Mental Illness, Violence and the Connecticut Mental Health System

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This week many people will speak with great passion and some reason, so I will give you some guidelines to help you evaluate their claims.

First, Connecticut has one of the **top-rated mental health systems** in the country. In the last national "Grading the States" report, the National Alliance on Mental Illness gave us a "B" overall and the *only* "A" in any part of a system. That was for Advocacy, which means that DMHAS can't get away with much because we are watching. It does not mean we are perfect, only that we have an evidence-based, *well-designed* but understaffed system. Some of our workers are tired, but the system as a whole has a progressive and successful approach to people with severe mental illnesses.

Second, a key part of any mental health system is responding to crises. Each area of the state has a **mobile crisis** program, which responds to people in crisis *in their homes* if necessary, and arranges for them to get the level of service they need. The motto of these programs should be "when in doubt, go out," and one of their quality indicators is the number of ER visits and hospitalizations they can *prevent* by providing timely alternative supports.

Recently we have seen another kind of crisis intervention from DMHAS. As you have heard, over 100 DMHAS and non-profit staff with special training spent weeks in Newtown supporting that traumatized community.

Third, you know that very few people with mental illness are violent, but also **very few violent people have mental illnesses**. Thus, anything you do to the mental health system has limited preventive impact because it targets the wrong people. Saying that anyone who *does* something crazy must *be* crazy is no help. We cannot predict violence very well in either group, but we have good *response* to potential violence in **Crisis Intervention Team (CIT)** training. Police who know it really like CIT, but some still resist it, especially the State Police. That has to change.

Fourth, **people with insurance usually cannot get the services** that keep people with severe mental illnesses stable. Private insurance companies cover physical rehab after a stroke, but not psychosocial rehab or case management after a psychotic break. That is an unusual parity issue. Because people with severe mental illnesses have been a state responsibility for 200 years, public systems have developed the necessary services, albeit by trial and error. Poverty is a side effect of mental illness, so the public system is much larger. Too few privately insured people need those services, and insured people are barred from the public system. We should create a fee schedule to get people what they need without making them enter "voluntary" poverty.

Finally, **outpatient commitment** is magical thinking. Like prohibition, it is a good idea that won't work. We can force violent people to take meds through probation or court orders. Few people have the stomach to forcibly medicate others. In fact, many relatives *give up* conservatorships because they don't like the coercion and find that it does not work anyway. As

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Com'r Rehmer said earlier, *no state* enforces outpatient commitment as it is written. Psychotic people are smart enough to see that enforcement is arbitrary. They may be intimidated into compliance once or twice, but not for long. Unenforced laws make both staff and clients cynical. Burned out treaters will find more excuses to coerce people to do what they cannot persuade them to do, which discredits us all.

So, help us find children who are so angry that they might grow up to do something horrible and give us the staff to treat them when we find them, but don't make a good system worse just to treat our universal anxiety about what we cannot control. Thank you.

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