Testimony before the Bipartisan Task Force
Mental Health Working Group
January 29, 2013
Submitted by: Marcia DuFore, Executive Director, North Central Regional Mental Health Board

Thank you for the opportunity to provide testimony about mental health services as it relates to Gun Violence Prevention and Children's Safety in Connecticut.

My name is Marcia DuFore. I am testifying as Executive Director of the North Central Regional Mental Health Board. Our Board is mandated by statute to study the mental health needs of people in our region and assist the CT Department of Mental Health and Addiction Services with setting priorities for improved and expanded services to meet those needs.

I'd like to speak about access to treatment for people who are eligible for services from the public and private behavioral health delivery systems as well as our Board's concern about proposals coming before the Legislature for involuntary outpatient treatment.

First the public delivery system: For the adults we work with, these services are provided by DMHAS and include a wide range of prevention, treatment, and recovery supports. They are targeted to people with serious mental illness or substance use disorders who do not have insurance coverage or the resources they need to meet their behavioral health needs. Connecticut's service delivery system has been rated as one of the best in the nation. The treatment modalities and recovery supports offered, such as supportive housing, supported employment and education, peer support and engagement strategies are robust, innovative and often very effective. There are problems, however. The system is underfunded, difficult to navigate, especially for people at either end of the age spectrum, there are waiting lists for many of the services, there are not enough psychiatrists, and there are not enough step down options for people coming out of inpatient treatment. We have seen a significant increase in people needing and qualifying for these services as a result of the economic downturn. Funding support for these services is critically needed or the problems I just described will only get worse.

It is often overlooked that the public delivery system is only one of the ways that people with behavioral health disorders get treatment. However, people who have private insurance or financial means can and do access services through psychiatrists, psychologists, social workers, APRNs, etc., who accept private payment. Sometimes the private system offers a greater choice of providers, but there are problems with this system as well. We hear frequently from individuals and families that their insurance will not adequately cover mental health or substance abuse treatment, that providers will not accept insurance, and that recovery supports that are so effective for people served by public mental health system are not considered medically necessary and never covered by insurance.

The Office of the Healthcare Advocate did an exhaustive study in 2012 of the access to care issues for children and adults for mental health and substance use disorders. They issued a number of key findings and recommendations that I hope will be considered by this commission.

And then there is the problem that some people for many reasons, do not seek or cooperate with treatment from either the public or private delivery system. Those who are proposing legislation that would allow for involuntary outpatient commitment seem to be concerned primarily about this group. They identify the reason for not seeking treatment as one of lack of acknowledgement of the illness or its significance. However there are many other reasons that people are reluctant to seek treatment. Many fear of the stigma or discrimination that comes with being identified as a person with mental illness. Many hate the side effects of medications that are prescribed to control their symptoms. They hate those side effects more than the symptoms themselves. These concerns are legitimate. Some of those side effects can lead to other serious health concerns. Also some people feel insulted by their treaters and the lack of control and respect they are afforded as equal players on the treatment team for choosing the course of treatment that works for them.

After the tragedy in Newtown our Board heard from a number of individuals who fall on both sides of the issue re: involuntary outpatient commitment. Some family members see this as an answer they have been long awaiting. This will insure that their loved one will get appropriate treatment – that the issue of refusal is the primary issue that has kept their loved one sick, and getting sicker, and being in harm's way as a result. Watching their loved one get sicker is frustrating and extremely painful. There also are people who associate mental illness with violent behavior. And there are people with mental illness who are now afraid that they will be treated as criminals because of this misguided association. The fact is that the majority of people with mental illness are more likely to be victims of violence than perpetrators of it. The discussion about how to engage people in treatment and how to reduce the stigma and discrimination associated with having a mental illness is a discussion we need to have.

Our Board is opposed to involuntary outpatient commitment as a solution to our concern for creating safer communities. We do not see it as an effective use of resources and believe, instead that it will divert resources from treatment and recovery supports to the cost of the court and legal procedures that would be necessary to carry out a commitment order. We believe there are adequate mechanisms in place through current legislation for involuntary inpatient commitment or conservatorship to address the needs of individuals who are a danger to themselves or others or gravely disabled. Treatment can also be ordered as a condition of release or probation. We do not believe that an involuntary outpatient commitment statute would have prevented the tragedy in Newtown or that we can count on it to prevent future tragedies. We are concerned that involuntary interventions will be inequitably imposed on ethnic minorities for whom cultural and language issues already present significant barriers to timely and effective treatment. We request that, if this work group finds that some action must be taken, that you initiate a

state-by-state study by the Office of Legal Research regarding outpatient commitment statutes, how they are implemented, and their effectiveness.

We have an opportunity with the advent of the Affordable Care Act that more of the medically necessary clinical services currently funded by the State of Connecticut will be covered by Medicaid, private insurance, of the Health Care Exchange. What can we do to enforce mental health parity in the private service delivery system? What can we do to make sure funds currently being spent on medically necessary clinical services are re-invested to address the current gaps in both the public and private mental health delivery systems – to augment the system of recovery supports, the prevention, outreach, engagement, and peer supports that we know are effective? How can we invest in community education such that the stigma and discrimination are reduced? These would be effective use of Connecticut resources, and although we cannot assume they will assure our safety, they will make a difference in the lives of people with behavioral health disorders and the communities in which they live.