Testimony to the Mental Health Services Working Group Tuesday, January 29, 2013

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Members of the Mental Health Services Working Group:
I am Dr. Harold Schwartz, Psychiatrist-in-Chief at the Institute of Living and Vice President for Behavioral Health at Hartford Hospital. I serve as a member of the Governor's Advisory Commission on Sandy Hook though I am not speaking as a representative of the 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 real and productive change. Given the many aspects of mental health which warrant discussion and the limited time for testimony, I will limit myself to discussion of involuntary outpatient treatment, mental health parity in the private delivery system and mandatory reporting

Involuntary Outpatient Treatment:
I highly recommend that the Connecticut legislature adopt a 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 is unable to recognize that one side of the body is paralyzed. For many such individuals, hospitalization becomes a revolving door. A psychotic episode leads to hospitalization. Discharge from hospital is followed by non-compliance with treatment which leads to the next hospitalization. With each psychotics episode incompletely treated, the evidence suggests the long term prognosis for recovery is worse. Estrangement from family and friends frequently occurs, along with homelessness, frequent arrests and, often, imprisonment. Families struggle to help their loved ones but, unless they meet criteria for involuntary hospitalization, nothing can be done. I understand the balance between liberty interests of the individual and the need to provide treatment. But I point out that in our efforts to protect autonomy we are acting to protect the decision making of individuals whose capacity for autonomous decision making has been severely impaired by mental illness.

Critics of involuntary outpatient treatment argue that it will diminish the therapeutic alliances between patients and treaters. But, if implemented properly, such a policy would affect only a small subset of patients – those who by virtue of their denial of illness are not likely to establish a workable therapeutic alliance. While some will argue that these programs don't work, the evidence argues that when appropriately implemented – and this will require funding for case managers and Assertive Community Treatment (ACT) teams, these programs do work to reduce repeat hospitalizations, homelessness, and imprisonment and improve the patient's perceived quality of life. I refer you to studies of "Kendra's Law" in New York State which reflect that a majority of patient in New York's program felt that it had been helpful to them.

Mental Health Parity in the private sector/gaps in coverage:

As you know Connecticut has a mental health parity law. I'm sure you are also aware that we await final rules from the federal government regarding implementation of the federal mental health parity statute. While the Connecticut statute has addressed the quantitative elements of parity (number of hospital days allowed, number of outpatient sessions allowed, etc.), it has not significantly addressed non-quantitative issues which dramatically impact the provision of behavioral health services in the private sector. These include the requirement for pre-certification of hospitalization and outpatient programs, ongoing certification of allowed days, the medical necessity standard and the availability of certain programs deemed non-medical in nature.

Why is it that we allow private insurers to require pre-certification before admitting a psychotic, suicidal patient to an inpatient psychiatric bed? Do we require precertification before admitting a patient with a myocardial infarction (heart attack) or a stroke? Is the suicidal and psychotic patient in less danger of loss of life? And once in the hospital, why do we allow the insurer to make the determination that on day three or four, the patient is no longer suicidal and no longer qualifies for hospitalization? The abuses of insurers around these issues are legion and seriously diminish access to care. The key issue is the definition of "medical necessity" which is routinely used to deny care. At the Institute of Living we spend thousands of hours each year contending with denials of care on this basis. We appeal many of these denials to outside parties and often win these appeals. To be fair and on a par with medical care in the rest of the hospital, "medical necessity" should be determined by the doctor who has the patient in front of her, not the hired gun doctor in the insurer's office. Lastly, there is absolutely no parity in the private insurance market around programs that are considered rehabilitative in nature, e.g., psychosocial or vocational rehabilitation and supportive housing. While these programs have been long recognized to be essential to the long term recovery of individuals with severe and chronic mental illness, they are not considered within the domain of obligations of private insurers. In this regard the patient is much better off to be in the public mental health system where such programs are available.

Mandatory Reporting:
As you know, New York State's recently passed gun control law includes a provision for mandatory reporting by clinicians of patients who they feel may be dangerous. Such reporting requirements are ill advised as they will intrude into the therapeutic alliance between clinician and patient and, I believe, do little to enhance public safety. We do not want to discourage patients from sharing their innermost thoughts, including thoughts they may have of harming themselves or others. Will knowledge of the reporting requirement discourage such self- revelation? What criteria for dangerousness will have to be met to cross the threshold for reporting? How much damage to therapeutic relationships will follow from over reporting by physicians concerned with liability? I encourage you to approach this issue with caution and, at most, study the ramifications carefully before considering actual legislation.
Thank you.