SANDY HOOK ADVISORY COMMISSION

MARCH 22, 2013

9:30 AM

Legislative Office Building

Hartford, CT

SCOTT JACKSON, Committee Chair
BERNIE SULLIVAN
ROBERT DUCIBELLA
HAROLD SCHWARTZ
ALICE FORRESTER
EZRA GRIFFITH
TERRY EDELSTEIN
KATHLEEN FLAHERTY
ADDRIENNE BENTMAN
DENIS MCCARTHY
BARBARA O'CONNOR

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AGENDA

I. Call to Order

II. Behavioral Health - Increasing Public Awareness & Decreasing Discrimination

Kim Pernerewski, National Alliance of Mental Illness - CT
Louise Pyers, Executive Director - Connecticut Alliance to Benefit Law Enforcement (CABLE, Inc.)
Deron Drumm, Executive Director - Advocacy Unlimited
Bryan V. Gibb, Director of Public Education - National Council for Community Behavioral Healthcare (Mental Health First Aid)

III. Access to Mental Health Care

Deputy Commissioner Anne Melissa Dowling, State Department of Insurance
Vickie Veltri, Connecticut Healthcare Advocate

IV. Assessment and Management of Risk

Marisa Randazzo, Managing Partner - SIGMA Threat Management Associates

V. Other Business

VI. Discussion

VII. Adjournment

(The proceedings commenced at 9:30 a.m.)

MR. CHAIRMAN: Thank you all for coming out this morning for this initial meeting of the Sandy Hook Advisory Committee. We do have an agenda for today's meeting, and I would ask our esteemed Governor Dannel Malloy to provide to this committee its charge.

MR. JACKSON: All right. It looks like we are prepared to begin today's meeting of the Sandy Hook Advisory Commission for March 22, 2013. We will call the meeting to order at 9:33. Why don't we introduce ourselves to the people in the room. We'll start from my left today.

Mr. Sullivan?

MR. SULLIVAN: Bernie Sullivan, former chief of police of City of Hartford and commissioner of public safety for the state of Connecticut.

MR. DUCIBELLA: Robert Ducibella, founding principal, Ducibella, Venter & Santore Security Consulting Engineers.

DR. SCHWARTZ: Harold Schwartz, psychiatrist and chief at the Institute of Living and vice-president of behavorial health at Hartford Hospital.

MS. FORRESTER: Alice Forrester. I'm the director at Clifford Beers Clinic, a child mental health clinic in New Haven.

MR. GRIFFITH: I am Ezra Griffith. I am on the faculty of the Department of Psychiatry at the Yale School of Medicine.

MR. JACKSON: Scott Jackson, mayor, Town of Hamden.

MS. EDELSTEIN: I'm Terry Edelstein, Governor Malloy's non-profit liaison.

MS. FLAHERTY: Kathy Flaherty, staff attorney, Statewide Legal Services of Connecticut, person living with bipolar disorder, and mental advocate.

MR. BENTMAN: Addrienne Bentman, psychiatrist, program director with residency in psychiatry at the Institute of Living.

MR. MCCARTHY: Denis McCarthy, fire chief and emergency management director for the City of Norwalk.

MS. O'CONNOR: Barbara O'Connor, chief at the University of Connecticut.

MR. JACKSON: Thank you.

I'd ask Ms. Edelstein to review the governor's charge to this panel as it pertains to mental health.

MS. EDELSTEIN: Thank you, Mayor Jackson.

Today, we're going to begin our focus on mental health issues, and I thought that it would be important for us to review as a Commission what the governor charged us with relating to mental health. As you know, as fellow

commissioners, we had agreed that in our preliminary recommendations to the Governor, which Mayor Jackson conveyed to the Governor on the 18th of March, we had agreed that we were not going to be focusing on mental health issues because mental health issues had not been brought before this Commission.

Today is the start of some of this discussion. To review what the charge is, the Governor charged us with looking at ways to make sure our gun laws are as tight as they are reasonable, that our mental health system can reach those that need its help, and that our law enforcement has the tools it needs to protect public safety, particularly in our schools.

And subsequent to the initial charge, the Governor added two other stipulations to us, whether additional changes to mandatory reporting laws should be considered, including appropriate behavioral and mental health criteria and whether physicians, behavorial health professionals, social workers and other professionals should be included as mandatory reporters of firearm safety.

That brings us to today's program.

MR. JACKSON: Thank you.

For most of the next several sessions we will be focusing in on the issues of mental and behavioral

health, although we will take some time to go back and speak to some other folks regarding school security, firearms and ammunition, as well. I would like to start the presentations today with Kim Pernerewski, president of NAMI Waterbury. That's the National Alliance of Mental Illness.

Ms. Pernerewski, thank you for coming in. Welcome.

MS. PERNEREWSKI: Well, I was asked to come here as a parent of a child who has mental health issues. And I say "mental health issues" because I don't think mental illness is such a nice word. My -- I am a parent. I don't represent any organization. However, I will tell you that I am a working parent, and my son comes from a two-parent family. And I want to stress that because we are a two-parent blended family. We both are divorced and remarried, and, going into having a child, figured this child would not have issues because he was going to be raised in a family that was together. And of our three children, he is the one child that has some very serious issues. So, clearly, a two-parent family is not the issue in this case.

I work at the Village of Brookfield Common, so this whole Sandy Hook issue has been very close to home. I work with several first responders who are having a very

difficult time with this, so this was very near and dear to them when I was asked to come here. So I thank you for asking me. One of the other things that I do is I'm a volunteer for NAMI Waterbury. I am their president, and I also teach several classes.

One of the classes I teach is NAMI basics, which is a six-week class for parents of children with mental health issues who can come, learn about what it is that their children have, how to deal with it, how to work with the schools, how to go forward and how to really take care of themselves, because if you're not taking care of you, you can't take care of that child. And there's a lot to take care of. There's a lot to deal with. It is not easy any day of the week, any hour of the week. Any moment of a year it is not easy.

The other thing I do is I teach -- well, I can't even say teach. I speak to teachers with a four-person panel. There's a teacher, there's a Family-to-Family educator. Family-to-Family is kind of like our NAMI basics class, except it's for -- more geared towards adults. And that is a twelve-week program, and that person, basically, will talk to teachers about what mental health is, mental illness is. There's a parent, which is my role, and then there's somebody who has mental health issues on that panel.

And we go and we talk to teachers about what it's like to have mental illness, what it's like -- what the experience is, what they should be looking for and where to refer those parents when they do spot these things. I can't imagine being a teacher in a class of 25 students having -- and I live in Waterbury, so, quite frankly, there's a lot going on in those classrooms. I can't imagine what they must be going through when they have, you know, 5 kids out of 25 who have some sort of mental health issue and they don't know how to deal with it, and they don't have the help they need to do that.

I know several teachers. I know that they struggle sometimes. And they will ask me, "Where do I turn? I have parents that are not willing to admit or who are not willing to accept." It's hard. It's very hard when you get that, well, "We think Johnny might have a problem," or "We need you to call somebody," or "We need you to go talk to our guidance counselor because we need you to look into something." That's tough, but, at least, it gives the teachers -- we give them information. That's really what we're doing, were giving them information. We're not diag -- we can't diagnose. We're not diagnosticians, we're just parents. We're parents who have been through this.

And the last thing that I do is a support group

called NAMI-CAN, Child & Adolescent Network. And we run our support group once a month, at least my support group in Waterbury. Parents can come and unload. And, quite frankly, that's what they need to do, is come unload.

Sometimes we laugh. Sometimes we cry. Sometimes it's just a shoulder to be there to talk to. I feel that it is probably the one time a month that I feel like somebody really understands what I am going through every single day, because sometimes I don't -- I'm not even sure that anybody else in my family really understands it because they're not there all the time, except for my husband, who has to deal with it, as well, but other people don't.

You have no idea how hard it is when somebody says to me, "Oh, my son just got straight A's," "Oh, my daughter is just going off to college," because I know that's not going to happen right away for my child because he is struggling. He is struggling.

So a little bit about what -- how this all came about for me. My son was diagnosed at the age of eight with bipolar disorder, eight years old. And let me tell you, when that happened, it was like somebody hit us with a brick, and we didn't know where to turn, we didn't know what to do, we didn't know who to look to. And the only resource I had at that moment was the internet. So I got

on the internet and I found NAMI, and I found another organization called the Child & Adolescent Network, which was mostly a thing that you could do online. And it had online chat rooms, which I spent hours on. And when I spent my hours on there, I got a lot of support from other mothers who are going through very similar situations.

My son always complained about how lonely he was, other children didn't understand him, other children still don't understand him. My son is not a child anymore. He will be an adult in a couple months. He is not ready to be an adult. He is not even close to ready to be an adult. He needs a lot more than what the schools were able to offer him, than what I've been able to offer him. He needs guidance. He needs somebody to help him do more. He needs training. He needs psychiatric help.

My experience with hospitals were horrendous. It's just been an uphill battle all the way. And I think what you do need to know -- and this is a very recent experience, so I think that you need to hear this because any parent who is going through this has had this happen to them. We had an experience where we were called to the school because my son was cutting, which is, in my mind, pretty serious. So I go rushing to the school from Brookfield to Waterbury. And we're sitting there, and the crisis counselor says, "We need to send him to the

hospital." "Okay."

We go to the hospital. He's put in a room probably the size of this room with adults and children in one room. There's two other private rooms on the side. My son is pushing the security guard, pushing the nurses, yelling and screaming. This happened on a Friday. The only thing that they're giving him to settle him down is Ativan, which is a little tiny pill, because they can't treat children in this hospital. He was seventeen. Then Saturday morning when I go in, they say, "Well, we think he's ready to be discharged."

Now, on Friday they told me he needed to be admitted to a hospital, but they could not find a hospital to take him because there were no adolescent beds anywhere. But now suddenly, Saturday morning at ten o'clock, he's ready to be discharged. What happened between ten o'clock Friday night and ten o'clock Saturday morning, outside the fact they couldn't find a bed? Really nothing, except they couldn't find a bed.

And so I now take a teenager home who's been cutting, who, when they asked him to lift up his shirt, had not only cuts up and down his arms, but had cuts all over his belly, too, and I had to take him home. It's a very scary experience. And that poor child for two weeks, every day I was in his face, like, "Are you okay?" "Is

everything all right?" I think -- I probably drove him insane, but I was scared. I don't want to lose my child.

Our system is broken. It's broken for children. There is nothing that is working for these kids and their parents. Their parents don't know where to turn. I don't know where to tell them to turn, and they come to me for help. I just don't know what to say to them. So if I don't know what to say and I'm the person they're coming to, we need to do something.

And I'm the one out there fighting for them, and I'm out there asking the schools to teach our other children how to treat these kids. I know money is tight. I understand that. But there's got to be a way. There's got to be a way. And that's all I ask, is that we work on this because we don't need another Newtown. And I believe that kid probably could have been helped. And my first thought that day was, "God, help his father because he's in for an awful rough road for the rest of his life."

Thank you.

MR. JACKSON: Thank you for your testimony and telling your personal story. One of the things that I think we need to -- we need to flush out is how do we create an environment in which we have a greater public awareness of mental health issues, less stigmatism about seeking mental health issues, beyond the fact that the

system, in many ways, doesn't seem to allow it. But there's this -- you know, this American ethic that you have to do it on your own.

What do you see as ways that -- you know the practical steps we may be able to take to say it's okay to ask for help, as a parent, as an individual, it's okay.

MS. PERNEREWSKI: I think part of it, we start at the school level. And I know we do an awful lot at the school level, but we've got to start at the school level. We tell kids it's okay at the school level a lot of things. We tell them no drugs. We've done all kinds of drug programs. There's no reason we can't do things about mental health at the school level.

I can't tell -- there was one town that called me -- a mother called me and said, you know, "I really would like if you would please go talk to my Girl Scout troop about mental health issues." And she goes, "Here's the troop leader's name. Could you please call her?"

So I said, "Sure, I'll call her." So I called the troop leader.

And she says, "We don't have those problems in this town."

I'm like, "Seriously? Really?" I go, "So we only have those problems here in Waterbury?"

And she says, "Well, you know, this is a small

town. We don't have those problems."

I go, "That's funny, because I just read in the paper the other day that you had a death due to a hanging. So don't tell me you don't have those problems in that town. You do have those problems."

"Well, our girls are only twelve."

I go, "Well, that's where it starts."

This needs to be in the schools. They need to understand it starts young. Parents need to be educated. And parents -- and, God, help me, parents are probably -- and us, we're probably the worst offenders because what do we do when we see somebody on the street that looks a little odd, we walk the other way, we hide. We're all guilty of it. I'm guilty of it. And I'm looking at my son, going he could be one of those people some day. It's scary. But we're all guilty of it. So, yes, I think that we do need to look at the schools, and go, okay, we need to talk to these kids about this.

There was a great program in Waterbury. It showed at the Palace just recently, called "I Am." And, basically, it's about I am, who I am and about being who you are. And I think that we need to let kids be who they are, be it whether they're gay, whether they're mentally ill, whether they're something else. They need to be who they are. And we need to let children know it is okay if

you don't want to go to college. It is okay if you want to be an electrician. It is okay if you want to be a musician.

I geared my kids to go to college. And I think about it now, and that was probably the worst thing I ever did because I have one that did go to college. That was his goal. I have another one who became an electrician. And now I have my youngest one who has mental health issues, who really is a musician. That's what he's going to be. He's creative. He's got a very creative mind. So why don't we start at the school level? Maybe we need volunteers to do it. I'd be willing to go and volunteer. But we also have to get our businesses to say, "Yeah, you can take a day and go to the school and do what you need to do." Would that be so hard?

MR. JACKSON: Thank you.

Questions?

Dr. Schwartz.

DR. SCHWARTZ: Thank you again for sharing your personal experience with us. I think one of the issues that is clearly of interest to the Commission is access to care, and your description of access to inpatient services and emergent -- at least one emergency department is stark. Could you elaborate? Is that -- was that experience typical of inpatient access experiences as you have

experienced them or others, you know, within NAMI, and could you also tell us a little bit about the experience you've had trying to access care in the outpatient arena?

MS. PERNEREWSKI: For children, yes, it's very difficult to find services. One of the things -- I actually went to Washington a few years ago with a bunch of psychiatrists to do some lobbying at Capitol Hill. And one of the things that they told us was that most of the psychiatrists for children are in New Haven. Now, if you live in the northeast corner of the state, what good is it to have a psychiatrist in New Haven, because, quite frankly, driving two hours to New Haven if you live in Pomfret is not going to really be very helpful, is it?

Even for me, I live in Waterbury, I work in Brookfield. To come home and pick up my kid and take him to New Haven is not -- that's a whole day's work just to do that. It's a lot of work to do anything to get services.

Back a few years ago, my psychol -- psychiatrist dropped my insurance, so I had to find a -- it took me four days to find a new psychiatrist, who was not a child specialist, but he would take children. And he was retired, so he couldn't admit to a hospital if there was an issue. So we were kind of stuck, but we did it. Managed. And then my son decided not to take meds anymore, so that was kind of the end of it.

Right now, I am privately paying for a psychologist because he's out of my network because he won't take my insurance. He told me if I was in the Husky program, I'd be much better off, because kids on Husky get better care under mental health than kids who have private insurance.

My husband works for the State of Connecticut. I have the top-tier plan. I pay the most for my insurance, and I can't get care for my kid? That's crazy. That's insane. But that's what parents are going through. Parents with insurance have a harder time and harder time -- and harder getting access to care than parents who don't have insurance.

But to answer your question, even finding somebody who will take your kid is almost impossible. And when you do find somebody who will take your insurance, there's no guarantee that person is very good or that your kid is going to like them. And if your kid doesn't like them, you might as well forget it because they're not going back. You've got to find somebody that these kids are going to relate to. It just doesn't work otherwise.

MR. JACKSON: Was there a second part to your question, Dr. Schwartz?

DR. SCHWARTZ: (No audio).

MR. JACKSON: Ms. Flaherty?

MS. FLAHERTY: Thanks so much for sharing your story. I really appreciate it.

I was just wondering if you had -- the presentations that you do, especially at the schools, the parents and teachers of the Alliance program, can you share a little bit with the panel about the sort of feedback you get from the teachers and the other audiences after you do those presentations?

MS. PERNEREWSKI: Sure. I did one presentation at a Bridgeport school a while ago, and it was a huge -- it was actually a huge audience. And it's a very powerful thing when you have the teachers speak first. The teacher will tell her story, and then they all -- it kind of grabs their attention, because now you have their peer saying, "Listen, I'm dealing with this, and I'm one of your peers." When they get to the parent, you see tears now starting to come down their eyes because they're starting to go, "Oh, my, God, we've been dealing with these kids." Then when the person next to me, the person with mental health issues speaks, it's even a little bit more powerful.

At the end, we have a question and answer time. And at this Bridgeport presentation, I had a teacher stand up, literally sobbing, and she said, "Oh, my, God, I have to think differently about how I teach my children. I have said those things to my students." That's a powerful

statement. That means they're not recognizing what's going on. Are we missing the boat in teaching our teachers? They've got a tough job out there. It's not easy being a teacher. And are they missing the boat? That's a really hard, hard thing for them.

I had another teacher there who came up to me and said, "I know who you're talking about because he was one of my students." I thought -- I was in Bridgeport, how possibly could any of those teachers ever have had my kid? But he had been one of my son's teachers. And he goes, "He was the best kid, and I really loved him. But I also have problems, so I think that's part of the reason I kind of took him in under my wing."

I can't tell you the number of teachers that come up to me afterwards and want to talk to me privately. And I know that everybody there, every panel member is saying, "I have a family member," "I have a friend," "I have a student," "I have a daughter." It's amazing. And it's not just there. It's after you leave, they're following you down the hallway. It's a very powerful, powerful presentation.

And in my NAMI basics class, those people come back to my -- back to my support group because they're dealing with an awful, awful lot of guilt. They feel like it's their fault. They feel like they've done something

wrong. It's not their fault. It's not their fault. And that's the hardest thing to get across to them, "It's not your fault."

MR. GRIFFITH: Good morning.

MS. PERNEREWSKI: Hi.

MR. GRIFFITH: I would like to ask you a question about your experience with the insurance. You say you have one of the finest insurance plans in the state. So does that offer you and your son care for a regular pediatrician?

MS. PERNEREWSKI: Oh, absolutely, yes.

MR. GRIFFITH: And there's no difficulty with that?

MS. PERNEREWSKI: Never.

MR. GRIFFITH: So explain -- explain to the Commission what the difficulty is then with finding a pediatric psychiatrist.

MS. PERNEREWSKI: There's very -- first off, there's very limited pediatric psychiatrists in my area. There's maybe --

MR. GRIFFITH: Well, let's assume -- let's assume -- let's assume there are.

MS. PERNEREWSKI: If I had a -- if there was a lot of them, a lot of them don't take the insurance.

MR. GRIFFITH: So tell us about that, because I

don't -- I'm not sure I follow you.

MS. PERNEREWSKI: Their claim is that they don't get paid enough by my insurance company to take the insurance.

MR. GRIFFITH: But I'm going to keep interrupting you just so I can --

MS. PERNEREWSKI: That's okay. Go ahead.

MR. GRIFFITH: -- so I can understand it. But your regular -- your regular pediatrician, what does he say about his payment?

MS. PERNEREWSKI: They complain, too. They all complain, I'll be honest with you. I work --

MR. GRIFFITH: So it's just --

MS. PERNEREWSKI: -- in healthcare, so I know exactly what they're complaining about.

MR. GRIFFITH: It's just the doctors then, they all complain about --

MS. PERNEREWSKI: They all complain about their reimbursement.

MR. GRIFFITH: So the pediatrician doesn't complain, though, quite as much as the pediatric --

MS. PERNEREWSKI: Right.

MR. GRIFFITH: -- psychiatrist?

MS. PERNEREWSKI: Right. And I have seen their reimbursement based on what they're charging, and it is --

it's less than half of what they're charging. So to keep up their offices and their billing and all of that, I can understand where they're coming from. It is a very reduced rate.

MR. GRIFFITH: And the psychiatrist, what he would be reimbursed or she would be reimbursed is more than 50 percent less than --

MS. PERNEREWSKI: It's -- yeah. Yes. So if they're charging $150 a visit --

MR. GRIFFITH: Uh-huh.

MS. PERNEREWSKI: -- they're getting about -- if I remember right, the last one I looked at, it was like $60 a visit, which is not a lot --

MR. GRIFFITH: But in your --

MS. PERNEREWSKI: -- for a psychiatrist.

MR. GRIFFITH: But, in your opinion, there's some discrepancy in the difference between the payment given to the pediatrician and the payment given to the pediatric psychiatrist?

MS. PERNEREWSKI: That I'm not positive --

MR. GRIFFITH: You don't --

MS. PERNEREWSKI: -- about because I don't see -- I don't see what goes to the -- to the pediatrician. I can get bill -- EOB's for the psychiatrist because I usually ask for those.

MR. GRIFFITH: So then the two problems, if I follow you, one has to do with the distribution of pediatric psychiatrists --

MS. PERNEREWSKI: Correct.

MR. GRIFFITH: -- in your community, and then the other thing is the reimbursement?

MS. PERNEREWSKI: Correct.

MR. GRIFFITH: Thank you.

MR. DUCIBELLA: Kim, thanks very much. I can appreciate that coming to the public forum with this is not easy, but it's helpful.

Whenever things aren't right, we have sort of a penchant in America for wanting to -- I hate to use the term fix them, but make them more normal. Is there, as a parent, a clear, what I'll call decision support template when you found out or when other parents find out or believe that their children are experiencing a mental health anomaly disorder? Is it clear whether you go to the school to talk to someone, whether you talk to the medical profession, whether, if there's a sign of violence, you go to law enforcement? Where does one go?

You have spent a great deal of time with this, but the normal parent has not. So if our vehicle is broken, we go to a mechanic. If our roof leaks, we call a roofer. This is a very complex situation. What is the

process that you see moving forward that someone who has this, where do they go to get a start on how to go about setting their situation into a circumstance where they and their children feel as those they're being helped?

MS. PERNEREWSKI: NAMI. Quite honestly, that's -- you really need to look for help. It's not something that's given to you. You go to the doctor, and they give you the diagnosis and kind of -- it depends on the doctor. I was fortunate when I went to my pediatric -- at that time, the pediatric psychiatrist I had suggested NAMI. Not all of them do. And that was where I started, which was a help. It was a huge, huge, huge help. Unfortunately, I've had many parents who came to me and said, "Oh, my, God, I wish I had found you sooner."

Several parents get online, they go to like the Children & Adolescent Bipolar Foundation, which is a huge, huge, huge help. It's a -- it's -- especially if you have children, because it's very hard to get out of your house to go to a support group. But if you can get online on a chat room, that's a big help, because, once your kids are in bed, you can get online, and you can talk to parents. That's helpful. But if you don't know to look for it, what good is that, you know?

If there's somebody out there, if you're -- even as a provider, you're saying, "Listen, there are

groups out there that can help you. Let me give you the name of one," that's a start because that one will tell you about somebody else. The parents need help just as much. And I will say the psychiatrist that we had did say to both my husband and I, "You both are going to need help through this. You're not going to get through this alone." I have had parents come to me and say, "They gave me the diagnosis, and that was it." It's not good.

Now, if they're lucky enough to get into a system where they've got the psychiatrists, the counselors, the psychologists and the whole kit and caboodle all in one place, then usually they'll get along pretty well. And there are places like that. Wellmore is like that. Yale has some of those services. A lot of parents don't have that luxury. And, really, I think like the northwest and northeast corners really suffer probably the most because they're rural.

MR. DUCIBELLA: I'm going to turn this back to the Commission. But if we have a broken finger or a broken leg, we go to the emergency room. It's a very clear opportunity when we are experiencing a physical problem. The sense that I have from you, and it's pretty clear, is that if this isn't a bodily injury, the process towards resolution in terms of finding out where you go and who you talk to and what to do, is significantly more unclear.

It is not necessarily intuitive unless you've dealt with it before. And there isn't a source where you can go to that everyone agrees is the right place to start, other than perhaps a psychiatrist, who may or may not, as Professor has mentioned with your conversation -- may not be a beneficial arrangement because of the compensation terms. That's the sense that I have about what you're saying.

MS. PERNEREWSKI: Exactly. There's no one place you can go to.

MR. DUCIBELLA: Yeah. Okay. Thanks very much.

MS. PERNEREWSKI: At least not what I've found.

MS. FORRESTER: Thank you so much for both your story and for every day with what you're doing to try to reach out to other parents. And I can't agree with you more in so many of the points that you made.

I think the point that you said about your son being so lonely and not being able to talk about that in his class or have other kids understand, you know, what he's experiencing, is something we see over and over again. You know, your son has a very -- it sounds like a clear diagnosis of bipolar, and we see so many kids who fit into lots of different diagnoses who have experienced some very high stress in their lives, too, and they also feel severely lonely. So I appreciate that.

And I also want to echo around the system, you know, being broken. And I think you pointed it out extraordinarily well, is that currently for Husky, a lot of the clinics that you mentioned that have everybody together, have been because of the way that the state has sort of forced the funding streams down has made it actually quite available to folks with Husky. And that a lot of the families even who live at -- who work at Yale or have very good insurance, often are on their own to find their own therapists and don't have a system the way that maybe Husky does.

I want to assure you that even though Husky is working well, it's still broken. There's still issues that arise for the kids with Husky. I think that the most important point, and this isn't really a question, but I just want to say, is around forming community that understands. I think that your point is is that it's not going to be the people with mental illness, nor the parents who are going to really make the difference. It's forming an understanding in a community that everyone understands what it is and how to address it and how not to walk by the kid on the street, but to have empathy and compassion and to, you know, not be afraid.

MS. PERNEREWSKI: Correct. I think that as a country, as a state, we tend to talk about empathy, we tend

to have incidents like Newtown, we tend to look for blame. We don't empathize sometimes, and we forget about it later on. And I think we need to sit down and really think about what's going on out there and who is hurting. I mean, we go through our daily lives, we work -- we go to work, we, you know, do whatever we do, and we forget that there are people out there that hurt every single day and who don't have the things that we have.

Now, the Husky kids, they can get great mental health care, but they can't get great, you know, regular care. I mean, what good is that, you know? I mean, they should be able to get the same health care as my kid who gets great health care, but can't get the mental health care he needs. I mean, it's just cra -- what a crazy world we live in. You know, it just doesn't make sense.

So I think as a society, we somehow need to teach that empathy. And I always thought it would be in churches. I never went to church as a kid, but my husband did. But I watch these people leave church, and, you know, they're great when they're there. And then they leave church, and they forget all about what they just heard in the sermon. I'm going, "Come on, guys, you know, that's what it's all about. It's about empathizing with people." And it's hard for me to watch because I've worked in nursing homes, I work now in assisted living. So I see

suffering and hurt every day. I watch families.

You know, caregiving is probably the ultimate job in the world. It's hard, but it's so rewarding. And I think if everybody went through that at least once in their life, they would look back and understand what this is all about, for anybody, not just people with mental illness, but for, you know, the elderly, for people who are sick, for people with cancer, for anything. And I think that's what we're missing. And somehow -- I don't know how we teach it, but somehow we have to get our kids to understand that, and we have to -- because once our kids understand it, they're the next generation. They're the people that are going to carry that forward. And no offense, I'm the end of the baby boomers. I need somebody to take care of me because in 25 years, 30 years, I'm probably going to be in assisted living or a nursing home, and I want to be taken care of.

And my son, even though he has mental health issues, he's probably one of the most empathetic kids I know, who would bring a bird home to take care of because he feels bad that it got hurt. So that I think is what we need to -- we really need to concentrate on. I don't want Newtown to happen again. I felt horrible that day. I was home sick that day watching TV, and it was like a train wreck. You couldn't take your eyes off of it. And I can

remember thinking, "Oh, my God, I know a doctor whose kids go there." "I know a nurse whose kids go there." "I knew a nurse who used to work there." "My God, what was in that kid's mind?" "What happened?" "Why did it happen?" Good Lord, that poor father, what must he be going through now?"

Nobody wants to be that parent. We can't let it happen again. It just can't happen again. So we've got to come up with -- is there a problem with guns? Yeah, but it's not just a gun issue. This is not just a gun issue. This goes much deeper, much, much, much deeper. And trust me, I don't like guns, but this goes much deeper.

MR. JACKSON: Do you have any final questions for Ms. Pernerewski?

Thank you very much for your testimony --

MS. PERNEREWSKI: Thank you very much for having me.

MR. JACKSON: -- and joining us this morning.

Next up we have Louise Pyers, executive director of the Connecticut Alliance to Benefit Law Enforcement, along with Sergeant McKee.

Thank you for joining us, and welcome. Before you start, if you just want to introduce yourselves to those here and those watching?

MS. PYERS: Yes. Thank you.

Thank you so much for inviting us here today.

Hopefully, the information that we can share with you can shed some light on some additional resources that communities can have in terms of trying to help people with mental illnesses. I have Sergeant Chris McKee from the Windsor Police Department, who will also be giving his perspective as a CIT officer, we'll be talking about that, as well as Officer Sue Bowman, who will also be talking about peer support for law enforcement.

A lot of people know and they understand that law enforcement opens the door to the criminal justice system. We know that. But a lot of people don't know that law enforcement can also open the door to the mental health system. We have 42 police departments within the State of Connecticut who have what we call crisis intervention teams. We have another 30 federal, state and law enforcement agencies that are in the process of forming their crisis intervention teams. So that's about a little over 70 law enforcement agencies in Connecticut who really believe in this.

What it does -- what CIT does is it diverts people with mental illnesses whenever possible, to the mental health system. And these officers are specially trained to recognize when someone might be in a psychiatric crisis and connect them to the services they need, rather than making an arrest. The Crisis Intervention Team

training is funded by the State of Connecticut's Department of Mental Health & Addiction Services. It started in 2003 with four police departments, and now we're up to close to 70 police departments across the state. It's done in collaboration with DMHAS, CABLE, the Connecticut Alliance to Benefit Law Enforcement.

I'm the executive director and founder. We started the training in 2003, and we did it in collaboration with DMHAS and NAMI of Connecticut. We're going to give you a little bit of information with regard to CIT. But just to tell you, CIT consists of people from all walks of life. It's not just law enforcement -- people teaching law enforcement. We're talking about family members of people with mental illness that teach. We're talking about, yes, law enforcement officers who are trained in CIT. We're talking about mental health professionals who also are part of the training. We're talking about people who live with mental illnesses themselves, who come and tell their stories to the officers. That encompasses that CIT training.

And it's highly effective for law enforcement to begin to understand what people with mental illnesses go through, so I'm going to try to play this video.

Do we have sound?

Is it all right to put it up here?

MS. WEIN (phonetic): I don't know.

MS. PYERS: If we can't, then we'll just have to talk about it. No, we'll just talk about it, just to save time. That's okay.

CIT is a partnership, and that partnership, again, is made up of law enforcement, mental health, people living with mental illnesses, both family members and people themselves who are experiencing the illnesses. It's a 40-hour training. That training covers recognizing symptoms. We're not asking police officers to make any kind of diagnosis, but recognizing symptoms that could be related to a mental health issue, and then partnering with the mental health system to get that person connected to the services that they need.

Do you want to add something?

MR. MCKEE: Absolutely. So would you like to go through the slides?

MS. PYERS: No, just talk more about CIT.

MR. MCKEE: So the traditional police response that many folks and many of the emergency service folks here know, is to respond to an emergency and respond to a crisis, assert ourselves, take control, make that scene safe, deal with the issue, and then move on quickly because that's what we do as first responders. CIT is a complete change of mindset where we slow it down.

We start with the recognition of our behaviors may cause or even worsen the situation if we were to run up on a person with a certain diagnosis of mental illness and start putting our hands on that person, "Hey, you, come here," "Hey, you." And we're trained to take control, as you know. But we need to recognize that there are many different signs and symptoms of mental illness, or just anyone in any type of a crisis situation, and the people who don't know that they've been diagnosed, our veterans coming back that may have some issues they aren't aware of and haven't seeked -- sought out any type of help.

So what this does is by providing CIT officers on the street -- by providing officers on the street that are trained in recognizing these behaviors, and then getting a toolbox of how do we deal with this situation, how do we not make it worse? And it goes against the traditional police model. The traditional police model is you wouldn't see Officer Bowman sitting down and listening and listening and listening and listening as someone in crisis is explaining their situation, but that's what CIT does. It changes our system. It tells me, as her supervisor, she's going to be here for a while, and she needs to be here for a while because we're not just going to come in and force the situation and upset or agitate this young man or woman, or in the event of adults, this --

these people. I say young man or woman because the model has been expanded to youth, and that's why -- that's my part of the presentation, being affiliated with the public school district and being responsible for our youth initiatives. But regardless of the age, this toolbox gives us an awareness.

And not only does it give us an awareness and does give us the tools which come from hearing from parents, hearing from folks that were just up here, and this is the life, this is what I live having a child with this affliction, with this condition, it gives us an understanding, but it also gives us relationships. It gives us relationships with those in our community. It gives us relationships with folks at NAMI, folks at our own local social services agencies that may have someone that can come help us. And it, certainly, gives us relationships with folks at -- in our different mobile crisis centers, that we can call so that -- sure, I can come in as a police officer and say, "You know what, let's stop this situation, Bowman." "I'm going to force you into an ambulance and make you go to the emergency room and make you someone else's issue."

Well, no, maybe there's another way. Maybe there's a way of bringing in these resources that I now know of, that I've now met face to face as a result of the

CIT training, and I can call my partner over in the Emergency Mobile Psychiatric Services, EMPS, which is available through 211, and I call them and they can come help, and the situation can be diffused. And maybe there's a better way of providing services other than the mean police officer show up, throw you in the ambulance, and then move on to our next issue. That is overall the benefit that I personally see of myself and for the staff that I supervise at the police department.

MS. BOWMAN: I think, too --

MS. PYERS: Did you want to add something?

MS. BOWMAN: No. That's okay.

MS. PYERS: I think also the training is forty hours, and a lot of police departments can't many times afford to have their police officers out in a training class for that amount of time. It costs overtime, backfill time. What DMHAS has done, they've been gracious enough to recognize this issue and for those departments who set up a CIT policy. DMHAS will pay up to $1,500 of overtime or backfill time incurred as a result of sending an officer to the training. So it's a win, win for everybody.

The police departments get excellent, excellent training for those police officers who take the CIT training. They're ready to hit the street, they're ready to work with their mental health departments in the

community, and they're ready to really find a whole new way of doing things when it comes to working with people with mental illnesses in the community.

MR. MCKEE: Can you give me (inaudible) and we'll just go forward?

MS. PYERS: Yes.

MR. MCKEE: Okay.

So as Louise said, this training is an advanced training. It's not something that comes with basic or accrued training. It's an advanced training that officers volunteer for because you have to, as with any other profession, have certain skills in order to be successful in this area. But who attends the training? Pretty much first responders, those men and women that are in unform, because we are responding -- unfortunately, most of our job is responding to someone's crisis, someone's problems, someone's issues. So the majority of attendees at CIT training are patrol officers, the men and women that are in the cruisers, or out there on foot patrol every day.

In addition, it's been very beneficial to have our school resource officers, our officers assigned, whatever level of school they may be in, our youth or juvenile officers, or other personnel that are dedicated to dealing with our kids in our communities. We've even gone as far as have public safety dispatchers, those that answer

the 911 calls and emergency -- EMS ambulance staff attend the training, because, again, it's about awareness, it's about when that person is even picking up the phone to answer a 911 call from a parent.

If they have been trained in awareness and recognition, then they can, hopefully, do their jobs better in our overall response. In addition to whoever attends the training on the law enforcement side of the house, there are, as I said, these clinicians, the mobile crisis folks that come out. So now, we have promoted the awareness to an officer that didn't realize I have this tool available, I have this person who's a lot more knowledgeable and has a whole lot more credentials than I do in the mental health field perhaps, and they can come out and they can assist and they can diagnose and they can give us feedback, as well. So they attend the training, as well.

Can you flip the next slide?

So the CIT training is a 40-hour training. It has recently in the past year and a half been expanded to include a -- or in addition to a CIT-Y, CIT for youth training portion, and we've been holding that in various parts of the state. And what CIT-Y is is it's an 8-hour additional training for those of us already trained in the CIT philosophy and the CIT techniques. What this training

does is it further assists officers and emergency personnel in recognizing adolescents going through the stress, adolescents going through crisis or those with mental health issues or concerns. It gives us the -- perhaps the early onset signs and symptoms that we should know as we're recognizing and responding to an emergency. It gives us what some effects of trauma are.

And, you know, we're talking about -- and this Commission is studying an incident. However, there is always the trauma -- and we have experienced the trauma of losing students in nearby jurisdictions to violence, and how does that affect their peers the next -- that following Monday -- on that following Monday school day, you know? So, in one particular instance, Officer Bowman, whose job is not normally in the halls of the schools, came in to assist because trauma affects people. Trauma affects people every day, as we know.

In addition, the CIT-Y training provides the steps that we need, going back to the toolbox, how can we help the situation, how can we help this young person, how can we deescalate this situation so that we are not simply jumping to arrest? And, as already mentioned, it partners us. There's a significant part of the second day training program that puts us at tables and mixes us up -- mixing up the police officers with the mental health folks with the

folks from the Department of Children and Families. And we get to understand each other's perspectives, and we get to establish some relationships and build a rapport with each other to find out how we can help each other.

What CIT and CIT-Y both do, is they create opportunities. They create opportunities -- I heard to the stigma -- the term "stigma" used in the last presenter by one of the Commission members. It reduces the stigma even by us, because we wear badges, we wear uniforms, but we're human beings. Do we have a stigma, do we have a perception of what mental health looks like or what a person in crisis looks like? It helps reduce that for everyone.

Significantly, another very important opportunity that it creates, is it helps reduce the number of arrests. Those familiar with the juvenile justice system know that it's built around a rehabilitative model. We don't want to con -- we don't want to put consequences on our young people, we want to address their issues and fix them and help them to become productive members of society. Well, that includes our juveniles and our youths that are in crisis.

So this -- having this type of training helps us realize it's not simply an arrest, just because somebody was mouthing off to a grownup or a parent or because there was something else. Well, was that crime -- was that

offense truly a crime or offense, or is there another reason, an underlying reason that may have led to that behavior? So can we divert that person? Are they better served by a mobile crisis center or by going to a hospital?

And we share this information with families that may not have these tools. And, ultimately, it helps improve things. We've all unfortunately seen the situations on -- you know, through the media of what happens when the police respond and someone doesn't respond to us and then force gets used. And do all these situations need to happen? I'm not here to say, yes, they do, or, yes, they should or shouldn't happen. But it helps provide -- it's a tool for us to reduce situations like that.

MS. PYERS: Okay.

CIT is also evidence based. We know it works. There was an 18-year study done in Memphis, Tennessee by the University of Memphis and the Memphis Police Department. They actually started the CIT program in Memphis. Basically, they found that --

Do I have it on -- okay.

The number of injuries to police officers, and this was something that nobody -- everybody was really concentrating on, how does this help people with mental illnesses? They found that injuries to police officers

themselves went down by 85 percent because they learned a new way of slowing things down, of not rushing in, of being able to ask the right questions and those types of things. So nothing ever rose to the level of having to use force.

Also, there was a big reduction of people with mental illnesses. And that's the important piece, again, because they don't have to use force many times as a result of their encounter. Again, people are safer. So really, it keeps police safer, it keeps people in psychiatric crisis a lot safer with using CIT. Another study done by the Department of Mental Health and Addiction Services, 2007, 2008, showed that the CIT program worked in terms of connecting people to services.

Thank you. I'll just keep going.

MR. MCKEE: (Inaudible) get up every time.

MS. PYERS: No. I'll just do this.

Approximately 1,500 people with mental illnesses were referred to DMHAS, referred to mental health services as a result of a CIT contact. And this was a study just with four large urban police departments. One was Hartford, one was Waterbury, New London, and New Haven. And just from those four departments in one year, they had 1,500 people who were connected to services, who might otherwise have ended up either in jail or slipped through the cracks and would eventually maybe ended up in jail

because they didn't have the service that they needed. So that's huge.

And when we're looking at, you know, now where we have 42 police departments, I mean, that number just grows expeditiously. We want to have this across the state of Connecticut. We really need to continue to push for more police departments to come on board with this, because, really, it is a win, win. It doesn't cost anything, and it really can help identify those kids and those adults who may, otherwise, not have been recognized as having some sort of an illness, people are just looking at the behaviors and saying, well, you know, he's just a -- he's just a jerk or a bad person or that kind of thing, where these specially trained officers can look and see what's the underlying thing going on with this behavior, what might be happening here? And to be able to recognize that and connect that person to services, helps all of us.

MR. MCKEE: So we've talked about in absence of a video, most of the bullet points up here about this enhanced training, that it will help us prevent -- "us," the police from escalating a situation. But what I'd like to do is bring your attention to the third bullet, the understanding of what the person may be experiencing can lead to more positive outcomes and less injuries.

What has not been brought to your attention is

that during this 40-hour training, we do hear from the parents, as was mentioned, of what it's like to live with a person that's experiencing mental illness, but we also are subjected -- we are subjected to a learning process, where, for example, in an exercise called "Hearing Voices," we are tasked with doing things. We're tasked with banking or writing an essay or trying to balance our checkbook, but, meanwhile, we're wearing an audio device and we're hearing voices telling us "Do this," "Do that," voices using obscenities.

And it's a -- and to actually be in the shoes of someone that, wait a minute, if I walk into a situation in someone's home and this is what they're going through and I'm telling them I need you to do this, but they can't focus on what I'm telling them, and it's not their fault, these type of experiences that are provided through this training certainly provides an understanding of what we're encountering and why we need to act a certain way in those certain situations.

And it gets as specific as folks coming in with all sorts of -- all sorts of diagnoses from -- not that -- and so we don't have the credentials that many folks in this room have. We don't -- we're first responders, but yet we are versed in -- we get an introduction and familiarization to what it's like to be bipolar, to have

autism. And we discuss the different medications that go with that, and we discuss what happens when you don't take your medication, and we discuss that vicious cycle of hopes that "I feel better so I'm going to stop taking my medication now." But, unfortunately, that leads to a crisis. And so the understanding part is what I would like to emphasize.

What CIT is not however -- if I may?

MS. PYERS: Yeah.

MR. MCKEE: Is it's not a cure-all. You've heard all these -- you heard (inaudible) positive things, but it is not a cure-all. It is not the fact that we the police, the first responder, the firefighter, or the EMS folks, who are responding to these calls, are not going to be able to solve the problems. It is also not a guarantee that unfortunately we will not have use of force situations. We'll have someone in crisis, and they will be posing a threat to themselves or to others. And CIT is not a guarantee that the police won't have to take control by using force in a situation.

And then the last thing is what CIT is not, is it is not something that tells us that forget that you have weapons on your big Batman belt and forget that you have all these tools. It does not promote unsafe tactics. It does not promote that we will compromise our own safety as

men and women who have families that we want to get to at the end of the day. What it is is yet another tool and another way of us handling our business out there every day, but still maintaining our own safety and the safety -- and protecting of those in our community.

MS. PYERS: I think what CIT does -- I mean, it really gives -- it helps officers believe that they really are making a difference. A lot of times in law enforcement, you know, you're seeing the same people over and over again. It's like when are they going to, you know, smarten up? You know, they see a criminal justice system that sometimes doesn't seem to be too just when, you know, they make an arrest and then the person is out the door the next day, and there's -- you know, sometimes they do ask themselves, you know, am I making a difference here?

With CIT they see it. They see it. They know when they link that person to help, it does make a difference. And so I -- I mean, I don't know of any sad CIT officers. You know, officers, many times, like in any profession, they can get disillusioned sometimes. But when they go to CIT, you see them light up. They just light up. And they know that they're making a difference, because their whole purpose for becoming an off -- a police officer to begin with, was to help people.

MR. MCKENNA: Let me add to that. Where you

see it the most is with the satisfaction of a family member or family members that finally have someone listening to them and someone offering out resources. There's plenty of good folks out there in the community and different organizations that want to help and do help, but there are plenty of families that say, "I don't know how to control this. I'm at the end of my rope with my child."

And, you know, for us to come in and sit for extended periods of time, up to hours, for us to say your child continues to run away because of his condition and gets near the highway, well, we're going to sit with you and the schools and everything else, and we're going to come up with a plan. That's not the traditional police model, but that is the most satisfying aspect of the CIT training program, is that you have folks that are at the end of the rope and don't know what to do, and we can provide some avenues.

MS. PYERS: We also want to let you know if you're -- if you want some more information, it will be in October. The CIT International Conference will be taking place in Hartford at the Hartford Convention Center. That's where CIT practitioners from all over the world come and share experiences, look at ways to enhance their CIT models. People from law enforcement, mental health advocates, people with mental illnesses, families, they all

come together to this conference, and it's amazing to see. But it gives you a lot of information in terms of how someone might be able to start a CIT program in their community, as well as a lot of other very valuable information. So we wanted to let you know about that.

One of the things that we don't want to forget, many times we focus -- and rightly so, we focus on those who've been injured, killed, and their families. And, you know, we can really empathize with what they may be going through during that time, particularly Newtown. I mean, you know, I just can't imagine what some of those family members were going through knowing that their babies were dead, and it -- you know, that's just unfathomable. We can't forget about the law enforcement officers. They need help, too.

And one of the things that CABLE has been doing since 2007, we started with training the state police for their state troopers offering Peer Support Program, and we've been training them ever since. We also are training municipal police departments, as well. We're training law enforcement officers how to help their peers, how to recognize when an officer is in crisis. And we're not talking about just for the big things like a Newtown incident, but police officers experience things every day that you or I as civilians would never dream of and would

never want to see. The same thing with firefighters, again you're talking about trauma over trauma over trauma over trauma over the course of a police officer's career, and then you talk about the big things like Newtown that could send an officer, firefighter, first responder right over the edge. We need to help them, as well, and we can't forget them.

And the Peer Support, I'll turn it over to Susan, who is also a Peer Support officer.

MS. BOWMAN: Good morning. Yes, Peer Support is an outgrowth of CIT, obviously. CABLE, started the training with CIT, which I have to say has probably been the best training in my career. I've been on the job eighteen years, and I wish I had it eighteen years ago. There is a certain officer that benefits maybe more from the training than others. Some of us have it already in us a little bit, but some officers might need a little bit of extra, you know, help to understand, be more understanding. Once I went through the training, I became the liaison with Louise and would go and try to be that law enforcement part of it and talk to officers while they were in the training if they had specific questions geared to law enforcement.

And then Peer Support started, and I thought to myself, right then and there, that by the end of my career, I would get a Peer Support Program in Windsor PD. It was

something that I felt very strongly about as I do CIT. So we began, and we got our training, and we brought it to the police department. And we now have an up and running Peer Support Program, which we've already -- we've used three times already. We've had debriefings for critical incidents in our town that affected officers. And as Louise said, we have things that affect us every day as do others.

We, yes, have a little bit -- a little different for us but -- and not every day. And as Sergeant McKee said earlier, we're all human beings first and foremost. When the Newtown tragedy occurred, my first thought was, as a parent, for the parents of those children. My second thought was for the officers that had to respond -- the officers, the ambulance personnel, fire department who had to see that, and it had to be horrific. And I don't care who you are and how strong you think you are, nobody came out of that unaffected, nobody.

And I hope that the officers, the ambulance personnel, anyone that was there that day, had somebody to go to and continues to have somebody to go to, because it will bother them for the rest of their lives. It bothers me to this day, and it will. I will always think about it. It happened on my birthday, so it has this extra special -- I will remember that every -- my birthday every year.

We, in our training -- traditional police training is military based, you know. We're supposed to be tough, we're supposed to be strong. But like I said, we're human beings. This Peer Support Program and the training helps officers support each other because sometimes -- they call it a brotherhood, sisterhood, you know, if you wear the badge. And we talk to each other. And we'll talk to each other in a different way as opposed -- if you go to a psychiatrist or a counselor, somebody -- talk to somebody, you might say it differently than I might say it to an officer when we go out to choir practice. I might joke about it. It sounds --

MS. PYERS: Explain what choir practice is.

MS. BOWMAN: Oh, I'm sorry. It's not about singing. We might have a couple beers. And if you don't drink, you don't have to. It's just comradery after the shift. Years ago, we would sit out in the parking lot and just be together or in the firehouse, you know, next door, which is right next door to us, and just talk about the shift, talk about three shifts ago, whatever it was you wanted to talk about, because sometimes we can't talk about those things at home.

You know, it's -- first of all, you don't want to hurt -- or affect other people, you know what I mean, you bring it home and to say to your spouse or your

friends, "You know, you can't believe what I saw today," and describe it to them, because you don't want them to have to carry that burden, too. It's bad enough you do. But then who -- it's all on you then. It's all on your shoulders. So this training helps us see in police officers what me might not see otherwise.

Stress, all of a sudden -- and they have stress at work plus the stress at home like everyone does. But we don't -- sometimes we don't see the stress at home. You know, we don't know what's going on, and we might see, you know, they're coming in late all the time, you know, they're calling out sick a lot, you know, things like that that might otherwise not be -- you know, well, maybe they're sick or they might be hurting emotionally.

And this training teaches us to reach out to them and to say, "If you need me, I'm there. And I will listen like your brother/sister officer like you want me to," you know? And to know -- and I know now after going through this training, that there's somebody there for me when I need it, because I will need it. I have needed it, and they were there for me.

It also helps us maintain a healthy lifestyle. Sometimes -- we talk about choir practice. We have a tendency to overindulge, do things that aren't good for us. We're risk takers, you know. That's why we're -- part of

the reason we're doing the job. We're not afraid to run in with a gun. And so sometimes, we do silly things, you know, that aren't good for us, smoke, you know. Smoking has stopped a lot. Most people don't smoke anymore. But years ago every cop smoked, you know. A cigarette and a beer right after work, you know, that was the thing. But now it's a little different.

Now we're trying to teach officers to take care of themselves, you know, mentally and physically, so that the stress that you're going to have isn't going to maybe affect you as much. You know, you'll be healthy inside and out. As Louise said, we need funding to provide additional trainings to no cost to the police departments so that they can get this. The Peer Support is an amazing, amazing thing. And I -- the STOPS Program through the state police, I believe was the pioneer, right --

MS. PYERS: Yes.

MS. BOWMAN: -- of Connecticut?

And the gentleman that runs -- the trooper that runs it has assisted us in our program, and he's willing to go out and help other departments. And I'm very proud to be part of it.

MS. PYERS: I think -- if I can add this, I think it's wonderful that the state legislature has said that they are willing to sign off on an agreement that

those officers who were still out as a result of Newtown, not able to come back to work, that the United Way and the banks and businesses within the community could help to pay because their sick time is out right now, they have no other ways of, you know, paying the bills and those types of things, to help pay for some of those costs as a result of what they had been through, for a year.

And I have to tell you, this is going to stay with them for a lot longer than a year. And then what's going to happen to those officers then? Just like those families, they won't be over their grief in a year. Every December 14th, every birthday, Mother's Day, all of those anniversaries, they will be thinking about their children. This is not done in a year.

And I hope that the legislature can find some way, especially with tragedies like in Newtown, where an officer has been emotionally scarred for life, that there is a much better way, which is to add that to the list of things that are covered under workers' compensation. Right now, it is not. And we have to recognize that sometimes things happen that are just too hard for people to bear alone, and they need help. We know those families will need help, probably for the rest of their lives. The police officers will, too.

MR. JACKSON: Thank you for your testimony.

Any questions?

Mr. Sullivan?

MR. SULLIVAN: Yeah, a couple.

(Inaudible) institutionalized this through the police officers' standards of training academy, where --

MS. PYERS: Yes, it is.

MR. SULLIVAN: -- all departments get some piece of this?

MS. PYERS: Yes, it is.

MR. SULLIVAN: Okay.

MS. PYERS: They get 29 1/2 post credit hours under human relations.

MR. SULLIVAN: Okay. And the second question -- and this is based on what Kim Pernerewski was talking about when she was here this morning, being with a child in school not knowing where to go. Have you thought about taking your program also into teachers and having them become a part of it?

MS. PYERS: Well, the NAMI teach parents and teachers that Allied's program is one way of bringing in the recognition, but we would love to be able to bring in deescalation, those types of things, to help a teacher, number one, understand how to slow it down rather than -- sometimes even, as a parent -- I have a -- I have a loved one with mental illness at home. And sometimes even as a

parent, we don't understand that sometimes we can escalate a situation. And to recognize that and learn ways of being able to slow that down, so that you can start -- you can communicate with each other.

So, yeah, we would love to be able to bring that -- we have CIT officers who would love to go into the schools and bring that education in. We would work very closely with NAMI, so that they could really get both pieces to understand what mental illness is, and then to learn how to work with young people in the classroom in a way that doesn't stigma -- further stigmatize them and in a way that's productive, where the person is connected -- that young person is connected to help.

DR. SCHWARTZ: Just as a comment, I think we're going to hear about Mental Health First Aid later this morning, which is another approach or a program to bring similar awareness and capabilities into schools. So I have two questions. I'm struck by the fact that only 42 of our police departments have this program, and I'm wondering what the obstacles are to rolling this out to every police department. I noticed that my own hometown is not on your list, and I would like to place --

MS. PYERS: What's your hometown?

DR. SCHWARTZ: West Hartford.

MS. PYERS: Okay.

DR. SCHWARTZ: I'm thinking of placing a call to the mayor to look into why that might be the case. But I'd be interested in hearing your view of what the obstacles to -- I understand that one is financial, but, clearly, 42 police departments have managed to move into this program.

My second question gets us back to the subject we had been discussing earlier, and it is about access to various aspects of the mental health system. You clearly come up against that question, you must in some circumstances and if your officers bring individuals to emergency rooms, you may bring them to other venues for care. Can you talk -- tell us a little bit about what you encounter as the major issues on the access side, whether it be at the emergency department level or anywhere else?

MS. PYERS: Well, with the second question, what the police officers do is connect them to a DMHAS mobile crisis person, who then takes the reigns and makes sure that that person is connected -- this is for an adult -- make sure that that person is connected to services. So even if the -- it turns out that the -- we try to stay away from the emergency room as much as possible. But if it turns out that an officer must take a person to the emergency room, let's say if it's a case where somebody is threatening to harm themselves, then that

DMHAS clinician will follow up with the emergency room and then make sure that when that person is released, that they're connected to outpatient services.

Right now if you take somebody to the emergency room, nobody follows up. That person may be given a slip of paper saying, you know, "Call your doctor in the morning," and released. And if they're floridly, you know, in another place, they're not going to remember that. And so we're doing people a disservice many times by bringing somebody to a hospital, but then there's no continuum of care to follow that -- follow through with that. That's what the DMHAS clinicians do.

It's the same thing with the emergency mobile psych services for children and teens. The officers learn how to work with their emergency mobile site services' clinician. That clinician can come out to the scene, do an assessment and say this child really doesn't need to be in the hospital. Here are the services. I will follow up, stay with them for six weeks to make sure that they're connected to those types of services.

Do you have anything to add?

MR. MCKEE: And if I may add to the second question? I'm not touching the first question. That's for Louise. But regarding the access, so the traditional -- the traditional forum by statute that allows us to send

someone to the hospital when they're a danger to themselves or others or they're gravely disabled, as Louise said, we would never get feedback.

Now, certainly, of course, with HIPAA and with laws that cover schools, information flowing back to us is difficult and challenging at times. But the benefit of this type of relationship when we have this training and when we operate in this model, is that we have -- we get -- we get followup. We get that followup. That is allowed and provided under the -- you know, that we can have, so that Officer Bowman or whatever police department's -- each police department generally has a coordinator for this program -- will maybe have meetings monthly with the mental health crisis clinicians that go out into the field.

And whatever we can be provided by law, we are provided, so and so was brought in and whatever it is, treatment or the -- anything that we should know for safety points for the community that can be shared, is shared.

And on the same token us being there 24/7, driving around in the middle of the night in snowstorms, if we know that, well, it's really not safe for someone to go to Mr. Smith's house alone because Mr. Smith has weapons or access to this or -- we can share the information with the clinicians, as well. So the access is limited, but it's a lot better than the old traditional model of you go into

the hospital, and then we don't know anything. They come back in ten minutes or they're -- they never come back, we don't know. The information sharing is a lot better than it ever was.

MS. PYERS: In some departments, some of the smaller departments that have the time to devote, some of the CIT officers who were involved in taking that person to the hospital or connected them with a DMHAS clinician, will many times just go the following week and follow up with that per -- "How are you doing?" you know, "I'm not here as a police officer necessarily. I'm here to see how you're doing. Did you make that connection with services?" you know, "If not, what stopped you? How could we further help you?" So, again, it's a totally different model than what regular policing usually -- usually is.

DR. SCHWARTZ: Just in followup to that question. Over a long career myself and the career of many of my colleagues, we occasionally had the need to call the police when someone -- when we believe someone presents a threat. And I have found, and I think the feeling amongst mental health providers generally is that the response is very variable, that some police departments are much more responsive to the information that we provide. It would seem to reflect an understanding of mental illness, and others are less so. I assume that you would agree that CIT

training has something to do with the quality of the response that mental health providers get when they place these calls to your --

MS. PYERS: Yes.

DR. SCHWARTZ: -- departments?

MS. PYERS: Yes, yes. With regard to your first question, how to be politically expedient with this, some departments really don't quite understand what CIT is all about. Some departments think it's connected to hostage negotiators. It's not. This is for first responders. Now, can the training be beneficial to hostage negotiators? Of course it can be. But this training is for your boots on the ground officer who's out there on the street just doing his shift every day, okay?

So they think, well, we already have hostage negotiators, so we're all set with that. And it takes them a while -- a while to start convincing people that, you know what, hostage negotiations has its role, and it's a very, very important role. It's very expensive to send out a hostage negotiations team when it's needed, and it takes time to also send that out. So it can take maybe up to an hour to get that team coordinated and to the scene.

We're talking about your first responder. We're talking about that first officer that gets to that scene. That's the one you want to have trained in CIT,

because they can keep a situation from escalating to the point where you need hostage negotiations. And let's say if you still do, that first responding officer can set the scene and provide valuable information to the hostage negotiators when they get there. So it's not an either or, it's both.

MR. MCKENNA: If --

MS. PYERS: Go ahead.

MR. MCKENNA: If I may add, though, I think to reflect on what was presented from a previous presenter from NAMI said, there needs to be an awareness, there needs to be an overall societal community awareness, and the police departments are not exempt from not having that awareness. We are simply a part of society.

And so maybe it hasn't filtered down to all of us that -- what we're discussing here, what you are hearing in every of your -- in every of your sessions, you know that it's very relevant and certainly very important to -- for us to be maintained in our knowledge of street gangs, for example, which is mandated by our police training counsel in our recertification every three years. But is it time to start to contemplate what are the types of calls for services we respond to every day, i.e., people in crisis? Should perhaps that be something to be considered? And it's just a simple level of awareness I would propose.

MR. JACKSON: Thank you.

MS. PYERS: Yeah, a lot of it is awareness. Some just may say we don't feel we need this, we feel our officers are well trained the way they are. And, you know, so we really can't say well, you really need this, because then the door would be shut in our face. So it's more likely that it's an under -- it's a misunderstanding of what CIT is all about. We try to educate departments in terms of what it is and what CIT does. But some understand that and some, you know, still prefer -- they feel that their police officers are well trained as it is, and they would just as well not.

Another piece to it, too, is even though CIT and DMHAS will pay up to $1,500 of backfill or overtime incurred as a result of sending an officer to a training, sometimes that money goes back into the general fund and not back to the police department. So they're -- they still feel -- and it's not in all cases, but in a few it's like that. And some departments feel, well, we're not getting that money back, it's going into the general fund. And we really have to realize that overtime is a concern for a lot of municipalities. And so we do understand that, but we also know departments who stepped up to the plate.

I think our first departments, New London and West Haven, they stepped right up to the plate and said,

"We're going to do this," and they paid overtime. They did everything that they needed in order to make that happen. So, you know, it's really difficult to say, you know, what a particular reason might be. But I think a lot of it has to do around misunderstandings of what CIT is all about.

MR. JACKSON: Thank you.

We're going to need to set up a video link for the next presenter, so is there one final question or comment?

We have two quick ones.

Chief and chief?

MS. O'CONNOR: I just want to follow up with what Mr. Sullivan suggested. He asked a question about post, and I heard you answer there's 29 hours. And I don't know why we couldn't make -- this Commission couldn't make the recommendation to expand that to 40, so that it becomes a minimum requirement coming out of the academy. We're not talking about a significant number of hours.

And then police chiefs have to be recertified and go through training over a course of a three-year period. And I don't know why we also couldn't make the recommendation that this be part of the police chiefs training to sort of get at, you know, that problem around awareness. You know, I think that might help very much. And then I would elaborate in terms of anybody listening,

UConn is actually hosting this --

MS. PYERS: Yes.

MS. O'CONNOR: -- program in May, so there will be spaces --

MS. PYERS: Thank you for that.

MS. O'CONNOR: -- available for that.

MS. PYERS: We thank you for that.

A lot of our university campus police have really adopted CIT as their model. They find it works extremely well, not just in a community at large, but on a college campus, as well.

MR. JACKSON: Chief McCarthy?

MR. MCCARTHY: Thank you for your testimony.

Is there a benchmark that you recommend for police departments as -- because having one police officer attend the training gets you on the list, but it doesn't represent a capacity of your --

MS. PYERS: Right.

MR. MCCARTHY: -- police department to respond.

MS. PYERS: Right. That's why we have the --

MR. MCCARTHY: Is there a benchmark for -- that police departments should strive towards, and also every police department, I would imagine, should have a CIT policy, which would be part of your recommendations?

MS. PYERS: Right.

MR. MCCARTHY: And while it -- let me just get the last question in.

The connection to CIT and school resource officers, could you just elaborate on that?

MS. PYERS: Okay. We'll do the CIT and the school resource officers. Yes, many -- we recommend that those are the officers on the list to be trained in CIT, and many police departments are doing that. With regard to the benchmark, yes, we have -- it's a quarter of a police department. In a larger police department, we recommend that a quarter of the police department be trained. That ensures that there are people from each shift that are CIT trained, who can be called upon in a crisis to go to that call.

The policy -- what the policy does, it says that if a dispatcher hears a mental health call coming in, recognize it as such, that they will send a CIT officer who's on that -- working on that shift to that particular call if a CIT officer is available. Okay. So that's -- now, the benchmark for smaller police departments, we recommend that everybody gets CIT trained in small -- like Middlebury, everybody is CIT trained, including the chief.

We have a number of police departments -- the state capitol police department, all of their people are CIT trained, and the chief is going to be taking the

training in April. So we do, you know, recognize that, you know, it's going to be different for each -- for the size of each police department. But the normal benchmark for your larger urban police department is, at least, 25 percent.

MR. MCCARTHY: What about the rural areas of the state where our communities are served by resident troopers? How would you characterize the availability of trained officers in those areas?

That's been a little bit tougher to get. We do have some resident troopers who have been CIT trained, but it's been more difficult to -- we probably have, at least, one from each troop, which we know that that's not enough. Its -- we need to make a more concerted effort in terms of working with the leadership of the state police, because it depends on the resident trooper. If they really buy into it, they'll send all their people. But if another trooper says, "Nah, we don't need that," then nobody goes. So we really have to make a concerted effort with the leadership, to say this is what we need to do and this is how we're going to do it.

MR. MCKENNA: If I may add one thing, sir? If I may add onto the chief -- onto the school resource officer question?

I think that most folks in this room know that

being a school resource officer, you're in very close proximity with youth. And one of the goals of that program is to have relationships, because, although this Commission was established for a person that was outside of a school, we do know, looking back at school shootings and violence, that sometimes it's our own students unfortunately that are in crisis, and it's not recognized and then leads to violence in a school system.

This would be an outstanding program for every school resource officer to attend, because if they understand the purpose of being an SRO, one of the three models is -- you know, one of the three responsibilities is as a mentor and to have relationships. So that even though Sue is having a bad day and Sue is not going to tell me, Sue's friend Louise says, "She's having a very bad day. She's been talking about hurting herself. She's been talking about cutting." The right SRO in the right place at the right time with this toolbox of information can make a world of difference.

MR. JACKSON: Officer Bowman, Sergeant McKee, Louise, thank you very much for coming here today and for your testimony.

MS. PYERS: Thank you. Thank you for inviting us.

MR. JACKSON: Moving forward, Bryan Gibb has

some scheduling limitations, so Deron Drumm has graciously allowed -- or offered us the opportunity to flip those slots. So we're going to move now to Mr. Bryan V. Gibb, director of public education at the National Council for Community Behavioral Healthcare, to speak about Mental Health First Aid.

Thank you to tech support and thank you to Mr. Gibb for joining us today. I know that you are on a tight schedule. So we'd love to hear your thoughts for the panel as to some things that we might be able to do to better deliver mental health services here in the state of Connecticut and beyond.

MR. GIBB: Well, first of all, thank you very much for inviting us to participate in this event today and to speak to the Commission. I apologize if I'm not (inaudible) too clearly or if you have any audio problems. I'm offsite, of course. And I apologize I wasn't able to actually join you in person in Connecticut, but the scheduling made that impossible.

I am Bryan Gibb. I'm the director of public education for the National Council for Community Behavioral Healthcare. I thank you very much for inviting us to talk about Mental Health First Aid, how it's been embraced in Connecticut before and after the Sandy Hook tragedy and some ideas on the future, as well as what Mental Health

First Aid is and how it might be useful. I'll speak for a short period of time on prepared remarks, and then, certainly, open it to your questions or discussions if that sounds okay?

MR. JACKSON: Yes.

MR. GIBB: You have, I believe, some printed materials that I shared. It's always a little bit more than I'm going to talk about specifically, but I'm a firm believer in giving people (inaudible) look at it a little bit more carefully later.

I also want to -- I've been watching the proceedings here this morning, and was very pleased to see the speakers from NAMI, which is an organization that we do a great deal of work with around the country. And we have instructors in our curriculum connected to NAMI's all over the country, and we do a lot of work with NAMI. I think that our programs really compliment each other nicely. And also to have the two speakers representing CIT. CIT and Mental Health First Aid also work closely together. I, myself, am CIT-certified, and I do some law enforcement training, which I can talk about a little bit later.

Mental Health First Aid has really kind of three curriculum. We have kind of a standard adult curriculum, we have a youth curriculum, and we have a public safety specific curriculum. But today, I think I'm

going to talk generally and also focusing on the youth and adolescent components and how that might be useful. Again, I'll talk about the program. And at the end, I'd like to delve into the content a little bit and share with you one of the scenarios that we use in our curriculum on how to train people to recognize some of the signs and symptoms of mental illness, how to reach out, how to provide comfort to a young person and refer that person to services if appropriate.

First off, my background. I'm the director of public education of our organization. But my background is as a classroom teacher. I started my career years ago in the state of California, teaching in the public school system, and have kind of worked my way around and into behavioral health education and public education and stigma reduction. And so that's where I am today. My role really is sharing the good news about Mental Health First Aid as I am here today, but also training instructors, as well as doing curriculum to develop (inaudible).

It was an extremely, you know, sad and unfortunate event that developed in the state of Connecticut. I know the entire nation is focusing on this issue. We ourselves have a little bit of experience with this in Mental Health First Aid, and that one of our close members (inaudible) located in Tu -- (no audio).

Got cut off. Are you still reading it? I just lost audio -- I lost video.

MR. JACKSON: We did lose video, but we can hear you.

MR. GIBB: You can hear me, okay. So I'm going to just continue, I guess. Are we on --

MR. JACKSON: Please do.

MR. GIBB: You know, (inaudible) southern Arizona and Pima County and Tucson -- there you go. I can see you.

MS. WEIN: Can you click on the littler camera on the bottom of your Skype? There's a little like white camera icon.

MR. GIBB: There we go.

MS. WEIN: I can see you.

MR. GIBB: So my point is that our program is embraced by the community, not only as a way of healing, but also as a way of looking at early intervention in the future. That is what I want to talk about here today. You know, what is Mental Health First Aid? A lot of people ask that question. Some of you on the Commission (inaudible) program (inaudible) very briefly for the benefit of those watching at home, as well as those on the Commission who aren't familiar with the program.

It's just like first aid. It's designed for a

general audience. It's designed like first aid. It's not to diagnose or treat mental illness, but to give individuals some skills in recognizing some of the signs and symptoms of mental illness, how to provide comfort to someone, as well as how to refer someone to services, or if they are in crisis, some deescalation strategies. Many of the strategies that your previous speakers talked about in CIT are mirrored in Mental Health First Aid for the general public. Of course, tactically, there's some differences as far as intensity, but they very much kind of come from a similar background.

There are ways to effectively help someone to calm down a little bit in a safe and effective way. It's not a substitute for counseling or treatment. Again, it's a first aid course. In our course, you, basically, learn about signs and symptoms of depression, anxiety, substance use, eating disorders, disorders in which a psychosis may occur, and then we talk about different types of crises that may be associated with that. Suicide -- suicide is one of them. Aggressive behavior is certainly one of them. A big goal of our program is not just education and practical response, but it's also stigma reduction.

We believe very strongly that the more that people understand that mental illness is like physical illness, it's common, it can be debilitating, but people

can recover, the less frightened they will be of mental illness because, as the Commission knows and your speakers and viewers know, oftentimes stigma can be a real barrier to treatment. And really, what we see is that the research shows that the sooner that someone gets help for a mental health problem, the more likely they are to have a positive outcome, the more likely they are to avoid crisis. So that's what we kind of -- we cover.

The program really is an international program. It started in Australia, came to the United States in 2008, and we piloted our youth program in 2012. There's some good evidence based to the course, both in Australia and domestically. They're listed in your briefing materials. I won't go into them in detail. Also, for those of you viewing at home, if you're interested, you can go to our website and check out stuff, as well. And some of the questions as to why mental health first aid, I think have been addressed by your previous speakers. Stigma, people just don't know how to respond to, etc.

Mental Health First Aid is really an attempt to provide some basic information for teachers, counselors, parents, neighbors, coaches, youth group leaders, police officers, really anyone who comes in contact with the general public or with young people or adolescents. What's a little -- what's kind of special I think about the

program is the action plan, ALGEE, A-L-G-E-E, which is a mnemonic device that we utilize to help individuals remember what to do and in what order. And they stand for, A, assess for risk of suicide or harm; L, listen nonjudgmentally; G, give in -- give reassurance and information; E, encourage appropriate professional help; and the second E, encourage self-help and other support strategies.

The program is in all fifty states. We have more than 2,500 instructors, and we trained over 100,000 people. In the state of Connecticut, which is our interest, of course, today, we have so far 24 instructors, who have, themselves, trained 1,441 individuals to date. Although there is a lot of activity in the state, which I'll talk about in a minute to expand that -- and we're very supportive of that effort at the National Council. There's -- in your briefing materials, there's kind of a list of some of the organizations in Connecticut that are teaching the course.

I'll list a couple of them, not all of them. They include, but aren't limited to, Birmingham Group Health Services in Branford and Ansonia, Ability Beyond Belief in Bethel, the Rushford Center in Newington. And I want to give a spe -- you know, a particular shout out to Jeff Walters at the Rushford Center, who has been

incredibly supportive of this program. Community Mental Health Affiliates in New Britain, the Wheeler Clinic in Plainville, the Southeastern Regional Action Council in Uncasville, I hope I didn't mispronounce that, I apologize to those of you in Connecticut, along with a number of other groups. You can go to our website and look for instructors in Connecticut.

You know, also the courses have been primarily held in general community through our National Council members. Again, the National Council represents community behavioral health centers around the country, including many in Connecticut. In the wake of the Newtown tragedy, there's been a renewed interest in increasing the presence of the program with a great deal of support through the Department of Mental Health Services. We are planning presently two instructor certification trainings in the state of Connecticut a little bit later this spring and summer, to develop a cadre of additional instructors. As I mentioned, there are 24 instructors. We're looking to add a net six -- a plus sixty instructors, which is similar to what we did in Arizona.

In Arizona there was a smattering of instructors, and there was a galvanizing of support for the program. And now Arizona is one of our most active states with support both from community behavioral health centers,

the state, as well as some private interests. Commissioner Reimer (phonetic) and (inaudible) have been very supportive of the program so far in the future, and so we thank them very much for that. You know, there's a lot on Mental Health First Aid and public policy in your briefing materials.

I'll just say very briefly that President Obama endorsed Mental Health First Aid in his suggestions on reducing violence in our communities. There are lots of suggestions. Of course, we were very honored to be included in some of the behavioral health suggestions in that report. And so that's in your briefing materials, as well. In your briefing materials, there's also some specific information about a toolkit that we're developing for states.

But also, really, I want to focus on -- I mean, our vision and our goal, really -- our agenda, if you will, is to make Mental Health First Aid accessible to individuals regardless of where they work across the country. We're a nonprofit organization. We're really supported by organizations like yours and by the federal government, as well as community behavioral health centers around the country. And our mission -- our passion and mission is to train individuals to interact with the community, to have the skills to help people who need help,

refer them to the services that they need, and also to deescalate crisis if that exists, as well.

And also I included in your materials, your briefing materials, a sample scenario for our youth curriculum. Again, what we do when we train individuals who work with adolescents, say teachers, counselors -- you know, public -- and our resource officers, etc., your previous speaker talked about resource officers -- we can -- I can talk about that in some more detail, our law enforcement, if you wish. But, really, looking at a scenario and applying that action plan, ALGEE, the scenario that I have listed in your materials, I'll read it very quickly.

Gendall's (phonetic) Story: Gendall is a 15-year old boy known for many years. He seems typical in every way. He has a normal amount of friends, has decent grades, and is involved in a few activities after school. He seems to get along well with friends, teachers and parents. We hear that over the summer he was involved in a pretty serious car accident with his older brother and another friend. The friend was driving. And everyone healed well from their injuries.

Gendall doesn't seem like himself this year. He seems less interested in things, although he still manages to keep solid grades. You notice, however, that he

seems a bit more emotional than he used to, and he doesn't hang out with friends, instead he seems only to want to be with his brother. You are Gendall's teacher, how do you approach him.

In our training, we walk through how do you approach this young person about these initial things that you noticed? And then as the scenario unfolds, it gets a little bit more serious. We learn a little bit more about Gendall, a little bit more -- we see that his stress level is more intense than we initially thought, etc. And as we move through the scenario, we train people, okay, how do you respond in a way nonjudgmentally so as to get this young person to talk about how they're feeling, to the point at the end of the scenario, where Gendall seems to be experiencing a panic attack or seems to be freaking out -- quote/unquote freaking out in the bathroom.

How do you respond in a safe way to that young person who seems to be in crisis? We walk people through not only what it could be that you're seeing, but really more importantly, how to respond to someone who seems to be experiencing these symptoms or seems to be in crisis. And, of course, we go through a number of scenarios, we have film clips, etc., lots of interactive activities. So that's really all I want to say as far as prepared remarks, but I do want to give you an opportunity to ask questions

or to discuss this issue.

Thank you so much for this time to kind of talk about Mental Health First Aid, how it's been utilized in Connecticut so far and just a little taste of what the curriculum might look like.

MR. JACKSON: Thank you for your remarks.

We'll open it up to questions.

Ms. Flaherty?

MS. FLAHERTY: Good morning and thank you for being available to us on such short notice. I actually have a couple of questions for you, Bryan. One is you did mention that you work a lot with NAMI and other organizations, and I appreciate having gone on your website and done some studying about what your presentations do in terms of reducing stigma.

My questions are this, is, one, who does your presentations when you do the Mental Health First Aid presentations, who is eligible to take the training to the trainers? And I notice that your final goal is exploring methods for including peer facilitators in leading Mental Health First Aid training programs. Don't you think it would do a lot to reduce stigma to have people with lived experience be actual Mental Health First Aid trainers.

Thanks.

MR. GIBB: Thank you for your questions, and

especially the last question. I agree with you completely. And our 2,500 plus instructors around the country, you know, we're proud to say that more than 20 percent of those instructors are individuals who are open about their own lived experience with mental illness, whether they themselves as temp survivors, as individuals who have experienced mental illness themselves that are in recovery or family members. Again, that's the (inaudible) connection with NAMI.

So it's definitely a goal of ours in the future always. Nothing about us without us, right, is what we say, that the curriculum about individuals experiencing mental illness should be taught by individuals of lived experience. And so that's definitely an important part of what we do. A little bit about the model, if you will. What we do is we do a train to trainer model, where we go around the country, and we're invited in by counties in California, community behavioral health centers in Arizona, states -- and Connecticut, etc. We come in and we train instructors. We train instructors.

The instructor candidates really can come from any group. Our requirement really is that those candidates have a background and a passion and an interest in behavioral health and helping others. So that could be a youth group leader, that could be a person with a clinical

background, but it doesn't need to have a clinical background. That individual then goes to that 5-day training, becomes an instructor, they then go back to their community, you know, whether it's there in Connecticut or elsewhere, and then they teach the course like someone would teach a first aid course or a CPR course. They use a standard curriculum.

And we have very kind of specific national fidelity standards that we, you know -- I won't go into them in detail, but we do an ongoing quality control process to make sure that the curriculum is being followed closely. So then they teach that in the community to their heart's content. They can teach it at a school site as an inservice. They can teach it in a public way in a church basement to the community and put flyers up around, etc. And so that's really the model.

The individuals who are the first aiders, who are the people who take the course, are really anyone who comes in contact with the general public. Like I said, it could be a teacher. I certainly wish I had had this training when I was a classroom teacher in California back in the early '90s. It could be a youth group leader. It could be a counselor. It could be a neighbor, or even just a parent who is looking for ways to better understand what their child is experiencing. And I think that's the place

where NAMI and Mental Health First Aid really compliment each other.

And then one your speakers talking about CIT, we do a lot of training with law enforcement. Your previous speaker talked about that 25 percent of a force that is CIT certified. CIT -- CIT is the gold standard in that type of training, in my opinion as someone who has been through that and works in the field.

But Mental Health First Aid for public safety would be a training for the other 75 percent of the force, who's not CIT-certified. And that's the model that the city of Philadelphia is adopting, as well as Washington DC. And we start in New York City next month following that model. So that's pretty much the model.

You know, I'd be happy to say more about -- in the state of Georgia, the state of Georgia supported an effort to train consumer and temp (phonetic) survivor instructors, so that really bolstered our roles of individuals with lived experience who teach the course. But, again, individuals with lived experience who teach the course, exist in almost every state.

MR. JACKSON: Any other questions, comments?

Going back to the Gendall -- Gendall's story. It appears that there's no right answer at the end of the training, there's no specific right answer, there's no

magic bullet solution, although there may be a number of wrong answers. Can you -- I mean, for example, your item number two is listening nonjudgmentally. Listening judgmentally would be a wrong answer.

Can you walk us through a little bit of what it's like in how you encourage the people who are being trained either at the end or as instructors and how they work through some of these -- these items?

MR. GIBB: Yeah. And thank you for that observation. Yes, there is no specific right answer, but there are some very less effective ways of approaching this young man. And listening judgmentally is one of them. We've -- in the course, we've walked through specific activities where we practice nonjudgmental listening, and that could be body language, that could be asking open-ended questions, that could be things like if I asked a question of a young man -- say I said something to Gendall like, you know, "Gendall, I mean, that car accident was like, what, months ago. I mean, you just need to shake it off. You know, I mean, it's no big deal. You get hurt. I don't know what you're worried about." Okay? That's not particularly supportive. That's, in some ways, judging him for what he's experiencing.

What we look at is how can a first aider reach out and say, "You know, Gendall, I can see that you're

upset." "Do you want to talk about it"? or "Do you want to tell me about how you're feeling?" or "Can I help?" again, with open-ended questions, nonjudgmental questions. The goal is to get the young person to talk about how they're feeling because that itself can really have a benefit. And the goal is to learn more, assess for risk of suicide or harm, to see if we need to make that assessment. Because if a young person is in danger to themselves or others, we want to make sure that we do that hand off as soon as possible.

But there are ways that we can do that in a supportive and approachable way, because the vast majority of interactions with individuals experiencing symptoms of mental illness are low intensity. You know, you've heard this on the Commission, I'm sure. We do a lot of work about violence and mental illness through our organization. We had a webinar recently about that from a gentleman named Jim Reinhard who's the former commissioner of mental health for the state of Virginia, and was on duty during the Virginia Tech crisis a number of years ago. When he did a webinar, he talked about -- he's a psychiatrist. He talked about violence and mental illness. And the reality is when we look at the aggregate, that individuals with mental illness are no more likely to be violent than the general population.

Now, certainly, when we look at alcohol and drug use, that does increase that risk. But so our goal in Mental Health First Aid is to look at the myths and facts about aggression and mental illness, certainly prepare people for unpredictable behavior, but at the same time, try to reduce stigma and approach a situation in a way that's gentle and supportive. And if it's necessary to hand that person off to law enforcement or to a clinician, we definitely (inaudible) do that.

MR. JACKSON: Thank you.

Dr. Schwartz?

DR. SCHWARTZ: So looking at the information in our packet that you provided, in trying to extrapolate from the numbers of first aiders and instructors, what do you think is enough? I mean, if there currently are 24 instructors and 1,400 first aiders in Connecticut and 2,500 instructors throughout the United States with 100,000 first aiders, just how big is the task in front of us if we were to try to roll out Mental Health First Aid to the extent that it would be available the way CPR and medical first aid is throughout our society? How many -- how many more instructors do we need, how many more first aiders?

MR. GIBB: Well, I mean, that's a good question. You know, let's look at Australia as kind of a test model. Australia is where the program originated in

2001. It's a country of about the same population as the state of New York. And since 2001 when it started, they've trained hundreds of thousands of people -- hundreds and hundreds of thousands of people. So their penetration, if you will, or outreach has been really successful.

Mental Health First Aid is really a household word in Australia, and it's something that's both embraced by their national health service in Australia, as well. So in order to achieve, say, access or penetration of even one percent in the state of Connecticut, I mean, I think that that number probably represents, you know, .01 percent penetration. You know, to make it accessible, I think, you know, it's -- you need many, many more instructors.

You know, I think, you know, 2,500 around the country. Some states have deeper penetration than others, New Mexico, Arizona, Iowa early adopters for the program have -- I think, the best by population penetration is the state of New Mexico. That has like .1 percent of the population trained in Mental Health First Aid. So I think that, you know, the work that Commissioner Reimer and (inaudible) is lining up for us here this year of training an additional sixty instructors, is a start. But I really think those numbers probably need to be much higher, and we really need to look at instructors from various walks of life and working with different groups.

You know, it could be instructors from school districts, but also instructors from corporate America. You know there's a proud Connecticut company, you know, AETNA corporation, which is very supportive of Mental Health First Aid and other companies in Connecticut that are looking not only to support Mental Health First Aid throughout the state and the country, but also to train their own employees and have their own internal instructors. So there's a lot of ways to do this.

I don't have a specific number for you, but with a sixty instructor -- additional instructors in Connecticut is a start. But I think when we look at a country of 310 million and change, it's just really scratching the surface, because the audience for this program is really everyone because mental illness, as you know, is common. Twenty-six percent of Americans will experience symptoms of mental illness in any given year. It's more common than almost anything else that we deal with, which is, oftentimes, under the radar.

DR. SCHWARTZ: All right. Can you tell us -- I heard that the trainer program is five days in length. What is the Mental Health First Aid program in length?

MR. GIBBS: Thank you. I should have mentioned that already. As I mentioned, the Train-the-Trainer Program is five days, but the public program presently is a

12-hour course, twelve hours of content, although we are developing and launching an 8-hour version of Mental Health First Aid. That will be launched -- actually, we're doing a soft launch at our annual conference in early April, and that will be available through our network just soon after that. Eight hours of content.

What we've done, is we've taken the original course, and we've done some -- we've distilled some of it down. We've created some efficiencies. We find that the 8-hour format is much more doable for many entities, whether they be school districts, police academies, (inaudible) based organizations, etc. So in the future, there will be eight hours of content. Presently, it's a 12-hour course. It will make that transition here in the next couple of months.

MS. BENTMAN: Hi. Thank you very much for your presentation. I have two questions. Has your group looked into the impact of Mental Health First Aid on incidents of sexual harassment and workplace violence, because it seems to me that that's another avenue in which we can approach?

MR. GIBB: You broke up a little bit on your question.

MS. BENTMAN: Pardon? Uh-huh. Sorry.

Has your group started the impact on the frequency of episodes of sexual harassment and work --

whoop. Hang on.

MS. WEIN: Bryan, can you still hear us?

MR. GIBB: I can hear you.

MS WEIN: Okay.

MS. BENTMAN: Can you hear me?

MR. GIBB: It broke up in the middle of your question.

MS. BENTMAN: Sure.

MR. GIBB: Do you mind asking your question again, please?

MS. BENTMAN: Sure.

It seems to me that Mental Health First Aid might also link to some of the efforts regarding education in prevention of sexual harassment and workplace violence. Do you have any data or sense of the way in which those things might be -- have been affected in the places where they've implemented that?

MR. GIBB: I don't -- we don't have any specific data on that question. So, you know, anything that I would share with you would be, you know, a guess.

MS. BENTMAN: Uh-huh.

MR. GIBB: So I don't really have any data on impact on those areas of the course. So I apologize, I can't really say.

MS. BENTMAN: I have a second question. And

this, in some ways, pertains both to the really marvelous presentation we had from the officers and to you. And that has to do with: At the moment we use the term "mental health," and really what we're talking about, in some circumstances, is emotional reactivity and behavioral disturbance, and not all emotional reactivity and behavioral disturbance implies a mental health problem. So how does your group educate about that complexity?

MR. GIBB: Thank you for your question. And it's a good point, very much so. And, you know, in the course that we teach specifically for adults who work with adolescents, we have a very in-depth section on what is typical adolescence and what potentially could be pathology because, often times, typical adolescence and mental illness can be indistinguishable from each other.

So we really train our -- that's my diplomatic way of putting that. And so what we really try to do is train our instructors and our first aiders to be -- to not over pathologize behavior that they see. You know, whether it's, you know, a young person who's all of a sudden, you know, acting -- not hanging out with their parents anymore. Well, that could be a sign of (inaudible), that could be a young person pulling away and that could be of concern, a typical and healthy response to becoming more independent.

So, absolutely, you know, we really -- you

know, I would say probably about every twenty minutes when I have the opportunity to teach the course, that we do not diagnose or treat mental illness. So as a first aider every time we look at symptoms, we do so with a great deal of humility. It could be this. It could just be someone having a bad day. It could be possibly an eating disorder. It could just be a physical change as a typical sign of adolescence, etc.

So we try really to be humble about our power as first aiders, talk about what those typical signs might be, and really -- but, really, try to focus on the action plan, which is assess, listen, give reassurance and information, encourage appropriate professional help, and encourage self-help. We don't diagnose people. We don't pigeonhole people. We try not to. And so we try to be very cognizant of that and sensitive to that fact.

You know, we recently -- the actress Glenn Close said something that I thought was very poignant. And she said that, you know, mental illness doesn't separate us from the human race, it makes us part of the human race. In fact, it's so common, it's so part of, you know, our experience, that it's as typical as any other behavior. It's just that when that behavior, when that anxiety, when those symptoms rise to the level where they interfere with someone's functioning, they rise to the level of disorder.

MS. BENTMAN: Thank you very much.

MS. FORRESTER: Thank you. I just have a quick question. I'm so struck by the idea of it as first aid, and, you know, I -- you know, the signs on the restaurant wall, signs of choking. And it's a wonderful, you know, way of changing the culture around understanding.

Gendall's story is in a lot of ways, I think, very sad because he experienced a terrible car accident in the summer, and wouldn't the First Aid really -- or, at least, education or psychoeducation have been made early on sort of -- you know, we've done some work on Psychological First Aid after a trauma here in Newtown. You know, wouldn't it be even a more fantastic way of having his parents maybe educated on signs and symptoms of mental illness right at the hospital after the incident could occur, you know, signs of distress so that he didn't need to wait months later and, you know, have his stress or all those months of stress? I wonder what you guys are doing in terms of addressing it immediately?

MR. GIBB: Thank you for your question, and it's a very good point. And another -- another -- and I want to give another endorsement, if you will, to another program. I mean, NAM -- one of those programs that NAMI does like Family-to-Family and Basics and CIT and Psychological First Aid, there's so much good stuff out

there. And Psychological First Aid really is a terrific program for first aiders for that initial trauma. We do talk about trauma in Mental Health First Aid in a little bit of detail.

In the example of Gendall's story, I gave you kind of all the chapters in Gendall's story so you could see how we worked through how to respond, but we're not suggesting that crisis is inevitable in Gendall's story. And, in fact, the conversation that we go through with our first aiders when we first revealed that first scene, might -- it might actually be supportive and help Gendall to the point where scene two, three or four don't happen. So what we do is we prepare people for how to respond in scene three or four or the last scene when he was in crisis, but they're not an inevitability.

Again, some very supportive and nonjudgmental and open-ended outreach to Gendall right after the accident, could very much make him comfortable with the idea of talking to someone about that right away. And, again, you know, the rest of the scenario might be a moot point. So we try to kind of, you know, talk about how most situations are low intensity, but situations can get worse and can actually result in crisis, but not inevitably. So we prepare people for what it might be like to interact with a young person at each of those stages. But you're

absolutely right, you know, some, you know, well thought out and caring response to Gendall right after the car accident might have nipped it in the bud, if you will.

MS. BENTMAN: I have another question. How do you manage -- how does your educational program manage the issue of boundaries, both boundaries and the -- and the issue of being too much of a do-gooder and the problems that come from that?

MR. GIBB: Well, thank you. The first thing, and I'll say it again, and I'll say it every ten minutes, is that we do not train people to diagnosis mental illness, treat mental illness anymore than first aid trains someone to diagnose hypertension or put in a breathing tube. We -- and so we really try to be aware of that. We also are very careful to suggest to first aiders that we are not training them to be super heros. We are not suggesting that they ever take over the role of first responders, unless, of course, they also have a role as a first responder.

What we're doing is giving them some tools to add to their toolkit. And if they feel safe, if they feel it's appropriate, if they feel like they're the right person in that circumstance, maybe they can use these tools to reach out and help someone who appears to be unwell or in crisis, but in no way do we require the first aiders to respond in that way.

In our course, as I mentioned, we do some deescalation training, whether it's someone who is behaving unpredictably because they're hallucinating because they may be experiencing schizophrenia or something like that or someone having a panic attack. So we talk about how you might deescalate that, but we always preface that with "if you feel safe, if it's appropriate for you to respond, we encourage you to think about using these tools."

We also when -- because we train so many different types of professional groups, we always say that in no way does Mental Health First Aid supplant your professional training, you know, whether the law is HIPAA that we're responding to or the involuntary commitment laws that affect first responders. We encourage you to always follow your professional training and your mandatory reporting requirements first. And if the tools of Mental Health First Aid can be helpful in addition to that, terrific, but in no way are we suggesting that this is the new way that you should approach every situation.

MS. BENTMAN: Thanks.

MR. JACKSON: Thank you very much for your time, Mr. Gibb. I know that you have another meeting. And we really enjoyed your presentation. And thank you for submitting so much information. We do have a lot of people who love to read. Thank you for your time, sir.

Also, thank you to April Wein for keeping your dialogue going.

MR. GIBB: Just one other thing. If anyone is interested on the Committee, my information is on your materials, but also our website, mentalhealthfirstaid.org. And there's a wealth of information on there. You can put in your ZIP code, and it will tell you where there is a Mental Health First Aid instructor or course near you based on proximity.

MR. JACKSON: Thank you very much. Very helpful. Thanks for your time.

(Hearing concluded at 11:49 a.m.)

CERTIFICATE

I hereby certify that the foregoing 97 pages are a complete and accurate transcription to the best of my ability of the electronic sound recording of the March 22, 2013 Sandy Hook Advisory Commission hearing.

_____ December 2, 2013

Kathleen A. Morin, LSR Date

Notary Expires: 3/31/18