four weeks for them to find the right medication, and that's what happened with my son.

The sad truth seems to be that the mentally ill do not get the help they need until there's a crisis. Can this be changed or is it just the nature of the illness? I would like to see restrictions lifted on parents for children over the age of 18 that are financially dependent on them.

Also I was really happy to see the mental health first aid legislation. I hope that will include some training and education for parents. I think a couple things I've heard today such as the outreach -- I thought that gentleman that was here that came with the operation was -- what he said was right. There needs to be more outreach. You know, with -- when you have schizophrenia you are not going to bring yourself in. You think you don't have a disease. And the outreach is really, really key.

And I also have to say what Charlene said, you know what? You do. You get left. Poor Charlene, I'm really sorry about, though. Poor Charlene there, that's what I went through. I had to fight and fight. I continue to fight and he's gotten really good treatment and he's doing really well. So want to really thank you for listening to my story.

SENATOR HARP: Thank you very much.

Are there questions?

Thank you. I think it really gives us insight into this population of people who are -- we consider adults but still live at home. And this is what I would call older adolescent population.

SUSAN GALLAGHER: Yeah. And it is, because that's what they were saying before, they're more like adolescents. And I think it's something that you could do that doesn't cost anything. It would not -- it doesn't cost anything to free us up so we can really -- we shouldn't have to fight so hard.

SENATOR HARP: Thank you very much.

Representative Wood has a comment. Excuse me.

REP. WOOD: No, just to thank you very much for sharing your story.

And I agree with Senator Harp. It's very illuminating to have all this information.

Thank you.

SENATOR HARP: Caroly Gibson -- oh, there you are. Followed by Deron Drumm.

CAROLY GIBSON: I'm Caroly Gibson and I come as, I guess, another frustrated parent, but -- and a frightened parent. You can tell by my age that it's been a long struggle. The child I'm talking about is a stepdaughter and she's 37 years old, so this has been a long, long fight.

We knew something was wrong when she was very, very little; didn't know exactly what was wrong. She didn't measure up to all the average standards. So typically as other people's stories go, in school they put her in special ed and labeled her learning-disabled, the big catchall phrase.

It wasn't until she was nine years old that doctors determined that she had had a stroke and the stroke occurred either in utero or at the moment of birth. It left her physically, emotionally, intellectually and psychologically impaired. What to do?

A very expensive neuro-psych exam showed her multiple limitations. There was a panic that came over our family. Was there any kind of help available for her? The schools were kind to Karen, but really had no suggestions for her future.

So I decided I would explore the state systems. I'm an ordained person. I'm fairly intelligent. I thought I could tackle the state systems so I began calling. I started what was in the old days the Department of Mental Retardation. They said, I'm sorry. We can't help you. She missed the criteria by one point.

Well, she's brain-damaged. How about I try the acquired brain injury program. I hear there's lots of good programs there. Oh, I'm sorry. We have a cut off. If the brain injury occurs before birth there's no program for her. You have to prove that it happened after birth, which I could not prove.

Countless hours, lots of frustration, lots of what seemed to me to be duplications of systems. We were at our wits' end. We finally found a nonprofit organization that would take her in, give her some life skills, but we didn't know at the time it wasn't nearly enough supervision for Karen. She started cutting herself, abusing alcohol and then finally when a romantic encounter with a young man next door wasn't returned she got mad enough to burn his house down. She lied about it.

And he built a new home. In an attempt to burn it down a second time she finally got caught. The crisis sent her to York where she was incarcerated for three years for arson. Real panic set in when in her thirties she was going to be released and there was no place to put her. The judge who released her into probation said, this young woman obviously needs 24/7 supervision. Where would we find that?

It's like a commercial for the Melissa Project because they -- we found out about them through NAMI, the National Association for Mentally Ill, and they have been guiding us through a very complicated system. At this point today we're looking for a place for Karen to live with 2/47 supervision because her story is a little different. Brain damage doesn't go away. She's not going to get well. The only way for her to

have any kind of a life with some joy, a part-time job, she needs supervision 24 hours and that's expensive.

And that's my frustration and my plea for help. Thank you.

SENATOR HARP: Thank you very much for sharing your story.

Are there questions? If not, thank you so much.

Deron followed by Laura Gerbe.

DERON DRUMM: Good evening. My name is Deron Drumm. I'm opposed to outpatient commitment, a.k.a. forced medication, a.k.a, forced drugging. I ask that before you consider forcibly treating people you look at the outcomes of the current mental health system.

In my life, in my personal recovery I've dealt with two different treatment models. I call the first one the medical model, which is what's used in most of America now to treat people in emotional distress. I call the other one the pure model.

I suffered emotional stress for most of my childhood. I had extensive routines I went through every day in order to prevent horrible things from happening. For example, if I did not change my cloths repeatedly before school I feared something bad would happen to my family. I rubbed my tongue against my teeth until I bled daily in elementary school. I was late to high school most days because of my routines. Every time I drove I thought I hit someone and would

circle back multiple times. I know what bullying feels like. I tried to hide in school.

I went to school for a total of 19 years and never once raised my hand to voluntarily participate. I was afraid of basically everything. I also felt very real anger. In my late teens I decided I could not take the suffering anymore. In what was the most courageous moment of my life I asked for help. I was sent to a psychiatrist office whose office was in a medical complex. Above the wing where his office was there hung a sign, a large sign that read, psychiatry.

Once inside and over the next few visits I was given a diagnosis and told I had a brain disease that resulted in a chemical imbalance. I was given a psych drug regiment and told to set my ambitions in life a little lower.

Over the next 14 years I tried dozens of psych meds and experienced terrible side effects, waking, insomnia, sexual side effects. I believed I was less than, quote, unquote, normal people. I believed I was broken. I simply believed what the mental health system told me.

I eventually found my own ways to stop the pain. I found somewhere I belonged where people were nice to me and I felt like I was someone where I thought I was good at something.

The place, that place was a casino. I became seriously addicted to gambling and destroyed everything in my life and my worst childhood fears came true. I had hurt people. I ended up in an awful psychiatric hospital where I was given drugs that made me forget who I was.

Now this is the pure model recovery I've gone through. My saint of a mother fought to get me into a rehab facility far away. My first day there I was approached by a men who said are you ready to start living? Are you ready to take responsibility for your life and deliberately built a new one?

I said, you don't understand. I did bad things and I deserve to die.

He said do you see this scar on my arm? It was from a police officer tackling him during an armed robbery. He said, do you see this scar on my head. It's where he put a pistol to his head and pulled the trigger.

This experience started me on what was an incredible journey. Many peers, people who've had comparable experiences helped me learn how to live. They taught me to be responsible, not be defensive, not control, not complain; be accountable and reliable. They taught me that I am not broken and that I have value. And they also taught me about nutrition and the impact of glutin and processed sugar on emotions. And they taught me about mind and body, yoga and meditation.

The biggest thing is I learned how to feel. I spent years thinking that if I felt anxiety, sadness, guilt or even happiness something must be wrong and I should take a pill or do something else to get rid of the, quote, unquote, symptom. Now that I know been an emotive human is normal. I'm okay having bad days. As my friend tells me, the parade doesn't always have to come to town.

I take full responsibility for my life today, but I do have those moments when I think, well, what if when I asked for help when I was teenager, what if they introduced me to e peer that taught me about recovery and holistic wellness, who let me know my feelings were within normal human diversity?

I can't go back and udo that. What I can do is fight to change this mental health system. Please truly look at reform. Please do not force treatment as it exists on people, understanding you will not be helping them. You will be hurting them. The United Nations says if you force meds on people you are torturing them.

Thank you.

SENATOR HARP: Thank you very much.

Are there questions or comments? Thank you very much for sharing your story.

Laura Gerbe. And I may be pronouncing your last name incorrectly. I apologize. Is it Gerbe?

LAURA GERBE: Gerbe.

SENATOR HARP: Okay. Sorry. You can begin when you're ready.

LAURA GERBE: Good evening. My name is Laura Gerbe. I'm here today to ask for a much-needed change to the law in regards to mentally ill patients and medication noncompliance in order to create a safer Connecticut. It is very important this is done without waiting any longer.

Connecticut needs to look into adopting the assisted outpatient treatment law, AOT, that 44 other states have already passed. See Kendra's law and S.B. 452.

AOT is court ordered treatment including medication for individuals who have a history of medication noncompliance as a condition of their remaining in the community. The six states that do not have AOT are Connecticut, Maryland, Massachusetts, New Mexico, Nevada and Tennessee. This touches my life personally as I have a brother who was diagnosed with schizophrenia 12 years ago. He has been suffering with this illness as has his family since that time. The average age of diagnosis of schizophrenia is 18 to 25.

After years of trying to find the right medical cocktail that actually works for my brother we have been lucky enough to find one. While on his medication he is very functional. He does not suffer from delusions, paranoia or hallucinations. He can smile engage and communicate. He can show and receive love from his family. He has even been able to obtain and hold a job and be an upstanding citizen as the rest of us are. However while off his medication he and his entire family suffer, seeing him decline severely.

The problem is this mental illness affects the patient's brain and the ability to make rational decisions that are in the best judgment of themselves and therefore others. Because the brain is compromised the patient, my brother, constantly thinks he does not need medication. The illness tell him this, so he stops taking it

each and every time he's discharged from hospital.

He's been in and out of hospital ten times now for at least six weeks per admission, costing Medicaid and the taxpayer hundreds of thousands of dollars, and he's only 38 years old. This is a waste of his life, the lives of his family and is a complete injustice to his human existence. The law the way it is, is not helping the patients at all and is making the state unsafe.

By mother has been appointed conservator of my brother and is allowed to manage all other aspects of his well being, which he and she both agree is helpful to him, however the law says she cannot assist in the decision making for him to take medication; no one can.

Medication is the foundation to his well-being. Without it he doesn't leave his bedroom because he has visual and auditory hallucinations and is so afraid. His doctor and the probate judge's hands are tied as well because of the law.

As we all know the way the law is written, until the person is a harm to themselves or others no one can do a thing. Why would we want to wait until someone is a harm to themselves or someone else before giving them the care they so need, care that works? This is dangerous and there are better ways.

We should not have to wait until a person decompensates so badly that we have to call the police on our loved ones. It's more dangerous to go on and off these meds than to stay on them continuously. What I'm asking is that Connecticut legislators look into allowing the

conservator along with the doctor and even including the probate judge, if you want to make sure one person does not have control over a patient, to decide whether the affected patient should be required to take medication.

Each diagnoses should be looked at differently. Each person should be looked at on a case-by-case basis. What are we waiting for? Please let those children and teachers in Newtown who gave their lives move you to look into making sure patients stay on their medication. This may not solve everything, but it would be a step in the right direction towards safety and helping patients and families not have to suffer from these crazy logistics in addition to the suffering of the illness itself, suffering that the opposing parties do not live with or understand.

Thankfully my brother is not and has never been a violent person by nature, however some people with or even without mental illnesses are. Without letting conservator/doctor/judge teams enforce medicine for our loved ones we are one of only six states that is saying, we'd rather let people with schizophrenia be amongst us in society off their medication with a potential to become violent and we'll deal with them when they break the law putting them in jail.

This is the perfect storm that we have to avoid from happening again in the future. Connecticut should be in the forefront sending the example. This will not take away someone's civil rights. Severe mental illness, not it's treatment, restricts civil liberties.

I truly believe the time for change is now. Thank you for considering my plea and for taking the time to review all testimonies to make change and do better.

SENATOR HARP: Thank you very much.

Are there questions?

Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

Just for my clarification, when these court ordered medications have to be given by the appropriate authorities in the other states, how are these medications given to that individual? Is it an intramuscular injection or are they oral all medication that the person has to take?

LAURA GERBE: I can believe it could be either. My brother has been on oral medications, which he has said that he has taken over a course of eight years and he ended up mouthing them and not taking them.

REP. SRINIVASAN: Right.

LAURA GERBE: But now he's on an injection which is once a month that he brings with him to the doctor's office and the doctor administers the injection intramuscular, and it lasts for 30 days.

REP. SRINIVASAN: So the way we confirm that the medication has been given has to be -- the route has to be a parental route and not an order route?

LAURA GERBE: I believe that -- my mom is the conservator and I feel that she has gone through a whole gamut of paperwork and testimonies to be granted that, that job. And I know that there's some concern about just allowing one person to make that decision for another person. And I do feel that there shouldn't be just one person making the decision on medication for another person, which is why I feel that with the direction and the guidance of a doctor and even the probate judge --

I mean, we've had a team of the conservator, the probate judge and the doctor all being in agreement that my brother is severely decompensated and needs to take his medicine. And because he simply says, no, I don't want to take it because I didn't hurt anybody, he thinks that he's hurt someone and he hasn't; they can't -- the probate judge, the doctor, my mom, with all the power that they should have, they can't do anything. So it just -- he just waits until he -- until we have to call the police on him and then they take him to the hospital for his -- a couple months' stay.

And it takes him a really long time to come out of that state each time, because he goes deeper and deeper into that, that paranoia and that fearfulness each time he goes off his meds. So --

REP. SRINIVASAN: Thank you. Thank you.

LAURA GERBE: Thank you.

SENATOR HARP: Can I ask a question? What happens that makes you call the police? Because you

said that he wasn't violent. I just wonder what happens.

LAURA GERBE: The first time was about 12 years ago. We were in Aruba and he stopped drinking water. He thought that water thinned his blood and wasn't thinking straight and was not drinking for a full week. So basically we found that because that is a harm to himself we could get him into the hospital at Yale, you know, when we got -- as soon as we got off the plane from JFK we brought him directly there.

So basically if he's a harm to himself, which the unfortunate part -- and it's fortunate but unfortunate he's not violent which is wonderful, but they sometimes push for us to say, like, the police will say, maybe, you know, has he threatened you? Kind of like making us say that he did threaten us.

And I just feel that we shouldn't have to lie. We shouldn't have to say that he's violent and we shouldn't have to push him to a point that he's becoming a harm to himself or to someone else because that, that does happen. I mean, he gives so paranoid and fearful that he will threaten my mom.

And it's just scary. You know, when someone's brain isn't working right and there are meds out there that, I mean, he's working right now 30 hours a week. He's doing so great on meds. So --

SENATOR HARP: Thank you very much.

LAURA GERBE: Thank you.

SENATOR HARP: Janine Sullivan Wiley.

While she's coming up I just wanted to let everyone know I forgot to tell you that the cafeteria will be open until seven o'clock. So you have 20 minutes.

Good evening. You can begin when you're prepared.

JANINE SULLIVAN WILEY: Okay. Good evening, Senator Harp, Representative Wood and all the members of the committee assembled here tonight, with your diligence staying this late. My name is Janine Sullivan Wiley. I'm Executive Director of the Northwest Regional Mental Health Board.

I think most of you know what the regional boards are and what we do, but basically we represent all the stakeholders in mental health and addiction services in the community. We conduct evaluations, assess unmet needs for behavioral self the services and work to address the stigma, noting that stigma is a barrier to treatment and recovery.

Sandy Hook is in our region. It has had a profound effect on so many people there, on the children, families and educators in the elementary school which experienced that unspeakable tragedy. It affected every person in that town and in the surrounding communities. It was not like the ripples from a rock thrown in a pool, but much more like an emotional tsunami that has absolutely swept through everything and everyone.

It's swept also through the lives of all the people in Connecticut, in the country, and

through the lives of all the people with mental illness and their families and it continues to rush on and continues to leave destruction in its wake.

I'm concerned today with unnecessary harm as a result of that event and maybe some increased hope. My hope is that this event will finally help bring about the investment and support and treatment that will help every family, every child, every individual get the help that they need without fear or shame.

As I mentioned, part of our legislative mandate is to conduct needs assessment and some of what we found is that right now in a region the 43 towns of Northwest Connecticut people are seeking help and support they need to recover and they cannot get it. Right now there are waiting lists for outpatient treatment. It's a resource issue.

People find themselves on spend-downs with Medicaid and cannot get the medications they need and count on for wellness. It's the opposite of saying, you know, you have to take it; they want to take it. They try to get their medication and they can't because they are spend-downs. That's a policy issue.

There's a chronic shortage of psychiatrists -- and I haven't heard that mentioned today -- it's a workforce issue. The programs that provide safety and security in the nonprofit sector are stressed and stretched from years of chronic underfunding, having to do with more with what is effectively less. And you heard from Barry Simon earlier, they have had to reduce hours,

they've had to reduce staffing and hours of operation.

Even the state-operated services are stretched. They're operating with staff vacancies. What I find is that the service system in Region 5, which is really the only one I'm comfortable speaking to, cannot do what they want to do and what they need to do and that's a resource issue.

Now there's been a lot of talk this evening about involuntary outpatient commitment -- that doesn't work. I'm not going to repeat all the things that you've heard actually on both sides, but I find it to be a great and tragic irony that making treatment involuntary is being considered when treatments that supports and that people are seeking is not there, and that's a matter of resource allocation policy and political will.

And I'm asking you to follow this tragic event and the emotional tsunami with decisions that foster hope, that enable people with behavioral health issues to recover and to just please -- and I can wrap it up -- please just support a robust service system so that it has prevention, early intervention, young adult services that divert people from the adult system.

And I've got a little picture on my testimony. People just need a bridge to help them get where they're trying to get to and I think you're all in a position to help assure that that bridge is strong and supportive.

Thank you.

SENATOR HARP: Thank you very much.

Are there questions?

Senator Gerratana.

SENATOR GERRATANA: Janine, thank you so much for coming in today and giving testimony here.

I've been hearing this over and over again, we need a needs assessment. We need to understand where the gaps are. You know, my approach of course is to integrate behavioral health with other health services, you know, we're moving towards that --

JANINE SULLIVAN WILEY: I agree.

SENATOR GERRATANA: -- patient-centered medical home. I see no differences here.

But what I do need help with as a Legislator is what kind of tool do we need to develop to do that needs assessment? In other words, what kind of survey? What kind of overview? Whatever it is that we need to understand where those gaps are and those loopholes are so that we can get to that goal.

JANINE SULLIVAN WILEY: Your legislative -- the wisdom that goes back many years, the regional boards are actually charged with that and we do those needs assessments every year where we have identified the gaps. It doesn't always translate into meeting the gaps. I mean, there's a big difference between assessing what's needed and implementing it.

One thing that I can put in a small plug -- and I don't know if Mike is still here -- but we review and evaluate programs. And although the Melissa's Project, it's really hard to kind of wrap your brain around what it is and how it works. It actually does work.

And I can tell you, for example, when we met with -- part of our process, we always meet with people who use the services and I honestly thought that given that it's kind of pushing services, requiring it that folks getting it would not be as happy. And that we found exactly the opposite, that the folks that are being served through the Melissa's Project are actually -- they like the fact that it seems to keep things wrapped together.

And we were in the midst of talking to one guy and he said, yeah, you know, I don't like taking my meds and I don't having to wait around when they come with them, but I was just called -- and it was Sarah who was his case worker -- I said, I called Sarah and bang. Fifteen minutes, they're here with my medication. I took it and I went on my way.

So I think sometimes just having a service that's truly client responsive makes it work. I don't think there's anybody out there that enjoys taking medication. I mean, you know, I'm not of the opinion of some people who have testified today that see them as the great Satan of the world. I think they're wonderful in how they can help some people as a tool, but they're just one part of people kind of getting it.

But anyway, needs assessment, they're done in every region. You can speak to your regional

mental-health board and they can tell you, like, chunk, chunk, chunk. Here's where we've identified the need -- in the adult system. We do not cover the child system.

SENATOR HARP: Thank you.

Further questions? If not, thank you very much.

JANINE SULLIVAN WILEY: Thank you for your patience staying here so late, everyone.

SENATOR HARP: Thank you.

Linda Lentini followed by Joseph Bensavage.

LINDA LENTINI: Good evening. I want to start off by separating the two issues that have been thrown together and seem to be woven really finely together, is gun control needs a great deal of focus that should not be associated with what we're talking about today.

Just as many people testified about gun control and said that people with mental illness should not be allowed to get guns, I say that no one should be allowed to get guns except in the military. My constitutional right is to be treated equally under the law is just as important as has the right to bear arms. I think it's much more important.

My name is Linda Lentini and I'm a person with lived experience who has and continues to work on my wellness on a daily basis. My life experience have and continue to be a

stigmatizing topic that is difficult to talk about in the general public, especially now.

I feel like it's time that people who are labeled as having mental illness show the general public that we can and do live a very good life of our choice; "choice" is the keyword. The three issues that I'm extremely concerned about are outpatient commitment, the database that's been communicated for people with mental illness, and screening for all children.

Mental illness is a subjective topic. When you view as -- what you view as normal may be odd to someone else. What one person views as symptoms another person views as adapting to life, responding to stress or adjusting to the facts of life. All of the treatments for mental illness have been medication experiments and there is a lot of evidence that show that these medications take 25 years off people's lives. The mental-health system, the way it stands needs to change. Wellness needs to be an option for people, not just medication.

Outpatient commitment means forced medication, period. That's what it means. It doesn't mean forced talk therapy or wellness tools or peer-to-peer recovery or any other option. Forcing people to take medication that puts them in a drug-induced state and giving people no other option, sentencing them to a life without hope, sedating them and taking choice away from them just because we were labeled as a person with mental illness should not be legal in a free society.

How many people actually reach out for help if they have to be concerned about being forcefully medicated? Some people just feel better after they go for a walk with a person that listens and is not limited to time, such as peer-to-peer recovery. Some people love to go to a gentle yoga class, do a mindfulness exercise if they knew that option was there for them.

Many people would love to meet with a nutritionist to find out how they can eat a healthy meal, stay away from foods that cause mood changes -- on the budget that doesn't hurt their family. "Option" is the keyword; give people options. I hope that no one on this committee is forced to deal with stress with medication-only. It should not be anyone's only option.

The next issue that is a huge concern of mine is the database of people with mental illness. This will increase labeling and stigma and decrease the amount of people who seek some treatment and some of them may actually need treatment. Imagine the doctors, the priests, the teachers, the police officers that would be afraid to ask for help for fear that their name would be placed on this database.

You have the rest of my testimony, but option and choice needs to be something that's woven into mental-health care and it needs to change and offer some wellness tools.

Thank you.

SENATOR HARP: Thank you very much.

Are there questions? If not, thank you so much.

LINDA LENTINI: Thank you.

SENATOR HARP: Joseph Bensavage followed by Laura Saunders followed by Richard Weingarten.

JOSEPH BENSAVAGE: How are you doing? I'm Joe Bensavage. The first time I've ever done anything like this.

And I've been Sandy Hook. I used to go dancing out there and I used to work down there, Southbury and into Newtown. And why this fellow done what he did, I don't know, but before he did what he did he shot his mother, if I remember right.

On March 29, 1974, I tried to kill my mother, and they put me in the Connecticut Valley Hospital and I had experience in when I was a padded cell up there. And then in the eighties I went down to Fairfield Hills State Mental Hospital down there two times. And I had a -- one psychiatrist that I remember that I had to see up in the Torrington Hospital quite a while ago that I liked. He's retired. And then there was a psychiatrist up in Litchfield that I didn't like.

And I analyzed myself a lot. And my mother signed me in the Marine Corps when I was 16 and she went and signed my older brother when he was 17. And I went to Guantanamo Bay, Cuba, 1962, and then I went through the Panama Canal 1963. I didn't know it at that time, but John Kennedy was down there and I was the presidential helicopter on the ship that I was on.

And what happened to me down there is I had -- they call it military sexual trauma, traumatic

brain injury and post traumatic stress, and I never got any help for it. I was -- I had asked Chris Murphy. I asked Senator -- he's the Senator now, Blumenthal, you know, he said he was in Vietnam. We all know he wasn't.

And I don't take any medication, because I told the doctor when I was first up in Connecticut Valley, I asked one of the doctors, what do you think the problem is?

He said, well, I think you're allergic to alcohol. At that time I never heard that. So after I went down to Fairfield Hills, I asked the doctor down there -- well, I didn't ask him; I told him. I said, you know, I think the doctor up there told me I'm allergic to alcohol. I said, I think these drugs you're giving me are killing me, because I was having bad -- I biting off my tongue trying to swallow my tongue. I was doing everything like that.

And I don't know why this guy shot his mother, but I really -- my mother was -- my mother -- when I was ten years old my mother tried to kill my father right in front of me. I was an eyewitness to attempted murder. Then when I was 13 years old she made me kill my dog and I had a mental block about that. My memory, I lost my memory -- until after I tried to kill her and then my -- they sent me down to be -- I got a year's probation. I had to be hypnotized. I was hypnotized and my memory came back.

And the best thing I ever did in my life so far is I joined a 12-step program. I bought a self-help book. I didn't know what to do. I didn't trust anybody. I still have a lot of problems trusting anybody. And I learned about Al-Anon.

I never heard of Al-Anon. So I started going to Al-Anon.

And it said anybody can go to AA meetings, because I didn't drink for 20 years and I thought I might -- I didn't know if I was an alcoholic or not. But that's the best thing I ever did, because I keep going to them 12 steps and I just keep going over and over and over and over and I keep learning.

My mother pulled me out of school when I was 14 and made me go work on her brother's farm and her aunt's and her sister's farm. And I got a paper that says I quit Litchfield High School when I was 15, which is not true. I was 14 and I didn't quit, because it wasn't old enough. I have two older brothers. My brother John died. He was 15, I'm almost positive. And my older brother had said he quit on his 16th birthday.

So I just -- I just want to get out of myself. I'm sick of carrying this stuff, all my pain, all my hurt all my life and I want to talk about it. And hopefully by talking about it -- they say in the program, sharing is caring, and I do care. And I care. I've got three young grand grandkids down in Georgia and I've got -- and they're the same age as those kids down in Sandy Hook. When I see their eyes -- I couldn't believe it.

Thanks for letting me talk. Thank you.

SENATOR HARP: Thank you very much for sharing your story with us. Thank you.

Laura Saunders followed by Richard Weingarten.

LAURA SAUNDERS: Good evening. My name is Dr. Laura Saunders. I'm a board-certified clinical psychologist. I work at the Institute of Living. I'm in a child adolescent psychiatric -- inpatient psychiatric unit.

There a couple key points that I'd like to highlight. The first has to do with psychiatric hospitalization. When I first started working on the inpatient service at Newington Children's Hospital we had a length of stay that was about 30 to 60 days, which sounds extraordinary compared to some of the standards we have now, but at that time we had little to no recidivism.

It gave us the opportunity to address many of these psychosocial issues that affect chronic mental illness, and that's what you've heard from other people here, is that a lot of it is the psychosocial issues. It's not just initial diagnosis and treatment, but the psychosocial issues are what lead to relapse.

Our Psychiatrist-In-Chief Dr. Hank Schwartz who testified earlier today, he cowrote a paper in the Psychiatric Services Journal in February of 2011. It highlights how inpatient hospitalization provides an opportunity to intervene in serious mental illness and address the family systems and serious complex psychosocial factors that hinder progress. It refers to our current system of ultrashort hospital stays and the lack of any research indicating that these ultrashort hospitalizations are better to stabilize severely mentally ill patients.

As an example, our census on the child and adolescent inpatient service yesterday had 23

patients of which greater than 40 percent had a previous admission, and over 50 percent had from three to ten previous admissions.

Short hospitalizations lead to cycling in and out of the hospital; prevents us from addressing the psychosocial issues that are the main cause of rehospitalization. And I believe our treatment is superior. This is not a reflection on our quality of care.

And of note for the eight patients under my direct supervision, four of them have had their insurance coverage denied to date, yet we are still treating them because they are not stable to leave the hospital.

The second point is the critical need for our state agencies to acknowledge the demand for a continuum of services for the subset of severely mentally ill children, adolescents and young adults. The sad reality is some of these individuals need time in congregant care settings to stabilize before they can return to their families and communities.

The complex set of vulnerabilities that contribute to the mental illness cannot always be treated within families and in the community. And there's a critical need for residential and group home beds for this subgroup. When there's a continuum of services there's less bottleneck in the hospital and we can open up beds for those that need the acute care.

In the wake of tragedy comes opportunity. The time is now to take mental health reform seriously, establish true parity in mental health services, maintain a continuum of

evidence-based services for in-home support and congregant care when necessary and let the decision making about treatment fall in the hands of psychiatrists, psychologists and social workers who have direct experience treating youth struggling with severe mental illness.

Thank you.

SENATOR HARP: Thank you.

Representative Ritter has a question.

REP. RITTER: Hi. Thank you for your testimony.

LAURA SAUNDERS: Thank you for being here.

REP. RITTER: I was interested as you were discussing with the recycling on the short state, if there is starting to be at least in the academic or research communities definitive studies about the effects or the -- how do you want to say it? The efficacy of the -- I mean, why we're going this way when everything that we're hearing at least today and in other areas is -- seems to be so counter to that as a wise approach?

LAURA SAUNDERS: You're talking about the ultrashort length of stay versus -- well, I think that's a concern. As I said, when I first started working in this field we had a longer length of stay and we saw really no recidivism. What is the critical factor to consider in all this -- and I think you heard it in ancillary ways in previous testimony is -- really it's the psychosocial issues.

Those stressors could not be addressed in a four-day or eight-day or nine-day

hospitalization. Those are the issues that affect medication compliance. They affect family systems. They affect community-based issues, school issues and it gives us more time to address those issues so that their actual is, you know, change and then they don't need to cycle back into the hospital. They can be in more community-based services.

REP. RITTER: But what I'm seeking is reinforcement for your statements here either from the research, from research world or from other people. I get it. I understand what you're saying. It makes sense to me, yet this is the way we're going.

So what evidence are we getting for a pushback on this trying to help rectify the situation? Because quite honestly, as long as -- I mean, you talk about the issues about insurance and who's going to pay for it and all that. And as long as that's there and allowed to operate evidence free, that it's a waste of money, so to speak.

LAURA SAUNDERS: Uh-huh.

REP. RITTER: We're not going to get anywhere. So my question is, do you think there's an emerging evidence or body of research that we can start looking at in order to organize pushback in a different way?

LAURA SAUNDERS: I think the hard part would be, you mean, in true research there needs to be, you know, control groups. So how do we set it up that, okay, you get to have the 30-day hospitalization where we can really deal with everything and hope that you not have to come

back in, and you only get the six-day hospitalization.

So that's what -- I mean, any of this becomes really anecdotal and correlational. So that's the difficult part, is that there is not real true research in the sense that we can't make comparisons because of the nature of the treatment.

SENATOR HARP: But what you can do -- and I'm just wondering why no one has done it -- if people are cycling in and out of your facility and in and out of emergency departments, that it could, you know, if it's done enough could cost more than a 35-day stay.

And so somebody somewhere needs to be able to say, patient X has cycled through. We did a forced stay here and over the year they've done four or five forced stays and they've gone into the emergency room four or five times. I mean, that's what we heard from my constituent's son.

That's expensive and somebody needs to be tracking that at least -- and I know that oftentimes Medicaid mimics what's done in the commercial world, but if it's costing us as a State more money and the outcomes are poor we need to have a way to look at that so that we can change our policy.

LAURA SAUNDERS: I think that's an excellent point and I know the advantage in the child and adolescent world is that we have, you know, Connecticut Children's Medical Center, that their emergency room is often the place where people go or children go when they are in crisis. Families bring them there.

We do -- I know they had started to track readmission within 30 days and readmission within 60 days. So we do have some of that data and, you know, I think your point is well taken that we can start to really build a case that, you know, when we had an eight-day length of stay we, you know, the rates of readmission were higher versus someone that we did fight and that maybe we did keep in for, you know, 14, 21, 28 days and their readmission rates were lower.

SENATOR HARP: I think that the economic point is really an important one, especially in this day and age. And -- but of course even more important is what we have heard from you folks today, you professionals is that more often there's a decompensation the less well a person gets over time.

So that it's really in our interests to try to -- this is what I took -- maybe I'm wrong. You can tell me I'm wrong -- it's in our interests to try to stabilize folks so that they don't decompensate as much so that they can ultimately function at a higher level. Is that right? Or --

LAURA SAUNDERS: Yes. And I'm sure Dr. Schwartz said it in his testimony, early intervention is critical. I mean, I feel an advantage in working in child and adolescent and young adult services, that if we could address some of these issues more seriously and more comprehensively now, when they're 30 and 40 and 50 they won't be as significant and serious, that we will have addressed them.

You know, there is a lot of research that talks about early diagnosis with psychosis and

schizophrenia leads to better longer-term outcomes. So yes, the early intervention can prevent long-term debilitating illness.

SENATOR HARP: Okay. Great. Thank you.

Representative Ritter.

REP. RITTER: Thank you. That actually was a great discussion. I just want to follow up because I want to put something on the record really. So you don't have to necessarily respond.

But it just seems to me, having spent some years up here trying to deal with some of the understanding between the world of insurance, largely private, but also the public pay programs and understanding how the interplay between -- I'm going to call everybody by their wrong names -- medical directors for insurance companies who look at their risk, who look at their return and their bottom line and what they're paying out on this -- don't figure this out.

And my only conclusion I guess could be either -- is sadly, maybe they have figured it out and they wear you out first. I get that. And that certainly seems to be what happens, but that's a terrible shame and I think that's a very tough realization perhaps for people to have. So I might put that challenge out to them as well because I think increasingly if nothing else the economics here are becoming clear and sadly maybe that's the easiest way to quantify the situation.

So you can leave me out there on that if you want to or comment.

LAURA SAUNDERS: Well, I never met a comment -- an opinion I didn't want to share.

So the -- I also testified at the public hearing for the Office of Health Care Advocacy, that they had a while back. And I think one of the critical things that we've started to do is really encourage parents to go to the Office of Healthcare Advocate when we get these frequent denials.

Because we do need to create a paper trail and we do need to -- they do need to be able to track which are these commercial insurance companies that are wearing people down. And you know, they have an appeal process, but sometimes that appeal process is really just, you know, part of the form and really doesn't do anything.

But it is holding them accountable and I do think there is, you know, an underlying tactic to just wear people down and hope that they don't make a stink about it. So more and more we're pushing them to go to the Office of Healthcare Advocate to create a paper trail.

SENATOR HARP: Thank you very much. Thank you very much for your testimony. Appreciate it.

LAURA SAUNDERS: Thank you.

SENATOR HARP: Richard Weingarten from my town, welcome.

RICHARD WEINGARTEN: Thank you. It's good to be here and thank you all for your patience and endurance and interest in these matters. I'm going to pretty much tell my story which is it's a different story than we've heard today, but I

hope it has some lessons that I've learned that might be -- you might be receptive to.

Almost 40 years ago at age 28 I was stricken with a deep and immobilizing depression. I entered psychotherapy and was given a grave prognosis of acutely reactive psychosis. My first therapist gave me the hope, though, that one day I'd be able to live a normal life if I could reconstruct my negative self-image. I have endeavored to do this, however recovery took much, much, much more hard work than that.

I left the therapist in Boston and moved to Southern California to complete my education. I was in and out of mental hospitals several times during terrible psychotic episodes. My doctors urged me to live a quiet life, take my medication faithfully like a person with diabetes and not attempt too much or not go back to work. This advice didn't mesh with my goals and I wanted to lead an active life again.

In the summer of 1986 after a long hospitalization and med change I joined a self-help group at a public mental health agency in Cleveland, Ohio. The self-help group was putting together a discharge handbook for patients coming out of Cleveland State Hospital.

The staff at the agency showed me incredible respect and empowered me with their generous support and hope about my future. Seeing the finished handbook, my first therapist suggested that I become an information giver for other people stricken with mental illness and the general public. I began writing and speaking out on behalf of people with mental illness and their families. With this new purpose and

direction and using my writing and speaking skills, my strengths, I began my journey of recovery.

I started to take responsibility for my life and tried to figure out what I wanted to do and I got a job working at mental health as an outreach worker. I worked for a while on a suburban newspaper and I even did some college teaching.

I found there was something genuine about working with people with mental disabilities. If they like you they came back another day. If they didn't they voted with their feet and you never saw them again. After a two-year job search I landed in New Haven in the summer of 1994 to work as director of consumer affairs at the Connecticut Mental Health Center.

Working every day in a meaningful role was the best medicine for me. Working enables me, like so many others, to focus our minds and energies and keep our demons at bay. It provides purpose and meaning to one's life. Knowing this I created many peer-run services and educational programs in New Haven, later in Bridgeport, that employed people in recovery to help others who are not as far along in their recoveries.

I have published more than 40 articles about my illness, recovery and work in the mental health field. I received a faculty appointment in the department of psychiatry at the Yale School of Medicine and being able to speak Portuguese from my Peace Corps days in Brazil I began lecturing and giving workshops in Brazil in the late nineties and brought out two books with my Brazilian colleagues in Portuguese that

introduced the concept of recovery to that country.

Later as a part-time faculty at Housatonic Community College I helped people with mental disabilities learn the skills and competencies that made them unemployable in the mental health field.

Despite these successes my illness has not gone away. I have adopted a disciplined lifestyle that maximizes the healthier aspects of myself. This includes a healthy diet, regular sleep and rest, almost daily exercise, meaningful work and a strong social support network. I still take medication and I see a psychotherapist for added support.

In 2003 I was given the Stigma Buster of the Year Award by DMHAS, NAMI Connecticut and the Connecticut Psychiatric Society for a NAMI program that brought to Connecticut, 'In our Own Voice.' I continue to work on reducing the harsh societal stigma towards people with mental illness and their families. We know stigma or discrimination causes people not to seek treatment and eliminates many life opportunities for people with mental disabilities.

The good news is that most people with mental conditions find the strength within themselves to recover and reclaim new lives. The bad news is that tragedies like the Newtown massacre give false credibility to the harsh notion that people with mental illness are violent and dangerous and that people don't recover from mental illness.

My hope is that with improved and better and comprehensive services and sensible gun legislation these senseless tragedies won't reoccur.

Thank you.

SENATOR HARP: Thank you very much.

Are there questions?

I guess one really small thread of a seam that I'm hearing from people today is the whole question of diet. And I was wondering whether or not treatment basically emphasizes diet and if there's opportunities to have healthy food, or if it's promoted and how that works together.

RICHARD WEINGARTEN: I think it needs to be promoted and I know clubhouses like in Stamford, the clubhouse there brings nutritionists to the clubhouse every week or every two weeks to give lessons to people interested in working on their nutrition. And I think there even are better eating peer-support groups for diets, for exercise, for smoking cessation.

So these kinds of issues are starting to be presented to consumers around the state I think. But it's a very important issue, though, and I think a lot of consumers don't have a good diet and need a lot of help along those lines.

SENATOR HARP: Thank you very much.

Representative Wood.

REP. WOOD: Thank you.

Just a point of clarification. The clubhouse, is that Laurel House in Stamford?

RICHARD WEINGARTEN: It's the Laurel House, yeah.

REP. WOOD: Great. Thank you.

SENATOR HARP: Thank you very much.

Ann Nelson and Carolyn Goodridge.

And I don't know if Karen Kengas is still here. Okay.

CAROLYN GOODRIDGE: Actually Ann wasn't able to come so I'm testifying for her, so that's why my name was given. My name is Carolyn Goodridge.

Ann Nelson has had a similar experience to me so I felt I could really connect with this. She's a parent of a 19-year-old daughter who was diagnosed with mental illness at age seven and throughout the time of her daughter's hospitalizations residential treatment, et cetera, she had to fight the private insurance company.

And I remember Ann saying she had the gold policy for private insurance and was very frustrated that she had to end up turning to DCF voluntary services to get help for her daughter.

The insurance company cited various reasons for excluding care for Emily. The treatment is not medically necessary. She does not meet the criteria for inpatient admission or ongoing hospital stay. She's been admitted recently so we are allowing her only 48 hours of inpatient stay. We do not cover community-based services

-- or perhaps a neighbor or family could provide you with some respite. This was actually statements from the insurance company.

So as a result of Ann's fight with HMO's refusal to pay for Emily's contracted mental health services, the family did turn to DCF voluntary services and they were able to obtain mental health services for their daughter.

The most effective as well as the cost-containing treatments offered by DCF were the intensive home and community-based services. Our family received respite care, intensive in-home behavioral management, therapeutic mentoring and parent training to help all of us navigate the journey of caring for a child living with mental health disorder. These preventive community-centered and evidence-based interventions provided by DCF were not covered by the private health insurance because they weren't considered to be useful.

With mental health parity law in effect in Connecticut as well as nationally the private insurance companies should be held accountable to provide similar community and evidence-based mental health services to children insured under all their plans with an ongoing collaboration between mental health subcommittees, mental health advocates, state legislators, individuals in recovery, family members, mental health providers, the office of Child -- Office of Healthcare Advocate, Office of Child Advocate, the Attorney General's Office and other mental health partners and stakeholders we need to collectively design a system which monitors as well as holds the private insurance industry

accountable to their contracts concerning mental health.

And she does cite all of the legislation that she's worked on over the years on this as well as she attached a page with her cost, the actual costs covered. And it is unfortunate that Connecticut Medicaid had to cover all of these costs when she had an excellent insurance policy.

And I can tell you even with my son when he was taken from college by ambulance because he tried to commit suicide, the insurance company said the ambulance trip was not a medical necessity. So if it was a heart attack or something else it would have been and I think this is where we really need to hold them accountable. We're the insurance capital of the world here and yet we pay in for years and get nothing back. So thank you on behalf of Ann, too.

SENATOR HARP: Okay. Thank you. Are there questions. Thank you so much for staying. I appreciate it so much.

Deborah Holt -- Hoyt -- I'm sorry. Deborah Hoyt. Robert Davidson. Followed by Dr. Steve Larcen.

ROBERT DAVIDSON: Thank you. You've heard a lot of praising us here today, but I wanted to commend the last two speakers who made eminent sense. I'll skip a lot of this.

You've heard -- well, we have a good mental health system. It's well-designed. It

functions pretty well, but that's the public system. The system that we don't have that is not a system is the private system and you've just heard eloquent testimony about that.

I think what we -- you know what? I'm going to skip most of this and just talk about insurance -- if I could find my notes about it.

There are two purposes for insurance. One is to cover illness, that's why individuals buy insurance and we're hearing that they don't do that. And all of the horror stories -- almost all of the horror stories you've heard today are from people with private insurance, people who live -- who have good jobs.

But the second function of insurance is a societal function, to spread risk. That's their job. It's not to make money, it's to spread risk that no individual can be expected to bear. And it seems to me that they're failing both of those tests.

So I would like to see regulation, in this insurance capital of the world, advance those goals. Policyholders need protection more than the insurance companies. Medical necessity or the limits of coverage should be defined universally and clinically, not by the language of the policy. Routine appeals should be handled promptly and by neutral professionals, not by an in-house kept person.

I think we should think of insurance as a public utility. That's the way it started, as a mutual aid society spreading risk among people who trusted each other, but who recognized that they had a common interest in preventing catastrophic

loss from one of them because it affected the others. We've lost that.

Mutual insurance companies that started as mutual insurance companies or as cooperatives -- Nationwide actually started as a cooperative -- converted to profit-making companies. And they, you know, they actually paid us off for the privilege.

So I would like to see the -- I think if there are bad guys here it's not people in the mental health system. It's not even gun people. It's people, the people who are not living up to their social responsibility.

I had a lot of other stuff to say. The only thing I will -- would like to go over time to say is that outpatient commitment is magical thinking. Like prohibition, it's a good idea that just isn't going to work. We can force violence people to take meds already and nobody has the stomach to make nonviolent people do it. You've heard Commissioner Rehmer say that no state enforces outpatient commitment the way it's written.

In fact, a lot of people who are conservators give up that coercive power because they're not comfortable using it and because it doesn't work. And a number of people -- right. Okay. So help us -- okay. Don't make a good system worse just to treat our universal anxiety about things we can't control.

Thank you very much.

SENATOR HARP: Thank you very much.

Senator Crisco has a question.

ROBERT DAVIDSON: I'm not surprised.

SENATOR CRISCO: No, just for your information, the Legislature has defined medical necessity, but we're one of the states in the country that has done that. Whether we should, you know, tweak it or not, we are looking at it at the present time.

ROBERT DAVIDSON: Good. Thank you. I'm glad to hear that.

SENATOR HARP: Thank you very much. I'm going to turn the meeting over to my cochair, Representative Wood.

REP. WOOD: Thank you, Senator.

Dr. Steven Larcen, Dr. John Foley and then we're going to have Dr. Traci Cipriano speak for Dr. Mehm, who was a couple of slots ago. Thank you.

Dr. Steven Larcen. Dr. John Foley.

JOHN FOLEY: Going into the on deck circle.

REP. WOOD: Perfect. You're on deck. You are up on deck -- no, no. You -- oh, yeah. You're on.

And then Dr. Cipriano and then Greg Benson and then Janet Auster.

JOHN FOLEY: Just putting on a timer. I'm going to try my best.

So Senator Harp, Representative Wood, my name is John Foley. Members of the committee, I'm a

cardiologist. I practice in Norwich, Connecticut and at Yale New Haven. I'm also president of the Connecticut State Medical Society, which is why I'm here today.

We represent 7500 physicians and in the statement, the Chapters of the American College of Physicians and Surgeons join us with these sentiments. We've also put out a position statement, which hopefully you've all gotten as well, dealing with the issue of violence.

What does a cardiologist have anything to do with mental health? I fix anatomically broken hearts all the time, but what I can't seem to fix are true broken hearts, and oftentimes the broken hearts of my patients' families, the parents that come before us whose children have behavioral or chemical or mental health problems, problems that they can't seem to get fixed.

And the stories, and you've heard many of them today, but you know, a parent brings home a child, this beautiful child, seemingly perfect, but sometime over that child's growing up years they begin to notice something is not right. They don't know what it is, but they hope it's going to go away, but it doesn't. And that isolation and anger grows and the behavior which used to be a problem only around a kitchen table spills over to the playgrounds and to the schools and the schools are not equipped to handle this.

And so the children are pushed to the periphery and sometimes removed altogether and the anger and the isolation grows. And they don't know what to do and they reach out and too many times

they're told by the hospitals or medical system that there's nothing we can do to help you. Just wait for the child to break the law or threaten someone and call the police and then you'll have your child removed. Then you'll have peace in the home. How tragic that the mental and behavioral health system for our children has become so fragmented that the best outcome a parent like this can have is that their child ends up in the criminal justice system.

We support the Office of Healthcare Advocate in their report in full. And as a state, we pride ourselves in what we discuss as parity -- that's been talked about a lot today. But what does that mean, access to insurance coverage that doesn't really lead to access to care? Is a blank and empty promise. So families spend thousands of dollars out of pocket trying desperately to get someone to help them.

Mental-health parity should be parity in access and parity in the mental health care provided, not an allusion to coverage, but actual and true benefit. Our psychiatrists and social workers and mental health providers continue to be overworked, underpaid and poorly valued. If we want to bring about real change we have to start by stopping the cuts to mental health care.

Instead of cutting funding for mental health services, let's make sure that every community in Connecticut has behavioral and mental health programs so that a child discharged from inpatient treatment has every chance to succeed.

When a child succeeds a family is saved. When a child and family are saved, our communities

become safer and enriched. In the end we can choose more violence and incarceration or a healthier community where violence is the exception, not the desensitizing rule. We must move beyond rhetoric to action. The physicians of Connecticut are committed to helping all of you make that happen.

I'll end by a quote that a friend of mine mentioned to me the other day in another context. We were talking about just, you know, making sure that we paid attention to life and didn't work too hard. And he said to me, you know, life is not a dress rehearsal. And I remember when I had my first child that quote meant a lot to me, because raising a child is also not a dress rehearsal.

We together have an opportunity today to get it right. And we have an obligation not to get it wrong. So I thank you for all of the work that you are doing and we pledge our support and our help to you as you move forward in this most important effort.

Our children are our future and we see that all the time. We have to put our money and our actions behind that statement.

And I thank you all very much.

REP. WOOD: Thank you.

Are there any questions from the panel? Thank you very much.

JOHN FOLEY: Thank you.

REP. WOOD: Dr. Traci Cipriano, please followed by Greg Benson and Janet Auster and then Gary Grabko.

TRACI CIPRIANO: Committee members, Senator Crisco, thank you for your time.

My colleague Dr. Mehm submitted testimony opposing outpatient commitment. I think you've heard a lot about it, so I'm going to focus on a different issue.

I've lost my timer. All right.

My name is Traci Cipriano and I'm the Director of Professional Affairs for the Connecticut Psychological Association, and I'm a clinical psychologist in private practice.

And like everyone today has expressed, we all want to find a quick solution and a -- the perfect solution to prevent senseless tragedy such as what has happened in Newtown, but it's really pertinent that we don't act in haste. These processes take time. We need to consider all of our options and we really need to focus on improving and increasing mental health services, rather than focusing on measures which may on their face actually appear helpful, but may have unintended consequences of deterring patients from seeking treatment or limiting access to treatment.

So we are asking you to not support a bill that would require psychologists to report a patient who's believed to be a danger to self or others to a local governing body. And as you've heard, psychologists already have statutory authority to send a patient to the hospital involuntarily

if they're a danger to self or others. Or if they're gravely disabled they can be involuntary committed on those basis. We are also -- have a common-laws duty to warn and notify the police if a patient -- if we learn of a specific threat of imminent physical harm to a known person.

This is very narrow. It's much more narrow than those broad criteria who are involuntary commitments. And the reason for that is we need to protect patients' privacy and confidentiality. And so that's where the New York law is problematic. It's very broad and it's really -- it stigmatizes and criminalizes mental illness and we're concerned that it will have unintended consequences.

What patient can come and talk to me about their feelings or urges or impulses when their concerned I'm going to go call the cops? They're not going to do it. So those who most need the care aren't going to get it.

And at the same time it really puts the psychologists in a bind, all mental health providers, because you know, there are all these cases, yet certainly there are cases of -- okay. We know this person has to go to the hospital, but those cases that fall in the gray area that require professional judgment -- excuse me -- and in those cases there may be times where you say, you know, I'm not sure, but just to be safe and ensure safety I'm going to send this person to the hospital, but at the same time you might be reluctant to call the police on this person.

So now psychologists, all mental health professionals are in an ethical and legal bind and it may start having people be reluctant to

take on patients they perceive to be a risk. And this happens already. As I've tried to have some high-risk people at the moment who need a psychiatrist and psychiatrists don't want to have it. And I think if you add increasing burdens like this -- and other therapists as well (inaudible) psychiatrist, but a lot of people don't want high-risk patients. And so I know this increasing risk for everybody.

So I think instead of acting on fear I think we should really focus on making it more easy for patients to access the treatment they need. And I think a better approach would be to establish services that would allow a family to get advice and learn when they're concerned about the health of their child or a young adult, and maybe get some funding for psychological evaluation. Maybe insurance companies don't fully fund a psych evaluation. And as you've heard, they're pretty expensive.

Okay. So I'm going to conclude by saying I know prevention is really difficult to support when we're in a difficult fiscal time and mental health is one of the first things to go, but increased access to mental health services will really increase the quality of life and day-to-day functioning of Connecticut residents and also ensure those most at risk will be able to access the treatment they need.

Thank you for your time.

REP. WOOD: Thank you very much.

Any questions from the panel?

Yes, Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair.

And thank you for being here and waiting and providing testimony.

What would your vision be for more comprehensive access for patients? How would we create a system that would work throughout the state and provide fairly equal access for people who need it?

TRACI CIPRIANO: I think we have to start with public education. People do not know where to turn for help. I mean, people without insurance, they go to the state system, they go to DMHAS; they know there's an outlet. But for people with private insurance, they don't even know where to turn.

And I think you saw in the healthcare advocates' report last fall, Vicki Veltri, she wrote that people who are insured actually have a harder time getting treatment. There aren't the beds. They have to -- someone who's a substance abuser actually has to overdose before they can get substance abuse treatment and things of that nature.

So educating people on what services are available and then making them more accessible. I haven't quite thought out a plan yet. One thing I feel that I think we've heard this throughout the day is parents are concerned about their kids, but they -- no one can do an evaluation. They don't know where to go to get an evaluation and that is something that I would like to see as an option for parents.

REP. JOHNSON: Thank you.

Thank you, Madam Chair.

REP. WOOD: Thank you.

Any other questions? Great. Thank you very much.

Next is Greg Benson followed by Janet Auster, Gary Grabko and Theodus Davis.

GREG BENSON: Hello. Thank you all for spending an entire day listening to us. My name is Greg Benson.

So I want to try and briefly articulate three points. The first one is very brief and that is in response to the terrible tragedy in Newtown. One of the quickest things I think we can do to improve our communities and the well-being of individuals in our communities is to simply not make things worse. So I want to present a counterargument to what a gentleman just said a few minutes ago.

I think that outpatient commitment is a bad idea and won't work. Not a good idea that won't work. So I think the first best thing we can do quickly is not make things worse. Outpatient commitment will make things worse. We can also not delude ourselves into believing that simply by increasing voluntary excess to current treatment that we're going to make our communities better.

And I'll share a little bit of my story about what treatment was for me. I reached out for help from the mental health system when I was 20 years old and was diagnosed with schizophrenia, diagnosed with all these different labels. And

I was told, if you don't take these psych drugs any efforts on your part to try and rebuild or create for a first time -- for the first time a meaningful life will probably fail. You know, and the psych drugs, you know, they might cause sexual dysfunction. They might cause weight gain, diabetes. They might lower your white blood cell count. They might cause arrhythmia, but it's really your best option to take them.

So I've heard numerous people throughout the course of the day say, you know, why in society should we wait until an individual becomes a danger to themselves or others or actually does something wrong? What do I have to wait until that stage in order to strip them of their liberty and force them to do things that they say they don't want to do? And the answer -- a sufficient answer should be in a democratic society, the Constitution.

So we have police power in our communities. Right? If someone commits a crime in Connecticut or is accused of a crime, not always even convicted of a crime, or a pseudo-crime like homelessness, vagrancy, being a nuisance, we already force -- medicate them and force things on them, things on them which often is a problem to begin with.

So to expand that and say, we should implement this shoddy pseudoscience of predicting whether or not a person is not able to take care of themselves, and consequently at a future date may become a danger to themselves or others, it's a preposterous idea in my opinion.

And it's not going to improve mental health treatment for several reasons, one being that

current treatment modalities have had disastrous outcomes. I encourage everyone sitting up here kindly listening to me to read a study conducted by a Joe Parks, Chief Clinical Officer for the Missouri Mental Health Authority.

He co-authored a study of services under his purview in collaboration with similar roles, high-up decision makers and other state mental health authorities. So they analyzed the services under their purview and wrote their own conclusions that individuals who access public mental health services on average die 25 years younger than general population.

Forcing people into that doesn't seem likely to make our communities more full of people who contribute to the greater good and aren't dangerous. And just increasing availability of those services voluntarily also isn't good enough.

What I think really turned my life around was when I started to challenge this idea that I'm broken or that all of my suffering in response to the world can be reduced to a biological brain defect, pathology or brain disease.

What I found very interesting is meeting with various roles throughout my journey through the mental health system, is that individuals including psychiatrists would openly question with me -- they would be very skeptical -- well, you know, I know it's a rudimentary science. We don't know what this chemical imbalance is, but it's there and we're going to give you these drugs and we don't know how they're going to treat this chemical imbalance that we can't clearly define, but they do.

So another theme that's been coming up today is, you know, I don't know why these people won't just stay on their drugs. Well, I really feel like I lost three years of my life on psychiatric drugs. Sleeping 16, 18 hours a day, sexual dysfunction, my face was twitching. I gained 30 pounds, sometimes in a much month. Loose 20 pounds the next month; gained 40 the next month.

So it's not simple. There's not an easy answer. There's not an easy fix, but what we can immediately stop doing is throwing all of our money into -- or all of our money and dedicated time into things that haven't been good enough for the past 100 years, probably longer.

So, you know, I'll end with what worked for me, was when I came off of psych drugs and when I began to put the effort into dealing with some painful things and to put daily effort into communicating with individuals who had lived through comparable experiences and trying to live deliberately with a goal in mind of what I wanted to do with my life, as opposed to constantly approaching my dissatisfaction with my life by having self absorbed conversations about my symptoms or how can I live a relatively symptom-free life with this brain disorder? You know, approaching life trying to manage your brain disorder wasn't a good enough motivation for me to stay well.

So thank you for your time.

REP. WOOD: And thank you for your testimony.

Any questions from the panel? Thank you very much.

Janet Auster, Gary Grabko, Theodus Davis, Patricia Harrity.

JANET AUSTER: I don't know how to start this. I was just going to read my testimony. I think what I'll do is save it for the end extemporaneous part. I'll read the testimony and then I'll save what I -- a new -- in something that happened today that will make the whole testimony make more sense and make me not feel that I'm walking away saying nothing that makes no difference at all. I'll say it at the very end.

Friends, legislators, advocates -- is this on? Okay. I'm sorry.

Friends, legislators, advocates and the Governor of Connecticut and the President of the United States, I stand before you quivering. Am I winning or losing.

REP. WOOD: Could you please give us your name for the record?

JANET AUSTER: Oh, I'm sorry. My name is Janet Auster.

REP. WOOD: Thank you.

JANET AUSTER: Thank you very much.

I'm not quite sure which -- right now is my extreme independence a positive thing or a negative thing? It is both, I think and a positive and a negative can stand for recovery, but will I recover with so few people to talk to and starving for encouragement and emotional love and support? I don't think so.

Will I ever recover totally if I keep taking a med that gives me chest pains and might cause a heart attack. I take lithium as well as Risperdal and I don't know why they just don't give me lithium, which I feel really helps me. Do you mean to tell me that because I'm independent they have to give me a medication that causes chest pains?

But because I don't believe in always being positive or always being negative I will end on a positive note. I wrote a book and completed it about six months ago and couldn't get it published. So Shepherd Park, where I live has it and they are publishing it professionally for the people at Shepherd Park. So you see, there is hope. Peer support and fairness in psychiatry is very important.

The title of my book is, My Treasured Voice. I truly feel that if you believe in us the whole mental health system will discover this treasured voice in every one.

But there's a few things I have to change here. First of all, Shepherd Park is not doing it now. They told me they didn't want to do it, publish the book. I did write the book, but it's not -- I don't know how it's going to get published.

The other thing I want to say, which is very important to me is that this afternoon before I came here I was panicking because I ran out of my Tegretol. I haven't taken it for three days. I was starting to think that everybody in the world wanted to kill me. My doctor wanted to kill me. The Legislators wanted to kill me. I mean, you know, and they told me that I was five

days late. I'd have to wait until Friday to get the medication. That was two days ago.

So I called them up today and I said, are you sure I can't get my Tegretol today? They said, let me -- and then they went through a whole rigmarole and they said, oh yeah. It's here. Come down and get it. So I came down and got it and I feel like a different person now. I'm not hallucinating. I don't think anyone is going to kill me. I'm sociable.

So I'm telling you that whatever anybody is saying about medication and the dangers of it, whatever, it works. It's helping me. It's saving me. The medication Tegretol is -- I'm on a much lower dose than I used to be. The doctor put it way down so it is less destructive and less dangerous.

And I think that there's a real kind of courage in facing that. Whatever we think we are or can do and who we are and we want to be, that we deserve help. We deserve nourishment, to be nurtured. We deserve care, whatever -- and good care. But some of it is already there.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel? No? Thank you again for sharing your story.

Next is Gary Grabko, Theodus Davis, Patricia Harrity and Teresa Craft.

GARY MICHAEL GRABKO: Greetings to the elected members of this State Legislature, their

assistants, appointees and all other interested parties and advocates. My name is Gary Michael Grabko. I am presently second vice president of the quasi-governmental institution, the South Central Mental Health Board. I'm also retired from state service for the Department of Mental Health and Addiction Services.

I believe I am given by my creator the right to pursue my own happiness and liberty. Cohesive measures such as outpatient commitment are abhorrent to these God-given rights. To bring this down to earth regard these facts, hard evidence for recovery by use of committed treatment is lacking. Also none of these states with OPC, as been testified here, have been able to force medication outpatiently.

Pertinent are these first-hand experiences of mine. Some interim Probate Judge Joseph Marino, after explaining the legal conservatorship process to our council had to admit there rarely are individuals with a court-ordered conservator that are ever released. He couldn't put a figure on it, but he called it miniscule.

While working as a mental health assistant for the State of Connecticut I witnessed the use of conservatorship status to force certain behaviors on patients. In order that benefit money be given to them these behaviors had to be fulfilled. It's totally illegal. We all knew it. The client didn't or didn't care.

Outpatient commitment will have similar pitfalls. It may look good on paper -- some would disagree. It will however be enforced by authorities who are acting in their interest of

public safety and tranquility that easily abuse the power given to them.

In closing, know that I was entrusted by the people of the State of Connecticut through the Department of Mental Health and Addiction Services to be in line of sight to a person deemed dangerous to themselves or others. My name is Gary Michael Grabko. I was diagnosed with schizophrenia in January of 1977. As we used to say up at the region, we are the evidence.

Peace and good to all who hear or see this testimony.

REP. WOOD: Thank you very much. Any questions from the panel? Great. Thank you again for your testimony.

Next is Thoedus Davis, Patricia Harrity and Theresa Craft. Is Thoedus Davis Here? Patricia Harrity. Theresa Craft.

Great. Come on up. Followed by Jay Siklick, Kimberly Zemo, Maryann Cole and Patrick Crean.

TERESA CRAFT: Oh, I need my reading glasses.

Well, good evening to everyone here. I'm so glad there are so many specialists in this room because what I have to say maybe you can help me with. My name is Teresa Craft. I want you to know exactly what it feels like to be a victim of an attempted murder by a mentally ill person.

It feels like heaven now, because I'm alive. It felt like hell while and after he stabbed me repeatedly in the head and shoulder. I would

not have been here to deliver this speech had it had not been for the neighbors who live upstairs; they heard my screams, called 911 and rushed down to chase him away.

The ambulance arrived; I was looking at the pools of blood all over my house along with the blood all over the walls -- I'm -- the hair that he pulled out with a butcher knife that he used to stub me with.

On the ride to the hospital they had to cut my bloody soaked clothes off to look for other stab wounds. I was lying naked in an ambulance. Two males who rescued me; normally I would have been so embarrassed, but I realized it was their job to save my life.

I want to let you know what led to this violent attack upon me. The 15-year-old who lived next door has been a friend for three years. His father had died and his mother needed help from someone who could watch the children occasionally. My work schedule allowed me to help her.

About four months ago this 15-year-old boy next door started texting me that he wanted to kill himself and his family. He had this feeling every time they made him angry. I talked to his mother about the text and told her she needed to get him some mental help now. She told me he was seeing a therapist at his magnet high school in Hartford.

The day before New Year's Eve he texted me that he was evil. He belonged in a grave. He didn't know whether to hang himself or to poison solve. On New Year's Eve I called the East Hartford

Police Department to tell them what was going on. They asked me when I got that last text. I told them it was yesterday. They told me there was nothing they could do.

I asked, what can I do and they suggested I text him and ask him to stop texting me. On New Year's Day I texted his mother and again said you have to get him help now. She said the same thing as before. Her response, the same response; he's seeing a therapist. I don't know whether he was on medication or not.

On 11 -- I'm sorry -- January 11, 2013, the young man knocked on door and said, Terry I need to talk to you. I opened the door. He raised his hand, lunged at me and began stabbing me over and over. He knocked me down, stomped on my head.

I blame his mother more than I do him. The laws that the law enforcement have to follow need to be changed. I want you all to remember it could be you -- you could be the next victim and you might not be as lucky as I am -- I was.

And I know that he was on -- I don't know if he was on medication or not. His trial is somewhere down the road. I want him to get the proper help whatever that might be. It has to be the right help and I don't believe that stricter gun laws or stepped up school security are going to help because mentally ill people who want to kill, they'll find a way to do it without a gun.

And I guess that's all -- I do have one other thing. One of the texts that he sent me was, he asked me if I believed in ghosts and I said,

well, I'm not sure, Michael. He said, I feel like I have an evil ghost that is in me telling me to do these things. I've let the East Hartford Police Department know they can subpoena all the text messages, because I've erased of them. And the arresting officer told me that that wasn't necessary, but I did make a call to the chief of police and told the secretary. And she couldn't believe they didn't want to subpoena, so I don't know what's going on with it now, but thank you.

REP. WOOD: Thank you for your testimony.

Any questions from the panel? Great. Thank you very much.

Next is Jay Siklick. It Jay here? Kimberly Zemo. Maryann Cole. Patrick Crean.

PATRICK CREAN: Here.

REP. WOOD: Yes, come on up.

Pat Sparkman. Is pat here? Okay. You're next after Mr. Crean. Dr. Ted Zanker. Great. And Sarah Esty.

PATRICK CREAN: Good evening. I'm going to try to beat the clock, so hello. My name is Patrick Crean. I've been a registered nurse since 2001 specializing in behavioral health. I provide care for acutely ill psychiatric patients. My job is to constantly assess them and evaluate their potential for danger either to themselves or others. Also I encourage them to maintain their medical -- medication regime, which along with group and one-to-one therapy are the pillars of their inpatient treatment.

More than anything else I want to see my patients succeed after discharge, achieve some level of routine with medication and therapy and return to their prior optimal level of functionality. But a major predictor of how any patient will do after discharge is where they go for their follow-up care.

Even a few years ago there were many more programs available that provided inpatient discharge opportunities. They are just not there anymore. The patients that need the most are the ones that are having a harder time finding discharge to an inpatient facility and there are far less opportunities for the most gravely ill to find a bed in a long-term psychiatric facility.

This should not come as a surprise to anyone. These facilities and programs have had their budgets steadily eroded and finally had their doors closed to make state budgets more palatable. This has been the direction in Connecticut for years.

People with a better understanding of economics that I have determined that this made good financial sense. So be it, but why is anyone surprised when after limiting or eliminating funding for mental health we see an alarming increase in violence from the same people we should have been helping?

Mental illness has borne an extremely unfortunate stigma for years. The simple fact is that anyone of us could be stricken with some form of it during our lives as easily as we could have cancer or heart disease. When was the last time you saw anyone cutting funding for

those? We all have a duty to help these people. These are our family, our friends, fellow citizens and constituents. We do not have the right to turn our backs on them.

An easy answer to all of this is gun control. People that are undereducated or scared or just looking for a quick response will be very much in favor of it. It gives them comfort and they have no desire to look beyond that, but I can promise you that an extremely ill patient who has decided to commit violence and has a plan will not be stopped by any law. They will find a way to act on their urges.

Please reconsider any gun control laws. They are not a band-aid in place of a tourniquet. They are a fairytale towards the people that desperately want to believe it will work.

Thank you for your consideration.

REP. WOOD: Thank you very much.

Any question from the panel? Great. Thank you for your testimony.

PATRICK CREAN: Thank you so much.

REP. WOOD: Pat Sparkman followed by Dr. Zanker And Sarah Esty.

PAT SPARKMAN: Good evening, Senator Harper and Representative Wood. This has been a wonderful day for -- very enlightening. I'm a retired pediatric psychiatric nurse. A close member of my family has been schizophrenic for decades since childhood and has always required the

highest level of care because of the severity of the illness.

I have worked with -- at the state level and the county level to write regulations for children and families, mental health issues. And I'm a founder of an organization that serves the families of children with mental illness.

I was extremely moved by the pictures of the perpetrators of the recent killings. To me they look psychotic. I wondered if they were experiencing command hallucinations, paranoia, agitation, depression. But mental illness is not a crime. I believe these mass murders are preventable.

At present, inappropriate legal restrictions sabotage proactive interventions. In the recent horrendous killings each of the young men were known to someone who suspected they had a problem. No one intervened. In Connecticut only a policeman or a psychologist can trigger an involuntary psych evaluation and there are no mandatory reporting.

If a family or friend or a good samaritan suspects immanent dangerous acting out, they must apply to the probate judge who then can request a person to have a hearing. And if he decides that it's appropriate, that he can order an involuntary evaluation. But this is ridiculous because crises move very fast and who would be able to find a probate judge on a Friday night?

A voluntary exam is almost always refused because the person says they're perfectly okay. Ideally at the family's request a policeman

would transport the person to an ER. It's very dangerous to take a person in that state in a car by yourself.

For a psychiatrist to give a quality psych exam he must know what has been going on in the last three days, however at present a doctor cannot interview significant people who know the person who is upset unless the person agrees to that. The patient's rights -- but I feel that patient's rights should be waived because there is the social -- the community's rights are more than the patient's rights.

The family should be able to be interviewed in private, not in the presence of the person who's upset and then the psychiatrist knowing that information should be able to examine the person in private.

The psychiatrist then could release the person. He could suggest outpatient treatment or he could order a three-day hospitalization for further observation before making his recommendations. The person has a right to humane treatment and a physical exam to rule out medical illness. The facilities should have staff that are skilled enough to care for a person with that degree of pathology. And the building itself should be secure with locked doors and a locked unit and a seclusion room.

The costs should be guaranteed so that money doesn't influence the decision making and that a community is not overwhelmed by unfunded mandates.

Malicious reporting should -- of aberrant behavior should be a crime and anyone who fears

violence and makes a wrong assessment and reports should be thanked for being a good citizen, because it's by the community putting their arms around everyone in that community and everybody being aware and being helpful and being respected when they think there's something dangerous going on is the key to making the thing work.

The horror of a violent incident can be avoided. The community maintains its lifestyle oblivious of the risk that has been avoided because proactive prevent -- action prevents tragedy.

REP. WOOD: Thank you very much.

Any questions from the panel? Thank you very much for your testimony.

Dr. Zanker followed by Sarah Esty followed by Diane Cox-Lindenbaum and Barbara Gerbe.

THEODORE ZANKER: Thank you very much.

Senator Harp, Representative Wood and the distinguished members of this mental health services working group, thank you for the opportunity to testify before you today. My name is Dr. Ted Zanker. I am a child psychiatrist practicing in New Haven for the past 46 years, as you can tell by my gray hair.

I've chosen for half my practice to be in the traditional office practice of child, adolescent, adult and geriatric psychiatry, which I refer to colloquially as from the womb to the tomb. And the other half I've chosen to practice in the community system in inpatient acute psychiatric care and I've been involved in

administration and developing emergency child psychiatry services, too.

And I'm speaking representing the Connecticut State Medical Society, our statewide organization of over 6500 physicians and physicians-in-training representing all of the medical specialties in the house of medicine. I'm also a past president of the Connecticut Psychiatric Society, past president of the Council of Child and Adolescent Psychiatry in Connecticut and the past president of the State Medical Society, and since its inception, chairman of its committee on disaster preparedness.

I was personally involved in helping to coordinate the mental health care provided in the immediate aftermath of Newtown visiting the counseling center and also personally serving as a volunteer child psychologist on Christmas Day.

The first thing I want to say is all of us have looked in the newspapers and we've seen some of the knee-jerk reactions in some states in terms of, we've got to get something through the Legislature immediately and hopefully it's sexy and will help everyone to be satisfied that we're doing something. And I'm very impressed by the careful thoughtfulness in this very difficult situation that you all have undertaken.

Addressing -- oh, because there are so few child psychiatrists in the United States -- I think the total number now is about 7500; my board certificate was 657 when I started -- and several of my colleagues have testified to the issues related to insurance and outpatient

treatment and inpatient treatment. I'm going to confine my remarks to child psychiatry acute inpatient services and those delivery of services. Hopefully I can do it briefly.

And one thing historically that I think Senator Crisco probably remembers is that Connecticut -- and most of you don't know -- he's a gray hair like me -- Connecticut was the very first state in the United States that mandated mental health services in group health insurance and you all have to be very proud of your predecessors. This was at about 1975.

I just want to tell you that you've heard others address the tattered mental-health service system, especially in child psychiatry which is very complicated, like peeling an onion. And there's much difficulty with integration. I'll try to keep my remarks super brief because I've overextended already.

Child psychiatry is really family psychiatry with the child as the identified patient and we need to have intensive family-oriented child psychiatry in order to avoid a significant number of admissions.

I too have recognized that the State has been giving a free ride to the insurance companies in terms of many of the voluntary services provided by DCF that we have to address, millions of dollars in that regard. And this is something you can fix as well as the cuts in voluntary service. These are desperate parents who are having the worst experiences.

Also in regard to the question of where we can get information, the behavior health partnership

through HUSKY is probably doing some of the best job, as you've heard, and they are collecting information on these systems.

I think I'll limit my comments here and leave it open if anyone has any questions.

REP. WOOD: Thank you very much for your testimony and your experience.

Any questions from the panel?

Representative Johnson.

REP. JOHNSON: Thank you, Madam Chair.

And thank you for being here and for your testimony. I have a couple of questions. One, since you have a good history of the treatment of children and psychiatric disorders in general, I was wondering if you could tell me in terms of the DSM manual, why haven't we made a transition and made it into a physiological condition as opposed to a psychiatric condition?

It seems as though a lot of the treatments that we have are altering the metabolism of people and having an impact on neurotransmitters and those kinds of things, which seems to me to be more a physiological situation.

THEODORE ZANKER: Very important question. The pendulum swings, and when I started in my psychiatric experience there were none of these drugs. I remember when Thorazine came out in the -- it was around the early sixties, and prior to that all we had was lithium. Since

1936 we were using a lot of sedatives. And so there's been a great excitement about the advances.

And they really have significantly helped millions of people around the world, including in the United States. And I think the fascination with trying to document scientifically in what's called evidence-based treatment as the pendulum has probably swung away from the humanistic side of psychotherapy -- we've heard this before.

When people ask me if they can come to my practice in the office for medication management I tell them I'd be happy to see, except that I don't think I'm smart enough to see someone in 15 minutes and make these major decisions about their life. I need to spend 45 minutes, especially if I'm going to be seeing them once a month to better understand what their life experience is.

The insurance companies have beaten most of my colleagues down into -- in order to survive financially, they've got to do this brief medication management.

REP. JOHNSON: So is there a way that we can -- is your association -- are they focused on trying to change how psychiatric disorders are addressed by changing how the DSM manual works and trying to move it into a medical condition for the coding? And do you have an annual meeting that addresses the coding and the procedures and that sort of thing? And I wondered has that ever come up?

THEODORE ZANKER: The DSM manual is -- the DSM 5 has a lot of controversy currently, but I think all of them have been attempts to define mental illness based on observable phenomena and some of them, they do better, sometimes there are improvements, but it's constantly a work in progress.

REP. JOHNSON: Thank you so much.

Thank you, Madam Chair.

REP. WOOD: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair.

This is actually an extension of Representative Johnson's question. You know, in managing patients with psychiatric illnesses medications alone is not the answer; we all know that. And it is the combination of multiple things, but obviously as you said, time restraints when patients are seen in the practice, handing out a prescription is the easiest thing to do.

But in a better setting we've heard earlier in the evening testimony, a long list of negative aspects about medications, what they do and what they don't do and how each of these individuals felt. In your professional opinion would medications, psychotherapy, family therapy, all of that need to be included in the management of a patient? And medications do have an important role. What is your feeling on that?

THEODORE ZANKER: Absolutely. To address the questions of some of the things we heard today about destructive psychiatric medications, in the case of each of the ones which were

described there are much more complicated answers. It's not as simple as it's been presented today and I don't want to take the committee's time.

You want me to speak to that?

REP. WOOD: Absolutely speak to that.

THEODORE ZANKER: Let's take the case of antidepressants, and who writes the warnings that we see on television and also in the PDR and so on and so forth? These are written by the company lawyers who are trying to avoid litigation and responsibility, and supported by the FDA in terms of how we can protect ourselves. So we can say, well, we warned you.

In the case of, take, antidepressants, trained child psychiatrists are aware and adult psychiatrists that at times people can become activated. For instance, if they have underlying bipolar disorder and they're not, they don't have a mood stabilizer on board, they can be activated into a manic episode with antidepressants, but this is part of the whole treatment that we're trained as physicians to do.

The studies which showed that they can cause people to have terrible harm and be all kinds of criminal things, especially suicidal are interesting because if you look, get down to the details of the studies and the checklists they use, self-injurious behavior which is a lot of the kids, for instance, cut themselves is considered suicidal behavior. So when you add all of that up it's an entirely different picture.

And again, under the rule of unintended consequences what happened when they put big black box warnings on and, the pediatricians for the most part freaked out and said, I'm not touching this. So then we started hearing, like, in the New York Times and so forth cases of child psychiatry -- antidepressant child psychiatry.

So one mother from New York had to wait three weeks to get an appointment with a psychiatrist in Las Vegas, Nevada, because it was months in New York to get her child on an antidepressant. It's very complicated.

Some of these other drugs do have side effects. All drugs, whether its aspirin or psychotropic drugs or antibiotics are foreign substances that don't usually normally exist in the body, except a few things like melatonin. And so we're always thinking in terms of risk benefit ratio and that's the way we're trained to things, as Dr. Srinivasan knows, so that we have to manage very complex issues.

REP. WOOD: Senator Harp.

SENATOR HARP: I have a question and maybe it's not a fair one to ask you, but as I think about drug therapy it would seem to me, you know, I'm just sort of wondering why we get these limits from insurance companies. That's really inexpensive therapy. Maybe the cost of the medication costs a lot, but since psychiatry is moved from a lot of talk therapy that was done initially to these, this sort of drug therapy, it would seem to me that that movement itself saved the healthcare system dollars.

And so I guess I wonder since those -- that has saved those dollars why there's this unwillingness to give enough days to assure that the medication is properly metabolized by the body when the overall treatment after that is relatively cheap, it would seem to me.

THEODORE ZANKER: You're talking about in the hospital?

SENATOR HARP: Well, I'm saying that once you've stabilized a person on the medication they're likely not to be hospitalized again. And so doesn't it make sense to keep them in the hospital long enough to stabilize them? Or maybe the question should be, do they need to be in the hospital to be stabilized?

THEODORE ZANKER: Well, I've been working in child psychiatry and acute child psychiatry for, like I said, for 44 years and there's no question in my mind that you're right.

I think like when I said the pendulum swung, it really should be a combination of both. A lot of these medications can serve also as a crutch to help get people out of the horrible depths of where they are to the point that where they have enough reality testing and enough psychic energy to work further on the issues in the psychosocial sense.

I refer to our reviewers as the barbarians at the gates. It's absurd what they do. They arbitrarily are using standards for commitment as justifications for continued inpatient stay. So it's sort of like, doctor, if your child has the noose off the neck why are they still in the hospital? It's an adversarial system. We

constantly have to fight for every day. They harass our utilization reviewers. You've got to answer a 30 minute protocol. They've got 30 patients to do this with. It's an absurd system. I mean, there's nothing rational about it except for the seven-figure salaries of the heads of these companies.

SENATOR HARP: And I guess the other question that I have is as a result of all of that. I know you said that there's scarce members of child psychiatrists nationwide and I would imagine there are scarce members here in the state. Of that scarce number what percentage won't take insurance and require self pay?

THEODORE ZANKER: I'm sorry. Could you?

SENATOR HARP: Yeah. I'm wondering of the psychiatrists, particularly child psychiatrists, but if you don't know the answer to that --

THEODORE ZANKER: Oh, I do know the answer. (Inaudible.)

SENATOR HARP: Yeah. How many of them won't take insurance anymore because of how difficult it is to deal with the insurance industry?

THEODORE ZANKER: This question was asked of me outside in the hallway earlier today and I'm going to tell you something that most of my colleagues are too polite to say.

When you see a psychiatrist or child psychiatrist especially, your -- it's not like you're seeing your family physician who even, there -- while it shouldn't be, generally you see them for ten or 15 minutes; they have

ancillary staff doing the various physical blood pressure and so forth, but what you're doing in effect is renting 45 minutes time.

And in order to justify it with the overhead and everything, the fees are more because it works out to about the same unless they persuade you to do ten-minute visit so that you can make more money. My overhead is 50 to 60 percent, like most physicians. My fee for a 45-minute session is $200. Anthem will pay, for instance, between 96 -- this was before the new coding -- now they're not paying for anything until we can get them to straighten it -- but between 96 and 135 dollars and my overhead is between 100 and 120 dollars.

So I would ask myself if I wanted to participate with them, why would I work for $15 an hour before taxes when I could close my office, give up all the responsibility and work at McDonald's, you know, for eight hours a day?

So this is, in polite company, not discussed, the economics of it all. I used to be a Medicaid provider from the time that I began practice in '67 until last January and I would see Medicaid patients with less frequency than Medicare patients, which I also see. And every time I saw one I was taking 50, 60 dollars out of my pocket after my overhead and everything like that.

And then last January I got another renewal contract of 20 pages to sign, fill out and sign. And about 15 of them were attestations I had to sign of the different ways they were going to convict me of a felony and at that point I said that's it. I'm done. So most of the child

psychiatrists who are already in small numbers are saying, you know, in order to -- we are among one of the -- probably one of the lowest paid specialties in medicine. In order to survive I can't do this. I don't know if that answers your question.

SENATOR HARP: So you're not taking -- so by and large the profession is not taking Medicaid or commercial insurance?

THEODORE ZANKER: Yes, and Medicare is next when we go over the cliff and Congress doesn't fix that. And all doctors are going to have the 37 percent cut in the already inadequate fees, which every year they kick down the road until they fix it.

SENATOR HARP: And so I guess I'm -- so ultimately unless you can afford $200 for 45 minutes, which may not be even be adequate because you may need more than one session per week, it's hard to access a child psychiatrist.

Now do you --

THEODORE ZANKER: There's one part to this, though. More and more people are having health insurance that allows for out-of-network benefits. So that if you have that, and most of the patients I see you in the office who do have out-of-network benefits, you pay a larger deductible. And then they pay the patient what they would pay the doctor if the doctor was participating. So the patient ends up, pardon my French, screwed with a larger co-pay, but it's within the realm of possibility.

SENATOR HARP: Okay. So the patient pays and then is reimbursed the lesser amount by the insurance company. Okay. All right. Great. Thank you.

REP. WOOD: Senator Markley.

SENATOR MARKLEY: Since you seem willing to stick your neck out on questions I appreciate it very much. And you have a long baseline to look back over treatment. So I'll ask you an impossible question that I think you probably can only answer anecdotally, really if you're willing.

But in your -- in the time you've that dealing with -- in the field of child psychiatry, how would you characterize the change in the incidence and severity of mental illness that you have to deal with? In other words, is this a problem that has increased dramatically or changed in nature since you've been in the field? Or is that simply -- as it seems to me -- or is that simply my own ignorance of the field?

THEODORE ZANKER: That's an absolutely outstanding question and it's something that my colleagues and I scratch our chins about all the time.

My own subjective opinion is that things have gotten worse. How much of that is due to the fact that when I was a kid growing up in the Bronx and someone has schizophrenia who's like Crazy Uncle Louis, is kept in the attic. And so how much more of that since the stigma is finally disappearing, that people are coming out of the shadows may be a part of it. Some of it I think has to do with some -- really breakdown in the families, too.

In the child psychiatry inpatient unit at the Saint Raphael Campus, at now Yale, we see the most disturb -- I shake my -- I've been doing this for so many years. I shake my head and I cannot believe the degree of dysfunction that we see. And there are -- most programs aren't even given the opportunity to work intensively with the families and it becomes a joke, a pathetic sick joke.

So in answer to your question, I think the answer is yes, but I don't know why.

REP. WOOD: Thank you.

Any other questions? Thank you very much.

THEODORE ZANKER: Thank you for your time.

REP. WOOD: Next is a Sarah Esty followed by Diane Cox-Lindenbaum, Barbara Gerbe, Tom Brant, Patrick Bordieri.

SARAH ESTY: Good evening. I'm Sarah Esty and I'm here on behalf of Connecticut Voices for Children.

We may never know what role if any mental illness played in causing the tragedy in Sandy Hook. Undoubtedly many of the affected parents, families, friends, first responders and community leaders will need access to acute and ongoing mental health services to help them heal in the coming weeks and years. We urge this group to help ensure that those affected by these events receive the highest level of evidence-based treatments for trauma, PTSD and other mental health issues that arise.

Yet the conversation that this horrific situation has begun extends much further than the question of the role of mental illness and violent acts, or how to address the immediate needs of the affected community. For decades hundreds of thousands of Connecticut's residents have struggled to access the affordable quality mental health services they need to lead happy, healthy lives. Children face these challenges even more acutely and the personal and societal costs of failing them are even greater.

Nearly half of young people are currently experiencing, or will in their lifetimes experience a mental disorder and one in five will experience a seriously debilitating mental illness, yet it is estimated that only about half of the children who need mental health care receive it.

To promote access and utilization of mental health services we would encourage you to look at proposals that promote early screening and intervention, address insurance related access barriers in both the public and private systems, build on the success of Connecticut's behavioral health partnership to encourage collaboration between agencies, reduce the stigma around mental illnesses so that those with needs or the parents of children with needs will seek out the help that they need and that will help them be successful and recover.

Treat mental illness as a health issue not a criminal one. Don't require people to enter the justice system to receive the treatments that they need, nor bar those in the justice system for receiving the treatments to recover and transition out of it.

Support school-based health centers which have been shown to be highly effective at getting access for children to services, particularly given some of the challenges we've been hearing about all evening in finding qualified providers for children.

Provide more mental health professionals in schools, so these include people like social workers and psychologists and guidance counselors and see if there are ways to help free up the time of these professionals who are often consumed with important tasks like supervising individualized education plans or providing college counseling, yet if they're doing this tasks -- are not available to provide mental health treatment which is also needed.

Address provider shortages and look at some of the reasons like the reimbursement rates that we've seen for a lack of trained providers and ensure that our most vulnerable children, those in DCF care and in the foster care system and juvenile justice systems do not fall through the cracks, and receive their services.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel?

Representative Hovey.

REP. HOVEY: Thank you.

This isn't a question. I just wanted to thank you for bringing up the issue of school social work. I think it's the first that I've heard of

it being spoken of today, but for me it's a very important issue within the context of this particular topic.

In a lot of our schools we have social workers that are divided between school and if you have a crisis in one school then the social worker has to leave all of the groups that she or he may have been doing in the other school to go and manage the crisis. And then all of those children who have supposed time with a social worker for counseling or group dynamics, it does not occur.

And so that level of intervention at the school, school level is intermittent, for lack of, you know -- I'm not going to go down the road of labeling too much -- but that's really a concern, when those are the individuals who are seeing kids in their midst that need support around the social skills. We've heard a tremendous amount about social skills and where do you learn social skills, but in small groups?

Where do you learn about, you know, learning divergence and how to appreciate divergence and individuals and be supportive and all the anti-bullying and all of that is done by those social workers that are just spread so thin that we really need to be looking at that particular issue within the context of our schools.

So thank you very much for bringing that up tonight.

SARAH ESTY: You're welcome.

REP. WOOD: Great. Thank you very much.

Diane Cox-Lindenbaum. Barbara Gerbe followed by Tom Brant, Patrick Bordieri, David Lawrence Hawley and Tom Burr.

DIANE COX-LINDENBAUM: Thank you for this opportunity and thank you for this undertaking by all of you. It's huge. I am here today seeking whatever help I can regarding a much-needed law change in assisted outpatient treatment for persons with a diagnosis of severe mental illness in Connecticut.

In light of the recent Newtown tragedy and my struggle for the past 12 years with a son diagnosed with schizophrenia I am requesting for politicians to become more actively involved in researching with individual families and healthcare providers to find out how this can be accomplished.

Over a year ago in late 2011 I began reaching out on this issue for a possible law change in Connecticut during 2012. That was after reaching -- reading Kendra Webdale's summary online. Quote from that summary: assisted outpatient treatment can save both the lives of people like my daughter and the lives of those imprisoned by predeceased; it is making a difference. Unfortunately it is making a difference in all but six states, Connecticut being one in the minority. A committee needs to be formed to adopt a new law change from what we have now.

Then in 2012 a tragedy occurs in Sandy Hook, Connecticut. Although we will never know all the facts which caused Adam Lanza to do such a horrific crime against such innocent beautiful human beings, mental illness was discussed as

being a part of his life and his mother's life before his evil act. It happened here in the state of Connecticut.

Safety in our schools, gun law changes and mental illness law changes need to be addressed. For Adam Lanza it was the perfect storm, not just the fact of his ability to obtain these weapons so freely, but what was going on in his sick mind probably for months even years that caused his action.

Maybe, just maybe his mother had tried reaching out for assistance at one point or another for help either medically or legally only to be stopped once finding out the laws here in Connecticut protect the mentally ill person's so-called rights.

Their rights are protected yet their health becomes compromised. Everyone is a unique individual and should be looked at as such. Some do have what I think of as a beautiful mind, yet inability to use it without the assistance of medications they are so unwilling to take.

It's now time for the lawmakers of this State to try and learn and understand more about mental health issues plaguing our community and make changes so as to get Connecticut on track and never allow this type of tragedy to happen again. How can our State's legal system explain another such occurrence? The risk is so much greater if we do not move now to change this law.

I am a court-appointed conservator, therefore should be able to make the rational decision

with the recommendation of a psychiatrist to enforce medication. Due to the liberal law here in Connecticut that some feel is best, my son and my family suffer and have suffered for the past 12 years. I'm sure others have similar situations.

In the hospital the law states he must take his medication. They get him back out of the psychosis state of mind, the delusions go away, his paranoia and fear goes away and he then goes home to a relatively somewhat normal life, even capable now of part-time employment. Each time he then stops his medications because in his mind he does not need medication, we then wait months to watch him slowly deteriorate, get so delusional and fearful from his paranoia and finally get him back to the hospital. It's a vicious cycle that damages his brain further each time this happens, one that could be eliminated if the law here in Connecticut was different.

Connecticut Legal Rights does not help my son, although he believes they do. He says all the time I don't need medication. I didn't do anything wrong. It's not a question of doing anything wrong. It's a horrific illness of the mind that he does not understand. If the law stated he needed to continue on his medication because of his doctors' and family's advice and recommendations he would probably do so knowing it was the law. How do we understand what goes through their minds? We can't. That is the illness, however we can try to fix things.

I am requesting more interest and involvement in mental health issues, something I never knew anything about it until it hit my family and I

have run into such legal obstacles. Please look into passing the assisted outpatient treatment law in Connecticut, or at least revising it. It may make a difference.

And thank you again.

REP. WOOD: Thank you to both you and your daughter -- excuse me -- for sharing your story and experience.

Any questions from the panel? Great. Thank you again.

Tom Brant. Patrick Bordieri. Next up David Lawrence Hawley, Tom Burr, Cherie Bragg-Acker and Brooke Cheney.

PATRICK BORDIERI: Dear members of the committee, my name is Patrick Bordieri. Thank you for giving me the time to testify today.

Connecticut budget cuts seemed aimed at saving money by cutting funding to nonprofit agencies that provided needed services to people who have disabilities or disadvantages ranging from down syndrome to mental illness. People with these services have a chance to rebuild their dignity, their potential and their futures.

Without these services the costs are astronomical, financially as well as emotionally. They have homelessness, hopelessness, illness, relapse and even crime. Does this have anything to do with Sandy Hook or does this have anything to do with the untreated mental illness? We have no idea yet, but it's one of the first things that comes to my mind.

At this present moment I have the opportunity to spend time with five males who suffer from mental illness. I do not work with these men. I actually live in a transitional housing with them and the services that the State offers to these individuals instills the core values which each one of them carry throughout their daily lives.

I've been able to have the chance to see it firsthand, though, when individuals don't follow their programs, miss their daily medications and choose to make something else out of their days than to follow the routines the State has set up for them. And what I've noticed is time and time again the guys would come through this house, is always the result of some kind of violence or crime.

Those who have access to treatment for mental illness are no more violent than anybody else, but cutting or denying services that clearly provides supervision, medical treatment, supported hope in the form of housing, education, purpose and community should not be tolerated.

Again, I don't know anything about the gunman, but I do know that funded services work and quite possibly save lives even beyond the people who receive them.

As always my thoughts and prayers go out to all that who have been affected by this tragedy.

Treatment works, but this treatment must continue. We need to wake up and prevent this from happening again. We need access to treatment options for all ages, more research

into medical treatment, more programs to build on strength and potential and assisted outpatient treatment to ensure that those who need help can and must receive it.

And once in a while we need to highlight these people whose lives are currently full and productive if they receive the treatment they need. They should be used as role models and they can show that treatment works, but this treatment must continue and the cost of not doing so might become unimaginable to me.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel? Thank you very much for your testimony.

David Lawrence Hawley, Tom Burr, Cherie Bragg-Acker and Brooke Cheney.

DAVID LAWRENCE HAWLEY: Senator Harp, Representative Wood, members of the committee. My name is David Lawrence Hawley. I'm the senior director of clinical services at Klingberg Family Centers. I'm speaking today both on behalf of the Klingberg CCSU Family Therapy Institute and at the request of my friend and colleague Nelba Marquez Green, the coordinator of the institute. Nelba's precious daughter Anna was killed at Sandy Hook last month.

Nelba called me the evening of December 14th. We only talked for a little while and I couldn't understand a lot of what she was saying given her state of shock and inconsolable grief, but at one point in the conversation she steeled

herself and said to me, David, we've got to do something. Our system isn't working and we've got to fix this. Those words will both haunt me and motivate me for the rest of my career as a mental health professional. Nelba is right. We have to fix this.

Our mental health system in Connecticut is incredibly complex. I know because at Klingberg we run many of the different types of mental health programs for children and families that make up the system. During the 11 years I've worked in Connecticut I've seen the State fund countless new models of treatment and evidence-based practices and this is laudable and necessary, but still families continue to tell me that they're not getting the services they need when and where they need them.

I listened to a father the other day who pleaded with me through tears of frustration to help him find a program for his son who had become very violent at home. He said to me, what if my son becomes the next Sandy Hook killer? His family had been referred to several different types of services, but none fit the family's needs. What then?

Families get shuffled from service to service in an attempt to fit them into the models of treatment available instead of fitting treatment to the family's needs. They receive inconsistent and often polarized perspectives and opinions about what treatment approaches are best from the various service systems they encounter. They work with state and private systems that don't communicate well enough, resulting in discontinuity of treatment and tremendous confusion. As a result families get

frustrated and overwhelmed and many eventually fall through the cracks. We need to fix this.

We need resources to fund individualized tailored treatment for families whose needs exceed or just aren't a good match for the prescribed treatment models we have. As a system, and that includes mental health professionals, educators, state agencies and communities, we need to do a much better job listening to families and addressing the barriers to treatment they face.

Klingberg Family Centers in Central Connecticut State University, through our partnership at the Family Therapy Institute, are organizing key experts from various mental health disciplines to come together and discuss the challenges we're facing in our mental health system. We'll use data and discussion to move towards a unified voice on the needs of our schools and communities regarding the gaps and shortcomings in our community mental health service delivery system so we can do our part in preventing a Sandy Hook massacre from happening again.

We'll present our findings with one unified voice to the Governor's task force to help guide mental health legislation that will fix our system. Other voices are needed. This is just a start. Klingberg Family Centers and our partners at CCSU stand ready to help in any way we can. We've got to do something. Our system isn't working and we've got to fix this.

Thank you.

REP. WOOD: Thank you very much.

Any questions from the panel?

Senator Gerratana.

SENATOR GERRATANA: I just want to thank you so much for giving your testimony today. I know we've met previously and spoke a little bit and of course I'm very familiar with Klingberg. It's not just in my district. It's in my neighborhood, so I thank you so very much.

And by the way, I'm going to need you when you leave outside the room.

Thank you.

DAVID LAWRENCE HAWLEY: Okay. Thank you.

REP. WOOD: Thank you again.

Tom Burr followed by Cherie Bragg-Acker, Brooke Cheney, Steven Fedewa and Ann Olson.

THOMAS BURR: Good evening, Senator Harp, Representative Wood and the members of the task force mental health services working group. I appreciate you folks staying so late and hearing all our stories.

My name is Thomas Burr and I am the communications manager for NAMI, the National Alliance on Mental Illness, Connecticut Chapter. I'm also a former board member of NAMI Connecticut as well as a former board member and president of the Manchester of affiliate of NAMI. I'm a member of the Keep the Promise Coalition as well as a trained support group facilitator for the Manchester affiliate.

However as you've already heard from our public policy director, Daniela Giordano, who has already given, you know, our official take on all this, I'm going to be speaking tonight on my own behalf.

As most everyone in the state of Connecticut, I was deeply shocked and saddened by what happened in Sandy on December the 14th and I applaud this Legislature's efforts to hold these hearings so some good can come out of this awful, awful tragedy.

As Ms. Giordano has already briefly covered our organization's recommendations, I just want to share my own perspective on things. I'm the parent of an adult child who is in recovery from bipolar disorder.

When our son became ill my wife and I endured eight years of what I can only describe as every parent's nightmare. At various times he was hospitalized, incarcerated, homeless and very, very sick, and in so much pain he tried to kill himself more times than I can bare to recall. And frankly, he tried to kill himself two times right in our own home in front of his two sisters who were two and four years old at the time. My wife and I had to make the awful decision to bar him from our home, as having him live with us was just too chaotic.

Now the good news is I can share with you that he's doing fine now. He's been in recovery for approximately five years. He's working. He's sober. He bought a condominium with his own money about three and a half years ago and he's engaged to be married to an amazing woman this spring. He is like a poster child for recovery

and I share this with you all because I want everyone to know that people can and do recover from serious mental illness.

As far as what this task force is chartered to do, again you've already heard a list of recommendations from Ms. Giordano, so I just feel compelled to reiterate a couple of her points.

As a state we must not take reactive or regressive measures which would further stigmatize and discriminate against people with mental illnesses which will reinforce people not seeking treatment.

I oppose reactive and aggressive measures such as involuntary outpatient commitment for numerous reasons including that it conflicts with Connecticut’s recovery-orientated system of care. It’s expensive and it diverts funds from needed and effective services and singles out persons with mental illness.

What we should do instead is replicate and expand the services and the models we know work well so that they are more widely available and can serve more people effectively.

Now in my son’s case he was forcibly restrained and forcibly medicated on several occasions which made it extremely challenging later on to get him to agree to seek treatment even though he so desperately needed it.

He simply did not trust the medical community after experiencing their ill-treatment from their hands. I suspect, though I can never prove, that the eight years he spent bouncing

around in crisis before beginning to seriously work on his recovery could have been dramatically shortened if he had not been treated against his will.

People suffering from severe mental illnesses need to feel in control of their lives. Forcing treatment upon them, no matter how well intentioned, is completely counter-productive as well as traumatic to the individual and I know because I saw it first-hand.

I should also add that because in my experience in watching this I can tell you that when I was originally faced with his crisis, when I didn’t know anything at all about mental illness, I would have been completely 180 degrees on this thing. I would have been begging you to forcibly medicate him and forcibly get him the help that he needed because I didn’t know any better. I didn’t know how traumatic that is to the individuals.

But when I host support groups I hear this from families who have been through this whole experience and they can tell you again and again that it is traumatic for the individuals and it makes them not want to get the help that they need.

I want to thank you for your time and I’d be happy to answer any questions you might have.

REP. WOOD: Thank you very much.

Any questions?

Great, thank you very much.

THOMAS BURR: Thank you.

REP. WOOD: Cheri Bragg Acker, followed by Brooke Cheney, Steven Fedewa, Ann Olson, Kim Nystrom.

CHERI BRAGG ACKER: Good -- good evening, Senator Harp, Representative Wood and distinguished members of the Committee. My name is Cheri Bragg Acker. I'm the daughter of a person living with Bipolar disorder. I've struggled with depression and anxiety and I'm the caregiver of a wonderful child who struggles with ADHD.

I've worked in the mental health field both in advocacy and direct service for over a decade and I've lived with the effects of mental illness my entire life. My mother was first hospitalized when I was two and she was institutionalized for decades. She does not believe to this day that she has a mental illness.

She would stop taking medications that often made her sleep all the time and end up back in the hospital. I worried when she was missing, sometimes was scared or confused when she experienced psychosis or delusions and I grieved immeasurably when she was suddenly re-hospitalized.

Today she believes that my family died in a car accident when I was 11 so as a daughter I don't exist so I get it. I understand why families might think outpatient commitment is the answer. I've spent over 40 years grieving and if outpatient commitment was that magic wand that would change it all, nobody would wave it harder

or faster than me, but my experiences tell me otherwise.

My mother has been hospitalized multiple times, often for very lengthy periods of time during which she was forcibly medicated. Not once did she decide that she has a mental illness. Not once did she decide that taking medication was the answer.

Outpatient commitment laws can be 90 days up to six months. What happens then? Are we back to square one or are we really talking about forcibly medicating people for life with medications that can have side effects worse than the illness and life expect -- expectancy reductions of an average of 25 years?

It also assumes that treatment will work and quickly. Many people live with treatment resistant psychosis and dilutions. Traditional treatment hasn't worked for them nor my mother. Outpatient commitment would also open up the doors for abuse by professionals as an easy short-term answer rather than work in engaging someone in treatment, a long-term solution. I've had this experience at my mother's nursing facility.

In addition Anosognosia results from physiological damage to the brain and cannot be changed by any period of forced medication. What can be changed is engagement and I -- you've heard this before but it's so important. People are what make the difference by being respectful, truly listening to someone, recognizing strengths versus focusing on deficits, employing peers who can offer hope, support, encouragement, even mentoring.

My mother remembers one doctor in all those years of treatment who listened to her and recognized her strengths, one.

I urge this Committee to invest in what works. Fostering relationships are not forced. And I'd also like to reiterate Commissioner Reimer's point I believe she made earlier which is the person who recently pushed someone under a subway train in New York as well as the Vir -- Virginia Tech shooter they were both under outpatient commitment laws. So again it's not that magic wand working -- especially if you're talking about preventing violence.

Working with children and families, the answer is the same. I work with children and families every day and I hear over and over from families that the school does not understand my child or their disability. We also know -- I had heard that it was the Number One reason for school dropouts. Somebody testified earlier it's Number Two under learning disabilities.

Either way neither one is a good reason for dropping out of school. Let's offer schools the preventative and early identification tools they need and the sport -- supports they need so we can give children and youth not just the academic but the social and emotional skills they need for a successful life in the community.

Chronically punishing children for behaviors that are really symptoms of a disability are just discounting them as weird, different, delinquent or hopeless that has consequences for all of us.

So in summary I urge this Committee to invest in recommendations that are positive, strength-based, evidenced-based and informed solutions for children, adults and families with -- with robust input -- robust input and guidance in the design from individuals and families who are directly affected. I can't emphasize that enough. It's the only way to create lasting, positive change.

Thank you for your time.

REP. WOOD: Thank you very much, words of truth spoken from the trenches. Thank you.

Any questions from the panel?

Thank you again.

CHERI BRAGG ACKER: Thank you.

REP. WOOD: Next up Brooke Cheney, is Brooke here?

BROOKE CHENEY: I am.

REP. WOOD: That's great

BROOKE CHENEY: (Inaudible) three days I know.

REP. WOOD: We're here with you.

Steven Fedewa followed by Ann Olson, Kim Nystrom and Martin Burke.

BROOKE CHENEY: Good afternoon. Last night when I wrote this I was hoping I'd get an early number. Senator Harp, Representative Wood and members of the Committee, my name is Brooke Cheney. I am

from Harwinton. I thank you for your time consideration.

Today we are here to discuss mental health. Over the last two days of testimony I have heard time and again how addressing mental health is important to many. If there is one thing most everyone agrees on, is that there was something terribly wrong with Adam Lanza. Who could kill their own mother?

I've heard about staffing issues in our schools and how everyone only has time for their PPTs, et cetera, but no one has really mentioned the roles of families. Today, however, I have heard many a family asking, yeah begging for the attention from the mental health professionals.

As I heard on Friday during the school safety there is no one size that fits all. We cannot legislate away a simple solution because there is none. In Statistics 101 in college we were taught that all of the proof is there but finding it is near impossible. You'll have studies that support one thing that people have told you today and you will have studies that support the other thing that people have told you.

The reality is everything works for someone but nothing works for everyone. I wish you luck in your quest to find some solution. I appreciate the fact that you have not jumped the gun as it were and did what New York did.

I thank you for spending your time listening to all these testimonies. I personally knew a doctor who was in group therapy for depression and suicide. He was dismissed because his

insurance company said your time is up, you've had enough. The doctors, the counselors sent letters of pleading to keep this doctor under -- in group therapy. The insurance company said no. A month later I went to his funeral to tell his family how much that he loved them and it was not about them that he had committed suicide. And for this I would definitely blame the insurance company because some bean counter decided that he had had enough.

And on the other hand, in defense of insurance companies, I understand. The insurance fraud that is out there is rampant and disgusting. There is no one solution.

Thank you for your time and consideration. Oh sorry and the testimony is on green paper because I've been told it's a calming color so enjoy reading.

REP. WOOD: Thank you very much.

Any questions from the panel?

Seeing none, thank you very much.

Steven Fedewa. Is Steven here? Ann Olson, Kim Nystrom, Martin Burke, Paul Acker followed by Mathew Hemby, Mary Winslow, Glenn Ginter.

PAUL ACKER: Good evening, Senator Harp, Representative Wood, distinguished members of this Committee. My name is Paul Acker. I am the co-chair of Keep the Promise Adult Committee, coordinator of social rehabilitation at InterCommunity in East Hartford and I'm also a person in recovery from long-term mental illness.

I want to talk to you today about mental health recovery and the importance of this model in helping people get better. I have seen in my own life and my current occupation the principles of choice, empowerment, shared decision-making, community integration and self-determination in playing a critical role in recovery.

It hasn't always been this way. In my own life I've been told what I can and can't do. Providers told me I could never work again in 1989. They said I couldn't handle stress and so they encouraged me to get on Social Security Disability.

I followed that path and I still remember today my case manager putting her hand on my shoulder when I got my approval and saying now you're set for life. She didn't tell me it was the life of poverty and a -- a life of social isolation.

Once you start down that road it's hard to find an off ramp. My depression fed my isolation which starved my self-esteem which fed my depression, a never-ending cycle. The system just told me medication compliance was the way to be and that was my only goal according to them.

Any other life goals were based on whether or not I was complying with my medication regime. Beaten down by the system with no hope left, I gave up. I dropped out of treatment and for 14 years I barely left my apartment.

That's a black hole in my life I will never get back. Eventually I figured I had to do something. I thought of getting a job. I went

to BRS hoping to get something part-time because I couldn't afford to live on Social Security Disability anymore.

I went through the extensive testing they have and was accepted into their program but my worker wasn't going to spend one red cent on me until I got help and she guided me to InterCommunity. To be honest with you I wasn't real excited about going. The system had told me basically that I'd been a problem all my life and that without meds I would always be a problem.

I could never get traction and the frustration just keep feeding into my depression. What was the system going to say this time that was different? Come to find out they had some new things to say. In my first session with the therapist she asked me what my goals were and surprisingly none of them were being medication compliant.

My initial goals were to get my own place. I had to move back home with my mom at the time because on disability you just can't afford to live anywhere else. Maybe get a part-time job somewhere but wasn't sure who would hire me and possibly get a friend or two.

Through partnering with providers and peers, having goals that I wanted in my life to work on and meeting other people who were successful in their recovery, I've been able to not only meet those initial goals but exceed them in ways I never could have imagined.

Today I've been working full-time for six and one half years. I'm no longer on disability.

I'm married. I have more friends than I can find enough time to spend with them and I'm giving back the best I know how because I'm grateful for what I have.

It took the system changing in order for me to be able to change. If the systems stayed the way they were, we would have been butting heads for the rest of my life.

I see how things like supportive housing, peer supports and the opportunity to pursue desired social roles and other opportunities of a person's choosing help the person down their path into recovery.

In the wake of the Newtown tragedy we should be thoughtful about how we approach mental health care reform in Connecticut. Knee-jerk reactions can cause more harm than good. Let's partner to bring about positive change and increase hope, respects personal choice, meets people where they're at instead of where we want them to be. Please don't send us back to the dark ages. Let the recovery model, an evidenced-based practice, guide your decisions as a Committee. It works. It has for me and it has for many others.

Thank you.

REP. WOOD: Thank you.

Any questions from the panel?

Yes, congratulations.

A VOICE: (Inaudible).

REP. WOOD: Well done. Thank you.

SENATOR HARP: Our next speaker is Mathew Hemby followed by Mary Winslow followed by Glenn Ginter followed by Deborah Strong.

And are you Mathew?

GLENN GINTER: I'm Glenn Ginter.

SENATOR HARP: Oh Glenn, okay. Come on down Glenn.

GLENN GINTER: I'm already here. Well I want to thank this Committee. You're much better than the one last night. At least you show a little interest in trying to come up with a solution.

Anyways just for the record I've -- I've had to move here from the State of Oregon to get away from someone who suffers from depression with some similar things that people have talked about today. But first off, just for the record, I am very disappointed in these last two days of certain politicians exploiting a bad situation for their own political agenda and this has been wrong.

But on that note, the most interesting thing I found out was last night people were complaining the government was taking their rights by taking their guns away and today we hear -- I mean controlling them by taking their guns away and today hear people are being controlled by the government by drugging them and it's kind of -- it's kind of funny. It's like two different sides. All of a sudden they're now the same.

However -- yes -- however though there was a gentleman yesterday, a chief of police, who stated, which is a terrible thing for public people to perpetuate these things, who said well

I think we should disband the firearm board and I should decide who's mentally fit to own a gun or not and if they don't like it they can go to the Supreme Court and that is not a good thing to say at these things. It just divides people.

Another thing I was appalled to find out is very simple thing, something my late mother told me was an ounce of prevention is better than a pound of cure. So when I hear that Adam Lanza tried to purchase a gun, was denied and the authorities did not follow up, that should be a huge red flag considering the number of people denied is very small. That may have solved this whole entire mess right there.

But on to that, yes, I've had two of my friends over the last 11 years commit suicide. One lost his job. I had been friends with him for awhile and he was like the happiest nicest person in the entire world. One day a friend called up and said hey did you hear about Doug? He killed himself last night and I was just like in shock of whoa.

And he was on Prozac and before he killed himself he decided it would be a good idea to shoot a gun at cars and eventually led to a police chase where he blew his brains out in front of the police.

So I think there is something I hope you've probably gathered it with the questions you've ask is yeah there is a -- anti-depressants in some of these situations is not a good deal. That needs to be further explored.

I had another friend last year, although it was almost a year ago, who decided to kill himself

too. He was not on any drugs and just took himself out. So again I would say do that.

But one of the solutions that I have is yes I've gotten away from the person suffering from depression. I've been to state police, I've been to mental health and they say no we can't do anything until they commit a crime or -- I said or -- or I'm dead and they're like yeah and I'm going this is not right.

So this person was going to a counselor so I tried to talk -- I'll finish in a second -- tried to go to the counselor and the counselor said I can't talk to you. There's a privacy issue here and if you want to do one thing like that woman who was almost stabbed and almost dead is allow someone who thinks another person is in danger to go talk to the counselor and give the information so a right decision can be made.

Here's how someone could be. I'm sure anybody here who is a counselor got text like this one was trying to say something is going to happen here, something can be done without interfering with the client/patient rights. But if you can't give information to the people who need it, this is going to continue and continue.

And the other issue on this, then I'll be done, is the word fear. When you have police officers talking like that, people are in fear of getting help to being labeled. People like me live in fear of what happens if you're in this person's life are you going to end up dead or, if you don't get involved and stay in their life, are they going to kill someone else. You've got counselors and others who are in fear of being

sued if they do something wrong and you're never going to get there with everyone living in fear of everything else.

This is a simple solution but yes, on that note, I believe that at certain times, when the indications are up, people and authorities should step in. It doesn't label you as crazy or others as people say but there are times, especially with depression, and I will be talking probably with the Chair here, that I can play you video tapes of -- this has been going on for five years and something bad is going to happen and that's why I've had to move away from everything that I have and do.

So I thank you and I will be in touch.

SENATOR HARP: Thank you very much.

Are there questions?

If not, thank you for sharing your story.

Deborah Strong followed by Stephen Mendelsohn.

Good evening.

DEBORAH STRONG: Good evening. I hope you'll bear with me just -- just a bit. I have asthma and I'm due for my inhaler which is at home.

Thank you Senator Harp, Representative Wood and members of the task force Mental Health Services Working Group for allowing me to address you today. I'd like to speak a little bit about forced treatment of people with mental illness and addiction issues.

Forced treatment does not work. There are well-meaning people trying to push legislation through that would give the courts, probate judges, the power of forced treatment for people with mental health and addiction problems.

I believe that community transitional services are what is needed for people to be successful. Further we need to treat the whole person for the person to be successful. This has been my experience. This is where we should spend our money.

Here’s why I know it doesn’t work. My brother and I have Bipolar disorder. Unfortunately my 50 year old brother Mark also has long-standing alcoholism probably started around 12. He began -- he spent -- he’s gone from everything from hospitals to treatment centers to spending six months in prison in North Carolina.

Mark lived in Connecticut for many years. My brother was functional for many years. Worked as a blacksmith, married and had two beautiful boys, paid and still pays taxes. Mark wrote -- now resides in New York and suffers serious traumatic brain injury when he was 43.

We were told he would die but we come from very strong stock. However we can no longer handle all of his -- he can no longer handle all of his affairs. My father and I were appointed his guardians. I am considered guardian of the person. I am responsible for everything from his abode to services he receives.

After three and one half years of TBI and rehabilitation -- and alcohol rehabilitation, Mark is ready to transition to the community.

He was on a nursing home prevention waiver -- Medicaid waiver. We set up an apartment and services for him, visited, called to check on him. It took me six months to set up his new home and services.

A caseworker checked up on him monthly. Mark went back to what he knew. There was no transition. He went from three and one half years in the hospital to a home situation and there was no -- it’s like falling off a cliff.

He has been involved in the justice system of late again and I encouraged him -- we had some words and he went into a -- a rehad -- detox and a rehab. I can force him to go into a detox but I can’t force him to go into a rehab.

He was unsafely discharged after the first step program, took a taxi home and stopped off to buy three bottles of liquor. Forced cajoled treatment doesn’t work. When I got to him, he -- he had consumed a great deal.

Mark -- Mark was transferred to a TBI waiver program from which he received his housing and services. He had an apartment, went to a day program sort of and had 24/7 supervision and oversight and a nurse came in once a week to make sure he was taking his medication, his forced treatment. I had no choice.

This was the only way to get the waiver which would provide his home and services. He essentially had babysitters he was able to intimidate. I feel the frustration. Mark wanted to feel like a man who had rights and choices.

He is in an excellent TBI program -- alcohol program in Orangeburg, New York. My father, his best friend, talked and cajoled Mark into going. Mark says he is working hard to turn his life around. And I think this is the part that's important. Mark does well in rehabs because he has support and community. Unfortunately there is a drop when he is released.

There are few transition services from hospitilation -- hospitalization and rehab to community. This is where the problem lies and why hospital rehabs and court systems see people coming through a revolving door. Transitional services are where we, as a community, need to concentrate our dollars.

Nothing we have done for Mark where he has been forced -- forced, coerced or cajoled has helped him. There is no community of his peers to surround him and mentor him into recovery when he is released from rehab. There are few programs that successfully help people with mental health and addiction problems. There are long waiting lines. Mark was waiting for a -- a transitional program but the wait was too long and he went back to what he knew, drinking.

Probate judges will continue to see the same people over again because these people have chronic, complicated problems. It's not simple. My brother has had the benefit of comprehensive care and -- and help of a loving engaged family. Yet here I am looking for a hospital rehab nursing home for him to live in because he has failed through both waiver programs.

No amount of forced or coercive treatment is going to help him. Community, community,

community is what would help him. Knowing that he is ill and knowing there is a community of mentors, people in recovery and professional staff to help him on his way would help. If he didn't feel alone, he would accept help.

If the community would also believe Mark has a chronic illness and not someone who just can't control his drinking, I believe he would accept help.

Mental illness and addiction are illnesses like any other. We, as a community, need to learn that in order to help people like Mark we need to know he wha -- he doesn't have a character flaw. He needs a community who believes he can be productive. This, in my opinion, is why people like my brother don't get better. They are not respected. Their illness is not respected. They are expected to become different people after a 7 to 28 day rehab with no transition services in the community in which they live.

We, as a community, can better use our dollars to find community solutions. Research is needed to develop ways of treating these illnesses. I honestly believe my brother and many, many others --

SENATOR HARP: Can you wrap it up please?

DEBORAH STRONG: -- would choose, if they -- where they are living. We as a community owe them treatment and transition that works and to respect people like by brother for the good people that they are.

SENATOR HARP: Thank you very much. I was wondering if there are any questions and if not I guess I have one.

Do you know of any programs like that in Connecticut that -- any community transitional services for this population?

DEBORAH STRONG: I am not well versed about these community services in Connecticut. I know that they exist in -- they're minimum in existence and there are these long waiting lines and people go back to what they know when they -- they have no -- no structure around their life. They've been structured, Senator, for the 7, 28, 60 days. My brother was structured for three and one half years after his TBI rehab. The first thing he did was start drinking because there was no transition and he went back to what he knew.

SENATOR HARP: Thank you. I think you make a very good point.

Further questions?

If not, thank you so much for staying.

DEBORAH STRONG: Thank you.

SENATOR HARP: Stephen Mendelsohn followed by Kathy Laudy followed by John Foster.

STEPHEN MENDELSOHN: Yes, my name is Stephen Mendelsohn. Senator Harp, Representative Wood, members of the Mental Health Working Group, I'm an autistic adult and psychiatric survivor.

We in the psychiatric survivors' movement join others in the disability community who are very concerned about exploiting tragedies like the Sandy Hook shooting to deprive us of both liberty and responsibility through policies such as involuntary outpatient commitment.

Let me explain my own -- I'll summarize my own story and try to be brief about it. I was bullied and as a child even though I was very -- very bright and eventually I managed to -- to be labeled a paranoid schizophrenic. I was put on many of these neuroleptic drugs, Mellaril, Stelazine, Navane which gave me severe dystonias and akathisia going like this against -- without my informed consent and when I expressed the idea that dying would be preferable to -- to the torture of these drugs, this was used as a reason for increasing the dosage.

I managed to get free and I've been free of psychiatric drugs for 33 years. I've been gainfully employed consistently since 1984 and I've led a -- a very productive life. Unfortunately that label of paranoid schizophrenia followed me all the way to 2003 when I sought assistance from BRS getting a new job. Again they labeled me paranoid schizophrenic and it wasn't until after that we found out that I was on the spectrum and it was -- and was able to, you know, to show how -- how things can -- can go -- go right.

My experience is not unique. I know thousands of other -- hundreds, if not thousands, of other psychiatric survivors out there like me. We can learn that the experts are frequently wrong and this can have severely negative consequences,

not merely in terms of health, but also in terms of personal liberty.

I know people have been electroshocked, even given forcible insulin coma in the past and this is a serious moral issue. In terms of stigma, the fact is when we view people as having broken brains and the biological model, this is -- the research actually indicates that this increases stigma. That is in some ways the -- what is often viewed as the solution can -- is -- is probably the problem here.

I also note how some of our inconsistencies on suicide. We have a bill raised by Representative Nafis and Senator Doyle, H.B. 5298 concerning involuntary shock treatment and I believe that’s a good bill that would eliminate one of the worst abuses and I think it shows the con -- we have a real contrast here between depriving people -- people with some disabilities of liberty in the name -- with things like forced striking and forced shock and on the other hand we have bills coming up in the Legislature that are being proposed to give people with other disabilities suicide assistance with the slogan my life, my death, my choice.

And I say nothing about us without us in the disability community. I note -- and in my written testimony I point out the -- the -- that we should be treating people as free and responsible and when we treat people as non-responsible that’s what helps foster crime.

On December 14, 2012, right after the shooting, Governor Malloy said correctly evil visited this community today. What happened at Sandy Hook

Elementary was evil, not sick, yet the Treatment Advocacy Center and others would use this tragedy to promote forced drugging even though we've heard testimony earlier today that the drugs themselves might be part of the problem.

It is easy to scapegoat quote the mentally ill for murder and mayhem and deny basic civil liberties. Those who cite second amend -- the Second Amendment while protesting against gun control ought to be especially wary of finding ways to deprive others of basic rights under the Constitution.

This scapegoating happens because most people think that quote we are sane. It is only those people who are mentally ill and need to be compelled to submit to psychiatric drugging. But if I could be labeled as one those people, so can any of you.

I ask the members of this Working Group to put themselves in the shoes of someone being subjected to forced psychiatric drugging. How would you feel if you were stripped naked against your will and forcibly injected in your buttocks with long acting Haldol, Risperdal or Zyprexa? How would you adjust to the neuromuscular side effects tardive dyskenesia, neuroleptic malignant syndrome, massive weight gain or diabetes?

Would it bring you healing or feelings of victimization and anger? Why is forced drugging considered torture when done to Soviet dissidents or to people deported by Immigration and Customs Enforcement yet perfectly acceptable for those people?

Let us remember the golden rule here. As taught by Hillel, what is hateful to you do not do unto any person, any person meaning well or sick, friend or foe. If you would deeply resent being forcibly drugged like this, then defend our right to resist the indignity of involuntary outpatient commitment. The liberty you protect just might be your own.

SENATOR HARP: Thank you very much.

Are there questions?

If not, thank you very much.

STEPHEN MENDELSOHN: You're welcome.

SENATOR HARP: Kathy Lauudy.

KATHLEEN C. LAUNDY: Laundy, like laundry without the r.

SENATOR HARP: Without the r I know. That's -- that what makes it so hard.

KATHLEEN C. LAUNDY: I pronounced his name wrong for four years before I got it.

SENATOR HARP: And he still marries you.

KATHLEEN C. LAUNDY: Then we got married. I hear the (inaudible).

Senator Harp, Representative Wood and distinguished members of the Mental Health Services Working Group, thank you for the opportunity to advocate for healthcare teams in Connecticut schools.

I am a licensed psychologist, licensed family therapist and licensed social worker. I'm a past president of the Connecticut Association for Marriage and Family Therapy and I have consulted with school systems since 1971.

I'm a faculty member in the Counseling and Family Therapy Department at Central Connecticut State University with Nelba and David and I help prepare family therapy trainings for certification and practice -- to practice in schools. I am currently writing a book about multidisciplinary team building in schools.

Since Public Law 94-142 was passed by the U.S. Congress in 1975, schools have been mandated to hire special services professionals to help students achieve academically and socially, regardless of their special needs. Originally the law was passed in the wake of the civil rights and women's movement to mandate that all children should have equal protection under the law.

Since that time the law has been reauthorized several times, as the Individuals with Disabilities Act -- Education Act or IDEA, to ensure that all children have access to appropriate educational opportunities regardless of disability. In the past 30 years -- or 35 years nurses, speech and language pathologists, physical and occupational therapists and special learning consultants have joined school teams.

Mental health teams have also grown. Connecticut now certifies school counselors, marriage and family therapists, psychologists and social workers. They are all trained to provide individual, group and some family

services and each discipline has unique and complementary skills as well.

The impact of Public Law 94-142 has been profound. Special ed budgets have grown exponentially to accommodate the services needed to educate children in the less restrictive environment and students have profited from such main stream support. Many achieve, some graduate out of special programs and schools actively utilize team services to prevent costly out-of-district placements.

Non-disabled students have learned compassion as they have learned side-by-side and mentored students with special needs but three trends have challenged that progress that you've heard a lot about today.

First the community mental health movement in the 1960s eventually forced the closing of several inpatient psychiatric facilities in Connecticut. Many of them are really all trained. Children, adolescents and families coping with serious mental illness were pressured to seek services in schools and community agencies and emergency rooms.

Second you've heard a lot about managed care. The managed care trend for the last two decades has really limited access to mental healthcare treatments available to children and families beyond psychotropic medications. As my old mentor from Child Studies, Fred Volkmar, says that if you're very, very poor or very, very wealthy, you can get services. If you have private insurance it's really hard.

So then -- the -- but the third -- the third is the fiscal constraints of the recent recession. It put just major limits on hiring and so what I want to do is I want to call for -- I have two recommendations. This unspeakable crock -- crisis of losing our children in Newtown calls for careful and proactive planning.

I offer the -- these two recommendations. First build mental health services in schools with less of a silo, you've heard about that today, and more a systems of care approach. Such multidisciplinary systems of care are emerging as preferred and economically feasible modes of treatment in medicine and healthcare.

The school-based clinics we talked about today are one such example of a medical home system applied to education and they fit systemically very well with the Public Law 94-142 structure already in place in our 159 towns. Solid relationships among children, families and schools can mitigate the isolation that begets violence. They can promote more awareness of psychiatric needs where they exist and primary prevention can offset the cost of hospitalization, out-of-district plaintment -- placement and more expensive alternatives.

And finally invest more resources in school-based mental health services and staff. It's important that we upgrade the credentials of mental health professionals currently school certified. Currently only marriage and family therapists are required by the State Department of Education to be also licensed by the Department of Public Health.

We need licenses for everyone to upgrade the competency and accountability standards of mental health professions.

Thank you.

SENATOR HARP: Thank you very much.

Are there questions?

Representative Johnson

REP. JOHNSON: Thank you, Madam Chair.

And thank you for your testimony this evening. Just one question. I -- I hear a lot in the testimony during the day about how relationships are so important in building good quality mental health services in the school system --

KATHLEEN C. LAUNDY: Um-hum.

REP. JOHNSON: -- that are consistent throughout the state are important as well. In terms of people who home school, has -- how should we address that? I don't believe there's anything that -- that addresses people who are home schooled. Is there or is there not?

KATHLEEN C. LAUNDY: Well the same services are available to children who are home skill -- home schooled as children who are in school. So that the four academics primarily they -- they are home schooled but they had access to all the range of services that every other student has.

REP. JOHNSON: Thank you.

Thank you, Madam Chair.

KATHLEEN C. LAUNDY: Um-hum.

SENATOR HARP: I'm going to just ask you this. It has nothing to do with your testimony so I'm probably going to be shot by the rest of the members of the panel here. No pun intended.

A VOICE: (Inaudible) has privilege.

SENATOR HARP: But I was wondering -- I-- I heard from a person who -- who does injury prevention yesterday that one of the thing -- that -- that what makes guns so bad is their lethality and that if you can't take the guns away that perhaps we should have a law that requires guns to be secured in one place and ammunition in another.

The reason that it was -- I raise it with you is he also claimed that suicide is most prevalent in those 15 to about 25 years of age, so does kind of the school population so that the nexus.

KATHLEEN C. LAUNDY: Um-hum.

SENATOR HARP: But I wondered what you thought about securing the weapons if you have a child that age in your home.

KATHLEEN C. LAUNDY: I think it's critically important to secure those weapons if you have a child in your home and yes you're correct about suicide in that population.

More girls attempt suicide; more boys succeed.

SENATOR HARP: Um-hum.

KATHLEEN C. LAUNDY: And boys do it more violently.

SENATOR HARP: Yeah.

KATHLEEN C. LAUNDY: So if they're at risk, they really need protection.

SENATOR HARP: Yes (inaudible). Okay, great. Thank you very much.

KATHLEEN C. LAUNDY: Thank you all for hanging in there this long.

SENATOR HARP: Our next speaker is John Foster followed by David Borzellino followed by Janette Phillips.

A VOICE: Kathy Laundy.

KATHLEEN C. LAUNDY: Yes.

A VOICE: Did you submit testimony?

KATHLEEN C. LAUNDY: I did.

A VOICE: Okay.

KATHLEEN C. LAUNDY: (Inaudible) early. I got here very early so I (inaudible).

A VOICE: All right, thank you.

JOHN FOSTER: Before I begin I'd like to say hi to my mother and -- and Boucher I'm going to get it right hopefully. I came here today to put a face on mental illness and I see there have been a lot of people before me already putting that face on it.

You know I was -- I was beat up -- beating myself up trying to figure out, you know, the

best way to do this, to come up with a sincere presentation. I was going to try to come up here and maybe talk to an empty chair but someone told me oh man I already did that.

So -- so I -- I guess that's out -- I guess that's out of the question. What I want -- wanted -- wanted to say -- I wanted tell you a little bit about my life story but I got real short attention span and I really like people and that's been a source of -- of enjoyment in my life so when I see us starting to get attacked, you know I -- I start taking up that -- that flag and I -- I want to pick up, you know, and -- and protect them.

And I see where we -- we've been -- been beat up pretty badly here today. You got one doctor who came in here a few minutes ago and he was saying that, you know, if given 15 minutes that he really can accurately give a description of -- of somebody and how they were -- they were doing but then 15 seconds later he said but give him 45 minutes he could -- he could give a whole background from their life.

I'm sitting up there saying whoa really, really. I've heard the mentally ill be called consumers here all day today. What happen to the Hippocratic Oath? When did we become consumers? I mean when I was sick I wasn't looking, you know, to go and buy a new pair of shoes or something like that. I was looking to get well.

When did I become a consumer of -- of meds? Who -- who is the consumer of meds? I don't understand that. But that's some lukewarm term that they've -- they've come up with and just to

slide things by so they don't offend anyone, you know, but -- but we have to become offended.

I mean you've got people on this side of the government, as the gentleman said, saying things about weapons and -- and guns and everything like that and then you got people on this side of the government saying about forced medication and it's -- it's bigger than me and it's bigger than little Timmy who can't sit still in school.

It's all about the NRA and pharmaceutical companies. The NRA is trying to protect themselves and make money. The pharmaceutical companies they become like these pill pushing ambulance chasers and they run behind these ambulances pushing things. And it -- and it all comes down to a small piece of paper that carries a lot of weight, you know. It's all about how much money they can make, it ain't about who they can help. It's about how much money they can make for them and they -- they -- their shareholders and it's an ugly thing.

Right now Today says Newtown, Connecticut stands at the forefront of America. All eyes are on us from around the world. We don't have to be a dumping ground for nobody. We can set this straight. We're the Constitution State. We can set this straight for America, all right? This ain't -- this -- this is not a game. These people are really attacking us and they're belittling us.

They -- they're using big dollars to make us seem small and inconsequential. This is we the people and this is the Constitution State and we're at the forefront. It's time for us to get

it right because if we don't and nobody else is -- nobody else will.

This is the last stand right here. Trust me on this. I -- I may -- I may not, you know, talk perfectly. I might not carry no PhDs behind me or anything like that. I do know this, if we fall behind them and allow them to get a toehold into how this thing is supposed to be done, we've lost. We've got to be the ones who make the decisions. We've got to be the ones wagging -- wagging the tail not the tail wagging us. Come on, please.

I -- I've been through this and when they say the medication doesn't hurt you, my tongue -- I was on medication but yes I do -- I was on -- I almost died. My tongue swelled up. They had to give some other medication to stop it. The next medication they forced me because I happened to go to jail; they forced me on that.

I would come down and see my mother. My mother would say baby what's wrong with you? Nothing wrong with me mom. All I knew that -- I could -- the walls weren't -- weren't closing in on me but at the same time I was biting my lip; I was eating inside my lip. This was like forced mutilation. I couldn't see it but she saw it.

I happen to end up going to a jail where there was a guy who grew up with me and he knew who I was before I got sick and he said John, you know, this isn't you. He said look we're getting you off the medication. He was in mental health too. He got me off the medication, he called me down and he talked to me and he gave me support and he gave me hugs and he -- and he said look this is what you need

to do. This how -- you need to find someone you can talk to and that's what I've been doing for the last few -- few years. I've been talking. I've been, you know, changing my old habits. I've been doing different things.

I -- you know I've been getting down on my knees; I've been praying to God. My life is starting to change now. I'm happy with myself. I can see those rainbows that I was missing. You know I can feel the rain drops on my skin. When I was in -- on the -- the influence of drugs I couldn't feel any of that. I couldn't see any of that. I couldn't dream. I couldn't do anything.

I'm sorry I stayed a little bit longer than I should. I just want to say that drugs do -- they do hurt you. This guy sells -- what -- that little black box that they put on -- on the side of the package, you know, it's scaring away a few physicians and whatnot. They put that up there for a reason. They put it up there because they have tested the medication and the medication has caused problems to other individuals who were paid to be tested.

So we know that the medication does hurt but they wouldn't put it up there for no reason.

Thanks.

SENATOR HARP: Very articulate spokesperson. Thank you.

Janette Phillips followed by David Woodworth followed by Matt Hyde.

JANETTE PHILLIPS: Before I get started I just wanted to say to Representative Johnson you asked a long time ago if there were models for school systems. There are and in Massachusetts there's the Responsive Classroom and it's associated with the work being done by Doctor Ross Greene in Boston on the explosive child. They have found ways to really integrate these children into school environments in a positive and meaningful way.

And Senator Harp you had asked someone awhile ago about data on the cost of revolving in and out of emergency rooms and inpatient per adults. Now that Connecticut Behavioral Health Partnership is including DMHAS, DMHAS is now part of them, they weren't in the beginning, now that they are I suspect that data is being recorded there or can be so that would be a -- a source for that.

My name is Janette Phillips. I thank you all for staying this late and listening. I am the mother of a 25 year old who is on the Autism spectrum. Some doctors have diagnosed Asperger's; some have diagnosed PDD/NOS. He also has a mood disorder and I have been on this journey since he was 18 months old when I realized there was something different about him.

I was told initially that it -- it wasn't a big deal, he was my first child. What I was seeing, you know, he would grow out, et cetera, et cetera. Well he didn't and things got worse and a lot of what's been said today has happened to us. We were commercially insured. We fell between the cracks. We weren't wealthy enough to purchase what we needed in way of assessments

and treatment and we weren't poor enough to -- to be in a system that would provide for us, we were in the commercial system.

So when my son was hospitalized and we were offered ICAPS for instance we couldn't get it because we were commercially insured and the team that was afforded to us did not take commercial insurance. And to this day there are some ICAPS teams out there where they don't offer commercially insured slots.

There are other -- other priorities in the state. So we've been involved in a lot of different systems throughout my son's journey. We feel very strongly that when the state got rid of the state institutions, the Norwich State Hospital, et cetera, that that was a good thing that -- that people shouldn't be locked up forever and ever.

But we didn't set up an infrastructure that would be comprehensive, collaborative, accessible to all. We didn't really set anything up. So what we have right now is a very fractured and siloed system that is failing people with mental health challenges.

So a lot of what's been said today has been my experience. Not being able to find appropriate treatment in a timely manner and near where we live. I live along the shoreline. It's -- it's a challenging place to live because we're not near any, you know, big city where there are more services offered.

So right now I think what's unique about my son and why I wanted to come here today because this is related to Newtown, is that my son is

Asperger's and does have the mental health challenges so we've lived both of those worlds. Unfortunately if we go to the Autism world, we don't get anybody that's experienced with the mental health piece. If we go the mental health world, he is in DMHAS, they don't understand the Autism piece.

So he's never received appropriate treatment and he's become treatment resistant. He doesn't want to go to people because he knows they don't understand him. When he finds somebody non-clinical who understands him, he's more than willing to engage. He's successful when he has a peer mentor working with him. He happened to get one for about 18 months through DMHAS a couple of years ago but because of the unions the minute that someone wanted that position this particular mentor got moved out of the system and my son lost him.

And he -- he wasn't in a peer mentor position professionally. His job description was that he was a mental health worker. He stepped it up to a peer mentor. And what worked for my son was to have somebody to talk to that went way beyond the 45 minute clinical session. And what -- that is what has helped him to be successful and right now he's between two systems.

He didn't get into DDS when the pilot was happening for Autism years ago because he was already in DMHAS and I was told that he couldn't go into that pilot because he was receiving services from DMHAS. He's been on a wait list with DMHAS for a Medicaid waiver so he can purchase his own mentor. He's been on that wait list for about four years.

As you probably know state agencies go together, DDS, DMHAS, I think DCF, got together and applied for the federal Medicaid waiver jointly. They worked three long years on preparing it and when it got submitted 18 months ago it was rejected by the feds because we have such a siloed and fractured system. They were not willing to -- to offer this funding. So now everybody applied individually. DDS applied; they just received their -- their funding. My son's not in the DDS system so he can't access a mentor. He's in the DHMAS system who will apply but they're telling me that it could take years before they submit an application and then receive the funding.

So he needs a service but because he's not in DDS he can't get it and because he's in DHMAS it's not available there either. And it best DHMAS is building an awesome peer mentoring program right now but they're leaving out the Autism population and they have people with Autism in the DHMAS system. It's a small fract -- you know a -- a small amount but I suspect there is many more in the DHMAS system who have Autism who have not been diagnosed.

They -- their -- their behaviors warranted a mental health diagnosis and nobody got to the bottom of what was causing these behaviors. So I -- I don't know. We're at a loss. I'm watching my son at home. There's nowhere for him to go when he needs something. He has a choice of being home with a -- maybe an individual therapist and a psychiatrist and go into full blown hospitalization. There's nothing in between.

And to get to full blown hospitalization he has to show that he's a danger to himself and others. So if he's not at that point, he can't into a hospitalization. So there's nothing in between. There are respite facilities that we have.

We have one in Middletown that's available to him through the DHMAS system. There's no smoking allowed. It's an inhuman act that we did when we disallowed smoking on these state campuses. These are people that smoke legally and they can't go out near a tree and have a cigarette so that they can receive the treatment they need.

My son resists going to that respite facility and the hospitalization at CVH for that factor alone and the respite facility is a -- is a place where they just have a bedroom. There's a nurse watching over people and there's a little living with a TV and maybe a place to eat.

There's no activities. There's no way of really having a social environment where they can really help these guys develop social skills. He's biggest problem are his social deficits. He looks typical so people don't get that he really doesn't understand how to integrate socially. He desperately needs a peer mentor and this is the one piece that we're not -- we've been on wait lists for years trying to get him.

He also -- when he was in high school we had him assessed by Dr. Orv Karan from UConn. He did a life skills assessment when my son was nearing graduation and he -- we were told, we were warned that he was hanging around with a

negative peer group and that if he continued, if someone didn't come in and take him away from that group and teach him the skills to integrate with positive peers, that he would be in trouble. And within four months my son was arrested and as a 14 year old social emotionally, 18 chronologically, he went off to adult jail for six months.

I got letters from inmates pleading with me to get my son out of there because he was being eaten alive. I can't imagine somebody on the Autism spectrum at the level of a 14 year old surviving six months in an adult prison. He still has nightmares from that. He has trauma from the system. He doesn't have trauma because my family abused him. He has trauma from the system.

And I watch him day after day suffering in my home -- in the basement of my home alone day after day, night after night because he doesn't know how to go out into the community and integrate himself into his positive peer group, people his age. He doesn't know how to do it. If did, he'd be doing it and he's suffering incredibly. I watch him go in and out of depression. If he's working and he has a peer mentor and he's home, he's really stable but right now he doesn't have a job. He doesn't have a peer mentor and he's dipping again.

I know I went way over and I apologize.

SENATOR HARP: What would you like to see happen?

JANETTE PHILLIPS: I would like to see some kind of other options for getting some help like -- like this respite facility. I would like to see them

beefed up so that it's a real place where he can go. We as a family can get respite. He can get like a break in a cycle. Like right now he's heading into a depression. He could go and he could be in a place where he could his needs met.

I will submit you some information. I didn't know I could submit my testimony but I will email you some of my ideas of what that would look like. But he definite -- we have to get peer mentors for these guys. He needs that more than the clinical pieces, he really does.

That is what he is going to benefit from. Someone who isn't going to limit him to a 45 minute session, let him open up raw and then let him go home and deal with that rawness for the -- a week until he can go see the therapist again. That isn't working.

So that's what I envision. I also envision a housing situation. He has a choice of living with his parents who can't afford a house with like an in-law apartment where he'd have some separation. He's under us. He has sensory issues; all the noise is magnified for him. Living underneath us causes problems.

His choice is to go to supported housing for those who are duly diagnosed with Autism and mental health. He tried that. It was mutually agreed after six months that it was not a good match for him. The staff, us as a family, my husband and I and my son, mutually agreed that this is not a good match for him. It was overly supervised for his needs.

He's very high functioning. He drives; he pays his own car insurance. When he works he's a great worker. He's very high functioning. So the other option to go from there was to go into an apartment by himself. So as soon as they started taking him to apartments, I saw my son decompensate. We couldn't figure out what was going on and we finally asked him and he said I can't live in an apartment by myself. I'll be alone, I'll become depressed and I'm afraid I'll be suicidal.

He knew himself. He knew he needed people around. So we said well come back home, let's regroup. That was his only option. So we need other housing options. I can envision him living in say a group home where they -- he -- they each have their own room but that they have a lot of social time together with people who are his peers who are at his function and level. I could envision that working for him.

SENATOR HARP: Representative Wood has a question.

JANETTE PHILLIPS: Sure.

REP. WOOD: Did he -- was he in public high school?

JANETTE PHILLIPS: He was.

REP. WOOD: Was he engaged at all in the public school system of any sort of social emotional learning program or social skills or anything like that?

JANETTE PHILLIPS: Well you have to understand because he's 25 it was very different years ago. We had Dr. Burt Plant, people know him from DCF, he was my son's therapist through child

guidiance -- guidance when he was in third grade. He came into the school district and said -- he observed my son in -- in the mainstream classroom that he was only in for a couple of classes; he was in an emotionally disturbed classroom the rest of the day but when he observed him, he made clear recommendations that my son be in a social group like a lunch bunch and that it be videotaped so that he could see himself and people could give him positive constructive guidance. The school refused.

We have been up against a school system that we have fought tooth and nail. From the time he was three years old I was with the assistant special ed director until he was a teenager and she was convinced that my son was the way he was because of what we were doing at home because for the most part they weren't seeing severe behaviors at school. He was falling apart when he came home after holding it together all day.

When he was a teenager I -- he was in a clinical program and the clinical nurse that was overseeing the clinical piece of this program, after two years of being with my son, through her hands up and said I've tried every strategy to change his behavior. Granted he was in the SED program, you know, seriously emotionally disturbed, but he was Autistic and no one knew.

So it was making him worse and she couldn't figure out what to do with him. I found Dr. Ross Greene, The Explosive Child, and I said this is my son, inflexible, easily frustrated, explosive; that's him. I don't care what diagnosis you give him, that's him.

I convinced the school to pay for all of the PPT to go and attend his workshop when he came to Connecticut. And that assistant special ed director, after ten years of being convinced that my son was the way he was because we weren't parenting appropriately, reached over after watching a videotape of a kid losing it in his house just because a film crew came in, 20/20, went in the basement to set up their crew equipment and thus the door, the cellar door was locked because they didn't want this child going down to the equipment.

Because the door was locked and had never been locked before, it was enough to throw this kid. That's the kid I lived with, unpredictable. Any little thing that is seemingly small could trigger him. That SPED assistant reached over and held my hand and said I had no idea.

At that moment she realized what we truly had been living for and asking for. Unfortunately within months, because she heard me and was advocating for my son, the SPED director stepped in, relieved the assistant of working with my family and she started to put the wall up because she was convinced that my son was the way he was.

She hired a psychologist from Connecticut Children's Medical to assess my son, to come to my home, she was convinced it was in my home, and he assessed in the home, he assessed in the office and he came back with his -- his findings and his recommendation and he did not say anything about his problems being caused in our home. Because he didn't say what she wanted to hear, she refused to invite him to a PPT meeting.

So here's a guy that she hired. Here's a guy that gave accurate findings on my son but I didn't have the benefit of him sitting at the PPT to talk to that team to figure out what was needed next. We have lived an incredible hard journey but I happen to have a spouse who's very supportive and the two of us have been able to live through the hell that we've been living through.

And I really want to -- I've started writing you a letter and I really want to list some of the things that we've gone through and some of the solutions that I think are viable.

REP. WOOD: Thank you.

JANETTE PHILLIPS: I -- I know I went way over so I -- I think I've said everything that I could say right now.

REP. WOOD: Thank you very much.

JANETTE PHILLIPS: But I -- I do want to be part of this process and I hope that you will allow for parents and caregivers and those who suffer from mental health challenges to be a real part of this process because if they're not heard and they're not going to buy in to this -- to whatever you come up with, you need their involvement so that they will buy in to the solution.

Thank you.

SENATOR HARP: Thank you.

Our next speaker is David Woodworth followed by Matt Hyde followed by Marsha DuFore

DAVID WOODWORTH: Good evening. Your time this evening is greatly appreciated. My name is David Woodworth and Connecticut must continue to fund the expansion of school-based mental health systems including school-based health centers. A stitch in time saves nine. This is my most memorable take away from my first counseling sessions with Tom Narducci at Charlotte Hungerford Hospital's Center for Youth and Families where I was treated for depression when I was 17.

I consider myself lucky and blessed despite the fact that I went through some rather troubling times emotionally. I had family and school staff that may not have been completely aware of the state of my mental health or least aware enough of my difficulties to direct me to proper care.

Tom offered admission to an inpatient program for treatment once or twice. I think my own prejudice and stigma surrounding mental hospitals led me to decline admission. I was already wary about taking anti-depressants, but after some in -- initial adjustments to prescriptions and dosages, the combination of counseling and medication gave me an increased level of functioning.

The choice to accept psychiatric meds was humbling yet empowering. I graduated high school with honors, a three sport scholar athlete. During college I reached a level of stability where I felt comfortable abstaining from meds and counseling. However within a couple of years I started experiencing extreme emotional highs and lows. I did graduate in

2004 with a B.S. but within a year of graduating started treatment for Bipolar disorder.

In 2008 I had a psychotic break that required two weeks of inpatient care at Waterbury Hospital's Center for Behavioral Health. I was uninsured at the time so luckily I was eligible for Medicaid insurance or the nearly $20,000 hospital bill would have been an enormous burden on my family.

After discharging from Waterbury Hospital I began counseling again at Charlotte Hungerford's Behavioral Health Center. I have that, God and all of the people involved in caring for my mental health over the years to thank for sitting here today as I am working steadily as a rehabilitation counselor with Prime Time House in Torrington and emotionally well.

I was one of the four children statistically that will develop an emotional behavioral disorder and among the 20 percent of that one in four that received the help I needed. In order for every school to offer a positive climate for learning and social development, Connecticut must continue to fund the expansion of school-based mental health programs, including School-Based Health Centers.

As my first counselor taught me a stitch in time saves nine. If we don't mend what needs to be fixed now, we'll all lose more than we can imagine sometime again when we least expect it.

Thank you for considering this matter.

SENATOR HARP: Thank you.

Are there questions?

Thank you for your testimony.

Matt Hyde followed by Marcia DuFore followed by David Blocker.

MATHEW RYAN HYDE: Good evening ladies and gentlemen of the, you know, Legislative board or whatever it is. Sorry about that. It's late; you know I've had a long night with all you folks out here.

My name is Mathew Ryan Hyde and I wrote this testimony on January 25, 2013. My story on how mental healthcare has been positive in everyday life. This is the positive note of the speeches tonight.

To whom it concerns, this is a brief description on how mental healthcare has positively affected my -- throughout my life. The positive things that helped me managed my mental illness throughout the years are food stamps, medications, counseling, therapists and organizations affiliated with mental illness such as DHMAS in Hartford and Torrington. I have also been supported by a nonprofit organization called Prime Time located in Torrington which helped me supportedly in a lot of years since I've been out with limited family support.

With these programs they play a big role in me keeping my mental illness under control. I learned to manage these diseases. I have with these support systems and all of the help that I received for which I am grateful for.

These organizations I've stated above helped me deal with everyday struggles with my mental health. The state facilities are a wide network of people who actually care for me.

I personally have four mental disorders, diseases, and which -- with these supports it is current and it's been a rough road but at least with these such organizations I can strive to plug along under any circumstances to succeed and achieve. Simply stated where would I be today without this support? The answer is you don't know and to be frank I wouldn't know either.

In conclusion for all of these programs with mental health care are great for me and the community. The question is how can we make it better and also who's willing to hope for us to get better and show us how we can strive to make ourselves better?

Thank you very much for listening today.

Mathew Ryan Hyde.

SENATOR HARP: Thank you very much for your testimony.

Marcia DuFore, Kathy Queen, David Blocker, Milagros Vega.

Are you David?

DAVID BLOCKER: Yes.

SENATOR HARP: Okay. Good evening and you can begin.

DAVID BLOCKER: Okay, okay. Senator Harp, Senator Markley and Representative Wood good evening, buenos noches to anybody on the panel that's Latin. I'll try to stay within the SOP standard of protocol.

Okay, my name is David Blocker and I have Bipolar. I live in Torrington, Connecticut. I've -- I've been to college, I went to the University of Connecticut Storrs, Naugatuck Valley Community College in Waterbury but I didn't graduate but hopefully one day I -- I will return back to school.

When college didn't work out, I went to school to be a certified nurses' assistant for the State of Connecticut and I still am registered as a certified nurses' assistant with the State of Connecticut. I find it very rewarding. I love helting -- helping young and elderly people.

I'm just going to throw out like a -- a little scenario here. If President Obama invited me to have dinner with him, he is reaching out to me. If he didn't reach out to me, how would I know? How would I accept his invitation? My point here is -- is that we all need help from -- from someone to re -- to reach out for us whether it's for Bipolar, Schizophrenia or some other diagnosis.

I take medication but medication is not always the answer. My medi -- the medication that I take is min -- minimal. This is just a hypothesis. I believe that if a child around the age of 11 is experiencing psychiatric symptoms, they should be treated for supplements instead of drugs, supplements such as Vitamin

B12. Start them on a -- a regiment at the age of 11 and keep them on that and document it and see if there is any change after a month or so because that's the way I was taught as a CNA by registered nurses. Documentation, see if there's any change, keep that abundance of B12.

I was -- I was intrigued about the Melissa Project in represent -- Representative O'Neill's testimony. A person should be judged by their morale integrity and their value like Mohat Moghandi and Dr. Martin Luther King reiter-- reiterated.

I'm involved in a group called the Brotherhood of Adversity at a church in Torrington and Miss Victoria Christgau, who is the director of the Nonviolence Center in Hartford, was there at one of our meetings and she said young adults today should be taught with patience, I repeat with patience, how to respect their parents and their guardians who are accountable.

Let us please pray for our -- our children. After all they are -- they are our future.

Thank you very much. May the good Lord bless you all.

SENATOR HARP: Thank you very much, Mr. Blocker, for your testimony. Thank you.

Milagros Vega, is he here? Judy Aron, is Judy here?

A VOICE: (Inaudible).

SENATOR HARP: Okay.

Thomas Gullotta is next.

JUDY ARON: Good evening, Mental Health Working Group. Thank you so much for being attentive and hanging in there. My name is Judy Aron and I live in the greater Hartford area.

The tragedy of Sandy Hook happened by the hands of a person who, by all reports, was unstable. Normal people don’t just wake up one morning and decide to smash up their computer, shoo t their mother in the face and set out to murder school children and teachers. You cannot possibly propose legislation to attempt to stop this horrific event from ever happening again unless you know the full details of what happened.

It isn’t just about guns. My guns did not kill those children in Newtown yet I stand to be punished for a crime I did not commit. We need to know what drugs Adam Lanza may have been taking and more importantly what their side effects were. We also need to know who Adam Lanza had contact with prior to his rampage. Who or what was it that pushed him over the edge? There had to be something that made him purposefully do the things that he did on that terrible morning.

I want answers, not just gee -- not just knee jerk reaction legislation. Absent today from public view is the toxicology report and any medical history that the murderer, Adam Lanza, possessed. And I truly hope that HIPPA laws are not keeping us from the medical truths that can help us determine what prompted him to do such a heinous crime.

I don’t believe that we should be placing blame on guns or be looking to stigmatize people with mental illness. That being said, I think we really need to examine closely what the side effects are of taking certain psychotropic drugs. Some Selective Serotonin Re-Uptake Inhibitors, anti-depressant drugs and other drugs, cause people to do violent things to themselves and to others and it alters their personality. We know this.

I want to know what Ad -- what drugs Adam Lanza was taking and how it affected him. We must know if they were a contributing factor for his irrational and destructive behavior. I want drug companies to be made responsible for the devastating side effects that these powerful mind-altering drugs produce far more than just making them put warning labels on drug containers.

These pharmaceuticals can be poison. They do help some people yes but we need to know which ones are being used wrong. Adam Lanza broke many laws that we have in place. Was he taking illegal drugs too? Was he abusing prescription medication? Was he under the care of a physician? Will we ever know the answers to these questions? I think we need to know the answers to these questions to adequately address the issue of mental illness with respect to this tragic event.

And most importantly I think we need to be very, very careful about who we decide is suitable or men -- or mentally ill especially with regard to who can own and operate firearms. It may seem pretty obvious but will people who disagree with the government be considered unsuitable?

Martin Luther King, Jr. owned firearms but could not get a carry permit because he was deemed unsuitable. So it seems to me that the question of suitability or mental stability is not so cut and dry and I am really concerned that our government may decide that people who are members of Second Amendment groups, who have spoken out against government policies may be deemed unsuitable or crazy or might be a potential terrorist.

That type of thing has happened before and we've already seen documents put out by the Department of Homeland Security which has claimed nonsensical pro-- has -- has claimed nonsensical profiling of who may be a potential terrorist.

We need to take a closer look at the mental illness and drug aspect of this Newtown tragedy. It wasn't just the guns; it was the madness of the man behind those guns that caused the carnage. Illegally stolen guns were merely his tools of choice.

And one last thing, I really request that any solution and legislation that this Task Force comes up with must not be hustled through the Legislature in any kind of emergency legislation tactic. You must allow the public to come out and comment on your bills before you put forth to the whole Legislature for a vote. That's how we do things here in Connecticut. We must not act in haste and we must not pass things in the middle of the night and we must make sure all bills are read and thoroughly understood by all interested parties.

Thank you so much for all the work that you're doing.

SENATOR HARP: Thank you.

Are there questions? Representative Wood.

REP. WOOD: Just a quick comment.

Thank you for your testimony and thank you and to everyone else who is still here.

Some good things to keep in perspective. Thank you.

JUDY ARON: I appreciate that.

SENATOR HARP: Thank you very much.

Jennifer Parzych please come on down.

JENNIFER PARZYCH: We're really at number 103?

SENATOR HARP: Christine Limone is next.

A VOICE: Yay.

JENNIFER PARZYCH: Good evening. My name is Jennifer Parzych. I am a school counselor and the middle level vice president of the Connecticut School Counselor Association. CSCA is a division of the American School Counselor Association which has a membership of over 25,000.

First it is important to realize that unlike school social workers and school psychologists who work with targeted populations, school counselors are charged with the responsibility to ensure the academic, career and personal social development of all students.

Schools are often one of the first places where mental health crises and needs of students are recognized and initially addressed. Research indicates that 20 percent of these students are in need of mental ser -- health services yet only one of five of these students receive the necessary services.

Further students of color and those from families with low income are at greater risk for mental health needs but are even less likely to receive the appropriate services. Students with untreated mental health issues can develop significant barriers to learning with nearly half of these students eventually dropping out of school.

Because of professional school counselors training and position they are uniquely qualified to provide education, prevention, intervention and referral services to students and their families. As a part of this component of a comprehensive program, professional school counselors collaborate with other educational professionals and community service providers to assist with student mental health issues and to promote healthy life style choices for all students.

Recent research has shown that explicit instruction in social and emotional skills does more than improve behavior and reduce bullying. It can also help students make significant gains in academic achievement.

In Connecticut there’s a scarcity of elementary and middle school counselors. Right now an average of only one in four elementary schools employs a school counselor. This means that the

majority of students in Connecticut do not have access to a school counselor until the age of 13. We at CSCA believe this is detrimental to students' personal, social and academic development.

In accordance with the American School Counselor Association, we also believe in a K-12 comprehensive developmental school counseling program.

Therefore we respectfully request that the Task Force recommend an increase in the number of certified professional school counselors, especially at the elementary and middle level, in order to provide equitable access to personal, social and academic services for all students.

I thank you very much.

SENATOR HARP: Thank you very much.

Are there questions?

If not, thank you very much.

JENNIFER PARZYCH: Thank you.

SENATOR HARP: Christine Limone, Manuel Sandoval.

MANUAL SANDOVAL: Good evening, Madam Chairlady.

My name is Manuel Sandoval and as a person who was forced into an out-treatment program, I'm in opposition of the forced out-treatment -- outpatient treatment and in favor of the peer to peer related services.

I ask this Committee was it not this country that just nearly three years ago was all but in a complete up -- uproar over the then proposed ObamaCare? Was it not the residents of this state as well as other states that were saying that it was a violation of our Constitutional rights that we should not be forced to have healthcare?

Now this was a law that was beneficial for most Americans if -- if not all, a law that was made to help each and every one of us. However, many of the people did not believe that and wanted it completely abolished. They believe it to be a complete violation of our Constitutional rights.

Now I ask you what can be more of a bigger violation of our, your, my Constitutional rights than to have someone forcibly medicate you, me or us, the United States citizens? I say you, me, us because not one person here in this room or in this entire state can foresee the future.

We know not what tomorrow may bring for tomorrow is not promised to anyone. Anyone of us can be stricken by a mental illness. If this law is to -- is passed, anyone of us can be forced into an out-treatment prog -- outpatient treatment plan against our will. Now this -- now that, that is by all means a violation of our God given, forefather provided Constitutional right.

I ask you, the Committee, do not we as Connecticut residents have a constitutionally protected liberty interest against the forced injection or submission of medication into a non-consenting person’s body as referred in Harper v. United States Supreme Court or Wiggins v. United States Supreme Court?

If the Supreme Court found just cause to say that the inmates in those two cases cited have constitutionally protected liberty interest to be free of forced medication, do we not also have those rights?

Lastly, I'd like to say that to be mentally ill is not to be evil but to be evil is to do harm at any expense even if it has to hide behind the face of mental -- mental illness.

In conclusion I, Manuel Sandoval, am opposed to the proposed bill and ask you, the Committee, to please be opposed as well. Thank you very much for your time.

SENATOR HARP: Thank you very much.

Are there questions?

I just want to make sure. I think I called Thomas Gullotta's name and I believe that he was not here. I just want to make sure. Yup he's not here.

Is Linda Henriquez here? Followed by Leroy Gardner.

LINDA HENRIQUEZ: Good evening and thank you for all your attention this very long day and evening. My name is Linda Henriquez. I am the only school social worker in a Hartford pre-K through 8 school that has an enrollment of about 600 students. I service 31 IDEA mandated students. That number reflects an increase of 12 students since the beginning of this school year.

I am involved in the process for identifying special education students and assist in

developing their individualized education plans. I also service any and all other regular education at-risk students who are referred to me, an additional case load of about 25 to 30 students at any given time.

The issues and diagnosis of all these students range from poor social skills to cognitive developmental delays, physical and sexual abuse to mood, anxiety, thought, trauma, explosive and psychotic disorders, many of which have not been formally diagnosed or treated outside of school.

Homicidal and suicidal ideation, depression, withdrawal and serious physical aggression is not that uncommon among even first or second graders. All the students on my caseload participate in individual and/or group counseling that addresses social skills development, bullying, harassment, self-esteem confidence building, anger management and character education.

The role of school social worker is not limited to what I have just described. We social workers provide case management which requires on-going collaboration with school staff, parents and outside agencies. We refer families to community-based organizations as al -- which also requires developing and maintaining an on-going working relationship for the benefit of the child who, after all, spends most of his or her working day -- days -- hours during the day in school.

We try to get to know our students and their families and we can and we do contribute much support and information to others who also provide services. But all too often we provide

the only counseling and support that the child will receive.

In addition, we are important and key members of various teams such as prevention teams which attempt to identify students who are at-risk and provide appropriate and early intervention; support personnel teams that collaborate with other school staff to service and advocate for children and families; positive behavior support teams that develop incentives for positive behaviors such as the programs that Dr. Sugai has developed which was referred to earlier; and crisis teams which address issues by creating policies and procedures for school safety, mass trauma events, grief and loss.

What I, as the only full-time social worker in my building, have just described is often a challenge for me to maintain given the high numbers and intensity and complexity of the issues presented. But my school has the luxury of at least one full-time social worker. Many schools have only a .3 or a .5 per week social worker. The needs are great but the workers and very few.

We live in a time in which adults, as well as children, are exposed to many traumatic events such as 9/11 and the Newtown tragedy. But trauma is also experienced due to conditions such as poverty, unemployment, homelessness, exposure to violence which often contributes to substance abuse, domestic violence, physical and sexual abuse and limited paring -- parenting skills all of which can have a significantly negative impact on the social and emotional development and well-being of children.

The developmental history and chronically manifested behaviors of many children are symptomatic for serious mental health disorders that require a formal diagnosis, interventions and treatment but often these do not occur.

Issues of payment, waiting lists, limited or non-existent programs, insurance company mandates regarding treatment, as well as the stigma affiliated with mental illness, prevent many families from seeking or aquin -- acquiring any consistent intervention.

Children’s mental health issues impact attendance, motivation, attentiveness, grades, compliance with school or societal rules, self-esteem, meaningful interactions with others and the ability to have a positive hopeful outlook on life, in short, to be able to trust adults to care for them. All children deserve that. All children deserve to fulfill their potential to be productive, well-adjusted, safe and happy. Today’s children will become adults and tomorrow’s caretakers. We owe it to our children and their children to make this state and nation an emotionally safer place now in which to live and grow.

Thank you very much for the opportunity to speak to you. I appreciate it very much.

SENATOR HARP: Thank you very much for your testimony.

Are there questions? Yes, Representative Hovey.

REP. HOVEY: Thank you for staying so late to kind of see us out here.

I just want to talk really briefly aroun -- about caseloads. As a social worker in a school and as you say your school is lucky to have you as the full-time social worker because most schools do not and maybe that's part of what we need to be looking at, but just tell me briefly what you perceive as being a manageable caseload.

I would assume that you have a caseload that is part of -- part of your -- of the IEP process in your -- in your school. But do you also have students on your caseload that may not be a part of the IEP but have kind of transient mental health issues that you're working on and -- I just -- can you give me a sense of that please?

LINDA HENRIQUEZ: Yeah when I -- when I referred to the 31 those are the mandated students, 504 and -- and you know the regular special ed students. The other 25 to 30 are referred to me and I would say, out of the 25, probably about 18 or 19 have some kind of mental health issue and many of them have not been diagnosed.

And what we're seeing in the classroom, of course, are behavioral -- some serious behavioral issues that -- that are on-going. I mean I -- I have one child who's been hospitalized three times since the last week in August and he comes to my office three and four times a day because he refuses to do work he's capable but he hallucinates at times and -- and just has some sensory issues as well and just cannot stay still.

I have another student who just cannot adapt to the classroom environment and it gets very physically ag -- I have several of those that

get physically aggressive. I had one yesterday that hit -- she's in kindergarten and she hit the teacher and bit her. Not uncommon. It doesn't happen every day but it's not uncommon.

I personally believe that some of the academic demands and structure that young children, pre-K through second/third grade, those demands I believe are just developmentally inappropriate for them and a lot of them cannot handle it. I see a lot of behaviors of children who just cannot cope with that kind of a structure, you know, that -- that -- that's very academically oriented.

REP. HOVEY: So were the two children that you described at first outside of your PPT?

LINDA HENRIQUEZ: Yes, but one of them is -- one of them is in IEP, the one who was hospitalized, he is an IEP student, the other one is not.

REP. HOVEY: Okay and would it be incumbent on you to make that referral?

LINDA HENRIQUEZ: Well I do make referrals to outside agencies and obviously call Mobile Crisis when we need to do that. I -- I'm the one that generally will do that. I will do an assessment and -- and then refer them.

There -- there are times when I do refer to Mobile Crisis when -- when the issues are severe but I'm really calling more because I know they will get the services more quickly and that there have been some ongoing issues that I've been dealing with. So it isn't always just a question of -- of safety in that moment (inaudible) ongoing issues that I'm working with

that I believe having Mobile Crisis involved can facilitate the services, some of which I can't access that quickly for parents.

REP. HOVEY: Okay, thank you very much.

LINDA HENRIQUEZ: Thank you.

SENATOR HARP: Thank you.

Are there further questions?

If not, thank you very much.

LINDA HENRIQUEZ: Thank you.

SENATOR HARP: Leroy Gardner? Is -- is Leroy here?

David Weal? Is David here?

A VOICE: (Inaudible).

SENATOR HARP: Oh David Neal. David?

Okay, from New Haven, David.

Malik Russell? Malik Russell?

Chris O'Brien?

No we've a couple more that didn't sign up.

CHRISTOPHER O'BRIEN: Through that whole list it's like I skipped to the front of the line all of a sudden.

Thank you, Honorable Senator Toni Harp and Representative Wood and the rest of the Committee. My name is Chris O'Brien. I have

been a emergency medical technician for the last 17 years and a licensed paramedic for the last six. From that perspective I have three observations from my professional life I want to give you.

One in addition -- one more that deals direct -- a proposal directly related to Newtown and then one final thought I want to leave with you as your role as legislators.

It may amaze you how many 911 calls and how many responses make up mental health cases that we see. Some days, especially Mondays and other days during the middle of the week, I'd say that one-third to sometimes one-half of our calls deal with mental health in the morning. We respond to group homes, schools. We -- in my commercial job we've probably transported to just about every mental health facility in the state with children or adults from Katonah to Natchaug down to Bridgeport.

Working the City of Waterbury we're one of -- actually watching the testimony on Friday dealing with schools and the subcommittee that met here on that day and it seemed like they're talking about how it would great if we had an inter-disciplinary communication between schools and law enforcement and the mental health community.

Well in the City of Waterbury and five other cities in the state they have crisis intervention teams and we're very thankful to have those. I think they work very well and I would just like to recognize the work of that team. It's two people, social workers, that respond to behavioral health emergency calls

that come in through 911. They carry a police radio. They respond between the hours of 9:00 a.m. and 11:00 p.m. They have a depth of information that are not available to us or the police officers that are on the same calls and they're able to write committal papers when necessary and also give follow-up reports to private and public agencies that will deal with that patient's care in the long-term.

As an EMT I've come across some patients that at one point were hospitalized at Fairfield Hills or some other psychiatric facility. One in particular used to call us about once a week. He would engage in such behavior as taking off his clothes in public, masterbating or attempting to in the back of the ambulance and other anti-social behavior that would be deemed offensive and he admits he certainly needs help. He's asked repeatedly to find someplace like Fairfield Hills to be readmitted to.

I've had -- heard a lot of discussion about outpatient commitment. I'm not sure if that's proper for this patient or not but it may be one solution and it's beyond my -- beyond my expertise to ascertain but that's one problem we've seen.

There's sometimes a gap within the emergency -- this is my third point dealing with my professional testimony -- the emergency committal process, Statute 17a-502 where a police officer can commit a person to be seen within 24 hours at a -- at an emergency room.

As a patient -- you know we all want to see most patients go voluntarily to seek help. That's probably the best thing for them whenever

possible and it's -- it's incumbent on them that they participate in the guidance of their own care. However as we get closer to the hospital, sometimes people will withdraw their voluntary consent and we're now left with a problem when we get to the emergency room. Police officers are not always available on these calls.

Sometimes we -- we're responding to a regular emer -- medical problem and the patient will reveal information that was not available to the police officer before and we as EMTs and paramedics may see, you know, this is a grave situation here. And when we get to the hospital they either will walk out of the ambulance and walk down the hill and out the street or the hospital will decline to even check them in because they don't have that police emergency committal form.

So I'm going to ask you consider, along with the officer of Emergency Medical Services, to see if we can possibly extend that ability to paramedics with the proper training. Every year we have to go through continuing medical education. That training could be as a part of that as it is through law enforcement as well and also be part of the original training for paramedics as well with no additional cost to the state I believe.

Going to point number four with respect to the tragedy in Newtown, I know we all wish we could have a glimpse into Adam Lanza's mind and final days and hours before he went on his rampage. I've seen some things on the internet that who knows maybe his mother tried to get him help and perhaps, just as I mentioned before, that some people get very scared and act out violently

when they believe that they are being forced against their will to do something and maybe that -- we can only hypothesize that it may -- that may have been the case.

I wonder -- I -- my Bachelors Degree is in law and society which had a mental health component and I understand that when people die their medical records often go along with them and are protected under confidentiality laws. I wonder if we can reconsider if an individual is involved in a criminal act, as part of their death maybe we can reconsider whether that information might be able to be disclosed to law enforcement and, if there's still a HIPAA or confidentiality component, maybe that information can be sequestered in some way where law enforcement can have access to it and the public can't or some other variation.

My final thought. We are all aware that a human being is made up of mind, body and spirit and we are very good at, especially in the last decade and one half, trying to break down the economic barriers to getting help for people that have physical ailments. Today I'm -- we're all happy to openly discuss mental health but the spiritual component is often one that we're neglecting and not discussing during the context of this discussion.

Spiritual wellness is important for the vitality of the mind and body. It gives us the drive to wake up in the morning and face the day. Spiritual health -- health can keep us going when everything else in our lives may be against us. Many of us can look towards perhaps relatives or friends who might have been dying of cancer, perhaps have had a mental diagnosis

on top of that, yet face -- still face life with the courage to keep on going so long as they live on the face of the earth. They're an inspiration to us all.

And I think with that I don't ask for any future laws but just ask you to understand the tone that's projected outside this building sometimes when we are too strict and I know you don't want to be too loose in certain laws especially when it comes to the educational setting where folks may decide to, you know, they -- they want to express the living and make people more open to spiritual health and avenues to become healed in whatever may be affecting them.

So thank you for your time and I welcome in participation any of the proposals that I've just mentioned and -- and thank you again.

SENATOR HARP: Thank you very much for sharing your experience.

Are there questions?

If not, thank you very much. We will consider what you said.

CHRISTOPHER O'BRIEN: Thank you.

SENATOR HARP: Appreciate it.

We have exhausted the sign-up sheet but we ask if there's anyone in the audience who did not sign up who would like to testify?

Come on down. Can you just give us your name?

AMY VIGNONE: Okay. Last name is Vignone, first name Amy.

SENATOR HARP: Do it again. My ears are so tired.

AMY VIGNONE: Oh I'm sorry. First name is Amy, last name Vignone.

SENATOR HARP: Amy Vignone.

AMY VIGNONE: Vignone, yes.

Good evening, Senator Harp, Representative Wood and members of the Committee. I feel for the Sandy Hook victims and I would like to talk about myself for a few minutes.

I've had anxiety since I -- a very young age and I was never treated or diagnosed. In first grade I was diagnosed with a learning disability and spent the next 11 years in special education and being bullied by classmates. At 14 years old I was diagnosed with anxiety and depression. Teachers not only told me to ignore the bullying but I was put in lower level classes with behavior problem kids.

I had never had a behavior issue but I was eager to learn and I was left behind from reaching my potential. I become a child left behind.

Teachers, college officials and others told me that I could possibly earn a Ba -- an Associate Degree but would probably not be able to earn a Bachelor's Degree. Well I proved them all wrong and earned a Bachelor's Degree in sociology in 2008.

I've seen various therapists for my anxiety and depression for my ongoing issues and have yet to locate the right counselor. The issue in the mental health system is that what I have experienced is that every -- they told me every two years that I had to switch a therapist so I've been through a variety of different therapists and this is what happens in the mental health clinics that take Medicare and Medicaid though you're fully covered.

Other than that since I was a child I've fallen between the cracks of the education, vocational and the mental health system. I've exhausted all my resources within the State of Connecticut that are currently available to me. The other issue of the mental health system is that I am limited to my bed demographic area so I've been living in South Windsor so I'm limited to mental health facilities in Manchester and one of the areas that I received the beneficial help was the -- in -- in a community mental health in East Hartford but I cannot -- they will not take me because I don't live in that demographic area.

I was also told that to receive help at The Institute of Living I would have to admit myself and I would have to go to the emergency room and have some type of crisis but I don't have a crisis so I can't get my foot in the door at The Institute of Living. So the resources are not there to find the right therapist. And anybody private Medicare only covers a certain amount and then I'm left to pay the rest which I can't afford.

So either way it's just not -- the mental health system does not work for myself. I don't know

about other individuals. But what I have found is that -- oh actually -- my current dilemma is that I live with my mother right now and she's looking to sell the house and I don't have any place to go. So I'm left possibly being homeless and not having any resources of that nature as well.

I've been with the -- the Bureau of Rehabilitation for about 16 years and they haven't placed me in one job even though I have a college education now which I funded on my own.

And that's about -- I've -- and I've (inaudible) what I've continued to do for my recovery is continue my education and try to find the right employment and the right therapist and I have not yet given up on doing any of those things. I just keep pushing myself forward so there has to be some type of job, you know, for me.

I don't know if anybody has any questions.

SENATOR HARP: Thank you very much for your testimony.

AMY VIGNONE: Sure.

SENATOR HARP: Are there questions?

I just want you to know that we really appreciate you coming out and sharing your story with us.

AMY VIGNONE: Sure. Thank you for your time, I appreciate it.

SENATOR HARP: (Inaudible). Thank you.

Is there anyone else who wishes to testify? Is there anyone else who wishes to testify?

If there's no one else who wishes to testify --

JENNIFER PARZYCH: I know I did. Is it possible for me to (inaudible) come up?

SENATOR HARP: Very quickly.

JENNIFER PARZYCH: Thank you.

SENATOR HARP: I think she wanted to just talk about counselors. She wants to answer your question.

JENNIFER PARZYCH: I -- I know your question is about school social workers and things --

SENATOR HARP: Could you come to the microphone and identify yourself please.

JENNIFER PARZYCH: I know your question before was posed to school social workers --

SENATOR HARP: Could you identify yourself?

JENNIFER PARZYCH: Jennifer Parzych again.

I know it was posed to school social workers about caseloads but I -- I worked a very hard to bring this speech to under three minutes so I wouldn't go over but what I omitted was really the detrimental harm that's being done to our kids by having the school counselor caseloads that are burgeoning and in many cases the schools, when they're forced to make budget cuts, the first things to go are the support services and I have worked in a district for 15 years that formerly had K-12 adequate services

that now we're lucky to have grade six through twelve covered and that's really unfortunate.

Right now in the State of Connecticut caseload counseling -- caseloads are 519 students to one school counselor. We service every student on our caseload and that's through a comprehensive model including classroom guidance lessons and individually planning with all students as well as responsive services when needed and also collaborating with community services and teaching staff as well to work for the kids.

And it is recommended at the national level that counselors are 250 students to one to be able to do right by these kids. So again I just -- I urge that you consider that piece of this early intervention piece of the puzzle.

Thank you.

SENATOR HARP: Thank you very much, appreciate it.

JENNIFER PARZYCH: Thank you.

SENATOR HARP: So if there are no further speakers, this hearing is adjourned.