BIPARTISAN TASK FORCE ON GUN VIOLENCE PREVENTION AND CHILDREN'S SAFETY
MENTAL HEALTH WORKING GROUP

STATEMENT OF JAN VANTASSEL, ESQ., EXECUTIVE DIRECTOR CONNECTICUT LEGAL RIGHTS PROJECT, INC.
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Good afternoon, Senator Harp, Representative Wood and members of the committee. Thank you for the opportunity to speak with you today about the interaction of persons with mental illness with Connecticut's judicial system.

My name is Jan VanTassel, and I am the Executive Director of the Connecticut Legal Rights Project (CLRP). CLRP represents low income adults with psychiatric disabilities on matters related to their treatment, recovery and civil rights. CLRP has staff assigned to represent clients at all state-operated DMHAS facilities, and has satellite offices at community sites throughout the state. I have also served on a number of mental health policy advisory groups, including the Governor's Blue Ribbon Commission on Mental Health, the Community Mental Health Strategic Investment Board, the Lieutenant Governor's Mental Health Cabinet, the Mental Health Transformation Grant Oversight Council and the Mental Health Block Grant Planning Council.

Under the Consent Decree which established CLRP in 1990, our attorneys are not allowed to appear as legal counsel in matters where there is appointed counsel. Therefore, we do not appear as counsel of record in criminal matters or in Probate cases. Nonetheless, because clients we are representing on other issues become involved in such actions, CLRP attorneys collaborate with appointed counsel on a regular basis.

I do want to note that the scope of my work involves persons receiving services through the publicly funded mental health system. This system, while one of the best in the country, cannot meet the demand for services and housing. Those covered by private insurance face their own problems obtaining mental health coverage. However, their experience with the judicial system is different than our clients.

INTERACTION WITH THE CRIMINAL JUSTICE SYSTEM

I will speak first about the interaction of our clients with the criminal justice system. As I am sure you know, it has been documented that persons with mental illness, adults and children, have become trapped in the juvenile and criminal justice systems due to behaviors related to their illness, and the lack of adequate services and housing to meet their needs.

The Public Defenders Office makes every effort to address the mental health needs of defendants with psychiatric disabilities. They have them evaluated for competency and those that are found incompetent to stand trial are sent to the restoration unit at

Connecticut Valley Hospital where they can stay for up to eighteen months. The Public Defenders Office has staff located at the hospital to represent their clients on matters related to their criminal case. If their competency is restored, they are returned to the Superior Court for trial. If not, DMHAS initiates a civil commitment proceeding which is most often approved by the Probate Court.

Specialized Training, Diversion & Re-Entry Programs

I am pleased to say that Connecticut has taken substantial steps, many initiated by the Criminal Justice Policy Advisory Council, to prevent the inappropriate and unnecessary incarceration of persons with mental illness. For years, Connecticut has funded Crisis Intervention Training (CIT) for police officers to train them to interact with persons with mental illness, intervene in a non-violent manner and refer them, when appropriate, to mental health services. Unfortunately, there is a resistance from some police departments to participating in this course.

For more than a decade, Connecticut has operated a statewide jail diversion program which refers persons with mental illness who are charged with crimes to mental health services when appropriate. This has significantly reduced the number of DMHAS clients sentenced to correctional facilities. In addition, through the collaboration of DMHAS, DOC and the Court Support Services Division of the Judicial Branch, there have been expansions of alternatives to incarceration as well as the development of specialized re-entry programs for persons with mental illness. This includes community forensics staff at DMHAS who work with colleagues to help assure that persons with serious mental illness have benefits, medical services and housing upon release, and specially trained probation and parole officers to work with persons with mental illness.

Unfortunately, it is reported that an estimated 40% of persons with serious and persistent mental illness are still released from prisons to shelters, because there are insufficient resources for staff to arrange for benefits and housing before release. I do not need to tell you that shelter life, even in shelters that provide services, is not the best environment to sustain recovery and rebuild lives. We need sufficient staff and resources to assure persons with mental illness have access to the benefits, housing and services essential to establish a stable life in the community immediately upon their release from prison.

PROBATE COURT PROCEEDINGS

In contrast to the developments in the criminal justice system, the Probate Court system in Connecticut has made only limited advances in addressing the unique needs of persons with mental illness. Clients consistently report that they regard the proceedings as biased, disregarding their preferences, and some have reported that they feel "violated" by the process. Some of this perception is, I believe, an outgrowth of the fact that the Probate System, when established, was regarded as serving a "parental" role, looking out for the best interests of persons with mental illness, who were presumed to be unable to understand their circumstances or options. Unfortunately, elements of this paternalistic

mindset, mixed with stigma and misunderstanding, persist, and proposals to expand the authority of this system to mandate community treatment are troubling.

In addition, this paternalistic perspective often carries over to the attorneys appointed to represent these clients, who are not paid their usual fees, and for the most part, have no training or experience with interacting with persons with mental illness. They are inclined to be heavily influenced by the psychiatric professionals, and allow their belief of what is in the best interests of the client to be a consideration in their representation. While acting with good intentions, this is inconsistent with their responsibility to be zealous advocates for their client's preferences. In fact, last year CLRP successfully argued a landmark case before the Connecticut Supreme Court (*Gross v. Rell*) which affirmed the professional responsibility of an attorney to be a zealous advocate for the client's preferences, even a client with a psychiatric disability, whether or not they agree with those preferences.

Given this context, Probate Court proceedings involving persons with mental illness on commitment, conservatorships or involuntary medication of hospitalized persons, rarely reflect the adversarial interaction found in a criminal matter. On the contrary, they tend to be cursory, witnesses are rarely called and the appointed attorney offers little or no evidence. Often appointed attorneys do not meet with the client until the day before, or sometimes the day of, the hearing, missing the opportunity to prepare and call witnesses or explore the possibility of alternatives to the action being proposed for the client.

Unlike the criminal system which has trained Public Defenders, or states like New York, which have a specialized legal program (Mental Hygiene Legal Services) to represent persons with psychiatric disabilities, Connecticut has no training requirements for attorneys representing clients with mental illness. Many have no knowledge of the mental health system, treatment and medication options, or the availability of community services and alternatives to institutionalization. Most have never heard of a recovery-oriented system of care or person-centered planning which is supposed to be at the core of the state's mental health system. It is likely that the only experience the appointed attorney has in interacting with persons with mental illness is in the Probate Court context. Nor do the Probate Court judges receive any mandatory specialized training on these topics. Consequently, it is not surprising that the proceedings are generally perfunctory, or that persons with mental illness believe they were disregarded in the process. Often, as a practical matter, they are.

I do not want to suggest that the Probate Court Administration has been indifferent to the evolution of the mental health system. They did collaborate with CLRP on a training for attorneys representing clients with psychiatric disabilities, and have had periodic trainings for the assembly. In addition, there has been increasing success in having the scope of a conservator's authority reduced, and having conservators removed. There has also been a collaborative effort with DMHAS through Melissa's Project to provide more intensive support to clients with conservators.

The civil commitment standard in Connecticut is broader than in many states. The judge may find by clear and convincing evidence that the person is dangerous to self or others, or that the person is gravely disabled, generally meaning the individual, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs and the person is mentally incapable of determining whether or not to accept hospital treatment because his or her judgment is impaired by psychiatric disabilities.

Sometimes this involves an individual who has not been, or is no longer, engaged in their mental health treatment. This can be the result of a disagreement between the psychiatrist and the patient regarding the type or dose of medication prescribed, or a treatment intervention that the patient does not find useful. In fact, CLRP recently represented a client who had to be hospitalized because the provider refused to change her case manager and that disrupted her services. And we are representing an increasing number of clients whose services are being reduced or terminated due to budget constraints. Despite a sincere effort to promote a person-centered, recovery-oriented system of care, the medical model often drives treatment decisions, leaving a patient with a "take it or leave it" situation which results in a decline in their health that could result in commitment, one that might have been avoided.

Colleagues at Mental Hygiene Legal Services in New York have reported to me that they are able, through early intervention in cases, to avoid court proceedings and/or substantially limit the length of hospitalizations. Because they exclusively represent clients with psychiatric disabilities and have broad expertise with the mental health system, they have negotiated with clinical professionals on behalf of clients to develop plans that address their needs and concerns. This approach both reinforces the recovery model and reduces expensive hospitalizations, keeping beds available for persons who require that level of care. It functions, in some ways, as the hospital equivalent of jail diversion. However, it requires training, specialized legal advocates, and adequate service and housing options to assure there are sufficient community options.

Connecticut has an excellent peer specialist training that has increased the involvement of persons in recovery in serving clients. However, I believe that we could improve upon it by adopting a New York program, called the Peer Bridger Program which helps ease the transition into the community of persons being discharged from hospitals. By having persons in recovery engage in a uniquely personal, positive relationship, which includes peer support meetings before and after discharge, there is a consistent, uninterrupted source of support for the persons with mental illness. This model was replicated in Wisconsin and Tennessee and demonstrated the results achieved in New York; substantial reductions in re-hospitalizations of persons engaged in this program. They also have peer programs to conduct intensive peer outreach to persons who have disrupted their treatment that are designed to "start where the person is," develop trusting relationships and keep them engaged in a dialogue about their circumstances and needs. These are similar to Connecticut's homeless outreach programs, which could be adapted to meet the specific needs of persons with psychiatric disabilities.

The Role of Supportive Housing and Housing First in Closing the "Revolving Door"

If the state wants to close the revolving door of persons with mental illness who go in and out of hospitals and homelessness, they must look to supportive housing as a core component of the solution. There is strong evidence based on Connecticut experience that supportive housing can be the foundation for rebuilding the lives of persons who have been incarcerated as well as those who have been hospitalized or homeless. Supportive housing, which combines permanent subsidized housing with access to flexible support services, has been demonstrated in Connecticut to reduce Medicaid expenditures for hospital and emergency room services for tenants by 71%, increase the participation of tenants in educational and employment activities, and raising their income, and contributed to increases in property values in the neighborhoods where it is located. Supportive housing targeted to persons who have a history of homelessness and high service use has also been shown to substantially reduce the rate of recidivism of tenants who had been released from correctional facilities.

In addition, a report issued last year by DMHAS documented that persons being discharged from long term hospitalization for the treatment of mental illness can succeed in supportive housing. Most significant is the finding that tenants do not engage in the destructive behaviors, such as terminating medications or substance abuse, that are typically anticipated by clinical staff when persons are discharged directly from hospitals to their own apartments. In short, supportive housing is a model that can address the needs of a broad group of people with mental illness. It must be recognized as a vital component of the mental health system.

A variation of supported housing developed in New York, called "Pathways to Housing: Housing First" is designed specifically for people with psychotic disorders and a history of non participation in services. Unlike most programs, which offer services in a linear, step by step continuum, this programs offers housing to the individual first, and then expects the person to work on recovery with the support of assertive community treatment (ACT) teams. While required to meet with the team regularly, it is the individual who determines his or her goals and approach to recovery. This program achieved an 88% housing retention rate after five years in contrast to a 47% retention rate for persons living in more structured, supervised residential settings. This represents a non-coercive approach to stabilizing persons who have a history of resisting treatment and through the intervention of peer support to supplement the ACT teams, offer a positive approach to long term recovery and an alternative to repeated hospitalizations or court-ordered forced treatments.

Promote the Use of Advance Directives

Advance directives are legal documents that allow a person to control health care decisions when they are unable to do so. They can specify personal treatment preferences and provide for the appointment of a health care representative to carry out those preferences. They can even recommend the person to be appointed as conservator for the individual if that is necessary. By executing an advance directive, a person with mental

illness can consider treatment options and make it possible for another person to carry out their preferences, reducing Probate Court proceedings. DMHAS has encouraged the persons it serves to execute advance directives, but it is still not widely done.

RECOMMENDATIONS

It is recommended that Connecticut consider the following measures to improve the interaction of people with psychiatric disabilities in the judicial system and promote measures to prevent such interaction:

> Assure benefits, housing and services in place when a person with psychiatric disabilities is released from correctional facilities ;
>
> Encourage/create incentives for all police forces to participate in Crisis Intervention Training;
>
> Establish mandatory training for judges on persons with mental illness, the recovery-oriented system of care, and community options;
>
> Establish a trained cadre of lawyers that specialize in representing clients with psychiatric disabilities and are familiar with mental health treatments and community services;
>
> Establish a referral system that allows lawyers to intervene early on behalf of clients who may be subject to commitment proceedings to provide time to negotiate alternatives that could avoid court proceedings and limit the length of hospitalizations;
>
> Expanding access to supportive housing to provide persons with psychiatric disabilities a stable place to sustain their recovery and rebuild their lives;
>
> Implement a "Housing First" housing option for persons who resist treatment, and supplement it with peer support services and peer outreach programs;
>
> Expand access to peer support for persons who are transitioning from a hospital or are the subject of repeated Probate Court appearances; and
>
> Increase outreach and awareness about the importance of advance directives.

None of these measures will prevent extreme and rare acts of violence. In fact, it is important to keep in mind that psychiatric professionals cannot accurately predict who will be violent. However, in combination with actions to create a culture of support in schools, including school based health centers, these actions can improve access to housing and services that meet the needs of persons with chronic mental health problems, including those who have been resistant to services.

2000 "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities" Psychiatric Services Tsemberis and Eisenberg

An innovative 'harm reduction' housing and support program model was able to achieve an 88% 5-year service retention rate and general stability among a group of primarily young men of color with psychotic disorders and previous histories of homelessness and non-participation with services...**the very same group** of those who have been "incapable of living and maintaining treatment in the community" that Kendra's Law proponents would have us believe can only be served via court order.

And Pathways does this without mandating treatment adherence or abstinence but by offering 'housing first' via a model that merges supported housing and ACT team services.

Psychiatr Serv. 2000 Apr;51(4):487-93.

Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities.

Tsemberis S, Eisenberg RF.

Source

Pathways to Housing Inc., 155 West 23rd Street, 12th Floor, New York, NY 10011, USA.

Abstract

OBJECTIVE:

This study examined the effectiveness of the Pathways to Housing supported housing program over a five-year period. Unlike most housing programs that offer services in a linear, step-by-step continuum, the Pathways program in New York City provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities who are homeless and living on the street. Support services are provided by a team that uses a modified assertive community treatment model.

METHODS:

Housing tenure for the Pathways sample of 242 individuals housed between January 1993 and September 1997 was compared with tenure for a citywide sample of 1, 600 persons who were housed through a linear residential treatment approach during the same period. Survival analyses examined housing tenure and controlled for differences in client characteristics before program entry.

RESULTS:

After five years, 88 percent of the program's tenants remained housed, whereas only 47 percent of the residents in the city's residential treatment system remained housed. When the analysis controlled for the effects of client characteristics, it showed that the supported housing program achieved better housing tenure than did the comparison group.

CONCLUSIONS:

The Pathways supported housing program provides a model for effectively housing individuals who are homeless and living on the streets. The program's housing retention rate over a five-year period challenges many widely held clinical assumptions about the relationship between the symptoms and the functional ability of an individual. Clients with severe psychiatric disabilities and addictions are capable of obtaining and maintaining independent housing when provided with the opportunity and necessary supports.

http://www.ncbi.nlm.nih.gov/pubmed/10737824

Background

Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and most national behavioral health experts promote peer support and indeed, the last decade has experienced a substantial increase in peer support services.[1] Unfortunately, the empirical evidence supporting peer-provided services lags behind their rapid proliferation. Studies that do exist rarely evaluate the unique aspects of the service.[2]

In an effort to proffer peer support for system-wide implementation, OptumHealth tasked a group with understanding and documenting the components necessary for implementation, replication, and sustainability of peer support services. A pilot, with two sites, was designed and implemented as a way to determine those systems and processes.

An independent evaluator was chosen to document the empirical evidence gathered through the pilot and an internal OptumHealth^{SM} team monitored the design and operational activities from pre-pilot to post-pilot.

Methods

Peer Bridger was chosen as the specific peer support model to be implemented and measured in the pilot.

> *Peer Bridger services, originally developed in 1994 by the New York Association of Psychiatric Rehabilitation (NYAPRS), are provided by individuals in mental health and/or addiction recovery who are trained in peer support and often certified as peer specialists or peer wellness coaches. They offer engaging hope and recovery focused mutually accountable relationships that help individuals meet their personal health, wellness and life goals. Peer bridgers provide transition assistance and linkages to services and natural supports in the community by offering individualized support for effective wellness management, independent living, social skills, and coping skills. Peer Bridger services are most often provided for individuals leaving inpatient treatment or other segregated environments such as residential treatment, adult (board and care) homes, prisons and jails.* http://www.nyaprs.org/peer-services/peer-bridger/

Services – called PeerLink due to potential confusion with an existing Tennessee consumer program named Bridges - were developed for pilot sites in southeast Wisconsin and West Tennessee along with Grassroots Empowerment Project (GEP) and the Tennessee Mental Health Consumer Association (TMHCA) as provider partners. OptumHealth, GEP and TMHCA worked collaboratively to design the pilot and to implement services. The pilot began in December 2009 and ended August 31, 2010.

The most impactful method of ensuring that peer support is implemented and sustained system-wide is to show its cost effectiveness. The objective of this

project was to demonstrate that Peer Bridger services decrease psychiatric inpatient bed days.

Dr. Chyrell Bellamy and her associates at Yale University's Program for Recovery and Community Health conducted the independent evaluation that included an analysis of the following: 1) hospital authorization data, 2) Peer Support Specialist encounter data, 3) surveys from OptumHealth staff, 4) Peer Specialist focus groups and 5) surveys from and focus groups with pilot participants.

Additionally, an internal team conducted a process evaluation and lessons learned were observed and documented throughout the project. The programs were not static; each site matured and changed as new information became available. Services continued at both sites following the pilot.

Results

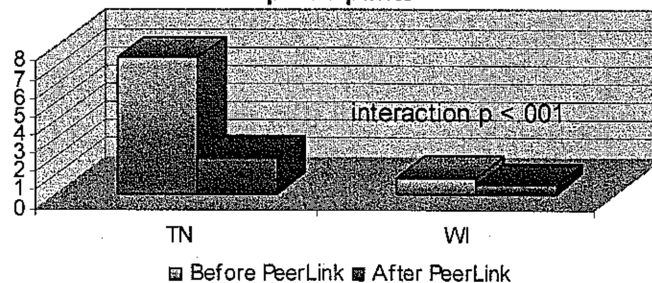
Empirical Data

Hospitalization data was analyzed for PeerLink members who had a history of at least one hospitalization from December 2008 through the month preceding enrollment in PeerLink. This subsample included 28 PeerLink members in Tennessee and 65 PeerLink members in Wisconsin.

In Tennessee, PeerLink participants spent an average of 7.42 days per month (*sd* = 7.52) in the hospital prior to receiving PeerLink services and experienced a **73.32% decrease in average number of hospital days after enrollment in PeerLink**, $F = 12.08$ (1, 27), $p = .002$.

In Wisconsin, the PeerLink participants spent an average of .86 days per month (*sd* = .83) in the hospital prior to enrollment in PeerLink and an average of .48 days per month (*sd* = .93) in the hospital after enrollment in PeerLink, $F = 4.75$ (1, 64), $p = .004$, **a 44.19% reduction in hospital days after enrollment in PeerLink.**

Average number of hospital days per month for PeerLink participants



Process Evaluation

Sample list of issues that can result in termination of a peer support program

Issue	Solution – not an exhaustive list
Inability to measure outcomes or determine cost effectiveness	1) Distinctly defined levels of peer support services, 2) process that allows encounter data to be stored and compared with other service data
Lack of billing and/or claims processing expertise (a provider and payer problem) results in poor payment history	1) detailed contract w/ no room for misunderstanding, 2) prior to service implementation, payer can verify that all claims processes support payment of non-licensed providers, 3) payer ensures a single point of contact for providers w/ billing and claims knowledge, 4) provider training
The program faces constant setbacks and nothing ever gets resolved	Partnership participants matter. The payer organization must be willing to truly integrate peer support in the service array, modify systems when needed, and provide a champion to keep the process moving. The provider organization must have strong leadership with a desire and the skill set to provide the services being purchased and to offer ongoing training and supervision for its employees.

Reason(s) Research Can Be Considered a Disruptive Innovation

The independent evaluation of the PeerLINK pilot adds to the body of knowledge verifying that peer support is effective and increases community tenure for its recipients.

The process evaluation provides a checklist for future implementations of peer support services and begins to offer guidelines for program sustainability. As a result of the project, OptumHealth is developing Level of Care Guidelines for seven distinct levels of peer or family support services, is developing credentialing criteria for both peer and family provider organizations, and is clarifying the claims process from point of service to provider payment to ensure that providers are not financially at risk.

[1] The Pillars of Peer Support Services Summit. *Pillars of Peer Support:* Transforming Mental Health Systems of Care through Peer Support Services. (Atlanta, Georgia. The Carter Center Nov 17–18, 2009) 1.

[2] Davidson, L., Chinman, M., Sells, D., Rowe, M. (2006). Peer Support among Adult with Serious Mental Illness: A Report from the Field. Schizophrenia Bulletin, Feb 3, 2006.

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Across the Country People Are Realizing Supportive Housing Is Cost-Effective

Research from around the country offers overwhelming evidence that supportive housing leads individuals and families from homelessness to stability and success. It reduces their use of high-cost public services like emergency rooms (ER), prisons, and nursing homes. Supportive housing is remarkably cost-effective, as demonstrated across the country.

Chicago
- 29% fewer hospital days, 24% fewer ER visits

California
- 22% fewer ER visits than support services alone

San Francisco
- 56% fewer ER visits, 44% fewer inpatient hospital admissions
- 1 year before SH = $33,686/person in healthcare costs
- 1 year in SH = $9,786/person in healthcare costs

Denver
- 34% fewer ER visits, 40% fewer inpatient hospital days, 82% fewer detox visits, 76% fewer days in jail
- 50% improved health status, 43% improved mental health, 15% reduced substance use
- Savings = $31,545 per person over 2 years

Maine
- 77% fewer inpatient hospitalizations, 62% fewer ER visits, 60% fewer ambulance transports, 38% fewer psychiatric hospitalizations, 62% fewer days in jail, 68% fewer police contacts

Massachusetts
- Savings = $8,949 annual savings per person

Prevention, coordination and followup – focused around a home they can afford – keeps people with complex challenges from the revolving doors of expensive systems.

Supportive housing works.
It's cost-effective. It can help end homelessness.

Supportive housing is permanent, affordable housing with available case management, support services and employment services.

It is a proven, effective means of re-integrating families and individuals with mental illness, chemical dependency or chronic health challenges into the community by addressing their basic needs for housing and on-going support.

Seattle
- 41% lower Medicaid charges, 19% fewer EMS paramedic interventions, 87% fewer sobering center admissions, 42% fewer days in jail
- Over 1 year, $372,000 spent on housing & services program - saved $1.5 million in other costs

Rhode Island
- $7,946 per person annual savings on hospitals, detox, ER, jails, prisons, and shelters

Portland
- 1 year before SH = $42,075/person
- 1 year in SH = $16,108/person
- 58% fewer inpatient hospital days, 87% fewer ER visits

Boston
- Average annual healthcare cost living on the street = $28,436
- Average annual healthcare for those who got housing = $6,056

Research compiled by Corporation for Supportive Housing - www.csh.org.
Links to these studies can be found at www.pschousing.org.

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