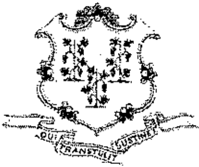

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

Testimony by Patricia Rehmer, MSN, Commissioner Department of Mental Health and Addiction Services Before the Mental Health Services Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety January 29, 2013

Good morning Sen. Harp, Rep. Wood, and distinguished members of the Task Force. I am Commissioner Patricia Rehmer of the Department of Mental Health and Addiction Services, and I want to thank the committee for asking me to speak before you today. I have been asked to address three (3) issues for your subcommittee: gaps in the mental health system; alternatives to outpatient commitment; and mental health first aid.

In order for me to address gaps in the system, I believe it will be helpful for you to have information about who DMHAS serves and what we provide to persons with serious mental illness. DMHAS serves approximately sixty thousand Connecticut citizens with serious mental illness. These individuals are either medically indigent (without health insurance or resources to pay for health care), on Medicaid or Medicare, or dually eligible for both. Many of the people we serve receive Social Security Disability Income (SSDI) due to the severity of their illness. I want to point out that if you are an individual with a mental illness and you have commercial health insurance or another resource with which to pay for care, it is very unlikely that you would fall within the purview of DMHAS. The only service that we may provide to an individual in the community with a mental illness that has private insurance or other resources would be if there was a situation where our mobile crisis team was called to provide assistance.

For the individuals served by DMHAS, we can provide within available appropriations, inpatient and outpatient mental health and substance abuse services, case management, medication management, group homes and supported apartment programs, psychiatric rehabilitation services, employment services, peer-operated support, education and advocacy services, and social integration opportunities through a network of public and private non-profit agencies. We assist people in learning to manage their conditions and live more independently in the community. Warm lines, wellness programs, and help to become involved in satisfying and meaningful roles in the communities also contribute to recovery and self sufficiency. We assist individuals with mental illness who have involvement with the criminal justice system and operate and fund programs for young adults with mental illness who are aging out of the DCF system. The people DMHAS serves who demonstrate higher risks also have increased outreach,

supervision, and monitoring. We have approximately 558 state operated inpatient beds and contract for additional beds with general hospitals. Connecticut has a strong system and has been recognized nationally for many of its programs as well as its commitment to a recovery oriented system of care. I have attached a more comprehensive list of our services to this testimony for your review.

Of course, we could always do more. We currently have three (3) Assertive Community Treatment (ACT) teams that have shown very good outcomes for individuals who have significant challenges. The case loads for ACT teams are smaller and the team wraps all necessary services around the individual. If we had the ability to expand this level of care we believe we would be able to keep more individuals out of the hospital and increase their success in the community. Increasing access to supportive housing to address the issue of homelessness and to move people out of expensive inpatient hospital beds would also benefit individuals served in our system. We know that stable housing significantly increases chances for recovery and engagement.

The bigger gaps, frankly, are for those individuals with private insurance. I am not an expert on health insurance, but I do know that while individuals with private insurance have limited access to inpatient services, outpatient services and medications, the additional services that are critical to an individual's recovery are oftentimes not covered by health insurance policies. No intensive residential rehabilitation, respite beds, social integration, case management or peer supports. I receive calls from families on a daily basis who struggle to fill these gaps by themselves. Additionally, the shortage of psychiatrists in both the public and private system makes it difficult to address both urgent and ongoing needs.

We know of many cases where, due to discrimination and the prejudice associated with mental illness, families choose to pay cash for treatment so that there is no evidence of their diagnosis. I believe that prejudice and discrimination are among the biggest challenges the people we serve face; that it is a significant inhibitor in choosing whether or not to seek treatment. Many individuals with mental illness, and their families, are afraid that the "label" will impact their employment opportunities, social interactions, access to education, and housing options.

There are currently forty four (44) states that have some form of "involuntary outpatient commitment" in statute. These laws are meant to compel individuals with mental illness into community treatment. I appreciate the opportunity this task force has given me to participate in the conversation about this issue. DMHAS has done a significant amount of research about the experiences in other states, though, I think before we discuss this, we should be clear that we all understand the involuntary treatment laws Connecticut currently utilizes. Today in Connecticut if it is determined that you are a danger to yourself or others, or you are found to be severely disabled, any physician you can have you hospitalized for emergency treatment at any time within three days of a face to face appointment. A certificate can be issued to admit you to an emergency room by any psychologist when it is believed that you are a danger to yourself or at

risk of harming others. Licensed clinical social workers and APRNs in certain with special training can also issue certificates. The police, upon encountering someone in the community who is in distress or creating an unsafe disturbance, can do the same. Probate judges can issue a warrant of apprehension under certain circumstances and individuals can be required to participate in treatment as a condition of release from jail or as a provision of probation.

Our research about the other states that have some sort of outpatient commitment law, has found that though many states have the law on the books, many of them do not implement it due to budgetary constraints. Systems would require additional funding for the probate courts, for access to care (in order to provide mandated treatment), and for an enforcement mechanism. It is also unclear as to who would pay for mandated services to be delivered to those individuals who were commercially insured.

I believe that additional resources if available could be better used to pay for more ACT teams, supportive housing, peer engagement programs, and higher reimbursement rates for providers. There has been a great deal of research conducted regarding these programs and they have been found to be recovery oriented, and conducive to engagement. These services will also give us the best value for our dollars and have the most impact especially in this difficult economic time and with us facing tough budget constraints. Our biggest success stories have come from using peers (other people in recovery) to work with individuals reluctant to accept treatment, ACT teams, and strong therapeutic relationships. Our successes with young adults have occurred through engagement and positive reinforcement. I have concerns that an involuntary outpatient commitment law may further inhibit people from seeking care when they need it and could possibly take resources away from people who are willingly engaged and succeeding in treatment, as well as concerns about how a patient with private insurance, or the means to pay for mental health care would be impacted by such a law.

President Obama — as part of his proposal to protect our communities from gun violence — has recommended Mental Health First Aid training to help teachers and other school staff recognize the signs of mental health disorders in young people and connect them with appropriate care. The Mental Health First Aid Act of 2013 (HR 274) in Congress calls for resources to train teachers/school administrators, students, emergency services personnel, police officers, faith community leaders, and primary care professionals. The adult Mental Health First Aid program has already been delivered to nearly 100,000 Americans through a network of more than 2,500 instructors. The youth version of Mental Health First Aid is an evidence-based training program to help citizens identify mental health problems in young people, connect youth with care, and safely deescalate crisis situations. The program, focusing on youth ages 12 to 25, provides an ideal forum to engage communities in discussing the signs and symptoms of mental illness, the prevalence of mental health disorders, the effectiveness of treatment and how to engage troubled young people in services. Youth Mental Health First Aid is primarily designed for adults — family members, caregivers, school staff, health and human services workers, etc. — who work with young people 12-25, but is also appropriate for older adolescents. DMHAS has a very

small amount of funding available for adult Mental Health First Aid trainings. We have provided or paid for training in Bridgeport and other parts of Fairfield County, as well as in the Middletown area. We will be looking to Washington for dollars to expand this training as well as become certified to do training for the youth version. This program can educate many individuals in the community about mental illness for a very small amount of dollars.

Thank you for your time and attention to these matters I would be happy to answer any questions you may have.

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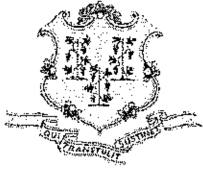

Addendum Testimony

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DMHAS Mental Health and Substance Abuse Clinical and Non-Clinical Services

Inpatient Services
- *** Medically Managed Detoxification (generally 3 to 7 days)**
- *** Acute Psychiatric Inpatient (generally 1 to 15 days)**
- Long-Term Psychiatric Inpatient (15 days to however long is necessary)

Residential Services
- *** Medically Monitored Detoxification (detoxification in a non-hospital setting; generally 3 to 7 days)**
- Intensive Substance Abuse Residential Treatment (post-detox and up to 21 days)
- Intensive Mental Health Residential Rehabilitation (generally 1-2 years)
- Intermediate Substance Abuse Residential Treatment (30-90 days)
- Mental Health Group Home (minimum of 1 year)
- Long Term Care for Substance Abuse (minimum of 6 months)
- Substance Abuse Halfway House (generally 3-4 months)
- Recovery House (up to 90 days)
- Supervised Mental Health Housing (as long as necessary)
- Supervised Recovery Housing

Community Based Clinical Services
- *** Outpatient** (both mental health and substance abuse (indefinite length of stay)
- * Medication Assisted Chemical Maintenance for Opiate Dependence (Methadone, Suboxone, Naltrexone; indefinite length of stay)
- *** Intensive Outpatient** (both mental health and substance abuse; generally 3 weeks)
- Partial Hospitalization ((both mental health and substance abuse; generally 1-3 weeks)
- *** Gambling Outpatient** (indefinite length of stay)
- *** Ambulatory Detoxification** (generally up to 90 days)

Forensics Community-Based Services
- Pre-Trial Intervention Programs (screenings and classes for individuals that have been arrested for driving under the influence; 12 weeks)
- Court Liaison Jail Diversion (screenings and referrals for individuals that have been arrested and have mental illness)

Case Management
- Mental Health Community Support Program /Recovery Pathways (skill-building and outreach for individuals with mental illness)
- Working for Integration, Support and Empowerment (WISE): (Includes assisting people with entitlements such as DSSI, SSDI, Medicare , Medicaid, food stamps, heating assistance, housing assistance)
- Outreach & Engagement (reaching out to individuals with mental illness that have been unwilling to engage in services)

- Mental Health Supportive Housing – Case management services for individuals living in federally subsidized housing.

Crisis Services

- * Mobile Crisis (serves anyone with or without insurance; clinicians go to where the individual in crisis is or is in a hospital emergency room to assess for risk, engage in services)
- Respite Bed (a short-term residential service for individuals that need a break from their living situation)

Social Rehabilitation – (club houses, and drop in centers intended for people with mental illness that offer structured and unstructured recreational and pre-vocational activities as well as peer support)

Young Adult Services (case management, vocational and housing services designed specifically for young adults with a behavioral health disorder who are transitioning from the DCF system of care)

Employment Services (an evidence practice whereby individuals with serious mental illness are provided with employment opportunities that include on-site assistance and other supports)

MH Assertive Community Treatment (an evidence practice whereby an inter-disciplinary team coordinates services in the community for individuals who are at risk for hospitalization or who have recently been hospitalized and need intensive clinical supports and frequent interventions)

*** - Denotes those behavioral health services that are also typically offered by private insurance companies.**