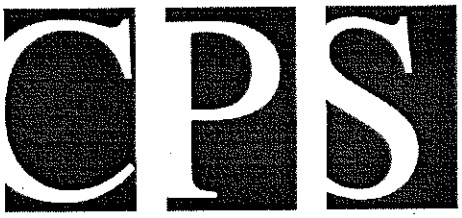

Connecticut Psychiatric Society

A District Branch of the
American Psychiatric Association

Good afternoon. My name is Carolyn Drazinic, 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, "That person had to be crazy to do that," when referring to a tragic event, and 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 (National Survey on Drug Use and Health, SAMHSA 2011) revealed that one in five American adults suffered with symptoms of a mental illness in the past year; one in twenty suffer with a severe mental illness.

It has also been well established that less than half of people suffering with mental illness are treated, and often, the treatment many do receive is less than adequate (World Federation of Mental Health).

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 (2008), 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 (349) are larger than the number who died from combat in Afghanistan (295), and most were men 18 to 24 years old, who did not seek help, presumably due to potential stigma.

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

But 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 system-wide 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, CT 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 or even those who go on their own asking for help, looking for voluntary hospitalization because they are suffering, 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 stay is one week, but the average length of time it takes our medications to work effectively is 2-4 weeks.

This leads to "revolving door" mental health treatment, whereby patients get rehospitalized rapidly after just having been discharged. In other words they were not treated long enough in the first place.

Second, CT psychiatrists all 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 (Assertive Community treatment), 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 they lose access to even the most basic services in a few months, simply because they have no permanent address. It is well known that disabled patients with stable and affordable housing have fewer hospitalizations and a better chance of living successfully in the community.

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

For example, renewals of medications that patients have been taking for years, and commonly prescribed medications now both require extensive prior authorization, leading to days or weeks of delays, during which the patients go without their medications, potentially leading to rehospitalization. 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 are 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 penalizing financially.

Psychiatrists are adjusting 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. Time invested in psychotherapy can help us assess the risk or treat a patient more effectively, based on numerous research studies 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 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.

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