The Connecticut General Assembly

Task Force To Study The Provision Of Behavioral Health Services For Young Adults

Co-Chairs:

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MEETING SUMMARY AND NOTES

December 31, 2013

Submitted by Task Force Co-Chairs: Daniel Connor and Sheryl Ryan

Members Present:	Dr. Daniel Connor, Dr. Sheryl Ryan, Dr. Anton Alerte, Dr. Aura Ardon, Dr. Richard G. Jimenez, Marcy Kane, Ph.D., Judge Robert Killian, Jr., Scott Newgass, LCSW, Ted Pappas, M.A., Kelly Phenix, Commissioner Patricia Rehmer, MSN, Marian Storch, Cara Lynn Westcott
Members Absent:	Stacey Adams, Anne Melissa Dowling, Sarah Eagan, Tim Marshall, Ashley Saunders, Laura Tordenti, Ed.D., Victoria Veltri, JD, LLM
Others Present:	Mickey Kramer for Sarah Eagan; Michael Williams for Tim Marshall; Jill Hall for Victoria Veltri, JD, LLM

Dr. Connor convened the meeting at 2:30 PM and provided an overview regarding the preparation of the final draft report of the Task Force. He explained that the draft report will be distributed to the members by mid-January to allow them to make any changes or add comments.

The meeting summary and notes from the meetings of November 19, 2013 and December 31, 2013 were approved unanimously.

The discussion of today's meeting was as follows:

- Items 10 and 12 of the Public Act 13-3 regarding the use of assisted outpatient behavioral health services and involuntary outpatient commitment; and the disclosure of communications by mental health professionals concerning persons who present a clear and present danger to the health or safety of themselves or other persons.

- Making a recommendation to amend the current statute for the age of consent for involuntary commitment from 16 years old to 18 years old.

Points and recommendations that were made for Item 12:

- The Task Force discussed expanding the disclosure of communication by mental health professionals to inform parents, teachers, or additional health personnel

Dr. Connor explained that there are already regulations in place so that the information will already go to the state if an individual is involuntarily committed to a mental health institution. In addition there is the physician emergency commitment law, which means that a person's civil rights can be taken away and can be committed to a psychiatric institution for a limited period of time.

Commissioner Rehmer noted that, under the public act 13-3, if a person voluntarily signs into any psychiatric facility in CT the appropriate state agencies are notified (for purposes only) so that if a person has applied for a gun permit or has a gun(s) registered in the state, to prevent gun and permit ownership.

Dr. Connor stated that the wording in Item 12 is too vague and difficult to interpret. He explained that his interpretation of the language is that the state wants a recommendation if the task force agrees to broaden the charge on clinicians to communicate patient care information if the clinician determines a clear and present danger. Is this a good or bad idea?

Commissioners Rehmer stated that the challenge with the language is that it appears by the current law that if someone presents a clear and imminent danger to themselves or others, they should be in the hospital. A family member or other licensed personnel can call 911, can take them to the hospital for an evaluation, and if they meet the criteria, they can either be voluntarily or involuntarily committed.

How is the Tarasoff statute different from this public act?

- Judge Killian explained that the Tarasoff statute is primarily to absolve the institution (i.e. hospital) or the individual (i.e. physician) of the responsibility if the person carries out the threat to cause injury to a specific individual(s)

- Conduct screenings – What is the responsibility if there is a screening that raises serious questions about taking it to the next step that go beyond, for example, just notifying the parents of a child. That may be what the legislature is trying to address.

- We already have existing statutes that allow people to take significant action in response to individuals that pose a threat to themselves or others. We do not need much more.

- Creating a "suspect list" that would require the reporting of individuals that voluntarily commit for treatment in a hospital or any other public entity is an obscenity, unless the hospital and/or physician determine that they pose a "Tarasoff" type threat.

Expanding communication beyond the police:

Dr. Ryan asked whether expanding communication would mean the requirement to report a threat that was reported to a physician--should the physician report beyond law enforcement officials.

Dr. Alerte explained that communication is purposeful. The police are notified in order to maintain safety and order. The referring hospital or emergency services are notified to continue treatment and care for the patient. By contacting anyone else may be more than necessary and may confuse and even delay the process, when the focus should be task and problem oriented.

Cara Westcott agreed that because we are not aware of the intent of Item 12, and also due to confidentiality laws and code of ethics as mental health professionals that we are bound to, we should recommend that the current laws regarding Item 12 are sufficient. If the intent is to alert the media of danger, then that is not in the best interest of Connecticut.

The members of the Task Force agreed that the existing laws regarding the recommendations for Item 12 do not need to be changed.

Judge Killian suggested that if the task force makes a recommendation that some type of screening is appropriate, there has to be a process to support getting individuals into screening. He explained to not just have mandating reporting but also include when there is a sense that they are going to be a danger to themselves or others. This would be a parent's role. It's not mandating treatment, but mandating diagnosis.

Dr. Kane stated we do have a medical neglect category for children– if a child is not receiving proper care for that illness--that falls into a mandated reporter's responsibility. She asked for clarification on what Judge Killian is referring to in the absence of this situation on the adult side.

Dr. Connor explained that individuals do not have to follow medical advice. However, it is the intermediate area that is not clear and asked the members if it should be best left on a case by case basis and the judgment of the clinician and the family without offering a recommendation.

Dr. Kane stated that is it possible to change the laws to make it easier for treatment professionals to gather collaborating evidence to make some of these difficult decisions for gravely disabled individuals.

Dr. Connor asked if we make a recommendation to amend the laws regarding confidentiality to help facilitate communication in certain psychiatric situations.

Judge Killian noted that we do a disservice for people with mental illness by limiting the ability of the inpatient hospital providers to gather information on what has transpired leading up to the hospitalization. The State does not allow that kind of communication.

Commissioner Rehmer stated that for the purposes of treatment, you can always have a conversation with the clinician. There are mechanisms in place for clinicians to communicate to gather information. If someone is saying they cannot share information, they are hiding behind the HIPPA laws.

Judge Killian stated that if that is correct, the clinical staff needs to be educated relating to the HIPPA laws because he has had other situations where the medical information was not shared. He added that many people end up having to get a conservator to get a release of information.

Commissioner Rehmer stated there are mechanisms in place that can gather information for the purposes of treatment is already in the law. I agree that we have to re-educate people regarding the release of information under the HIPPA law as to what you can and cannot share.

Judge Killian stated that the existing state statutes are inadequate because they don't clearly spell out the limits of when you can speak with a prior treating clinician or even a family member, for example, to find out where a person received treatment.

Dr. Connor asked if the members are recommending that the law be amended and clarified or should there be increased professional training under the existing law.

Michael Williams, DCF stated that he agrees with Commissioner Rehmer within our provider system and even among the staff, there is a lot of misunderstanding of the sharing of information under HIPPA laws. There are bureaucratic barriers that exist that prevent people from knowing what they can and cannot do. He added that our efforts should be directed at removing barriers to allow for the transmission of information.

Dr. Ryan clarified that the issue of neglect under 18 years old falls under the parent's responsibility. If a child today develops psychoses, for example, and you are worried about it, she cautioned the members to be careful not to mandate it as neglect because psychoses develops over time. She further explained to be careful about expanding mandating reporting beyond abuse and neglect due to fear for safety from someone else. For example, if a teacher hears a child saying I'm going to hurt someone, the teacher is not mandated to report that. They are mandated to report abuse and neglect of a child. That doesn't fall under neglect by a parent.

Dr. Kane clarified that if a student makes a clear threat to hurt someone, the teacher is mandated to report under the Tarasoff law. We do need to make a recommendation to look at the existing laws and allow education to providers about the state HIPPA laws in sharing information. We need to allow for communication between family members and providers to get the history on the individual if the person is not present in an extreme emergency.

Cara Westcott stated that the issue is about raising the awareness of mental health issues. There is already significant language in the bill around medical first aide and pre-service and in-service education for teachers and allied health professionals. We need to include, however:

- Public Health Campaign to reduce stigma and educate people when to say something
- Helping individuals who have more interaction with adults – i.e. primary care providers, schools, or the courts –so they know when to make a call.

Commissioner Rehmer suggested that a recommendation of the task force should be to clarify the law and also include training for people in the mental health system.

Judge Killian also suggested that the recommendation be included that the former treater talks to the inpatient hospital.

Dr. Ardon stated that she experiences more difficulty getting collateral information in an outpatient setting when it is not a crisis. She added that usually she doesn't experience any difficulty when treating a patient in the emergency room in crisis or will need a patient's consent to get information from other providers. How we communicate, however, is the issue and it depends on the setting and where patient is at.

Dr. Ryan stated that she is unable to receive collateral information from a school because it is not considered a clinical setting. The school is where I could probably get the most important information.

Dr. Ardon stated that there are a lot of private matters between the family and the patient. Sometimes there are concerns about the privacy issues with respect to the child, especially around what can be reported. The lack of providers in the school system also prevents us from acquiring information, including the lack of time that we have to obtain the information.

The following points were made regarding Item 10 (Assisted patient outpatient behavioral health services and involuntary outpatient commitment as treatment options)

Judge Killian explained that his recommendation would impact 800 to 900 potential clients in the outpatient commitment concept in CT per year. He highlighted the following points:

- Individuals that have already been found by a court to have been a danger to themselves or others within the past six months.
- Prevents individuals from experiencing a criminal prosecution and subsequent incarceration in order to get the mental health treatment that they need.
- Prevents individuals from losing supportive housing for failure to continue their medication
- Programs already in place (the Psychiatric Security Review Board, Diversionary and Re-Entry)

(Note: a hand-out was distributed outlining his recommendations to amend the civil commitment statutes.)

Commissioner Rehmer offered clarification:

- Psychiatric Security Review Board is almost a hundred percent for people discharging from Whiting Forensic not prisons.
- Diversionary and re-entry programs have decreased the number of people that go into the prisons.

She further expressed strong concern about 18-25 years olds, many of them who have no involvement with the criminal justice system that may be included in this commitment statute. How would we enforce outpatient medication in the community if this becomes a law?

Judge Killian provided the following comments:

- People acknowledge the responsibility to adhere to an order, because of the alternative, for example, of being re-hospitalized. Those that do take medications once they are hospitalized, do so in order to be released.
- Many of these individuals will be re-hospitalized shortly after their discharge within the six month period. I don't believe that out of the 800, there would be a significant amount that would be taken advantage of. We have an opportunity to extend the requirement beyond the six month period for at least 600 or more of these individuals. Also, out of the individuals that I have seen that are 18-25 years old, a very high percentage have had significant involvement with the law enforcement. He further explained that there are hearings on a monthly basis at the Hartford Correctional Institution to put a conservator in place when people our being released. Just the threat of being re-incarcerated is often sufficient enough to get an individual to comply with taking their medication.

Dr. Connor asked should the recommendation be a legal recommendation about the power of the state versus the rights of the individuals, or should those individuals be mandated to intensive case management or in-home services if they meet specified criteria.

Commissioner Rehmer explained her concerns regarding having an involuntary commitment statute because DMHAS (Department of Mental Health and Addiction Services) has just received funding to create ACT Teams and place people in the courts to help to engage people in to treatment as opposed to having them committed. It is too early to determine the outcome of these programs. She provided the additional information

- The recent funding will go to people in the public sector.
- Privately insured individuals, if they are released out of the psychiatric institutions after 15 days or sooner (average length of stay is 10 days), they will not be on ACT Teams and we may not get them to be compliant to taking medication. We will probably be able to
- It is too early to be having this discussion on the moral imperative on having people committed to taking medication through a court order. There will be some that will

comply and others that will not and we will run the risk of young people becoming involved with law enforcement.

Commissioner Rehmer emphasized her concern about public perception. She explained that there are forty-four states that have involuntary treatment statutes. Currently there is no forced medication in the community. At least two or three of the very violent issues that have occurred in the last two years that have made this issue very public were committed to outpatient services. This gives a false illusion of safety if we do something that coerces people into treatment rather trying to engage them into treatment. Also, the racial disparity is very high for people who are committed to outpatient treatment which is probably related to insurance. I will research the numbers relating to racial disparity and forward it to the task force members. To have a system that is not fully capable of meeting all of the needs of all of the people in Connecticut is unethical. There are a group of individuals that will not be able to avail themselves of these very intensive services.

Dr. Ryan asked if there should be a recommendation to correct this imbalance between privately and publicly insured.

Kelly Phenix suggested that there needs to be legislation that covers private insured the same as the public insured for mental health services. For involuntary commitment, the private insurance does not cover DMHAS programs for treatment even if it is court ordered because private insurance doesn't deem that to be medically necessary.

Jill Hall noted that we have been trying to address these issues for privately insured individuals.

Dr. Jimenez stated that the private insurance companies that he represents do provide coverage for outpatient programs if they meet medical necessity criteria.

Jill Hall made a recommendation that more uniformed standards be developed for commercial insurance companies regarding medical necessity across all levels of insurance and coverage. Members further discussed the issues of court ordering individuals to take medication(s):

- Focus on understanding why individuals refuse to take medications and address these issues, as opposed to mandating and regulating forced medications.
- Forcing medications would create liabilities for medical providers and unforeseen consequences that will create a fear of providers to be involved with the management and treatment of individuals.
- Problems with access and coverage of care for mental health services
- We do require forced treatment of people in many instances. The test is always that whether their refusal is a knowing refusal, and a willing acceptance of the consequences.
- This a small percentage of the population that commands a much larger percentage of the total dollars spent under this proposal.
- A Lobotomy, ECT (Electroconvulsive Therapy) and Psychotropic medications are exclusive to all other medical treatments –they cannot be forced. A court order for these treatments can only be done under inpatient circumstances.

- Hearings can be held to determine an individual's capacity to make an informed consent decision or their lack of capacity to do it.
- Outcomes of individuals that have been assigned a conservator relating to compliance.
- Concerns with the Administration of forced medication for 16-25 years old:
    - What are the potential risks with forcing medications?
    - Understanding the feasibility of forced medication.

- Social workers may utilize the forced medication option as opposed to utilizing improved techniques and technology to engage young adults into treatment and will create ethnic and racial disparity.
- Coercing young adult population to engage by involuntary treatment creates distrust between them, the social workers, and therapists. Many get involved in illegal activities and the criminal just system as a result. Instead provide more community support, educational opportunities, housing, and jobs.
- Other options outside of forced medication – i.e. in-home treatment to build an alliance to engage treatment

Dr. Ryan suggested that perhaps a recommendation should be that there is not a consensus and there needs to be further discussion about this very complicated issue.

Jill Hall stated that we need to focus on the lack of options and inadequacies for people with mental health disabilities and how to increase the effectiveness of community based mental health services.

Judge Killian expressed that there are many programs that are benefitting at least 75% of the population that are mentally ill, however, there is still small segment of the population that mental health services are not being extended and met in the least restricted manner.

Meeting adjourned.